DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 7EFL

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY A	GENCY		Facility ID: 27752	
MEDICARE/MEDICAID PROVIDE (L1) 245619 2.STATE VENDOR OR MEDICAID N (L2) 753490000		3. NAME AND AL (L3) SAINT THE (L4) 5200 OAK ((L5) BROOKLY)	CRESE AT OX GROVE PARK	BOW LAK	(L6) 55	5443	4. TYPE OF ACT 1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint	
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEG	GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA		7. On-Site Visit 9. Other 8. Full Survey After Complaint		
6. DATE OF SURVEY 1/19 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/ 2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR EN	DING DATE: (L35)	
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF 64 (L37) (L38) 16. STATE SURVEY AGENCY REMARKS	64 (L18) 64 (L17) WN 19 SNF (L39)	Compliance1. A B. Not in Comp Requirements ICF (L42)	ance With equirements e Based On: cceptable POC diance with Progra and/or Applied V IID (L43)	am Vaivers:	2. Techni	ical Personnel ur RN RN (Rural SN afety Code	The Following Require 6. Scope of 7. Medical F) 8. Patient R 9. Beds/Roo (L12) (L15)	Services Limit Director oom Size	
17. SURVEYOR SIGNATURE Gloria Derfus, Unit Super	visor	Date :	1/22/2010	6 _(L19)	18. STATE SURV Kamala Fiske-			Date: Decialist 01/22/2016	
PAI	RT II - TO BE	COMPLETED I	BY HCFA RE	I			FATE AGENCY	(120)	
DETERMINATION OF ELIGIBIL	ITY articipate	20. COM	MPLIANCE WITH		21. 1. Sta 2. Ow	tement of Finan	icial Solvency (HCFA-2 l Interest Disclosure St		
22. ORIGINAL DATE OF PARTICIPATION 07/16/2013 (L24) 25. LTC EXTENSION DATE: (L27)		S DATE	4. LTC AGREEM ENDING DA' (L25) (L44)		26. TERMINATI VOLUNTARY 01-Merger, Closur 02-Dissatisfaction 03-Risk of Involunt 04-Other Reason for	e W/ Reimburse tary Termination	05-Fail ment 06-Fail OTHER	rider Status Change	
28. TERMINATION DATE:	29	. INTERMEDIARY/	(L45) /CARRIER NO.		30. REMARKS				
	(L28)	03001		(L31)	•				
31. RO RECEIPT OF CMS-1539		. DETERMINATION	N OF APPROVAL						
	(L32)			(L33)	DETERMINA	TION APPR	ROVAL		



Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245619

January 22, 2016

Ms. Brandi Barthel, Administrator Saint Therese At Oxbow Lake 5200 Oak Grove Parkway Brooklyn Park, MN 55443

Dear Ms. Barthel:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective January 13, 2016 the above facility is certified for:

64 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 64 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Kumala Fiske Downing

Licensing and Certification Program Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697



Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered January 22, 2016

Ms. Brandi Barthel, Administrator Saint Therese At Oxbow Lake 5200 Oak Grove Parkway Brooklyn Park, MN 55443

RE: Project Number \$5619003

Dear Ms. Barthel:

On December 21, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 4, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On January 19, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 4, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 4, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 13, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 4, 2015, effective January 13, 2016 and therefore remedies outlined in our letter to you dated December 21, 2015, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumala Fiske Downing

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

POST-CERTIFICATION REVISIT REPORT

IDENTIFICATION NUMBER 245619 A. Building B. Wing 1/19/2016 NAME OF FACILITY STREET ADDRESS, CITY, STATE, ZIP CODE	TE OF REVISIT
NAME OF FACILITY	19/2016 _{Y3}
NAME OF FACILITY	
SAINT THERESE AT OXBOW LAKE 5200 OAK GROVE PARKWAY	
BROOKLYN PARK, MN 55443	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITE	М	DATE	ITEM		DATE	ITEM		DATE
Y4	••	Y5	Y4		Y5	Y4		Y5
ID Prefix Reg. # LSC	F0312 483.25(a)(3)	Correction Completed 01/13/2016	ID Prefix F	F0323 83.25(h)	Correction Completed 01/13/2016	ID Prefix Reg. # LSC	F0329 483.25(I)	Correction Completed 01/13/2016
ID Prefix	F0356 483.30(e)	Correction Completed 01/13/2016	ID Prefix F	F0428 83.60(c)	Correction Completed 01/13/2016	ID Prefix Reg. # LSC	F0431 483.60(b), (d), (e)	Correction Completed 01/13/2016
ID Prefix Reg. # LSC	F0465 483.70(h)	Correction Completed 01/13/2016	ID Prefix _ Reg. # LSC _		Correction	ID Prefix Reg. # LSC		Correction
ID Prefix Reg. # LSC		Correction	ID Prefix _ Reg. # LSC _		Correction	ID Prefix Reg. # LSC		Correction
ID Prefix Reg. # LSC		Correction	ID Prefix _ Reg. # LSC _		Correction	ID Prefix Reg. # LSC		Correction
REVIEWE STATE AC REVIEWE CMS RO FOLLOW 12/4/201	ED BY	REVIEWED BY (INITIALS) GD/kfd REVIEWED BY (INITIALS) Y COMPLETED ON		TITLE K FOR ANY UNC	RE OF SURVEYOR 18623 ORRECTED DEFICIENCIES (CMS-2567)		A SUMMARY OF	9/2016 :s □ NO

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER A Building O1 - MAIN BLOG		DATE OF REV	/ISIT
DENTIFICATION NUMBER A. Building 01 - MAIN BLDG B. Wing	Y2	1/4/2016	Y3
NAME OF FACILITY STREET ADDRESS, CITY, STATE, ZIP CODE	:		
SAINT THERESE AT OXBOW LAKE 5200 OAK GROVE PARKWAY			
BROOKLYN PARK, MN 55443			

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITE Y4		DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix		Correction	ID Prefix	Correction	on ID Prefix	Correction
Reg. #	NFPA 101	Completed	Reg. #	101 Complet	ed Reg. #	Completed
LSC	K0029	12/06/2015	LSC K0050	12/21/201	15 LSC	
ID Prefix		Correction	ID Prefix	Correction	on ID Prefix	Correction
Reg. #		Completed	Reg. #	Complet	ed Reg. #	Completed
LSC			LSC		LSC	
ID Prefix		Correction	ID Prefix	Correction	on ID Prefix	Correction
Reg. #		Completed	Reg. #	Complet	ed Reg. #	Completed
LSC			LSC		LSC	
ID Prefix		Correction	ID Prefix	Correction	on ID Prefix	Correction
Reg. #		Completed	Reg. #	Complet	ed Reg. #	Completed
LSC			LSC		LSC	
ID Prefix		Correction	ID Prefix	Correction	on ID Prefix	Correction
Reg. #		Completed	Reg. #	Complet	ed Reg. #	Completed
LSC			LSC		LSC	
REVIEWI STATE A		REVIEWED BY (INITIALS) TL/kfd	DATE 1/22/2016	SIGNATURE OF SURVEYO	PR 19251	DATE 01/04/2016
REVIEWI CMS RO		REVIEWED BY (INITIALS)	DATE	TITLE DATE		
FOLLOWUP TO SURVEY COMPLETED ON 12/2/2015				R ANY UNCORRECTED DEFI CTED DEFICIENCIES (CMS-2		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	_	-			AND TRANSMITTAL TE SURVEY AGENCY		ID: 7EFL Facility ID: 27752
1. MEDICARE/MEDICAID PROVID (L1) 245619 2.STATE VENDOR OR MEDICAID (L2) 753490000	ER NO.	3. NAME AND ADDRESS OF FACILITY (L3) SAINT THERESE AT OXBOW LAK (L4) 5200 OAK GROVE PARKWAY (L5) BROOKLYN PARK, MN				4. TYPE OF ACT 1. Initial 3. Termination 5. Validation	CION: 2 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9) 6. DATE OF SURVEY 7. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	OWNERSHIP 04/2015 (L34) (L10)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	OPPLIER CATEGO 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	ORY 09 ESRD 10 NF 11 ICF/IID 12 RHC	02 (L7) 13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	7. On-Site Visit 8. Full Survey A: FISCAL YEAR EN 06/13	
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDO	64 (L18) 64 (L17)	1. Ac	equirements Based On:	ram	And/Or Approved Waivers Or 2. Technical Personne 3. 24 Hour RN 4. 7-Day RN (Rural S 5. Life Safety Code * Code: B 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	6. Scope of	Services Limit Director oom Size
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION D	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENC	Y APPROVAL	Date:
Rebecca Wong, HFE NE	II		01/04/201	6 _(L19)	Kamala Fiske-Downing	, Enforcement Sp	<u>peciali</u> st 01/21/2016
PA	RT II - TO BE	COMPLETED F	BY HCFA RE	GIONAL	OFFICE OR SINGLE	STATE AGENCY	
19. DETERMINATION OF ELIGIBI 1. Facility is Eligible to 2. Facility is not Eligible	Participate		IPLIANCE WITH ITS ACT:	CIVIL	21. 1. Statement of Fin2. Ownership/Cont3. Both of the Abox	rol Interest Disclosure St	
22. ORIGINAL DATE OF PARTICIPATION 07/16/2013	23. LTC AGREEN BEGINNING		4. LTC AGREEM ENDING DAT		26. TERMINATION ACTION VOLUNTARY 01-Merger, Closure	<u>INVOL</u>	(L30) UNTARY to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbur		to Meet Agreement
25. LTC EXTENSION DATE: (L27)	-	VE SANCTIONS n of Admissions: uspension Date:	(L44) (L45)		03-Risk of Involuntary Terminati 04-Other Reason for Withdrawai	OTHER	vider Status Change
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
	(L28)	03001		(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE			

(L33)

DETERMINATION APPROVAL

(L32)



Electronically delivered December 21, 2015

Ms. Brandi Barthel, Administrator Saint Therese At Oxbow Lake 5200 Oak Grove Parkway Brooklyn Park, Minnesota 55443

RE: Project Number S5619003

Dear Ms. Barthel:

On December 4, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit:

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gloria Derfus, Unit Supervisor Metro C Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite #220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900

Email: Gloria.derfus@state.mn.us

Phone: (651) 201-3792 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 13, 2016, the Department of Health will impose the following remedy:

State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition

of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by March 4, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if

deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 4, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us

Email: tom.linnoff@state.mn.us

Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

PRINTED: 01/22/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245619	B. WING _		12/	04/2015	
	PROVIDER OR SUPPLIER	LAKE		STREET ADDRESS, CITY, STATE, ZIP COD 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENT	-S	F 00	00			
	as your allegation of Department's acception enrolled in ePOC, yat the bottom of the	of correction (POC) will serve from the otance. Because you are our signature is not required first page of the CMS-2567 ic submission of the POC will ion of compliance.					
F 312 SS=D	on-site revisit of you validate that substate regulations has been your verification.	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with EARE PROVIDED FOR IDENTS	F 3:	12		1/13/16	
	daily living receives	nable to carry out activities of the necessary services to tion, grooming, and personal					
	by: Based on observat review, the facility for of 3 residents (R4)	NT is not met as evidenced ions, interview and document ailed to provide grooming for 1 who was dependent for ing (ADL) reviewed for ADL.		R4 was given grooming assis facial hair on 12/3/15. Facility wide audit on groomin completed. Care plans were individualized preferences.	g was		
	seated on the whee closed. When appro- have multiple white	3 p.m. R4 was observed elchair in her room eyes bached R4 was observed to facial hairs approximately /4) on her lower chin and on		The policy and procedure on I Care Grooming was reviewed Staff will be re-educated on th 1/13/16.			
ABORATORY	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	VATURE	TITLE		(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

12/30/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES OF CORRECTION				E SURVEY IPLETED	
		245619	B. WING _		12/	04/2015
	PROVIDER OR SUPPLIER	LAKE		STREET ADDRESS, CITY, STATE, ZIP C 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			I SHOULD BE	(X5) COMPLETION DATE	
F 312	her cheeks. On 12/1/15, at 8:17 hairs bothered her them removed the for me" as she felt to when asked if the son her bath day R4 me they would." On 12/2/15, at 7:13 up and dressed. Whow she had slept If the community life signed to her. R4 was multiple facial hairs cheeks. CLS-A cue CLS-A wheeled R4 observed brush the dentures as CLS-A 7:17 a.m. CLS-A was obturned around and offered to remove to CLS-A wheeled R4 room by the bed, go dresser handed the Kleenex. At 7:21 a the room to the dinia.m. CLS-A brough offered coffee still refacial hairs. At 7:25 a approached R4 said R4's face never offe facial hairs. At 7:47 R4 provided condination never offered to remove to the condition of the dinical hairs. At 7:47 R4 provided condination of the dinical hairs. At 7:47 R4 provided condination of the dinical hairs. At 7:47 R4 provided condination of the dinical hairs. At 7:47 R4 provided condination of the dinical hairs. At 7:47 R4 provided condination of the dinical hairs. At 7:47 R4 provided condination of the dinical hairs. At 7:47 R4 provided condination of the dinical hairs. At 7:47 R4 provided condination of the dinical hairs. At 7:47 R4 provided condination of the dinical hairs.	a.m. when asked if the facial R4 stated "Yes. I would like parber used to take them off the hairs on her left cheek. Staff help me to remove them stated, "They have not told a.m. R4 was observed to be then approached and asked R4 indicated "good." R4 stated specialist (CLS)-A was really still observed still with around her mouth and d R4 to brush her teeth after close to the sink R4 was teeth and applied her was straightening the bed. At as observed wet a wash towel 4 to wash the face. At 7:18 served comb R4's hair as she looked at R4's face never the facial hair. At 7:19 a.m. out of the bathroom into the oft R4 eye glasses from the m to R4 to put them on and a m. CLS-A wheeled R4 out of the part of the dining room and the a.m. the household coordinator d "good morning" looked at the facial hairs which a.m. another staff approach thents and spoke briefly to R4 nove the facial hairs which a.m. R4 wheeled out of the	F3	Audits will be completed on residents weekly for 90 day compliance and results will the QA Committee meeting developed as needed, and the need for ongoing monitor. Clinical Director and/or des responsible for ongoing cor	s to ensure be reported to , action plans will determine oring.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPI JER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				E SURVEY IPLETED
		245619	B. WING			12/	04/2015
	PROVIDER OR SUPPLIER	LAKE		5	STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443	<u>,</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 312	DR into the hallway coordinator and and R4 and offered to ri went into R4's room converse with R4 a open at this time nefacial hairs. At 9:20 nurse (RN)-C was coare for R4 never of hairs. On 12/2/15, at 1:57 least expect the CL provide residents we required which including high ending and cheeks. On 12/3/15, at 7:57 was still observed we lips and cheeks. On 12/3/15, at 8:29 facial hairs. RN-A we hairs bothered here because I touch the remove them for here of the going to get a razor when asked what the chin hair, RN-A provided the bath so bath day was Thurs if the staff documer removed RN-A statindicated she was get a recommendation of the staff documer removed RN-A statindicated she was get a recommendation of the staff documer removed RN-A statindicated she was get R4's diagnoses included.	At 8:33 a.m. the household other staff both approached de back to room. Both staff in were observed and heard bout her life/family door wide ever offered to remove the a.m. to 9:25 a.m. registered observed completed wound ffered to remove the facial p.m. RN-C stated he would at S's who worked with him to eith assistance for all cares uded grooming, personal and eating as some residents ist with cares. a.m. when approached R4 with multiple facial hairs on her a.m. RN-A verified R4 had as overheard asked R4 if the e and R4 stated "Yes they do em." R4 asked RN-A to er and RN-A indicated she was to remove them. At 8:32 a.m. he expectation was to remove stated on bath days. RN-A chedule which indicated R4's eday evening and when asked atted if facial hair had been ed "no they don't" as she going to take care of it.		312			
	posture obtained from 12/3/15.	om Admission Record dated					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		MPLETED	
		245619	B. WING _		12/	04/2015	
	PROVIDER OR SUPPLIER	LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443	, .=-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICIENCY)) BE	(X5) COMPLETION DATE	
F 312	Continued From pa	ge 3	F 3	12			
	2/10/15, indicated re	a Assessment (CAA) dated esident required extensive oL functions at this time.					
	indicated R4 had in extensive assist wit shaving. Grooming indicated resident regrooming/hygiene r glaucoma. Goal "I v in personal hygiene The care plan directions."	num Data Set (MDS) 10/8/15, tact cognition and required h personal hygiene including care plan dated 10/9/15, equired extensive assist with elated to debility and vant to participate as I am able and remain neatly groomed." ted staff to provide extensive nember for grooming tasks, are.					
	services (DNS) stat	a.m. the director of clinical sed she expected staff to s directed by the care plan sheets.					
F 323 SS=E	2014, indicated nursus assistance with groto resident needs. 483.25(h) FREE OF		F 3:	23		1/13/16	
	environment remain as is possible; and	sure that the resident ns as free of accident hazards each resident receives on and assistance devices to					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION IG		E SURVEY PLETED
		245619	B. WING _		12/	04/2015
	PROVIDER OR SUPPLIER	LAKE		STREET ADDRESS, CITY, STATE, ZIP COI 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 323	This REQUIREMEI by: Based on observareview, the facility function for mearesidents (R71, R5 assessed to need addition, the facility were safely secure the risk of injury for R52) reviewed for a Findings include: R71, R44, R52, and in the dining room of the Rhode house 7:17 a.m. to 8:37 a observed in the dinframe. R71: On 12/3/15, R71 w was noted: - At 7:17 a.m. one reating peaches, co - At 7:27 a.m. R71 in the dining room of the dining room of the reating peaches, co - At 7:28 a.m. R71 then coughed twice juice were placed in - At 7:31 a.m. R71 - At 7:32 a.m. hous stopped by and sporant of the dining room and coffee and the reating	tion, interview and document ailed to ensure necessary als was provided for 4 of 5 2, R25, R60) who were supervision for meals. In failed to ensure bedside rails d to the bed frame to minimize 3 of 3 residents (R71, R44, accidents. d R60 were left unsupervised during continuous observation e dining room on 12/3/15, from .m. No nursing staff was ing room during that time as observed and the following resident in dining room was ffee and orange juice on table. and three other residents were eating breakfast. drank thickened coffee and a front of R71.	F 32	Orders received on R71, R60 re-evaluation of swallowing an supervision. Care plan will be and will be updated with final recommendations per SLP. Hospice referral made for R5 swallowing and meal supervision and will be reviewed an with final recommendations. R25 chart review completed, passed away 12/18/15 on hose residents with altered diets/or will be reviewed for the need supervision with meals. Care updated as needed. Dining times were adjusted to proper supervision of the diniteduring meals by nurse/design. Resident Dining Policy has be and updated to ensure supervisident safety that require are and feeding assistance. Education will be completed to Random audits will be completed to results will be compliance and results will be the QA Committee meeting, and developed as needed, and withe need for ongoing monitorin Director and/or designee will be completed and results will be the need for ongoing monitoring Director and/or designee will be completed and results will be	and need for a reviewed and need for a reviewed and resident apice care. Consistencies of a plan will be a ensure and room ee. Seen reviewed vision for a latered diet and altered diet apice ereported to action plans all determine and. Clinical	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245619	B. WING			12/0	04/2015
	PROVIDER OR SUPPLIER HERESE AT OXBOW	LAKE		52	TREET ADDRESS, CITY, STATE, ZIP CODE 200 OAK GROVE PARKWAY ROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	- At 7:57 a.m. staff dining room and lef were in the dining r food in front of ther - At 7:59 a.m. R71 started coughing habouts at that time At 8:05 a.m. licens moved the medicat room, - At 8:14 a.m. LPN-entered the dining remained in dining the dining room eat HC-A sat down nex - At 8:28 a.m. direct was overheard spetabout the reason the assistants, HC-E st watch the dining room - At 8:30 a.m. HC-E then no nursing state room At 8:37 a.m. R71 thickened juice. R71's annual Minim 8/28/15, indicated frimpaired, requiring daily living (ADLs) iteating. R71's diagnobstructive pulmon	brought three residents to the timmediately. Eight residents oom with beverages and or in. was eating oatmeal and ard. R71 had two coughing sed practical nurse (LPN)-B ion cart outside the dining. B left the dining area HC-E room. No nursing staff room. Eight residents were in ting breakfast or drinking. It to a resident. It or of clinical services (DCS) aking to HC-E. DCS asked here were no nursing rated "[LPN-B] asked me to om." E had left the dining room and ff was present in the dining coughed after drinking num Data Set (MDS) dated R71 was severely cognitively assistance with all activities of including supervision with oses included chronic ary disease (COPD) Heart inxiety, dementia and	F3	23	responsible for ongoing compliance R52, R71, and R44(R48 is not in the resident sample) side rails were into by the bed manufacturing company technician on 12/8/15. Repairs that needed were completed. New side were ordered for R52, R71, and R4 will be replaced upon arrival. A preventative maintenance procedure/checklist for the electric including side rails has been added will be completed on all beds. The Positioning Device: Positioning Rails/Bed Transfer Bars/Sheppard policy was reviewed. Staff will be educated on functionathe side rails and when to report saconcerns by 1/13/16. Maintenance will be educated on preventative maintenance procedure and function of the side rails by 1/13/16. Audits will be completed on 10% of weekly for 90 days to ensure compand results will be reported to the Committee meeting, action plans developed as needed, and will detet the need for ongoing monitoring.	beds dand Hooks Hooks beds dand beds dand beds dand contains dand contains dand beds dand contains dan	
	8/28/15, indicated F Concentrated Swee	Assessment (CAA) dated R71 was receiving a No et diet NDD2 diet (a ed dysphagia diet) with nectar			Operations Director and/or designed be responsible for ongoing compliant to the composition of the compositi		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245619	B. WING			12/	04/2015
	PROVIDER OR SUPPLIER HERESE AT OXBOW	LAKE		5	STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 323	thickened liquids be The Speech Theral Treatment dated 1/ high risk of choking During interview on practitioner (NP) st choking because o it was expected R7 eating in the dining During interview on member (F)-A state January 2015 with infection (UTI) and expect him to be su	pecause of dysphagia. Dy Evaluation and Plan of 13/15, indicated R71 was at a and aspiration pneumonia. Description of 12/3/15, at 1:26 p.m. nurse ated R71 would be at risk for f dementia. The NP confirmed 1 would be supervised when	F3	323			
	observed and the formal observed and the formal observed and the formal observed and the formal observed and formal observed a	entered the dining room.					

Facility ID: 27752

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		245619	B. WING _		12	/04/2015	
	PROVIDER OR SUPPLIER HERESE AT OXBOW	LAKE		STREET ADDRESS, CITY, STATE, ZIP C 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 323	assistants, HC-E st watch the dining ro - At 8:30 a.m. HC-E coughed four times were no nursing sta - At 8:31 a.m. R52 after drinking coffer room. R52's admission MR52 was cognitively assistance with AD admission MDS incompleted assist with Parkinson's. R52's care card da required assistance	ason there were no nursing tated "[LPN-B] asked me to om." Eleft the dining room and R52 after drinking coffee. There aff in the dining room. coughed three more times e. No nursing staff in dining DS dated 9/12/15, indicated y intact and required Ls. R52's diagnoses on clude Parkinson's and arthritis. AA dated 9/16/15, noted R52 eating at times related to	F 32	23			
		2 p.m. HC-E was observed bites of turkey. No coughing					
	a.m. to 8:23 a.m. n - At 8:12 a.m. regis encouraged R25 to oatmeal. - At 8:15 a.m. RN-A - At 8:16 a.m. R25 RN-A asked "are yo today?	uous observation from 8:12 oted the following: tered nurse (RN)-A use a spoon, not a fork for A sat down and fed R25. coughed after eating oatmeal ou having trouble swallowing ate a spoonful of oatmeal and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		245619	B. WING _	····	12/	04/2015	
	PROVIDER OR SUPPLIER HERESE AT OXBOW	LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 323	- At 8:19 a.m. R25 thin water At 8:19 a.m. RN-A-At 8:20 a.m. RN-A-thickened apple juid At 8:23 a.m. R25 at coughed. RN-A heatemp taken and list On 12/3/15, R25 waroom and was conta.m. to 8:37 a.m At 7:17 a.m. one reaches, coffee an - At 8:33 a.m. the corought R25 to the thickened water and R25 quarterly MDS was severely cogniassistance with AD quarterly MDS indiccoughing or chokin During an interview stated we are fully residents normally nursing staff being the staff are unavait to monitor the dinin time that the might RN-A said that ther are on a regular die Someone should havith R71 and R25 said, "My expectation."	coughed twice after drinking A went out to kitchen A offered sip of nectar ce, no coughing heard. The abite of oatmeal and then ard to say to LPN-B "I want a ren to lungs, update hospice." The as in the Rhode House dining inuously observed from 7:17 The esident in dining room eating dorange juice on table. Ilinical life specialist (CLS)-E dining room brought R25 do juice, then left. The cated 9/25/15, indicated R25 tively impaired and required List including eating. The cated R25 experienced go during meals or medications. The cated R25 experienced go during meals or medications.	F 32	3			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG		E SURVEY MPLETED
		245619	B. WING		12/	/04/2015
	PROVIDER OR SUPPLIER HERESE AT OXBOW	LAKE		STREET ADDRESS, CITY, STATE, ZIP CO 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	aide-Ā said, "If I heathey are ok. I will girinse it down. I will gir sounds like choki today. I did not cheatrying to get everyo During interview on asked how do you HC-A replied, "I thir that decision based NDD3 is at risk. I retell me no one has would to do if heard replied, "Make sure soon as possible or there I did not hear remember hearing remember [R71] coaround and did an adining room for breathrough the dining rand supper sometiment on dining rooms or During interview on said all of the dietar Heimlich maneuver if anyone required ewould help them. "I nursing staff memb Dietary staff are no risks involved with experience in the said and the said and the said all of the dietar heimlich maneuver if anyone required ewould help them. "I nursing staff memb Dietary staff are no risks involved with experience in the said and the sai	12/3/15, at 11:59 a.m. dietary ar someone coughing I ask if we them some water to try to go get the nurse if it is bad or if ng. I heard [R71] coughing ck on him, I was pretty busy ne food." 12/3/15, at 12:50 p.m. when know a resident's choking risk, nk you should be able to make I on their diets; NDD2 and ead the cards, no one needs to told me." When asked what he I a resident coughing, HC-A they are ok, get the nurse as get [RN-A]. While I was in any one coughing. I cannot [R52] coughing. I do oughing this morning I turned assessment. I supervise the akfast most days, I pass from at lunch 80 % of time ne. I have not had any training feeding since starting here." 12/3/15, at 10:09 a.m. DCS by staff are trained to do the coughing assistance nursing staff would expect a CLS or other er to be in the dining room." It trained to observe for other eating.	F 3	23		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245619	B. WING			12/	04/2015	
	PROVIDER OR SUPPLIER HERESE AT OXBOW	LAKE		520	REET ADDRESS, CITY, STATE, ZIP CODE 00 OAK GROVE PARKWAY BOOKLYN PARK, MN 55443			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 323	On 12/3/15, at 1:16 bring residents to the liquids and tell kitch stay in the dining roup. I brought (R25)	ge 10 p.m. CLS-E said, "When we he dining room we give them hen they are here. We do not som until all the residents are to the dining room this kened liquids and let the	F3	23				
	R60 was observed on 12/2/15, at 7:40 a.m. to 7:59 a.m. during breakfast, several residents were observed in the dining room. The dietary aide was observed serve out beverages, bananas and breakfast plate. During that time noted staff come in and out of the dining room and residents were alone in the dining room except when dietary aide brought the food from the kitchenette and would retrieve back briefly leaving the residents who were eating unsupervised. -At 7:59 a.m. R60 was observed resident coughing after taking the last bite of eggs, then sneezed three times, then was able to cough some more and spit the eggs out of mouth into a napkin and some fell on the clothing protector. Resident then continued to take a bite of the toast. No facility staff were in the dining room at the time of the observation. -At 8:02 a.m. dietary aide came out of the kitchenette and stood at the far table.							
	indicated resident h tolerate a regular te plan directed staff " annual MDS dated required supervisio	nutrition dated 7/3/15, nistory of dysphagia, but exture diet currently. The care Assist me with eating." R60's 9/25/15, indicated resident n with eating after set up.						
		ssessment dated 9/26/15, vas on a regular diet, had no						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG	-	(X3) DATE SURVEY COMPLETED		
		245619	B. WING		_	12/0	04/2015
	PROVIDER OR SUPPLIER HERESE AT OXBOW	LAKE		STREET ADDRESS, CITY, ST. 5200 OAK GROVE PARKW BROOKLYN PARK, MN	'AY		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		BE	(X5) COMPLETION DATE
F 323	chewing/swallowing dysphagia, but tole: The assessment al affected nutrition/hy of dysphagia and ir eating." On 12/3/15, at 12:2 plan should read shand if she was tired. When asked if a stain the dining room was room when residen R60 was safe to ea RN-A stated "I say able to do it fine. The At 12:37 p.m. RN-indicated R60 did not the listed active dia recent progress not the speech therapy dated 12/2/14, had for aspiration pneur required close supe When asked what I staff during meals is supposed to be suphad dysphagia. RN R60 had a diagnos being listed even of On 12/3/15, at 1:27 stated staff was suproom during meal thall other residents is would have deferred.	ge 11 g concerns, had history of rated a regular textured diet. so indicated factors that redration status included history dicated "Needs assist with dicated "The care he is variable from day to day a staff will provide assistance." aff person was supposed to be when residents were being he were eating RN-A stated of omeone around the dining its are eating." When asked if the by herself in the dining room of she is awake and fine she is nere has not been any issues." A reviewed R60's chart of have dysphagia as one of gnoses in the physician most are dated 11/1/15. RN-A verified evaluation and treatment plan indicated R60 was at high risk monia and/or chocking and ervision with oral intakes. Her expectation was of her RN-A stated resident was bervised during meals if R60 and her current physician orders. The provide the NP oposed to be in the dining me to supervise residents and the thought. NP indicated she do to the recommendations dindicated to provide	F3	23			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245619	B. WING _	·····	12	/04/2015	
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F 323	supervision with me aspiration pneumous the family had decl consistency recome R60 had a diagnos not been notified of Resident Dining podirected staff: "I. The nurse is result 1 nursing staff menthe dining room uncompleted. A. Nurse monitors safety issues, and dignity of residents food intake, and reattention. The nurs residents as needed.	eals as resident was at risk for nia and choking Even though ined to follow with diet mendation. NP further verified is of dysphagia however had f any concerns with coughing. Dicy dated November 2012, sponsible to designate at least mber to be physically present in til the meal had been for adequate assistance, infection control practices, proper positioning, adequate sident behaviors needing the assists with feeding ed"	F 32	3			
	a.m. The right trans was noted to be loce either way when the R52's diagnoses in bimalleolar fracture Parkinson's, difficu obtained from Adm R52's fall CAA date is a potential risk for	oserved on 12/1/15, at 7:35 sfer bar attached to the bed ose and gave way two inches e rail was tested. Included non-displaced e, muscle weakness, lty walking and osteoarthritis hission Record dated 12/3/15. Included 12/3/15, indicated "resident or falls while in this facility history of falls in the past 0-30					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245619	B. WING _		12	/04/2015
	PROVIDER OR SUPPLIER HERESE AT OXBOW	LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	Bimalleolar fracture places him at high medication and hist Parkinson's disease R52's Positioning D 10/11/15, indicated bed to aid with repeasessment did not checked to make sthe bed frame. R52's 14 day schedindicated R52 requiof one to two staff vrespectively. Care pR52 needed help to mobility, degenerat had functional strerindicated R52 used bed mobility. R52's Fall Risk Assindicated resident history, had decrear equired hands on a to place. R71's room was oba.m. and the left rai bed with approximate R71's annual MDS	t on his right foot due to a e." "Fall risk assessment risk for falls related to tory of falls and a diagnosis of e." Device Evaluation dated resident had transfer bars in ositioning and mobility. The trindicate the device had been ture it was properly affixed to duled MDS dated 10/21/15, irred extensive physical assist with bed mobility and transfers olan dated 11/14/15, indicated to move in bed due to limited in itransfer bars to assist with transfer bars to assist with the essment dated 12/1/15, and a high fall risk, had a fall sed muscle coordination and assistance to move from place asserved on 12/01/15, at 8:45. If was noted to be loose on the ately 15 degrees of flexibility. dated 8/28/15, indicated R71's COPD, Heart failure,	F 32	3		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245619	B. WING _		1:	2/04/2015
	PROVIDER OR SUPPLIER	LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	needed assistance back pain and decr reposition myself si bars." The care plat bars to aide with be R71's Fall CAA dath had the potential ris for falls, required extransfers, was non-had a diagnosis of R71's Visual Bedsid 10/5/15, indicated rwith bed mobility. R71's Positioning E 11/20/15, indicated however did not indicated and did not indicated	red 6/17/15, indicated R71 to move in bed due to chronic eased mobility, "I am able to de to side in bed with transfer in indicated R71 used transfers ed mobility. ed 8/28/15, indicated resident sk for falls, was at a high risk stensive assist of two for ambulatory at that time and	F 3:	23		
	supervisor (POS) a R71's rooms, POS into the grove to pro when asked how th to the bed frame. P with the manufactu tightened. When as checked the transfe stated, "They have maintenance excep them. I have never and now will have t them apart I would	p.m. the plant operations nd surveyor went to R52's and stated "it's a clip that snaps event it from snapping out" e transfer bars were mounted OS indicated he would check rer how the bedrails would be sked how often and who er bars for proper fit POS not been checked by it nursing would as they use gotten any reports about this to look at them. Without taking not know until I take one or at the wear and tear on the				

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY MPLETED
		245619	B. WING			12/	/04/2015
	PROVIDER OR SUPPLIER HERESE AT OXBOW	LAKE		Ę	STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	beds as they have I years." POS verifier in R52's and R71's room on the same which were observed bed frame. On 12/1/15, at 3:32 and R71 used the tassisted with cares from side to side. We concerns were reposeing loose, CLS-Bupdated and would transfer bars. On 12/2/15, at 1:37 acknowledged the touching them indicated the touching them indicated the touching them indicated the was a pin that thought was suppoparts would not be on 12/2/15, at 2:02 asked what her expreport loose transfers should report loose and nurse should pwould call. It's a saftigher up on the list would not let it sit. I maintenance, along maintenance slip in a system of checking which was supposed to the saftigher up on the list would not let it sit. I maintenance slip in a system of checking which was supposed to the saftigher up on the list would not let it sit.	deen used for the last four dethe transfer bars were loose beds after going into another floor with the transfer bars ed to be firm and affixed to the p.m. CLS-B indicated R52 ransfer bars when being which included turning around when asked who maintenance orted to regarding transfer bars stated maintenance would be then come and fix the loose after transfer bars were loose after transfer bars to supervisor ut a maintenance director (MD) are bars, DNS stated "staff transfer bars to supervisor ut a maintenance slip in, and fety concern, it would be to for maintenance to do. We with the process of putting a time with the process of putting a time." When asked if nursing had and to make sure transfer bars		323			
	preventative mainted DNS also stated the if resident could no	tion, DNS stated that would be enance for maintenance to do. e CLS's would let nurses know t use rails, then they would be acknowledged maintenance					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		ATE SURVEY DMPLETED
		245619	B. WING _		1:	2/04/2015
	PROVIDER OR SUPPLIER HERESE AT OXBOW	LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	should have an ontransfer bars. Positioning Device: Transfer Bars/Shep March 2013, indicadevice may be used promote resident in however did not inceach time to make who was responsib. Service Manual Hill Manual Product Nour Inspection: Do a pure all bed function the safety features not limited to these. Connectors who together; tightened. Siderail latching. Caster braking Even though the more features to be checked for the had been purchase. On 12/2/15, at 7:21 bed. At 8:52 a.m. For the had been purchase. On 12/3/15, at 7:49 providing cares for rolled over to her right. Face sheet diagnost.	Positioning Rails/Bed pard Hooks policy dated ted bed/wheelchair positioning do to aid in mobility and dependence. The policy licate if device was checked sure it was properly fitting and le for doing it. -Rom® 100 Low Bed Service .P3930 147731 Rev 1 directed eriodic inspection to make as operate correctly, especially Safety features include, but the ere the bed sections bolt as necessary genechanism systems anual outline the above ked periodically the beds had or four years within which they do and used. a.m. R48 was sleeping in late was seated at the ting for her meal. p.m. R48 stated she used her		23		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	RIPLE CONSTRUCTION NG	(X	COMPL	
		245619	B. WING			12/04	4/2015
	PROVIDER OR SUPPLIER	LAKE		STREET ADDRESS, CITY, STATE, ZIP COD 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443)E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	_	(X5) COMPLETION DATE
F 323	cognitively intact, remobility, was extensional toileting, and require assist with dressing. The CAA dated 8/14 impaired balance discussions with balance discussions with bed mobility for falls due to land diagnosis of lurneeded help to move mobility, fracture, paimpairment. R48 was grab bar and assist R48 used transfer bar was just as loose, and 12/2/15, at 10:0 transfer bars and st loose. She further sused them, they she call maintenance for On 12/2/15, at 10:1 bars were a little loc could not be tighter to be replaced. She spatial mattress to passist with dressing to little loc could not be spatial mattress to passist with dressing to little loc could not be spatial mattress to passist with dressing to little loc could not be spatial mattress to passist with dressing to little loc could not be spatial mattress to passist with dressing to little loc could not be spatial mattress to passist with dressing to little loc could not be spatial mattress to passist with dressing to little loc could not be spatial mattress to passist with dressing to little loc could not be spatial mattress to passist with dressing to little loc could not be spatial mattress to passist with dressing to little loc could not be spatial mattress to passist with dressing to little loc could not be spatial mattress to passist with dressing to little loc could not be spatial mattress to passist with dressing to little loc could not be spatial mattress to passist with dressing to little loc could not be spatial mattress to passist with dressing to little loc could not be spatial mattress to passist with dressing to little loc could not be spatial mattress to passist with dressing to little loc could not be spatial mattress to passist with dressing to little loc could not be spatial mattress to passist with dressing to little loc could not be spatial mattress to passist with dressing to little loc could not be spatial mattress to passist with dressing to little loc could not be spatial mattress to passist with dressing to little loc could no	5/15, indicated resident was equired transfers with bed sive two person assist with ed extensive one person and personal hygiene. 4/15, indicated R48 had uring transitions. 12/3/15, visual/bedside ated R48 used transfer bars to bility and needed assist of two indicated R48 was at history of falls with fracture inbago. It indicated R48 was at history of falls with fracture inbago. It indicated R48 was at history of falls with fracture inbago. It indicated R48 was at history of falls with fracture inbago. It further indicated has able to assist with use of of one. It further indicated hars to assist with bed mobility. a.m. CLS-D stated R48's left as loose, the other transfer bar and R48 could transfer herself. O a.m. LPN-B observed ated both transfer bars were stated it did not matter if R48 bould be fixed and she would repair. 3 a.m. RN-A stated transfer ose, they had a pin in them, and and would probably have further indicated R48 had a prevent arms from getting bars for transfers, and felt	F 3.	23			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	COMPLETED	
		245619	B. WING		12/	04/2015
NAME OF PROVIDER OR SUPPLIER SAINT THERESE AT OXBOW LAKE				STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	On 12/2/15, at 2:02 should report loose supervisor, the nurs and calls. She furth concern and would maintenance work. included a call to m process of entering stated the system for would be preventationally inform nurses if a rebars and they would indicated maintenant transfer bar equipm. Fall protocol assessindicated "II. Planni will be reviewed and established to preventationally indicated maintenant transfer bar equipm." Positioning Device: bars/shepherd hool "residents and familidecision to utilize si	p.m. LPN-B stated loose a safety concern. p.m. DCS stated CLS's transfer bars to their se enters a maintenance slip er stated it was a safety be higher up on the list for They would not let it sit. That aintenance, along with the a maintenance slip. DCS or checking transfer bars ive maintenance. CLS's would esident could not use transfer d be re-assessed. She noce should have an on-going	F 3.	23		
F 329	function. I. resident bed positioning dev verbal education pr positioning device e education of reside device use."	s that would benefit from a rice will be assessed and ovided as needed. B. evaluation may include and the risk/benefits of EGIMEN IS FREE FROM	F 3.	29		1/13/16

		IDENTIFICATION NUMBER.		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245619	B. WING		12/0	04/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 329 SS=D	unnecessary drugs drug when used in duplicate therapy); without adequate n indications for its u adverse consequel should be reduced combinations of the Based on a compreresident, the facility who have not used given these drugs expected and expected and expected grad behavioral interventions.	DRUGS ag regimen must be free from a. An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of nces which indicate the dose or discontinued; or any	F3	329			
	by: Based on interview facility failed to ensindications for the cantipsychotic drug illness), including rebehaviors related to disorder in which the impaired that contains and the contains and	NT is not met as evidenced v and document review, the sure 1 of 5 residents (R25) had use of Seroquel (an used to treat various mental esident specific target o psychosis (a severe mental nought and emotions are so act is lost with external reality), release (an antidepressant)		Behavior and Psychologic Dementia and Psychotrop and Monitoring Policy was revised. All nursing staff were re-ec policy by 1/13/16. R25 chart was reviewed, r	ic Medications reviewed and ducated on the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245619	B. WING _		12/	04/2015	
	PROVIDER OR SUPPLIER HERESE AT OXBOW	LAKE	STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CEACH CORRECTIVE ACTION OF CEACH CORRECTIVE ACTION OF CEACH CORRECTION OF CEACH CORRECT	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 329	and for Trazodone medication) used for Findings include: R25's Social Service 6/10/15, 6/16/	(an antidepressant or sleep. See Review Forms dated /30/15, indicated no behaviors. iew Form dated 9/25/15, noted to be very restless and at of wheelchair on multiple is also noted to be aggressive attempting to provide cares on sions. See Care Area Assessment ated adverse side effect of hibited by R25 were anxiety adverse side effect of bited by R25 were lethargy, irium. The adverse side effect anxiety) exhibited by R25 disturbances of gait, delirium and the following was noted: oquel on 8/17/15. A review of es indicated R25 fell on an and had no injury, 8/28/15, skin tears to left elbow, 9/7/15, skin tear to right forearm, an with no injury, and on	F 3:	away 12/18/15 on hosp An audit was completed whom have psychotropiand comprehensively accompliance. Ongoing audits will be of Clinical Director/design compliance for 10% of ongoing per RAI schedube reported quarterly at	d on all residents ic meds ordered ssessed to ensure completed by the ee to ensure the facility and ule. Findings will		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245619	B. WING		12	/04/2015
			STREET ADDRESS, CITY, STATE, 2 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 554	ZIP CODE		
PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 329	pulmonary disease addition, the quarter not experiencing his behaviors. R25's care plan pri BEHAVIOR: "I have statements and atthave a history of bestaff and strike out history of expression refusing meals. I his psychology and my currently. I take tradepression and hesleep and appetite restless/agitated/cotake Seroquel to minterventions including medication per MD practitioner] order, from Trazodone, Shours of sleep ever environment at night MOOD: "My diagnor insomnia places midepression and an altered mood. At risoutlook and experie episodes of delusical altered mental stat staff will offer TLC reassurance, and to behind my symptor light box in my room and shuts off at night of family for reassurance.	erly MDS indicated R25 was allucinations, delusions or any onted 10/7/15, instructed staff: e a history of making suicidal empting to harm myself. I also eing verbally aggressive with at them physically. I have a cons of sadness, isolation, and ave been evaluated by a behaviors are managed zodone to manage my lp increase my hours of restful. I have become more combative with cares and now lanage my symptoms. I have been evaluated by lp increase my hours of restful. I have become more combative with cares and now lanage my symptoms. I have been evaluated by lp increase my hours of restful with cares and now lanage my symptoms. I have been evaluated by led administer psychotropic land loctor/nurse monitor for adverse effects eroquel and Cymbalta. Monitor ry shift. Provide dark, quiet	F3	329		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
		245619	B. WING		· · · · · · · · · · · · · · · · · · ·	12	/04/2015
	PROVIDER OR SUPPLIER HERESE AT OXBOW	LAKE		5	STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	quiet environment a Social service to vis questions/concerns socialization and old depression/anxiety. The Physician Orde indicated R25 was milligrams (mg) one mg two times a day delusions. R25 coumg every six hours agitation. The Physindicated R25 was release capsule 60 and Trazodone 25 Behavior symptoms A review of Medica (MAR) Sheets and Sheets from Septemoted the following September 2015 MAR-Seroquel 25 in needed (prn) for ag September 2015. Fadministration, behwere charted only tinterventions attern administration were Progress Notes wh 2015 going forward	at night and close his door. Sit 1:1 prn to assist with S, encourage activity, offer Diserve for symptoms of The Summary signed 11/17/15, To receive Seroquel 25 The time a day and Seroquel 50 The for anxiety, agitation and The did also receive Seroquel 25 The as needed (PRN) for The sician Order Summary also To receive duloxetine delayed The major of the sician order of the sician o	F3	329			
	movements: indica get up/down (the T where the resident	for Seroquel: Frequent ted R25 had 17 attempts to BF lacked information as to would get/down from) and six st. R25 experienced					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245619	B. WING _	·····	12	2/04/2015	
NAME OF PROVIDER OR SUPPLIER SAINT THERESE AT OXBOW LAKE				STREET ADDRESS, CITY, STATE, ZIP COI 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 329	There was a check indicated a side eff the side effect was would be necessar signs were not exp and did not match TBF lacked specific medication. October 2015 MAR-Seroquel 25 was given 13 times Seroquel administr medication were classification were classification were classificated to medication admonce in the progress TBF-dated Sep-15 up/down) indicated delusions and did resultation was given 2015 MAR-Seroquel 25 for agitation was given 2015. Prior to PRN behaviors warrantic charted. Nonpharmattempted prior to not charted in the FTBF-dated Novem Frequent movement indicated R25 had delusions/hallucina	e effects on five of 30 days. It mark in the box which ect, but it was unknown what and if medical intervention y. The check marks and plusulained in the progress notes, the administration times. The cotarget for the antipsychotic mg q 6 hours prn for agitation in October 2015. Prior to PRN ration, behaviors warranting narted only once and all interventions attempted prior inistration were charted only as notes or medication record. If or October: Agitation (getting I R25 had nine attempts and last indicated R25 had nine not experience side effects. Imag q 6 hours as needed (prn) wen three times in November I Seroquel administration, and medication were not nacological interventions medication administration were Progress Notes or MAR. Iber 2015 for Seroquel: hts, attempting to get up/down	F 32				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245619	B. WING		12	/04/2015
	PROVIDER OR SUPPLIER	LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 329	information dated Nachizophrenia and for use. It also indicated proved for the tradementia related produced, "Patients of orthostatic hypotheeling dizzy or lighth may lead to falls), similated dose titration re-initiating treatmed. Non pharmacologic care plan printed 1 offer TLC [tender lease plan printed 1 offer plan printed 1 off	h package insert and label May 2, 2013, for Seroquel lists Bipolar Disorder as indication cates "Seroquel is not eatment of patients with sychosis." Package insert also should be advised of the risk tension (symptoms include theaded upon standing, which especially during the period of and also at times of ent or increases in dose." Cal interventions identified on 0/7/15, indicated all staff will bying care], reassurance, and reasons behind my symptoms I have a light box in my room morning and shuts off at night. The cook to family for open shades and turn light on Provide a dark, quiet and close his door. Social	F 329			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

AND BLANCE CORRECTION IDENTIFICATION NUMBER		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		245619	B. WING _	·····	12	/04/2015
	PROVIDER OR SUPPLIER HERESE AT OXBOW	LAKE		STREET ADDRESS, CITY, STATE, ZIP CO 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 329	delayed release: ar did not have any or four times. R25 did effects. Eli Lilly and Compadated June 2015, folists major depress disorder, Diabetic pribromyalgia, Chrothe indication for us listed as an indication steep: TBF- dated Sep-15 antidepressant): ina had trouble four evide effects. TBF-dated October to sleep indicated Fredusals of cares to side effects once. TBF-dated Novembinability to sleep indicated Fredusals of cares to side effects once. TBF-dated Novembinability to sleep indicated Fredusals of cares to side effects once. TBF-dated Novembinability to sleep indicated Fredusals of cares to side effects once. TBF-dated Novembinability to sleep indicated Fredusals of cares to side effects once. TBF-dated Novembinability to sleep indicated problems and described in the side of the	der 2015, for duloxetine agry outbursts indicated R25 atbursts and had restlessness not experience any side my prescribing information or duloxetine delayed release ion, generalized anxiety peripheral neuropathic pain, nic musculoskeletal pain as sage. Angry outbursts was not on for use of Cymbalta. for Remeron (an ability to sleep indicated R25 enings and did not experience re-2015, for Trazodone: inability R25 had trouble one day shift, wo times. R25 experienced over 2015, for Trazodone: dicated R25 did not have any 25 did not experience any id not experience side effects. euticals USA Remeron label information dated sts major depression as the	F 32			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		TE SURVEY MPLETED
		245619	B. WING _		12	/04/2015
	PROVIDER OR SUPPLIER	LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 329	Even though the fabehaviors for the p target behaviors for each In addition, the meadministration lack interventions and n for the use of the p During interview or life specialist (CLS) down the behaviors physical, might try my room. When do try to explain what work, we would foll likely leave him and On 12/0/15 at 2:45 stated, "We monito watch how they rearesidents and daily effects, physical ch practitioner as neceffects every day. I blood pressures or the behavior book, nurses." On 12/04/15, at 7:4 (LPN)-C stated, "If showing hallucinati would give him a predirecting before r times. We chart who	cility had identified target sychotropic medications, the cked appropriate specific of the psychotropic categories.	F 32	9		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

AND DIANIOE CODDECTION IDENTIFICATION NUMBER		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		245619	B. WING _		12	2/04/2015
	PROVIDER OR SUPPLIER HERESE AT OXBOW	LAKE		STREET ADDRESS, CITY, STATE, ZIP OF STATE, Z		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 329	asked if R25's behastarting on the med really, he is about to the converse with you. Think he is status quantipsychotics "We Medication Quarter analysis that shows don't see anything for use of PRNs or effectiveness. I wo something to show	dication to give it." When avior had improved since lication LPN-C stated, "No, not he same." 5 a.m. the house coordinator-A tys been pretty quiet, will Some days he is more tired. I uo." 2 a.m. RN-E stated for use the Psychotropic ly Review. I don't see any if this medication is working. I in the progress notes either, analysis quarterly of ald think yes we should have that the medication is effective usage on admission, annual		29		
	services (DCS) state chart the reason for electronic medication to complete the assessments to effectiveness of the need for continued. Psychotropic Medical January 2013 instruction and medical have an approved informed consent patherapeutic goal and the dose possible only.	is a.m. the director of clinical ted, "I would expect them to r administering a PRN in the on record. I would expect them sessments and I would expect to contain analysis of the emedication side effects and use." cations and Monitoring dated use." cations and Monitoring dated use. I diagnosis, reason for use, orior to initiation of medication, and symptoms monitored. The dispersion of the lowest after non pharmaceutical attrol/alter the behavior have				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		245619	B. WING		12/	04/2015	
	PROVIDER OR SUPPLIER HERESE AT OXBOW	LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443	·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ILD BE	(X5) COMPLETION DATE	
F 356 SS=C	residents that have the primary purpose behavior, and/or sle B. "Behaviors must the drug ordered. A need further explici V. Side effect mon residents with psyc Orthostatic hypoter and document on Trecord). 483.30(e) POSTED INFORMATION The facility must por a daily basis: o Facility name. o The current date. o The total number by the following cat unlicensed nursing resident care per slength or Registered nucle and processional nurses (and the control of the facility must pospecified above on of each shift. Data o Clear and readab	r monitoring will be initiated for orders for any medication with a to change or alter a seep pattern." be specific and appropriate to gitation, anxiety, abusive etc. to behaviors identified." itoring will be completed for all hotropic medication orders. Itsion will be assessed monthly fAR (Treatment administration of NURSE STAFFING) That is the following information on and the actual hours worked egories of licensed and staff directly responsible for nift: The itside is the staff in the staff	F 3			1/13/16	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		` '	SURVEY PLETED
		245619	B. WING		_	12/0	04/2015
	PROVIDER OR SUPPLIER HERESE AT OXBOW	LAKE		STREET ADDRESS, CITY, STATE 5200 OAK GROVE PARKWA BROOKLYN PARK, MN 5	ΛY		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		BE	(X5) COMPLETION DATE
F 356	The facility must, up make nurse staffing for review at a cost standard. The facility must make staffing data for a norequired by State later and the staffing data for a norequired by State later and the staffing data for a norequired by State later and the staffing data for a norequired by State later and the staffing staff poster and the survey were located inside the counter. Upon the daily staff poster a clear plastic protein binder instead. At 11:49 a.m. staffing the staff poster and on the was supposed when she got in the Friday and on the was supposed when she got in the Friday and on the was supposed when she got in the Friday and on the was supposed when she got in the Friday and on the was supposed when she got in the Friday and on the was supposed when she got in the Friday and on the was supposed when she got in the Friday and on the was supposed when she got in the Friday and on the was supposed when staffing the staffing of the	con oral or written request, a data available to the public not to exceed the community a data available to the public not to exceed the community a data available to the public not to exceed the community a data available to ensure daily nurse not make the number of the standard of th	F 3	Posting of Nursing Freviewed and update Staffing coordinator a will be educated on the standard and the stan	ed. and Licensed S he policy by 1/ e completed we compliance. d at the QA action plans d, and determinitoring.	Staff 13/16. veekly ne the	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION		E SURVEY PLETED
		245619	B. WING	 	12/0	04/2015
	PROVIDER OR SUPPLIER	LAKE	5	TREET ADDRESS, CITY, STATE, ZIP CODE 200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428 SS=D	staff posting for the Administrator acknown daily staff posting for the previous days the previous days the previous day sheet office." The policy of the posting was responsible for the posting was accurrent day." 483.60(c) DRUG RIRREGULAR, ACT The drug regimen of the posting was accurrent day." The drug regimen of the posting was accurrent day." The drug regimen of the posting was accurrent day." The drug regimen of the posting was accurrent day." The drug regimen of the posting was accurrent day." The drug regimen of the posting was accurrent day." The drug regimen of the posting was accurrent day." The drug regimen of the posting was accurrent day.	current date/day. Developed even though the public and residents would and policy dated April dated rected staff to "3. Remove for that shift and file in staffing lid not however indicate who removing and making sure curate and reflected the EGIMEN REVIEW, REPORT	F 356			1/13/16
	by: Based on interview pharmacist failed to had indications for antipsychotic drug uillness), including rebehaviors related to disorder in which the	NT is not met as evidenced and document review, the ensure 1 of 5 residents (R25) the use of Seroquel (an used to treat various mental esident specific target o psychosis (a severe mental ought and emotions are so ct is lost with external reality),		Clinical Director reviewed facility p with Pharmacy Consultant to ensur residents have individualized consu- completed per guidelines. Behavior and Psychological Sympton Dementia and Psychotropic Medica and Monitoring Policy was reviewed	e all ults oms of ations	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	` '	SURVEY PLETED
		245619	B. WING			12/0	04/2015
	PROVIDER OR SUPPLIER HERESE AT OXBOW	LAKE		52	TREET ADDRESS, CITY, STATE, ZIP CODE 200 OAK GROVE PARKWAY ROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	and for Trazodone medication) used for failed to respond to recommendations of the failed to respond to recommendations of the failed to respond to recommendations of the failed to recommendations o	release (an antidepressant) (an antidepressant or sleep. In addition, the facility ensure consultant pharmacist were acted upon for R25. The Review Forms dated (30/15, indicated no behaviors. Items from dated 9/25/15, noted to be very restless and at of wheelchair on multiple is also noted to be aggressive also noted to be aggressive attempting to provide cares on sions. The Area Assessment atted adverse side effect of hibited by R25 were anxiety adverse side effect of bited by R25 were lethargy, irium. The adverse side effect anxiety) exhibited by R25 disturbances of gait, delirium and the following was noted: oquel on 8/17/15. A review of es indicated R25 fell on an and had no injury, 8/28/15, skin tears to left elbow, 9/7/15, skin tears to right forearm, an with no injury, and on	F 4	.28	revised. R25 chart reviewed and resident paway on 12/18/15. A facility audit was completed on Pharmacy consult reviews to ensurcompliance with responses. An audit was completed on all resident whom have psychotropic meds ordered and comprehensively assessed to compliance. Clinical Coordinators re-educated densuring that consults get complete timely by 1/13/16. Ongoing audits and tracking of morpharmacy consults will be complete monthly by Clinical Director to ensurcompliance. Findings will be reported quarterly at the QAA.	dents ered ensure on ed nthly ed ure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245619	B. WING		12	/04/2015
	PROVIDER OR SUPPLIER HERESE AT OXBOW	LAKE		STREET ADDRESS, CITY, STATE, ZIP CC 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 428	assistance with act The Quarterly MDS included heart failu pulmonary disease addition, the quarter not experiencing has behaviors. R25's care plan pri BEHAVIOR: "I have statements and atterd have a history of be staff and strike out history of expression refusing meals. I hapsychology and my currently. I take tradepression and hel sleep and appetite. restless/agitated/cotake Seroquel to minterventions including medication per MD practitioner] order, from trazodone, Sehours of sleep everenvironment at night MOOD: "My diagnor insomnia places midepression and an altered mood. At risoutlook and experie episodes of delusical altered mental statical discourses and an altered mental statical discourse and altered mental statical disc	ivities of daily living (ADLs). Sindicated R25's diagnoses re, chronic obstructive, depression and dementia. In erly MDS indicated R25 was allucinations, delusions or any onted 10/7/15, instructed staff: a history of making suicidal empting to harm myself. I also eing verbally aggressive with at them physically. I have a cons of sadness, isolation, and ave been evaluated by behaviors are managed zodone to manage my p increase my hours of restful. I have become more ombative with cares and now anage my symptoms. Sed administer psychotropic living monitor for adverse effects eroquel and Cymbalta. Monitor ry shift. Provide dark, quiet ht and close door." Desis of depression and e at risk for symptoms of xiety. At risk for confusion and sk for having a negative encing mood swings. I have ons/hallucinations due to us. Interventions included all	F 4	,		
	reassurance, and 1 behind my symptor	[tender loving care], 1:1 prn. Assess for reasons ms and notify MD/NP. I have a m that turns on in the morning				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		245619	B. WING			12/	04/2015
	PROVIDER OR SUPPLIER HERESE AT OXBOW	LAKE		52	TREET ADDRESS, CITY, STATE, ZIP CODE 200 OAK GROVE PARKWAY ROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 428	and shuts off at nig to family for reassu turn light on during quiet environment a Social service to vis questions/concerns socialization and obdepression/anxiety. The Physician Orderindicated R25 was milligrams (mg) onemg two times a day delusions. R25 coumg every six hours agitation. The Physindicated R25 was release capsule 60 and Trazodone 25 in Behavior symptoms A review of Medicar (MAR) Sheets and	ht. Involve spiritual care. Look rance prn, Open shades and the day prn. Provide a dark, at night and close his door. Sit 1:1 prn to assist with se, encourage activity, offer oserve for symptoms of "" Per Summary signed 11/17/15, to receive Seroquel 25 to time a day and Seroquel 50 or for anxiety, agitation and ald also receive Seroquel 25 as needed (PRN) for sician Order Summary also to receive duloxetine delayed mg every day for depression mg for insomnia. S: tion Administration Record Target Behavior Form (TBF)	F 4	28	DEFICIENCY)		
	noted the following: September 2015 MAR-Seroquel 25 r needed (prn) for ag September 2015. F administration, beh were charted only t interventions attem administration were Progress Notes wh 2015 going forward TBF dated Sep-15	mg every (q) 6 hours as pitation was given 17 times in Prior to PRN Seroquel aviors warranting medication wice and nonpharmacological pted prior to medication e charted only once in the ich were reviewed from August					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED
		245619	B. WING _		12	/04/2015
	PROVIDER OR SUPPLIER HERESE AT OXBOW	LAKE		STREET ADDRESS, CITY, STATE, ZIP CO 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 428	get up/down (the T where the resident delusions of the pa undocumented side There was a check indicated a side eff the side effect was would be necessar signs were not exp and did not match to TBF lacked specific medication. October 2015 MAR-Seroquel 25 was given 13 times Seroquel administr medication were chonpharmacologica to medication administr medication soft the progress of the padelusions of the padelusions and did residuation was given 15 MAR-Seroquel 25 of agitation was given 2015. Prior to PRN behaviors warrantin charted. Nonpharmattempted prior to rot charted in the FTBF-dated November 15 of the padelusions warranting the	BF lacked information as to would get/down from) and six st. R25 experienced effects on five of 30 days. The mark in the box which ect, but it was unknown what, and if medical intervention y. The check marks and plus lained in the progress notes, the administration times. The cotarget for the antipsychotic mg q 6 hours prn for agitation in October 2015. Prior to PRN ation, behaviors warranting narted only once and all interventions attempted prior inistration were charted only as notes or medication record. for October: Agitation (getting R25 had nine attempts and st indicated R25 had nine not experience side effects. In g q 6 hours as needed (prn) wen three times in November Seroquel administration, and medication were not nacological interventions medication administration were Progress Notes or MAR. Der 2015 for Seroquel: hts, attempting to get up/down	F 42			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245619	B. WING _		12	/04/2015
	PROVIDER OR SUPPLIER HERESE AT OXBOW	LAKE		STREET ADDRESS, CITY, STATE, ZIP CC 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 428	Continued From particles delusions/hallucinal delusions/hallucinal any side effects. The Cardinal Healt information dated M Schizophrenia and for use. It also indicated particles demential related particles of orthostatic hypotogeneous deling dizzy or light may lead to falls), eximital dose titrations re-initiating treatments. Non pharmacologic care plan printed 10 offer TLC [tender lot 1:1 prn. Assess for and notify MD/NP, that turns on in the Involve spiritual care.	,	F 42	DEFICIENCY)		
	environment at nigli service to visit 1:1 pagestions/concerns socialization and oldepression/anxiety box were in place page Mood symptoms: TBF- dated Sep-15 release: angry outboutbursts and expesside effect once.	Provide a dark, quiet ht and close his door. Social print to assist with so, encourage activity, offer observe for symptoms of ." All interventions except light prior to starting on Seroquel. If for duloxetine delayed pursts indicated R25 had four prienced an undocumented r-15 for duloxetine delayed				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245619	B. WING _		12	/04/2015
	PROVIDER OR SUPPLIER HERESE AT OXBOW	LAKE		STREET ADDRESS, CITY, STATE, ZIP (5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 428	outburst and expereffect once. TBF-dated November delayed release: and did not have any or four times. R25 did effects. Eli Lilly and Compart dated June 2015, folists major depress disorder, Diabetic properties of the indication for usure indicated for sleep in	bursts indicated R25 had one ienced an undocumented side of 2015, for duloxetine agry outbursts indicated R25 utbursts and had restlessness not experience any side any prescribing information or duloxetine delayed release ion, generalized anxiety peripheral neuropathic pain, unic musculoskeletal pain as sage. Angry outbursts was not ion for use of Cymbalta. If for Remeron (an ability to sleep indicated R25 enings and did not experience are 2015, for Trazodone: inability R25 had trouble one day shift, wo times. R25 experienced over 2015, for Trazodone: dicated R25 did not have any 25 did not experience any id not experience side effects. But all all all all all all all all all al	F 42	28		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		E SURVEY PLETED
		245619	B. WING			12/	04/2015
	PROVIDER OR SUPPLIER HERESE AT OXBOW	LAKE		520	REET ADDRESS, CITY, STATE, ZIP CODE DO OAK GROVE PARKWAY ROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	significant MDS da MDS dated 9/25/15 having any trouble not listed as an ind Trazodone. Even though the fabehaviors for the patarget behaviors for each In addition, the meadministration lack interventions and not the use of the paraget behaviors for each In addition, the meadministration lack interventions and not the use of the paraget behavior and the lack of the behavior/symptoms medications.	ted 6/30/15, and quarterly is, did not indicate R25 was sleeping. Refusal of care was ication of use for Remeron or cility had identified target sychotropic medications, the cked appropriate specific of the psychotropic categories. dications that were ed non-pharmacological nonitoring of adverse effects sychotropic medication. macy Visit Log indicated the cist reviewed R25's chart and ations as indicated: nart, hitting x1, agitation x1, voluntary Movement Scale it irregularity dent] stable, morphine nificant irregularity agitation, seroquel increased, gularity gnosis for delusional disorder, gularity [orthostatic] bp [blood es stable non significant irregularity or syluarity to the use of the medications	F4	28			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245619	B. WING _		12	/04/2015
	PROVIDER OR SUPPLIER	LAKE		STREET ADDRESS, CITY, STATE, ZIP CO 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 428	down the behaviors physical, might try my room. When do try to explain what work, we would foll likely leave him and On 12/04/15, at 7:4 (LPN)-C stated, "If showing hallucinati would give him a predirecting before r times. We chart what we tried first. you click on the measked if R25's behastarting on the measked if R25's behastarting on the meareally, he is about to On 12/4/15, at 8:15 said R25 "had alwade converse with you. think he is status quarter analysis that shows don't see anything for use of PRNs or effectiveness. I work something to show and analysis of its using [significant] characteristics (DCS) states and the services (DCS) states and the services (DCS) states and the services (DCS) states are services and the services and the services (DCS) states are services and the services are services are services are services are services and the services are services ar	and be stated, "We do not write so, the nurses do. R25 could be so hit staff or scream get out of sing that, we will call nurse to we were doing. If it does not ow what nurse says, most direapproach later." 19 a.m. licensed practical nurse he is grabbing in the air ons or if he is agitated we may be a giving a PRN and lit comes up for charting when edication to give it." When avior had improved since lication LPN-C stated, "No, not he same." 15 a.m. the house coordinator-A may been pretty quiet, will some days he is more tired. I uo." 16 a.m. RN-E stated for use the Psychotropic sit his medication is working. I in the progress notes either, analysis quarterly of all think yes we should have that the medication, annual	F 42	8		

STATEMENT OF DEFIC AND PLAN OF CORREC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245619	B. WING			12/	04/2015
NAME OF PROVIDER SAINT THERESE				5	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		,,
	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
electron to complete asset effective need for the asset effective need for the asset effective need for the asset effective in the asset effective expect and every expect and every expect usage of the asset effective would of the asset effective would of the asset effective effective effective would of the asset effective ef	colete the assessments to eness of the or continued interview or acist stated, in July. I will ry time I cheant irregular acy recomm se by next we sponse. For an AIMs where six monteressures at the facility is to see docuple on pharmal expect to see or sthat triggeness The or choose but interpret to see or sthat triggeness that triggeness The or choose but interpret in approved and consent properties on the peutic goal and consent provided to the contempted.	on record. I would expect them sessments and I would expect contain analysis of the emedication side effects and	F 4	128			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION ING	` '	(X3) DATE SURVEY COMPLETED	
		245619	B. WING		12.	/04/2015
	PROVIDER OR SUPPLIER	LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 428	the drug ordered. A need further explicit V. "Side effect mon residents with psycl Orthostatic hypoten		F 4	28		
F 431 SS=E	483.60(b), (d), (e) DLABEL/STORE DR The facility must en a licensed pharmacof records of receip controlled drugs in accurate reconciliat records are in order controlled drugs is reconciled. Drugs and biological labeled in accordant professional princip appropriate access instructions, and the applicable. In accordance with facility must store a locked compartment controls, and permit have access to the	nploy or obtain the services of sist who establishes a system t and disposition of all sufficient detail to enable an ion; and determines that drug r and that an account of all maintained and periodically als used in the facility must be accewith currently accepted ales, and include the ory and cautionary expiration date when State and Federal laws, the ll drugs and biologicals in a to sufficient to separately locked, evide separately locked,	F 4	31		1/13/16
	permanently affixed controlled drugs list	I compartments for storage of ed in Schedule II of the ug Abuse Prevention and				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245619	B. WING			12/0	04/2015
	PROVIDER OR SUPPLIER HERESE AT OXBOW	LAKE		52	TREET ADDRESS, CITY, STATE, ZIP CODE 200 OAK GROVE PARKWAY ROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	abuse, except when package drug distri quantity stored is more be readily detected. This REQUIREMENT by: Based on observation	and other drugs subject to n the facility uses single unit bution systems in which the ninimal and a missing dose can	F 4	31	Controlled Substance policy was reviewed, all Licensed staff were		
	boxes were double. This had the potent who had narcotic mocated in the nursing located in the nursing located in the nursing located in the nursing located located in the located loc	locked to prevent diversion. tial to affect the 10 residents nedications stored in cabinet ng station. 11 p.m. during a medication 5, registered nurse (RN)-B was abinet above the sink located ursing station. Upon opening small key, two red boxes were a each of the shelves. The two Box were observed to have a not locked even though RN-y used those to store narcotics. 7 p.m. during a random Rhode House neighborhood, a observed when a staff			reviewed, all Licensed stall were re-educated on current policy by 1/ Audits will be completed to ensure narcotic medications are double looper policy weekly x 90 days by the Director/designee and findings will reported quarterly at the QAA.	that the cked Clinical	
	member unlocked a cabinet at the nurse's station. The boxes were observed with padlocks on both but the padlocks were not locked. On 12/1/15, at 8:39 a.m. registered nurse (RN)-C stated residents who received Tramadol and						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		245619	B. WING _	· · · · · · · · · · · · · · · · · · ·	12	/04/2015
	PROVIDER OR SUPPLIER	LAKE		STREET ADDRESS, CITY, STATE, ZIP CO 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE COMPLE DATE	
F 431	the cabinet and we locked. On 12/3/15, at 6:22 (LPN)-B was obserthe sink where the LPN- reached out good boxes off the shelv counter and both hocked, opened one the narcotics with t LPN-B put the boxelocked it. At 6:26 at to open the cabinernarcotic boxes pad When asked if the locked LPN-B ackrosupposed to be docabinet was locked boxes. On 12/3/15, at 2:30 services stated "I will double locked narce expectation of staff." On 12/4/15, at 7:48 cabinets are support the red boxes are marcotic boxes are the padlocks. LPN-	stored at the nursing station in the supposed to be double. 2 a.m. licensed practical nurse eved open the cabinet above narcotic boxes were stored. The grabbed both red narcotic estand set them on top of the add the padlock but was not a after the other and counted the night LPN-A. At 6:25 a.m. estand surveyor requested LPN-B and RN verified both red llocks were left unlocked. Padlocks were supposed to be nowledged the padlocks were uble locked even though the last narcotic were stored in the locked expect them to follow the cotic policy" when asked her	F 43	,		
	January 2015, dire	olled Substance policy dated cted staff "F. All Controlled d in a locked box in a locked ion room."				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245619	B. WING		12/0	04/2015
	PROVIDER OR SUPPLIER HERESE AT OXBOW	LAKE	STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465 SS=E	SAFE/FÚNCTIONA E ENVIRON The facility must pr	AL/SANITARY/COMFORTABL ovide a safe, functional, ortable environment for the public.	F 465			1/13/16
	by: Based on observat review, the facility f was maintained in a good repair for 13 of Findings include: On 12/3/15, at 9:02 was completed with administrator, admi housekeeping supe director. R25's bathroom toi stained yellow. During tour, housel bathroom toilets an once a week and in cleaned either toda stated staff calls if t concern. In addition housekeeping close R25's Quarterly Mir 9/25/15, indicated F impairment and rec	a.m. an environmental tour axecutive director, assistant		R25, R60, R40, R52, R44, and R7 bathrooms were cleaned and sanitized R25, R60, R44, R9, R24, R19, and walls in resident room were repaired R52 scooter was cleaned. All resident rooms were reviewed for necessary repairs. Repairs were completed. All cleaning schedules for resident rowere reviewed and updated to incluincreased cleanings of resident bathrooms. The Department Housekeeping policy was reviewed and a Cleaning of Residents Bathrooms policy was crudicromain scheduling policy and preventative maintenance inspection policy were reviewed. Staff education on policies and environment cleaning/maintenance completed by 1/13/16.	zed. R45 d. or rooms ide icy eated.	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		E SURVEY PLETED
		245619	B. WING			12/0	04/2015
	PROVIDER OR SUPPLIER	LAKE		5	TREET ADDRESS, CITY, STATE, ZIP CODE 200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	TION SHOULD BE THE APPROPRIATE	
F 465	During tour, HS cor and stated it had no out when it would be director (POD) state entryway scratches bed. R60's annual MDS indicated R60 had rand required extens assistance with mor R40's bathroom toil bowel movement si On 12/3/15, at 9:42 out when the room and indicated toilet toilets were cleaned director (ED) stated R40's quarterly MD indicated R40 did nassessment and reassistance with mor R52's scooter's foor stained yellow. On 12/3/15, at 9:52 privately owned and moved to facility. El R52's 14 day MDS	served with multiple large mears. Infirmed smears on toilet riser of been cleaned and would find e cleaned. Plant operations ed he would repair wall and wall scratches near the assessment dated 9/25/15, moderate cognitive impairment sive one to two person st ADL's. et riser was observed with mears on the seat. a.m. HS stated he would find was scheduled for cleaning risers, surfaces, all around d. In addition, executive I it would be cleaned. S assessment dated 10/8/15, ot have a cognitive quired extensive one person	F	165	15% of resident rooms weekly for to ensure compliance and results or reported to the QA Committee meaction plans developed as needed will determine the need for ongoing monitoring. Plant Operations Director and/or d is responsible for ongoing compliance.	will be eting, and	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245619	B. WING		12	/04/2015
	PROVIDER OR SUPPLIER	LAKE		STREET ADDRESS, CITY, STATE, ZIP C 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 465	ADL's. R44's room near be odor, there were secolored stains were entryway, a short growth bed, and bathroom stains on it. On 12/3/15, at 9:32 line was from whee ED stated stains we wall would be spot and several was one to two person at R25's oxygen tubing floor and several was ink in entryway. Elimpairment and reciperson assistance williving (ADL's). R9's room observed walls near entryway repaired. R9's annual MDS a indicated R9 had m	ed was observed to have urine everal four to six inch light dripping down room wall near ray line on the wall near head om floor had red/brown colored a.m. POD stated gray wall elchair and would be repaired. Ould be cleaned and HS stated painted. S assessment dated 11/15/15, cognitively intact and required assistance with most ADL's. In the property of the entical lines on wall across from D stated these would be considered extensive one to two with most activities of daily In with long scratch marks on the entical lines on the entice of daily and with long scratch marks on the entity of the entity of daily and with long scratch marks on the entity of the entity of daily and with long scratch marks on the entity of the entity of daily and with long scratch marks on the entity of the entity of daily and with long scratch marks on the entity of the entity o	F 4	65		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		E SURVEY MPLETED
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	PROVIDER OR SUPPLIER HERESE AT OXBOW	LAKE		STREET ADDRESS, CITY, STATE, ZIP COI 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	'E ACTION SHOULD BE COMPLET D TO THE APPROPRIATE DATE	
F 465	near entryway. On 12/3/15, at 9:41 be repaired. R24's annual MDS indicated R24 was extensive one personal ADL's. R19's admission MR19 was cognitively one to two personal On 11/30/15, at 6:2 was observed with On 12/3/15, at 9:45 repaired. R19's admission MR19 was cognitively one to two personal R71's annual MDS indicated R71 had and required extensistance with moon 12/1/15, at 8:40 observed with black several gouges on On 12/3/15, POD s	a.m. POD stated they would assessment dated 8/25/15, cognitively intact and required on assistance with most DS dated 9/9/15, indicated intact and required extensive assistance with most ADL's. 7 p.m. R19's bedroom wall long scratch mark in entryway. a.m. POD stated it would be DS dated 9/9/15, indicated it would be DS dated 9/9/15, indicated it would be assessment dated 8/28/15, severe cognitive impairment sive one to two person st ADL's. a.m. R71's bathroom wall interest across from sink and wall. tated repairs would be made.	F 46	55		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		TE SURVEY MPLETED
		245619	B. WING _		12	/04/2015
	PROVIDER OR SUPPLIER HERESE AT OXBOW	LAKE		STREET ADDRESS, CITY, STATE, ZIP CO 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 465	indicated R45 was extensive one pers ADL's. On 12/3/15, at 9:21 Thanksgiving they building walk-through reviously it was do HS stated he routin walk-through's with monthly building was supervisors. On 12/3/15, at 9:26 periodic painting m reported nursing ar concerns. He state system for mainten order and maintenaissues.	assessment dated 8/25/15, cognitively intact and required on assistance with most a.m. ED stated before were going to begin weekly gh environmental tours. One on an as needed basis. The left of the also did weekly and alk-through's with his a.m. POD stated he did aintenance, including any and housekeeping staff d the facility used Micromain ance. Staff entered a work ance picked up and resolved	F 46	55		
	think it acceptable to only once a week. See reason for houseked enable staff to cleason 12/3/15, at 11:5 life specialists (CLS between weekly rown 12/3/15, at 12:2 walk-through's to on 12/4/15, at 8:50 stated if he had a hould call the HS anot working or he house in the see only on the see only on the see only only only only only only only only	on a.m. ED stated she did not that room toilets were cleaned. She further stated that was the seping closets on each unit, to a toilet when it was dirty. 2 a.m. HS stated community. Should be spot cleaning in om cleanings. For p.m. POD stated he did daily beserve for any issues. a.m. registered nurse (RN)-C, ousekeeping concern he and report it. If call lights were ad another maintenance update the clinical coordinator.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245619	B. WING		12/	/04/2015	
NAME OF PROVIDER OR SUPPLIER SAINT THERESE AT OXBOW LAKE				STREET ADDRESS, CITY, STATE, ZIP CO 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 465	12/4/15 at 8:55 a.m housekeeping or m would call houseke Micromain scheduli indicated "policy: to are attended to in a Micromain work ord maintenance staff r communication reg orders and who is wone are missed for work order request repairs policy dated requests for repair through Micromain Preventative mainted dated 9/10, indicated conduct regular insidentify maintenance services to remedy maintain a sanitary interior. Procedure: will be scheduled of follow-up random a plant operations dirensure proper com Department House	aintenance concern, she eping or maintenance. ing policy dated 1/16/15, ensure that all work orders atimely manner. Purpose: ders need to be timely and all need to have clear arding the status of work working on the work order so or periods of time." t - building maintenance and 8/7/07, indicated "policy: work orders will be routed software system." enance inspections policy ed "plant operations staff will pections of the facility to be issues and provide repair all issues. Purpose: to a quarterly basis. E) undits will be conducted by the ector on a quarterly basis to pletion and quality." keeping policy dated 10/15/11, sident rooms will be cleaned	F 4	65			

PRINTED: 01/04/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BLDG 245619 B WING 12/02/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5200 OAK GROVE PARKWAY SAINT THERESE AT OXBOW LAKE **BROOKLYN PARK, MN 55443** (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on December 02, 2015. At the time of this survey, Saint Therese at Oxbow Lake was found not in substantial compliance with the requirements for participation in Medicare/Medicaid, 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. **EPOC** PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

12/30/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: 27752

PRINTED: 01/04/2016 FORM APPROVED OMB NO. 0938-0391

		& MEDICAID SERVICES	T	TIPLE CONCERNICATION	(X3) DATE SURVEY
THE PROPERTY OF THE PROPERTY O		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BLDG		
		245619	B. WING		12/02/2015
	5200 OAK G		STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		
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K 000		state.mn.us RRECTION FOR EACH ST INCLUDE ALL OF THE	K 0	00	
	to correct the defice 2. The actual, or proceed as a composition of the actual of the	roposed, completion date. In title of the person rection and monitoring to ence of the deficiency. Center is a 2-story building the building was constructed in ermined to be of Type II (111) utomatic fire sprinkler out. The facility has a fire alarm the detection in the corridors and a corridors that is monitor for tiffication. The facility has a swith a census of 62 at the			
K 029 SS=E	NFPA 101 LIFE SA Hazardous areas a with 8.4. The area fire-rated barrier, w without windows (ii	FETY CODE STANDARD are protected in accordance s are enclosed with a one hour with a 3/4 hour fire-rated door, n accordance with 8.4). Doors automatic closing in	K0	29	12/6/15

Event ID: 7EFL21

PRINTED: 01/04/2016 **FORM APPROVED** OMB NO. 0938-0391

(X3) DATE SURVEY

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BLDG B. WING 12/02/2015 245619 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5200 OAK GROVE PARKWAY SAINT THERESE AT OXBOW LAKE BROOKLYN PARK, MN 55443 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 029 K 029 | Continued From page 2 This STANDARD is not met as evidenced by: On 12/6/15 doors were installed on the Based on observations and staff interview, the soiled utility room that have a one hour facility has failed to provide proper protection from a hazardous area in the facility. This fire rating. deficient practice could affect 20 residents, as Plant Operations Director is responsible smoke from a fire in this room could enter the for monitoring these practices and to corridor making it untenable. perform regular review of the fire rated doors. Findings include: On facility tour between 9:00 AM and 12:00 PM on 12/02/2015, it was observed in the Road House Wing that the soiled utility room door had a 20-minute fire rated door and not a 45-minute fire rated door. This deficient practice was verified by the Administrator at the time of inspection. 12/21/15 K 050 NFPA 101 LIFE SAFETY CODE STANDARD K 050 SS=D Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: On 12/21/15 a new schedule was created Based on review of reports, records and staff

Facility ID: 27752

PRINTED: 01/04/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BLDG 245619 B. WING 12/02/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5200 OAK GROVE PARKWAY SAINT THERESE AT OXBOW LAKE BROOKLYN PARK, MN 55443 PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETION (FACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 050 K 050 Continued From page 3 for the 2016 Fire Drill Schedule to identify interview, it was determined that the facility failed the month, date, time of day, and location. to vary the times fire drills in the last 12-month All items will be staggered to meet the period. This deficient practice could affect how requirements of the fire drill portion of the staff react in the event of a fire. Improper reaction by staff would affect the safety of all residents. Life Safety Code. Plant Operations Director is responsible Findings include: for monitoring the Fire drill information and documentation and will be reviewed On facility tour between between 9:00 AM and with the Safety Committee and the 12:00 PM on 12/02/2015, a record review Administrator. revealed that the facility conducted the Evening-Shift fire drills in 2015 between the hours of 2:45 PM-3:30 PM and the Night-Shift fire drills between the hours of 5:40 AM-6:05 AM not varied times as required. This deficient practice was verified by the Administrator at the time of the inspection.

(X2) MULTIPLE CONSTRUCTION

Event ID: 7EFL21



Electronically delivered December 21, 2015

Ms. Brandi Barthel, Administrator Saint Therese At Oxbow Lake 5200 Oak Grove Parkway Brooklyn Park, Minnesota 55443

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5619003

Dear Ms. Barthel:

The above facility was surveyed on November 30, 2015 through December 4, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number. that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order.

Saint Therese At Oxbow Lake December 21, 2015 Page 2

This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gloria Derfus at (651) 201-201-3792 or email: gloria.derfus@state.mn.us.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to the eNotice.

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

PRINTED: 01/04/2016 FORM APPROVED

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING _ 27752 12/04/2015

		LITUL			2/04/2013		
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE			
SAINT TI	HERESE AT OXBOW LA	5200 OA	K GROVE PA	K GROVE PARKWAY			
JAINT 11	ILITEGE AT OXBOW LA	BROOK	LYN PARK, M	N 55443			
(X4) ID PREFIX TAG	(EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
2 000	Initial Comments		2 000				
	****ATTEN	ΓΙΟΝ*****					
	NH LICENSING C	ORRECTION ORDER					
	144A.10, this correcti pursuant to a survey. found that the deficie herein are not correct not corrected shall be	linnesota Statute, section ion order has been issued If, upon reinspection, it is ncy or deficiencies cited ted, a fine for each violation e assessed in accordance es promulgated by rule of tment of Health.					
	corrected requires co requirements of the re number and MN Rule When a rule contains comply with any of the lack of compliance. I re-inspection with any result in the assessm	ether a violation has been impliance with all ule provided at the tag enumber indicated below. It is several items, failure to e items will be considered Lack of compliance upon y item of multi-part rule will lent of a fine even if the item ing the initial inspection was					
	that may result from rorders provided that a	earing on any assessments non-compliance with these a written request is made to n 15 days of receipt of a t for non-compliance.					
	receipt of State licens the Minnesota Depart Informational Bulletin	participate in the electronic sure orders consistent with tment of Health 14-01, available at te.mn.us/divs/fpc/profinfo/in licensing orders are	f				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 12/30/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		27752	B. WING	····	12/0	4/2015
SAINT THERESE AT OXBOW LAKE 5200 OAK			DRESS, CITY, S GROVE PA			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Department of Hea you electronically, is necessary for Sta enter the word "cortext. You must then State licensure procompletion date, the corrected prior to electronic Department on November 30, Is surveyors of this Deabove provider and orders are issued. electronic plan of coreviewed these ord they will be complemented by will be complemented to Minnesota Departmented they will be complemented to Minnesota Departmented they will be complemented to Minnesota Departmented they will be complemented to Minnesota Departmented to Minneso	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. December 1, 2, and 4, 2015, epartment's staff, visited the the following correction Please indicate in your correction that you have ers, and identify the date when ted. The of Health is documenting agriculture orders using agriculture for a state statutes/rules for the compliance is listed in the compliance is listed in the ent of Deficiencies" column to Comply" portion of the compliance is listed in the ent of Deficiencies" column to Comply" portion of the state statute, "This Rule is not met as wing the surveyors findings Method of Correction and crection. ARD THE HEADING OF THE	2 000			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:		(X3) DATE SURVEY COMPLETED		
					40/04/04	
NAME OF		27752	B. WING	274TF, 7/D 00DF	12/04/	2015
	PROVIDER OR SUPPLIER	5200 OAK	GROVE PA	STATE, ZIP CODE RKWAY		
SAINTI	HERESE AT OXBOW	BROOKL	YN PARK, M	T		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	THIS WILL APPEA	R ON EACH PAGE.				
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 830	MN Rule 4658.0520 Proper Nursing Car	O Subp. 1 Adequate and re; General	2 830		1.	/13/16
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a he attending physician that the in in bed or the resident				
	by: Based on observation review, the facility for supervision for mean residents (R71, R52) assessed to need supervision, the facility were safely secured the risk of injury for R52) reviewed for a Findings include:	ent is not met as evidenced on, interview and document ailed to ensure necessary als was provided for 4 of 5 2, R25, R60) who were supervision for meals. In failed to ensure bedside rails d to the bed frame to minimize 3 of 3 residents (R71, R44, accidents.		Orders received on R71, R60 for re-evaluation of swallowing and no supervision. Care plan will be reviand will be updated with final recommendations per SLP. Hospice referral made for R52 to swallowing and meal supervisory of Care plan will be reviewed and upwith final recommendations. R25 chart review completed, residuated passed away 12/18/15 on hospice	review needs. dated	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING	•	
		27752	B. WING		12/04/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
SAINT T	HERESE AT OXBOW	I AK F	GROVE PA		
OAIIII I	TIERLEGE AT OXBOTT	BROOKLY	/N PARK, M	N 55443	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE COMPLETE
2 830	Continued From pa	ge 3	2 830		
	in the dining room during continuous observation of the Rhode house dining room on 12/3/15, from 7:17 a.m. to 8:37 a.m. No nursing staff was observed in the dining room during that time frame. R71: On 12/3/15, R71 was observed and the following was noted: - At 7:17 a.m. one resident in dining room was eating peaches, coffee and orange juice on table At 7:27 a.m. R71 and three other residents were in the dining room eating breakfast At 7:28 a.m. R71 drank thickened coffee and then coughed twice. The thickened water and			Residents with altered diets/consis will be reviewed for the need of supervision with meals. Care plan updated as needed.	n will be
				Dining times were adjusted to ens proper supervision of the dining roduring meals by nurse/designee.	
				Resident Dining Policy has been rand updated to ensure supervision resident safety that require an alter and feeding assistance.	n for
	juice were placed ir - At 7:31 a.m. R71 - At 7:32 a.m. hous stopped by and spo - At 7:43 a.m. a sta to the dining room a and coffee and their residents remained breakfast At 7:57 a.m. staff dining room and lef were in the dining r food in front of ther	n front of R71. coughed twice. ehold coordinator (HC)-E oke to R71 then left. Iff member brought a resident and gave the resident juice in left immediately. Five in the dining room eating brought three residents to the t immediately. Eight residents oom with beverages and or in.		Education will be completed by 1/2 Random audits will be completed on varying meals for 90 days to er compliance and results will be rep the QA Committee meeting, action developed as needed, and will det the need for ongoing monitoring. Director and/or designee will be responsible for ongoing compliance.	weekly nsure orted to n plans termine Clinical
	- At 7:59 a.m. R71 started coughing had bouts at that time At 8:05 a.m. licens moved the medicat room, - At 8:14 a.m. LPN-entered the dining remained in dining the dining room eat HC-A sat down next.	was eating oatmeal and ard. R71 had two coughing sed practical nurse (LPN)-B ion cart outside the dining B left the dining area HC-E room. No nursing staff room. Eight residents were in ing breakfast or drinking.		R52, R71, and R44(R48 is not in tresident sample) side rails were in by the bed manufacturing compantechnician on 12/8/15. Repairs the needed were completed. New sid were ordered for R52, R71, and R will be replaced upon arrival. A preventative maintenance procedure/checklist for the electric including side rails has been adde will be completed on all beds.	aspected by s at were le rails 444 and be beds

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		27752	B. WING		12/0	4/2015
SAINT THERESE AT OXBOW LAKE 5200 OAK BROOKLY (X4) ID SUMMARY STATEMENT OF DEFICIENCIES		ODRESS, CITY, S K GROVE PA YN PARK, M ID PREFIX		ON	(X5) COMPLETE	
PREFIX TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)		DATE
2 830	was overheard spe about the reason the assistants, HC-E st watch the dining rotate and the sistem of the non nursing star room. At 8:30 a.m. HC-E then no nursing star room. At 8:37 a.m. R71 thickened juice. R71's annual Minim 8/28/15, indicated Fimpaired, requiring daily living (ADLs) it eating. R71's diagnobstructive pulmon failure, diabetes, and difficulty. Nutrition Care Area 8/28/15, indicated Fimpaired (difficulty). Nutrition Care Area 8/28/15, indicated Fimpaired (difficulty).	aking to HC-E. DCS asked here were no nursing stated "[LPN-B] asked me to om." E had left the dining room and iff was present in the dining coughed after drinking num Data Set (MDS) dated R71 was severely cognitively assistance with all activities of including supervision with loses included chronic ary disease (COPD) Heart existly, dementia and y swallowing). Assessment (CAA) dated R71 was receiving a No let diet NDD2 diet (and dysphagia diet) with nectar exause of dysphagia. The py Evaluation and Plan of 13/15, indicated R71 was at and aspiration pneumonia. The 12/3/15, at 1:26 p.m. nurse lated R71 would be at risk for for dementia. The NP confirmed 1 would be supervised when	2 830	The Positioning Device: Positioning Rails/Bed Transfer Bars/Sheppard policy was reviewed. Staff will be educated on functionathe side rails and when to report sconcerns by 1/13/16. Maintenance will be educated on preventative maintenance procedure and function of the side rails by 1/13/16. Audits will be completed on 10% of weekly for 90 days to ensure com and results will be reported to the Committee meeting, action plans developed as needed, and will dethe need for ongoing monitoring. Operations Director and/or design be responsible for ongoing compliance.	d Hooks ality of safety se staff sionality of beds pliance QA termine Plant nee will	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		27752	B. WING		12/0	04/2015
	PROVIDER OR SUPPLIER HERESE AT OXBOW	5200 OA	DRESS, CITY, S C GROVE PA YN PARK, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	They should encoure eat]." R52: On 12/3/15, from 7: observed and the formula on the formula of	rage him to slow down [to	2 830			
	room At 7:43 a.m. R52 and given juice and eating breakfast and dining room At 8:00 a.m. dieta including scrambled At 8:14 a.m. HC-E Eight residents wer At 8:28 a.m. the d (DCS) was overheat asked about the reassistants, HC-E st watch the dining root At 8:30 a.m. HC-E coughed four times were no nursing stars.	was brought to dining room coffee. Five residents were d no nursing staff were in the ry staff brought R52 breakfast d eggs and toast. Eentered the dining room. ee eating breakfast. irector of clinical services and speaking to HC-E DCS ason there were no nursing ated "[LPN-B] asked me to				
	R52 was cognitively assistance with ADI admission MDS inc	DS dated 9/12/15, indicated vintact and required Ls. R52's diagnoses on lude Parkinson's and arthritis. AA dated 9/16/15, noted R52 eating at times related to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					3) DATE SURVEY COMPLETED	
		27752	B. WING		12/0	4/2015
	PROVIDER OR SUPPLIER	JAKE 5200 OAK	DRESS, CITY, S GROVE PA (N PARK, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 6	2 830			
	R52's care card dat required assistance	ted 11/7/15, indicated R52 with eating.				
		2 p.m. HC-E was observed bites of turkey. No coughing				
	a.m. to 8:23 a.m. no - At 8:12 a.m. regis encouraged R25 to oatmeal. - At 8:15 a.m. RN-A - At 8:16 a.m. R25 of RN-A asked "are yo today?	· ·				
	then coughed At 8:19 a.m. R25 of thin water At 8:19 a.m. RN-A - At 8:20 a.m. RN-A thickened apple juic At 8:23 a.m. R25 at coughed. RN-A hea	coughed twice after drinking A went out to kitchen A offered sip of nectar ce, no coughing heard. te a bite of oatmeal and then ard to say to LPN-B "I want a en to lungs, update hospice."				
	room and was cont a.m. to 8:37 a.m. - At 7:17 a.m. one r peaches, coffee and - At 8:33 a.m. the c brought R25 to the thickened water and	as in the Rhode House dining inuously observed from 7:17 resident in dining room eating d orange juice on table. linical life specialist (CLS)-E dining room brought R25 d juice, then left.				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		27752	B. WING		12/0	4/2015
	SAINT THERESE AT OXBOW LAKE 5200 OA			STATE, ZIP CODE RKWAY N 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	was severely cognic assistance with ADI quarterly MDS indic coughing or choking. During an interview stated we are fully stated we are fully stated we are fully stated to monitor the dining the staff are unavaited to monitor the dining time that the might RN-A said that ther are on a regular die Someone should havith R71 and R25 staid, "My expectations someone in there if room. There should During interview on aide-A said, "If I heat they are ok. I will girinse it down. I will girinse it down. I will girinse it down. I will girinse it sounds like choking	tively impaired and required Ls including eating. The cated R25 experienced g during meals or medications. on 12/3/15, at 8:52 a.m. RN-A staffed. When asked if ate in the dining room without present, RN-A replied, "No." If lable the nurse was supposed g room. There may be a short be unattended, five minutes. It was no risk if the residents at and able to feed themselves. The area are the dining room should be supervised. RN-A on is that there should be there is a feeder in the dining	2 830			
	buring to get everyo During interview on asked how do you in the state of the stat					

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-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		27752	B. WING		12/0	4/2015
	PROVIDER OR SUPPLIER HERESE AT OXBOW	5200 OAK	ORESS, CITY, S GROVE PAI 'N PARK, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	around and did an adining room for breathrough the dining rand supper someting on dining rooms or During interview on said all of the dietar Heimlich maneuver if anyone required would help them. "Inursing staff memborisks involved with a During interview on administrator said wone staff in dining round one staff in dining round in the dining round. I brought (R25)	assessment. I supervise the akfast most days, I pass from at lunch 80 % of time me. I have not had any training feeding since starting here." 12/3/15, at 10:09 a.m. DCS by staff are trained to do the complete Dietary staff do monitor only, eating assistance nursing staff would expect a CLS or other er to be in the dining room." It trained to observe for other eating. 12/3/15, at 10:45 a.m. the we should have a minimum of	2 830			
	7:59 a.m. during browere observed in the aide was observed and breakfast plate come in and out of were alone in the dietary aide brough and would retrieve residents who were -At 7:59 a.m. R60 v	on 12/2/15, at 7:40 a.m. to eakfast, several residents he dining room. The dietary serve out beverages, bananas. During that time noted staff the dining room and residents ining room except when the food from the kitchenette back briefly leaving the eating unsupervised.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	27752	B. WING		12/0	4/2015
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
SAINT THERESE AT OXBOW	IΔKF	K GROVE PAF YN PARK, MN			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
some more and sp napkin and some from Resident then cont toast. No facility state the time of the obsection At 8:02 a.m. dietarkitchenette and stockitchenette and stockitchenette are glan for indicated resident to tolerate a regular to plan directed stafficannual MDS dated required supervision. R60's Nutritional Assindicated resident to chewing/swallowing dysphagia, but tole The assessment at affected nutrition/hy of dysphagia and in eating." On 12/3/15, at 12:2 plan should read stand if she was tired When asked if a stain the dining room served breakfast a "There should be some when resident R60 was safe to eat RN-A stated "I say able to do it fine. The Listed active dia stated active	es, then was able to cough it the eggs out of mouth into a ell on the clothing protector. inued to take a bite of the aff were in the dining room at ervation. ry aide came out of the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		27752	B. WING		12/0	4/2015
	PROVIDER OR SUPPLIER	5200 OAK	DRESS, CITY, S GROVE PAI N PARK, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	the speech therapy dated 12/2/14, had for aspiration pneur required close supe When asked what is staff during meals is supposed to be suphad dysphagia. RN R60 had a diagnosibeing listed even or On 12/3/15, at 1:27 stated staff was suproom during meal to all other residents is would have deferre speech therapy had supervision with measpiration pneumor the family had decliconsistency recome R60 had a diagnosinot been notified of Resident Dining podirected staff: "I. The nurse is residents in the dining room untompleted. A. Nurse monitors is safety issues, and is dignity of residents, food intake, and residents as needer SUGGESTED MET The director of nurse residents as needers.	evaluation and treatment plan indicated R60 was at high risk monia and/or chocking and ervision with oral intakes. Her expectation was of her RN-A stated resident was pervised during meals if R60 reached during meals in spite it in the current physician orders. In p.m. via telephone the NP reposed to be in the dining ime to supervise residents and she thought. NP indicated she do to the recommendations dindicated to provide reals as resident was at risk for hia and choking Even though med to follow with diet mendation. NP further verified is of dysphagia however had any concerns with coughing. It was also did to designate at least reached to be physically present in it the meal had been for adequate assistance, infection control practices, proper positioning, adequate sident behaviors needing assists with feeding	2 830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		3) DATE SURVEY COMPLETED	
		27752	B. WING		04/2015
	PROVIDER OR SUPPLIER HERESE AT OXBOW	JAKE 5200 OAK	DRESS, CITY, GROVE PA (N PARK, M		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	is receiving appropriservice.	ge 11 riate care during the meal R CORRECTION: Twenty-one	2 830		
2 850	Subp. 2. Criteria for proper care. The cadequate and proper D. Assistance	or determining adequate and criteria for determining	2 850		1/13/16
	by: Based on observatireview, the facility for 3 residents (R4) activities of daily liv Findings include: On 11/30/15, at 4:4 seated on the whee closed. When apprhave multiple white quarter inch long (1 her cheeks. On 12/1/15, at 8:17 hairs bothered her them removed the for me" as she felt in the service of the service	ent is not met as evidenced ons, interview and document ailed to provide grooming for 1 who was dependent for ing (ADL) reviewed for ADL. 3 p.m. R4 was observed elchair in her room eyes oached R4 was observed to facial hairs approximately /4) on her lower chin and on a.m. when asked if the facial R4 stated "Yes. I would like barber used to take them off the hairs on her left cheek. staff help me to remove them		R4 was given grooming assistance for facial hair on 12/3/15. Facility wide audit on grooming was completed. Care plans were updated per individualized preferences. The policy and procedure on Resident Care Grooming was reviewed. Staff will be re-educated on the policy by 1/13/16. Audits will be completed on 10% of residents weekly for 90 days to ensure compliance and results will be reported to the QA Committee meeting, action plans developed as needed, and will determine the need for ongoing monitoring.	

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		27752	B. WING		12/0	4/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SAINT T	HERESE AT OXBOW	I AK F	GROVE PA			
O 7		BROOKLY	/N PARK, MI	N 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 850	Continued From pa	ge 12	2 850			
	on her bath day R4 stated, "They have not told me they would." On 12/2/15, at 7:13 a.m. R4 was observed to be up and dressed. When approached and asked how she had slept R4 indicated "good." R4 stated			Clinical Director and/or designee versionsible for ongoing compliant		
	the community life s good to her. R4 was multiple facial hairs cheeks. CLS-A cue CLS-A wheeled R4	specialist (CLŠ)-A was really s still observed still with around her mouth and d R4 to brush her teeth after close to the sink R4 was				
	observed brush the teeth and applied her dentures as CLS-A was straightening the bed. At 7:17 a.m. CLS-A was observed wet a wash towel then handed it to R4 to wash the face. At 7:18 a.m. CLS-A was observed comb R4's hair as she					
	offered to remove the CLS-A wheeled R4 room by the bed, go	looked at R4's face never he facial hair. At 7:19 a.m. out of the bathroom into the ot R4 eye glasses from the em to R4 to put them on and a				
	Kleenex. At 7:21 a.m. the room to the dini a.m. CLS-A brough	m. CLS-A wheeled R4 out of ng room (DR) table. At 7:23 t R4 into the dining room and never offered to remove the				
	approached R4 said R4's face never offer facial hairs. At 7:47	a.m. the household coordinator d "good morning" looked at ered to remove the visible a.m. another staff approach				
	never offered to rer were visible. At 8:3	nents and spoke briefly to R4 move the facial hairs which 1 a.m. R4 wheeled out of the 1. At 8:33 a.m. the household				
	coordinator and and R4 and offered to ri went into R4's room	other staff both approached de back to room. Both staff n were observed and heard				
	open at this time ne facial hairs. At 9:20	bout her life/family door wide ever offered to remove the a.m. to 9:25 a.m. registered observed completed wound				

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		27752	B. WING		12/0	4/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SAINT T	HERESE AT OXBOW	IAKF	GROVE PA			
(VA) ID	SHIMMA DV STA	TEMENT OF DEFICIENCIES	/N PARK, MI	PROVIDER'S PLAN OF CORRECTION	- NI	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 850	Continued From page 13		2 850			
	care for R4 never o hairs.	ffered to remove the facial				
	least expect the CL provide residents w required which includes	p.m. RN-C stated he would at S's who worked with him to ith assistance for all cares uded grooming, personal and eating as some residents ist with cares.				
	On 12/3/15, at 7:57 a.m. when approached R4 was still observed with multiple facial hairs on her lips and cheeks.					
	facial hairs. RN-A whairs bothered here because I touch the remove them for he going to get a razor when asked what the chin hair, RN-A provided the bath s bath day was Thurs if the staff documer removed RN-A stat	a.m. RN-A verified R4 had vas overheard asked R4 if the and R4 stated "Yes they do em." R4 asked RN-A to er and RN-A indicated she was to remove them. At 8:32 a.m. he expectation was to remove stated on bath days. RN-A chedule which indicated R4's eday evening and when asked hed if facial hair had been ed "no they don't" as she going to take care of it.				
		uded glaucoma and abnormal om Admission Record dated				
	2/10/15, indicated r	a Assessment (CAA) dated esident required extensive oL functions at this time.				
	indicated R4 had in extensive assist wit	num Data Set (MDS) 10/8/15, tact cognition and required h personal hygiene including care plan dated 10/9/15,				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
		27752	B. WING		12/0	4/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
SAINT TI	HERESE AT OXBOW	IAKE	GROVE PA 'N PARK, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 850	Continued From page 14		2 850			
	grooming/hygiene r glaucoma. Goal "I v in personal hygiene The care plan direct assist of one staff n hygiene and oral ca On 12/3/15, at 9:44 services (DNS) stat	a.m. the director of clinical ted she expected staff to s directed by the care plan				
	2014, indicated nur	Grooming policy dated July sing staff was to provide oming AM and PM according				
	director of nursing (in-service all staff o living (such as shave	THOD OF CORRECTION: The (DON) or designee could in performing activities of daily ring) for residents. Also the or designee could monitor for				
	TIME PERIOD FOR Twenty-one (21) da					
21535	MN Rule4658.1315 Drug Usage; Gener	Subp.1 ABCD Unnecessary	21535			1/13/16
	must be free from unnecessary drug is A. in excessive therapy; B. for excessive C. without adec	al. A resident's drug regimen unnecessary drugs. An s any drug when used: dose, including duplicate drug e duration; quate indications for its use; or nce of adverse consequences				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE S	
		27752	B. WING		12/04/2015	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
CAINT	UEDECE AT OVDOW	5200 OAK	GROVE PA			
SAINT THERESE AT OXBOW LAKE BROOKL			'N PARK, M	N 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE	
21535	discontinued. In addition to the dipart 4658.1310, the with provisions in the Code of Federal Research 483.25 (1) found in Operations Manual Long-Term Care Fadepartment of Health Care Finance This standard is inconvailable through the system and the Standard to frequent This MN Requirements.	lose should be reduced or rug regimen review required in e nursing home must comply e Interpretive Guidelines for gulations, title 42, section Appendix P of the State Guidance to Surveyors for cilities, published by the th and Human Services, ing Administration, April 1992. orporated by reference. It is e Minitex interlibrary loan te Law Library. It is not change.	21535			
	Based on interview facility failed to ensign indications for the unantipsychotic drug unilpsychotic disorder in which the impaired that contact duloxetine delayed and for Trazodone (medication) used for Findings include: R25's Social Service (6/10/15, 6/16/15, 6/10/15, 6/16/15, 6/10/15, 6/16/15, 6/10/15, 6/16/15, 6/10/15, 6/16/15, 6/10/15, 6/16/15, 6/10/15, 6/16/15, 6/10/15, 6/16/15, 6/10/15, 6/16/15, 6/10/15, 6/16/15, 6/10/15, 6/16/15, 6/10/15, 6/	used to treat various mental esident specific target psychosis (a severe mental ought and emotions are so ct is lost with external reality), release (an antidepressant) can antidepressant		Behavior and Psychological Symponementia and Psychotropic Medicand Monitoring Policy was reviewed revised. All nursing staff were re-educated policy by 1/13/16. R25 chart was reviewed, resident away 12/18/15 on hospice care. An audit was completed on all resimplements and comprehensively assessed to compliance. Ongoing audits will be completed to Clinical Director/designee to ensur compliance for 10% of the facility and ongoing per RAI schedule. Finding reported quarterly at the QAA.	ations ed and on the passed dents dered ensure by the re and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		27752	B. WING		12/0	4/2015
	PROVIDER OR SUPPLIER HERESE AT OXBOW	JAKE 5200 OA	DRESS, CITY, S K GROVE PA YN PARK, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21535	two separate occass Psychotropic Drug dated 7/2/15, indica antidepressants extand delirium. The antipsychotics exhild depression and deliof anxiolytics (antial included sedation, cand depression. The progress notes 2015 going forward R25 started on Serve R25's progress notes 8/23/15, at 6:55 p.n. at 7:20 a.m. with sk at 5:45 p.m. with at 9/18/15, at 9:30 a.m. 10/3/15, at 1:15 p.n. R25 quarterly MDS was severely cognit assistance with action The Quarterly MDS included heart failur pulmonary disease addition, the quarternot experiencing has behaviors. R25's care plan primate and attention of the progression of the staff and strike out history of expression refusing meals. I has signed at the strike out history of expression refusing meals. I has signed and strike out history of expression refusing meals. I has signed and strike out history of expression refusing meals. I has a signed and strike out history of expression refusing meals. I has a signed and strike out history of expression refusing meals. I has a signed and strike out history of expression refusing meals. I has a signed and strike out history of expression refusing meals. I has a signed and strike out history of expression refusing meals. I has a signed and strike out history of expression refusing meals. I has a signed and strike out history of expression refusing meals. I has a signed and strike out history of expression refusing meals. I has a signed and strike out history of expression refusing meals. I has a signed and strike out history of expression refusing meals. I has a signed and strike out history of expression refusing meals.	use Care Area Assessment ated adverse side effect of hibited by R25 were anxiety dverse side effect of pited by R25 were lethargy, irium. The adverse side effect anxiety) exhibited by R25 disturbances of gait, delirium and the following was noted: oquel on 8/17/15. A review of es indicated R25 fell on an and had no injury, 8/28/15, skin tear to right forearm, an with no injury, and on	21535			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		27752	B. WING		12/0	04/2015
	PROVIDER OR SUPPLIER HERESE AT OXBOW	JAKE 5200 OAK	DRESS, CITY, S C GROVE PA YN PARK, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21535	currently. I take traz depression and hel sleep and appetite. restless/agitated/cotake Seroquel to mandication per MD practitioner] order, from trazodone, Se hours of sleep ever environment at night MOOD: "My diagnor insomnia places mandepression and any altered mood. At risoutlook and experie episodes of delusionaltered mental statustaff will offer TLC [reassurance, and 1 behind my symptom light box in my room and shuts off at night to family for reassurant turn light on during quiet environment a Social service to visquestions/concerns socialization and obdepression/anxiety. The Physician Order indicated R25 was milligrams (mg) one mg two times a day delusions. R25 coumg every six hours agitation. The Physician Order indicated R25 was milligrams (mg) one mg two times a day delusions. R25 coumg every six hours agitation. The Physician Order indicated R25 was milligrams (mg) one mg two times a day delusions. R25 coumg every six hours agitation. The Physician Order indicated R25 was milligrams (mg) one mg two times a day delusions. R25 coumg every six hours agitation. The Physician Order indicated R25 was milligrams (mg) one mg two times a day delusions. R25 coumg every six hours agitation. The Physician Order indicated R25 was milligrams (mg) one mg two times a day delusions. R25 coumg every six hours agitation. The Physician Order indicated R25 was milligrams (mg) one mg two times a day delusions. R25 coumg every six hours agitation.	codone to manage my princrease my hours of restful I have become more embative with cares and now anage my symptoms. It is a considered administer psychotropic monitor for adverse effects roquel and Cymbalta. Monitor y shift. Provide dark, quiet and close door." It is sis of depression and at risk for symptoms of ciety. At risk for confusion and sk for having a negative encing mood swings. I have ins/hallucinations due to us. Interventions included all tender loving care], in prince Assess for reasons in and notify MD/NP. I have an that turns on in the morning the living care. Look rance prince prince prince prince and the day prince prince and the day prince prince assist with a circumstant in the contract of the contract with the contract of the contrac	21535			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		27752	B. WING		12/0	4/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SAINT T	HERESE AT OXBOW	I AK F	K GROVE PA YN PARK, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21535	release capsule 60 and Trazodone 25 in Behavior symptoms A review of Medicate (MAR) Sheets and Sheets from Septer noted the following: September 2015 MAR-Seroquel 25 in needed (prn) for ag September 2015. Padministration, behavere charted only transcriptions attern administration were progress Notes wh 2015 going forward. TBF dated Sep-15 movements: indicate get up/down (the TI where the resident delusions of the part undocumented side There was a check indicated a side effect was, would be necessary signs were not expland did not match to the side effect was and the side effect was and did not match to the side effect was and	mg every day for depression mg for insomnia. S: tion Administration Record Target Behavior Form (TBF) mber through November 2015 in the interior to PRN Seroquel aviors warranting medication wice and nonpharmacological pted prior to medication e charted only once in the ich were reviewed from August	21535	DEFICIENCY		
	was given 13 times Seroquel administra	ng q 6 hours prn for agitation in October 2015. Prior to PRN ation, behaviors warranting parted only once and				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		27752	B. WING		12/0	4/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SAINT T	HERESE AT OXBOW	I AK F	(GROVE PA (N PARK, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21535	Continued From pa	ige 19	21535			
	to medication admi	al interventions attempted prior nistration were charted only as notes or medication record.				
	up/down) indicated delusions of the pa	for October: Agitation (getting R25 had nine attempts and st indicated R25 had nine not experience side effects.				
	for agitation was given 2015. Prior to PRN behaviors warranting charted. Nonpharm attempted prior to results.	mg q 6 hours as needed (prn) ven three times in November Seroquel administration, ng medication were not lacological interventions medication administration were Progress Notes or MAR.				
	TBF-dated November 2015 for Seroquel: Frequent movements, attempting to get up/down indicated R25 had nine attempts and delusions/hallucinations indicated R25 had one delusions/hallucinations and did not experience any side effects.					
	information dated N Schizophrenia and for use. It also indica approved for the tre dementia related po- indicated, "Patients of orthostatic hypot feeling dizzy or ligh may lead to falls), e initial dose titration, re-initiating treatme	h package insert and label May 2, 2013, for Seroquel lists Bipolar Disorder as indication cates "Seroquel is not eatment of patients with sychosis." Package insert also should be advised of the risk ension (symptoms include theaded upon standing, which especially during the period of and also at times of ent or increases in dose."				

Millinesc	nta Department of He	aim				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		27752	B. WING		12/0	4/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
		5200 OAK	GROVE PA			
SAINT T	HERESE AT OXBOW	IAKE	(N PARK, MI			
(VA) ID	CLIMMA DV CTA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	N.	(VE)
(X4) ID PREFIX		/ MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE
				DEI ICIENCT)		
21535	Continued From pa	ge 20	21535			
	offer TLC (tender lo	ving care], reassurance, and				
		reasons behind my symptoms				
		have a light box in my room				
		morning and shuts off at night.				
		e. Look to family for				
		pen shades and turn light on				
		Provide a dark, quiet				
		nt and close his door. Social				
	service to visit 1:1 p					
	questions/concerns, encourage activity, offer socialization and observe for symptoms of					
		" All interventions except light				
		prior to starting on Seroquel.				
	Sox Word III place p	mor to ctarting on corequen				
	Mood symptoms:					
		for duloxetine delayed				
	0,5	ursts indicated R25 had four				
		rienced an undocumented				
	side effect once.	d E fan distance datased				
		r-15 for duloxetine delayed				
		ursts indicated R25 had one enced an undocumented side				
	effect once.	enced an undocumented side				
		per 2015, for duloxetine				
		ngry outbursts indicated R25				
		itbursts and had restlessness				
		not experience any side				
	effects.					
	Eli Lilly and Compa	ny proparihina information				
		ny prescribing information or duloxetine delayed release				
		ion, generalized anxiety				
		peripheral neuropathic pain,				
		nic musculoskeletal pain as				
		sage. Angry outbursts was not				
		on for use of Cymbalta.				
	Sleep:	for Demonstration				
	TBF- dated Sep-15					
	anilidepressant): Ina	ability to sleep indicated R25				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		27752	B. WING	·····	12/0	4/2015
NAME OF PRC	OVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SAINT THE	RESE AT OXBOW I	ΔK F	K GROVE PA YN PARK, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
ha sic The too Rosin trop of the too Rosin Plants sic Manner Tree to the too Rosin for the too Rosin R	de effects. BF-dated Octobers sleep indicated Refusals of cares to de effects once. BF-dated Novembrability to sleep indicated Restlessness and discrepancy Pharmace ackage insert and actober 30 2012, list dication for usage D-RX Pharmaceut sert and label information of the properties of the properti	enings and did not experience -2015, for Trazodone: inability 25 had trouble one day shift. vo times. R25 experienced er 2015, for Trazodone: icated R25 did not have any 25 did not experience any d not experience side effects. euticals USA Remeron label information dated ets major depression as the	21535			

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE \$200 OAK GROVE PARKWAY BROOKLYN PARK, MN \$543 SUMMARY STATEMENT OF DEFICIENCIES (RACH DE FICIENCY MUST BE PRECEDED BY FULL TAG PREFIX TAG CRECULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG COntinued From page 22 work, we would follow what nurse says, most likely leave him and reapproach later." On 12/0/15 at 2:45 p.m. registered nurse (RN)-D stated, "We monitor residents on antipsychotics, watch how they react with cares or with other residents and daily activities. We watch for side effects every day. I am not sure about orthostatic blood pressures or labs. Only the nurse's chart in the behavior book, the nursing assistants tell the nurses." On 12/04/15, at 7:49 a.m. licensed practical nurse (LPN)-C stated, "If he is grabbing in the air showing hallucinations or if he is agitated we would give him a prn. We try reposition tolleting redirecting before medications, it works some times. We chart why we are giving a PRN and what we tried first. It comes up for charting when you click on the medication to give II. "When asked if R25's behavior had improved since starting on the medication in LPN-C stated, "No, not really, he is about the same." On 12/4/15, at 8:15 a.m. the house coordinator-A said R25 "had always been pretty quiet, will converse with you. Some days he is more tired. I think he is status quo." On 12/4/15, at 8:32 a.m. RN-E stated for	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE \$200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443 CALL DEFICIENCY MUST BE PRECEDED BY FULL TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX CACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX TAG CROSS REFERENCE TO THE APPROPRIATE DATE DATE DATE DATE CROSS REFERENCE TO THE APPROPRIATE DATE DATE			27752	B. WING		12/0	4/2015
CALL DESCRIPTION CALL DEFICIENCES PROVIDER'S PLAN OF CORRECTION CALL PROVIDER'S PLAN OF CORRECTION CALL PROVIDER'S PLAN OF CORRECTION CALL PRECIDED BY FULL PRECIDENCE OF THE APPROPRIATE COMPLETE DATE 21535 Continued From page 22 21535 Continued From page 22 work, we would follow what nurse says, most likely leave him and reapproach later." CON 12/0/15 at 2:45 p.m. registered nurse (RN)-D stated, "We monitor residents on antipsychotics, watch how they react with cares or with other residents and daily activities. We watch for side effects, physical changes and update nurse practitioner as necessary. We monitor for side effects every day. I am not sure about orthostatic blood pressures or labs. Only the nurse's chart in the behavior book, the nursing assistants tell the nurses." CON 12/04/15, at 7:49 a.m. licensed practical nurse (LPN)-C stated, "If he is grabbing in the air showing hallucinations or if he is agitated we would give him a prn. We try reposition to liditing redirecting before medications, it works some times. We chart why we are giving a PRN and what we tried first. It comes up for charting when you click on the medication to give it." When asked if R25's behavior had improved since starting on the medication LPN-C stated, "No, not really, he is about the same." CONTENT OF THE PROVIDED OF THE PRO	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21535 Continued From page 22 work, we would follow what nurse says, most likely leave him and reapproach later." On 12/0/15 at 2:45 p.m. registered nurse (RN)-D stated, "We monitor residents on antipsychotics, watch how they react with cares or with other residents and daily activities. We watch for side effects, physical changes and update nurse practitioner as necessary. We monitor for side effects every day. I am not sure about orthostatic blood pressures or labs. Only the nurse's chart in the behavior book, the nursing assistants tell the nurses." On 12/04/15, at 7:49 a.m. licensed practical nurse (LPN)-C stated, "If he is grabbing in the air showing hallucinations or if he is agitated we would give him a prn. We try reposition toileting redirecting before medications, it works some times. We chart why we are giving a PRN and what we tried first. It comes up for charting when you click on the medication to give it." When asked if R25's behavior had improved since starting on the medication LPN-C stated, "No, not really, he is about the same." On 12/4/15, at 8:15 a.m. the house coordinator-A said R25 'had always been pretty quiet, will converse with you. Some days he is more tired. I think he is status quo."	SAINT T	HERESE AT OXBOW	I AK F				
work, we would follow what nurse says, most likely leave him and reapproach later." On 12/0/15 at 2:45 p.m. registered nurse (RN)-D stated, "We monitor residents on antipsychotics, watch how they react with cares or with other residents and daily activities. We watch for side effects, physical changes and update nurse practitioner as necessary. We monitor for side effects every day. I am not sure about orthostatic blood pressures or labs. Only the nurse's chart in the behavior book, the nursing assistants tell the nurses." On 12/04/15, at 7:49 a.m. licensed practical nurse (LPN)-C stated, "If he is grabbing in the air showing hallucinations or if he is agitated we would give him a prn. We try reposition toileting redirecting before medications, it works some times. We chart why we are giving a PRN and what we tried first. It comes up for charting when you click on the medication to give it." When asked if R25's behavior had improved since starting on the medication LPN-C stated, "No, not really, he is about the same." On 12/4/15, at 8:15 a.m. the house coordinator-A said R25 "had always been pretty quiet, will converse with you. Some days he is more tired. I think he is status quo."	PREFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
antipsychotics "We use the Psychotropic Medication Quarterly Review. I don't see any analysis that shows if this medication is working. I don't see anything in the progress notes either, for use of PRNs or analysis quarterly of effectiveness. I would think yes we should have something to show that the medication is effective and analysis of its usage on admission, annual	21535	work, we would followed likely leave him and the likely leave him and daily effects, physical charactitioner as necestificates every day. I blood pressures or the behavior book, nurses." On 12/04/15, at 7:4 (LPN)-C stated, "If showing hallucination would give him a predirecting before not times. We chart who what we tried first. I you click on the measked if R25's behave starting on the measked if R25's behave starting on the measked if R25's behave as a starting on the measked if R25's had alway converse with you. The likely	ow what nurse says, most direapproach later." p.m. registered nurse (RN)-Direction residents on antipsychotics, act with cares or with other activities. We watch for side anges and update nurse assary. We monitor for side am not sure about orthostatic labs. Only the nurse's chart in the nursing assistants tell the signabbing in the air ons or if he is agitated we may be are giving a PRN and at comes up for charting when adication to give it." When avior had improved since dication LPN-C stated, "No, not he same." The a.m. the house coordinator-A may been pretty quiet, will some days he is more tired. I wo." The a.m. RN-E stated for use the Psychotropic ly Review. I don't see any if this medication is working. If the progress notes either, analysis quarterly of all think yes we should have that the medication is effective that the medication is effective.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		27752	B. WING		12/0	4/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SAINT T	HERESE AT OXBOW	IAKE	K GROVE PA YN PARK, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21535	sig [significant] cha On 12/4/15, at 8:46 services (DCS) star chart the reason for electronic medication to complete the ass the assessments to effectiveness of the need for continued Psychotropic Medic January 2013 instructor receiving a medical have an approved of informed consent patherapeutic goal a drug chosen should dose possible only interventions to cor been attempted. "IV. Target Behavior residents that have the primary purpose behavior, and/or sle B. "Behaviors must the drug ordered. A need further explicity. Side effect mon residents with psyc Orthostatic hypoter and document on T record). SUGGESTED MET The director of nurs responsible for pair regarding rating pa	a.m. the director of clinical ted, "I would expect them to radministering a PRN in the con record. I would expect them sessments and I would expect to contain analysis of the emedication side effects and use." cations and Monitoring dated used staff all residents tion to alter a behavior are to diagnosis, reason for use, rior to initiation of medication, and symptoms monitored. The dibe administered in the lowest after non pharmaceutical attrol/alter the behavior have				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION ((X3) DATE SURVEY COMPLETED		
		27752	B. WING		12/0	4/2015
	PROVIDER OR SUPPLIER	5200 OAK	DRESS, CITY, S C GROVE PA YN PARK, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
21535	Continued From pa	ge 24	21535			
	was affective for pa	in relief.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21540	MN Rule 4658.1315 Usage; Monitoring	5 Subp. 2 Unnecessary Drug	21540			1/13/16
	monitor each reside unnecessary drug to home's policies and pharmacist must re resident's attending physician does not home's recommend adequate justification believes the resider adversely affected, matter to the medical director is rethe medical director is rethe medical director physician does not the order and if the change the order, the review to the Quality (QAA) committee rethe attending physician does not the attending physician does not the order and if the change the order, the attending physician physician does not the quality (QAA) committee rethe attending physician does not the attending physician does no	g. A nursing home must ent's drug regimen for usage, based on the nursing a procedures, and the port any irregularity to the physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist not's quality of life is being the pharmacist must refer the all director for review if the not the attending physician. If or determines that the attending have adequate justification for attending physician does not the matter must be referred for y Assurance and Assessment equired by part 4658.0070. If cian is the medical director, macist shall refer the matter				
	by: Based on interview pharmacist failed to had indications for tantipsychotic drug to	and document review, the ensure 1 of 5 residents (R25) the use of Seroquel (an used to treat various mental esident specific target		Clinical Director reviewed facility prowith Pharmacy Consultant to ensure residents have individualized consucompleted per guidelines.	e all	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		27752	B. WING		12/0	4/2015
	PROVIDER OR SUPPLIER HERESE AT OXBOW	STREET AD 5200 OAK	DRESS, CITY, S GROVE PA (N PARK, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21540	behaviors related to disorder in which the impaired that contact duloxetine delayed and for Trazodone medication) used for failed to respond to recommendations of the failed to recommendations of the failed to respond to recommendations of th	o psychosis (a severe mental lought and emotions are so ct is lost with external reality), release (an antidepressant) (an antidepressant or sleep. In addition, the facility ensure consultant pharmacist were acted upon for R25. The Review Forms dated (30/15, indicated no behaviors. Item Form dated 9/25/15, anoted to be very restless and at of wheelchair on multiple is also noted to be aggressive attempting to provide cares on sions. The Area Assessment atted adverse side effect of thibited by R25 were anxiety diverse side effect of thibited by R25 were lethargy, irium. The adverse side effect anxiety) exhibited by R25 disturbances of gait, delirium and the following was noted: oquel on 8/17/15. A review of the indicated R25 fell on an and had no injury, 8/28/15, skin tears to left elbow, 9/7/15, skin tears to right forearm, an with no injury, and on	21540	Behavior and Psychological Symp Dementia and Psychotropic Medic and Monitoring Policy was reviewed revised. R25 chart reviewed and resident away on 12/18/15. A facility audit was completed on Pharmacy consult reviews to ensucompliance with responses. An audit was completed on all reswhom have psychotropic meds or and comprehensively assessed to compliance. Clinical Coordinators re-educated ensuring that consults get completimely by 1/13/16.	eations ed and passed are idents dered ensure on	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		27752	B. WING		12/0	4/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SAINT T	HERESE AT OXBOW	I AK F	K GROVE PA YN PARK, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21540	R25 quarterly MDS was severely cognit assistance with acti The Quarterly MDS included heart failur pulmonary disease, addition, the quarte not experiencing habehaviors. R25's care plan prir BEHAVIOR: "I have statements and atte have a history of be staff and strike out history of expression refusing meals. I hapsychology and my currently. I take traz depression and helpsleep and appetite. restless/agitated/cotake Seroquel to mainterventions including medication per MD/practitioner] order, if from trazodone, Se hours of sleep ever environment at night MOOD: "My diagno insomnia places medepression and and altered mood. At risoutlook and experie episodes of delusional altered mental statustaff will offer TLC [reassurance, and 1	dated 9/25/15, indicated R25 tively impaired and required vities of daily living (ADLs). indicated R25's diagnoses re, chronic obstructive depression and dementia. In rly MDS indicated R25 was allucinations, delusions or any detect 10/7/15, instructed staff: a history of making suicidal empting to harm myself. I also sing verbally aggressive with at them physically. I have a ms of sadness, isolation, and are been evaluated by behaviors are managed rodone to manage my poincrease my hours of restful I have become more mbative with cares and now anage my symptoms. ed administer psychotropic (NP [medical doctor/nurse monitor for adverse effects roquel and Cymbalta. Monitor y shift. Provide dark, quiet and close door." sis of depression and a at risk for symptoms of ciety. At risk for confusion and the for having a negative encing mood swings. I have ns/hallucinations due to us. Interventions included all	21540			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		27752	B. WING		12/0	4/2015
	PROVIDER OR SUPPLIER	5200 OAK	DRESS, CITY, S GROVE PA (N PARK, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21540	light box in my room and shuts off at nig to family for reassu turn light on during quiet environment a Social service to vis questions/concerns socialization and obdepression/anxiety. The Physician Orderindicated R25 was milligrams (mg) one mg two times a day delusions. R25 coumg every six hours agitation. The Physindicated R25 was release capsule 60 and Trazodone 25 in Behavior symptoms A review of Medicate (MAR) Sheets and Sheets from Septemoted the following: September 2015 MAR-Seroquel 25 in needed (prn) for ag September 2015. Padministration, behavere charted only transmitted in were charted only transmitted in the recommendation were administration were	n that turns on in the morning ht. Involve spiritual care. Look rance prn, Open shades and the day prn. Provide a dark, at night and close his door. Sit 1:1 prn to assist with seencourage activity, offer been serve for symptoms of " Per Summary signed 11/17/15, to receive Seroquel 25 to time a day and Seroquel 50 or for anxiety, agitation and ld also receive Seroquel 25 as needed (PRN) for ician Order Summary also to receive duloxetine delayed mg every day for depression mg for insomnia. Signature Behavior Form (TBF) mber through November 2015 In gevery (q) 6 hours as itation was given 17 times in the prior to PRN Seroquel aviors warranting medication wice and nonpharmacological pted prior to medication to charted only once in the ich were reviewed from August	21540			
		for Seroquel: Frequent ted B25 had 17 attempts to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		27752	B. WING		12/0	04/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
SAINT T	HERESE AT OXBOW	IAK⊢	K GROVE PA YN PARK, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21540	get up/down (the TE where the resident delusions of the pas undocumented side There was a check indicated a side effect was, would be necessary signs were not expland did not match t TBF lacked specific medication. October 2015 MAR-Seroquel 25 r was given 13 times Seroquel administra medication were chnonpharmacologica to medication adminonce in the progres TBF-dated Sep-15 up/down) indicated delusions of the past delusions and did not match the progres. TBF-dated Sep-15 up/down) indicated delusions of the past delusions and did not match the progres. TBF-dated November 2015 MAR-Seroquel 25 r for agitation was given 13 times seroquel 25 r for agitation was given 15 up/down) indicated delusions and did not match the progres.	BF lacked information as to would get/down from) and six st. R25 experienced effects on five of 30 days. mark in the box which ect, but it was unknown what and if medical intervention y. The check marks and plus ained in the progress notes, he administration times. The chartest for the antipsychotic mg q 6 hours prn for agitation in October 2015. Prior to PRN ation, behaviors warranting arted only once and all interventions attempted prior instration were charted only s notes or medication record. for October: Agitation (getting R25 had nine attempts and st indicated R25 had nine ot experience side effects. Ing q 6 hours as needed (prn) in three times in November seroquel administration, and medication were not accological interventions in edication administration were progress Notes or MAR. In the service of the seroquel: attempting to get up/down in the service of the seroquel in the seroquel				
	indicated R25 had r delusions/hallucinate	tions indicated R25 had one				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		27752	B. WING		12/0	4/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SAINT T	HERESE AT OXBOW	I AK F	K GROVE PA YN PARK, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21540	delusions/hallucina any side effects. The Cardinal Healtl information dated N Schizophrenia and for use. It also indicapproved for the tredementia related psindicated, "Patients of orthostatic hypot feeling dizzy or light may lead to falls), einitial dose titration, re-initiating treatme. Non pharmacologic care plan printed 10 offer TLC [tender lodder TLC [tender lodder TLC] that turns on in the Involve spiritual car reassurance prn, Oduring the day prn. environment at night service to visit 1:1 guestions/concerns socialization and obdepression/anxiety. box were in place publications. TBF- dated Sep-15 release: angry outboutbursts and expessive effect once. TBF-dated October	tions and did not experience In package insert and label May 2, 2013, for Seroquel lists Bipolar Disorder as indication rates "Seroquel is not eatment of patients with sychosis." Package insert also should be advised of the risk ension (symptoms include theaded upon standing, which especially during the period of and also at times of int or increases in dose." Ital interventions identified on 0/7/15, indicated all staff will loving care], reassurance, and reasons behind my symptoms I have a light box in my room morning and shuts off at night. The Look to family for the Look to family for the shades and turn light on provide a dark, quiet that and close his door. Social for to assist with the encourage activity, offer the serve for symptoms of "All interventions except light for duloxetine delayed	21540	DEFICIENCY)		
		ursts indicated R25 had one enced an undocumented side				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		27752	B. WING		12/0	04/2015
	PROVIDER OR SUPPLIER HERESE AT OXBOW	5200 OAK	DRESS, CITY, S K GROVE PAI YN PARK, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21540	effect once. TBF-dated November delayed release: andid not have any out four times. R25 did effects. Eli Lilly and Compart dated June 2015, for lists major depression disorder, Diabetic pribromyalgia, Chrothe indication for us listed as an indication. Sleep: TBF-dated Sep-15 antidepressant): inabad trouble four everside effects. TBF-dated October to sleep indicated Free Refusals of cares to side effects once. TBF-dated November inability to sleep indicated Free Refusals of cares to side effects once. TBF-dated November inability to sleep indicated Free Refusals of cares to side effects once. TBF-dated November inability to sleep indicated Free Refusals of cares to side effects once. TBF-dated November inability to sleep indicated Free Refusals of cares to side effects once. TBF-dated November inability to sleep indicated Free Refusals of cares to side effects once. TBF-dated November inability to sleep indicated Free Refusals of cares to side effects once. TBF-dated November inability to sleep indicated Free Refusals of cares to side effects once. TBF-dated November inability to sleep indicated Free Refusals of cares to side effects once. TBF-dated November inability to sleep indicated Free Refusals of cares to side effects once. TBF-dated November inability to sleep indicated Free Refusals of cares to side effects once. TBF-dated November inability to sleep indicated Free Refusals of cares to side effects once. TBF-dated November inability to sleep indicated Free Refusals of cares to side effects once. TBF-dated November inability to sleep indicated Free Refusals of cares to side effects.	per 2015, for duloxetine agry outbursts indicated R25 atbursts and had restlessness not experience any side my prescribing information or duloxetine delayed release on, generalized anxiety eripheral neuropathic pain, nic musculoskeletal pain as age. Angry outbursts was not on for use of Cymbalta. for Remeron (an ability to sleep indicated R25 enings and did not experience recorded and the company of the co				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
		27752	B. WING		12/0	4/2015
	PROVIDER OR SUPPLIER HERESE AT OXBOW	5200 OAK	DRESS, CITY, S GROVE PA (N PARK, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETE DATE
21540	not listed as an indi Trazodone. Even though the far behaviors for the ps target behaviors lack behaviors for each In addition, the medadministration lack interventions and made recommendated the ps The Undated Pharman and recommendated the ps T	cation of use for Remeron or cility had identified target sychotropic medications, the cked appropriate specific of the psychotropic categories. dications that were ed non-pharmacological conitoring of adverse effects sychotropic medication. macy Visit Log indicated the cist reviewed R25's chart and ations as indicated: mart, hitting x1, agitation x1, voluntary Movement Scale] at irregularity" dent] stable, morphine conificant irregularity" agitation, seroquel increased, gularity" agitation, seroquel increased, gularity" bp [blood pressure]-unable resent irreg [irregularity]" Visit Log was requested and the pharmacist did not non-pharmacological of the use of the medications	21540			

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY. STATE, ZIP CODE SAINT THERESE AT OXBOW LAKE S200 OAK GROVE PARKWAY BROOKLYN PARK, WIN 55443 PROPRIETE ADDRESS. CITY. STATE, ZIP CODE S200 OAK GROVE PARKWAY BROOKLYN PARK, WIN 55443 PROVIDER'S PROVIDER'S PLAN OF CORRECTION (EACH OEPRICEAPOR WIST SEP PRECEDED BY BUILL (REQUILATORY OR LSC IDENTIFYING INFORMATION) 21540 Continued From page 32 work, we would follow what nurse says, most likely leave him and reapproach later." On 12/04/15, at 7:49 a.m. licensed practical nurse (LPN)-C stated, "If he is grabbing in the air showing hallucinations or if he is agitated we would give him a pri. We try reposition folleting redirecting before medications, it works some times. We chart why we are giving a PFN and what we tried first. It comes up for charting when you click on the medication to give it." When asked if R25's behavior had improved since starting on the medication to give it." When asked if R25's behavior had improved since starting on the medication to give it." When asked if R25's behavior had improved since starting on the medication to give it." When asked if R25's behavior had improved since starting on the medication to give it." When asked if R25's behavior had improved since starting on the medication to give it." When asked if R25's behavior had improved since starting on the medication to give it." When asked if R25's behavior had improved since starting on the medication to give it." When asked if R25's behavior had improved since starting on the medication is working on the progress notes early analysis that show that the medication is working. I don't see anything in the progress notes either, for use of PRNs or analysis quarterly of effectiveness. I would think yes we should have something to show that the medication is effective and analysis of its usage on admission, annual sig [significant] change and quarterly." On 12/4/15, at 8-46 a.m. the director of clinical services (DCS) stated, "I would expect them to chart the reason for admin	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
SAINT THERESE AT OXBOW LAKE CALL DATE CALL			27752	B. WING	·····	12/0	4/2015
INCOMPANDED SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION CASE	NAME OF I	PROVIDER OR SUPPLIER			,		
PRÉFIX TAG CANDESCIENCY MUST BE PRECEDED BY PULL REQUIREMENT TAG CROSS-REFERENCE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DATE 21540 Continued From page 32 work, we would follow what nurse says, most likely leave him and reapproach later." On 12/04/15, at 7:49 a.m. licensed practical nurse (LPN)-C stated, "If he is grabbing in the air showing hallucinations or if he is agitated we would give him a prn. We try reposition toileting redirecting before medications, it works some times. We chart why we are giving a PRN and what we tried first. It comes up for charting when you click on the medication to give it." When asked if R25's behavior had improved since starting on the medication LPN-C stated, "No, not really, he is about the same." On 12/4/15, at 8:15 a.m. the house coordinator-A said R25' had always been pretty quiet, will converse with you. Some days he is more tired. I think he is status quo." On 12/4/15, at 8:32 a.m. RN-E stated for antipsychotics "We use the Psychotropic Medication Quarterly Review. I don't see any languist that shows if this medication is working. I don't see anylaing in the progress notes either, for use of PRNs or analysis quarterly of effectiveness. I would think yes we should have something to show that the medication is effective and analysis of its usage on admission, annual sig [significant] change and quarterly." On 12/4/15, at 8:46 a.m. the director of clinical services (DCS) stated, "I would expect them to chart the reason for administering a PRN in the electronic medication record. I would expect them to complete the assessments and I would expect them to seemed the assessments and I would expect them to semester and the progress of the semester and the progress and progress	SAINT T	HERESE AT OXBOW I					
work, we would follow what nurse says, most likely leave him and reapproach later." On 12/04/15, at 7:49 a.m. licensed practical nurse (LPN)-C stated, "If he is grabbing in the air showing hallucinations or if he is agitated we would give him a prn. We try reposition toileting redirecting before medications, it works some times. We chart why we are giving a PRN and what we tried first. It comes up for charting when you click on the medication to give it. "When asked if R25's behavior had improved since starting on the medication LPN-C stated, "No, not really, he is about the same." On 12/4/15, at 8:15 a.m. the house coordinator-A said R25 "had always been pretty quiet, will converse with you. Some days he is more tired. I think he is status quo." On 12/4/15, at 8:32 a.m. RN-E stated for antipsychotics "We use the Psychotropic Medication Quarterly Review. I don't see any analysis that shows if this medication is working. I don't see anything in the progress notes either, for use of PRNs or analysis quarterly of effectiveness. I would think yes we should have something to show that the medication is effective and analysis of its usage on admission, annual sig [significant] change and quarterly." On 12/4/15, at 8:46 a.m. the director of clinical services (DCS) stated, "I would expect them to chart the reason for administering a PRN in the electronic medication record. I would expect them to complete the assessments and I would expect them to complete the assessments to contain analysis of the	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
effectiveness of the medication side effects and need for continued use."	21540	work, we would folk likely leave him and On 12/04/15, at 7:4 (LPN)-C stated, "If I showing hallucination would give him a predirecting before notimes. We chart who what we tried first. I you click on the measked if R25's behastarting on the med really, he is about the On 12/4/15, at 8:15 said R25 "had alway converse with you, think he is status quere analysis that shows don't see anything if for use of PRNs or effectiveness. I would something to show and analysis of its using [significant] chart the reason for electronic medication to complete the asset the assessments to effectiveness of the	ow what nurse says, most a reapproach later." 9 a.m. licensed practical nurse he is grabbing in the air ons or if he is agitated we now the try reposition to leting hedications, it works some by we are giving a PRN and the comes up for charting when dication to give it." When the try when the try when dication to give it. When the try when dication LPN-C stated, "No, not he same." a.m. the house coordinator-A by been pretty quiet, will some days he is more tired. I wow the Psychotropic by Review. I don't see any if this medication is working. In the progress notes either, analysis quarterly of all think yes we should have that the medication is effective isage on admission, annual high and quarterly." a.m. the director of clinical ed, "I would expect them to administering a PRN in the on record. I would expect them to essments and I would expect contain analysis of the medication side effects and	21540			

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		27752	B. WING		12/0	4/2015
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 12/0	172010
SAINT T	HERESE AT OXBOW	IAKF	GROVE PA			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21540	During interview on pharmacist stated, facility in July. I will log every time I che significant irregular pharmacy recommeresponse by next vif no response. For expect an AIMs whand every six mont blood pressures at believe the facility is expect to see docu usage of non pharm would expect to see behaviors that trigg effectiveness The cwould choose but if Psychotropic Medic January 2013 instructoring a medical have an approved informed consent patherapeutic goal addrug chosen should dose possible only interventions to corbeen attempted. "IV. Target Behavior residents that have the primary purposibehavior, and/or sleep. "Behaviors must the drug ordered. A need further explicity. "Side effect mon residents with psycials."	12/4/15, at 9:32 a.m. "We started coming to the make a note on the pharmacy ock the chart. If I write non ity on the log I will write a cendation and expect a sist. A request will be rewritten residents on an antipsychotic I cen the medication is started, hs. I would expect orthostatic minimum quarterly although I is doing them monthly. I would mentation in the chart of nacological interventions. I ce them document the ers use of a prn and it's diagnosis for R25 is not what I is appropriate. The stations and Monitoring dated for a behavior are to diagnosis, reason for use, rior to initiation of medication, and symptoms monitored. The is abenducted the lowest after non pharmaceutical attrol/alter the behavior have	21540			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE COMP			SURVEY LETED
		27752	B. WING		12/0	4/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SAINT T	HERESE AT OXBOW	IAKF	GROVE PA N PARK, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21540	Continued From pa	ge 34	21540			
	and document on T Record]."	AR [Treatment Administration				
	The director of nurs revise the policies a medication monitor provide education to could develop a mo	ETHOD FOR CORRECTION: sing (DON) could review and and procedures related ing. DON or designee could or all involved staff. The facility enitoring system to ensure the and report the findings to the Committee.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty one				
21615	MN Rule 4658.1340 Preparation Area;So	O Subp. 2 MedicineCabinet & cheduleII	21615			1/13/16
	nursing home must compartments, peri physical plant or me	of Schedule II drugs. A provide separately locked manently affixed to the edication cart for storage of ted in Minnesota Statutes, odivision 3.				
	by: Based on observati review, the facility fa boxes were double This had the potent	on, interview and document ailed to ensure 2 of 5 narcotic locked to prevent diversion. ial to affect the 10 residents redications stored in cabineting station.		Controlled Substance policy was reviewed, all Licensed staff were re-educated on current policy by 1 Audits will be completed to ensure narcotic medications are double to per policy weekly x 90 days by the Director/designee and findings will reported quarterly at the QAA.	e that the ocked Clinical	

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Minnesota Department of Health

27752 B. WING 12/04/2015	12/04/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
SAINT THERESE AT OXBOW LAKE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443	
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	OULD BE COMPLETE
21815 Continued From page 35 On 11/30/15, at 12:11 p.m. during a medication observation for R25, registered nurse (RN)-B was observed open a cabinet above the sink located in the back of the nursing station. Upon opening the cabinet using a small key, two red boxes were observed observed on each of the shelves. The two boxes labelled ProBox were observed to have pad locks that were not locked even though RN-indicated the facility used those to store narcotics. On 11/30/15, at 6:07 p.m. during a random observation on the Rhode House neighborhood, two red boxes were observed when a staff member unlocked a cabinet at the nurse 's station. The boxes were observed with padlocks on both but the padlocks were not locked. On 12/1/15, at 8:39 a.m. registered nurse (RN)-C stated residents who received Tramadol and narcotic had those stored at the nursing station in the cabinet and were supposed to be double locked. On 12/3/15, at 6:22 a.m. licensed practical nurse (LPN)-B was observed open the cabinet above the sink where the narcotic boxes were stored. LPN- reached out grabbed both red narcotic boxes off the shelves and set them on top of the counter and both had the padlock but was not locked, opened one after the other and counted the narcotics with the night LPN-A. At 6:25 a.m. LPN-B put the boxes back into the cabinet and locked. When asked if the padlocks were supposed to be double locked when asked if the padlocks were supposed to be locked LPN-B acknowledged the padlocks.	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			D WING			
		27752	B. WING		12/0	4/2015
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S GROVE PA	STATE, ZIP CODE		
SAINT TI	HERESE AT OXBOW	IAKF	'N PARK, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21615	Continued From page 36		21615			
	services stated "I w	p.m. the director of clinical rould expect them to follow the otic policy" when asked her nurses.				
	cabinets are supporting red boxes are narcotic boxes are the padlocks. LPN-	a.m. LPN-C stated the sed to be kept locked because arcotic boxes. LPN-C the supposed to be locked with C indicated one of the box had Norco, Clonopin and				
	Medications: Controlled Substance policy dated January 2015, directed staff "F. All Controlled Drugs will be stored in a locked box in a locked cabinet or medication room."					
	The director of nurs assure the narcotic staff are trained reg	THOD OF CORRECTION: sing and or designees could box is double locked, that garding the proper procedure is monitored, assessed and e compliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21665	MN Rule 4658.1400	O Physical Environment	21665			1/13/16
	functional, comforta environment, allowi	ust provide a safe, clean, able, and homelike physical ng the resident to use s to the extent possible.				
	This MN Requirements	ent is not met as evidenced				

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Minnesota Department of Health STATE FORM

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		27752	B. WING		12/04/2015	
NAME OF I	PROVIDER OR SUPPLIER	CTDEET AD	DDECC CITY (STATE, ZIP CODE		
NAIVIE OF I	PROVIDER OR SUPPLIER		GROVE PA			
SAINT T	HERESE AT OXBOW	I AK F	YN PARK, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE COMPLETE	
21665	Continued From pa	ge 37	21665			
	Based on observation, interview and document review, the facility failed to ensure environment was maintained in a sanitary manner and was in good repair for 13 of 35 residents.			R25, R60, R40, R52, R44, and R7 bathrooms were cleaned and sani R25, R60, R44, R9, R24, R19, and	tized. d R45	
	Findings include:			walls in resident room were repair	ed.	
	On 10/0/15 at 0:00	a m. an anvironmental tour		R52 scooter was cleaned.		
	was completed with administrator, admi	a.m. an environmental tour executive director, assistant nistrative intern, ervisor, and plant operations		All resident rooms were reviewed necessary repairs. Repairs were completed.	for	
	stained yellow.	All resident rooms cleaning schedules were reviewed and updated to include increased cleanings of resident bathrooms.				
	bathroom toilets an once a week and in cleaned either toda stated staff calls if t	deeping supervisor (HS) stated dentire rooms get cleaned dicated the room may be yor tomorrow. He further hey had an immediate a, they have access to the		The Department Housekeeping policy and preventative maintenance inspection policy were reviewed.		
	R25's Quarterly Mir	et supplies after hours. nimum Data Set (MDS) dated R25 had severe cognitive		Staff education on environment cleand maintenance will be complete 1/13/16.		
	impairment and rec	uired extensive one to two with most activities of daily		Environmental audits will be comp 15% of resident rooms weekly for to ensure compliance and results reported to the QA Committee me	90 days will be	
	bowel movement si			action plans developed as needed will determine the need for ongoin monitoring.	, and	
	and stated it had no out when it would b director (POD) state	ofirmed smears on toilet riser on toen cleaned and would find e cleaned. Plant operations ed he would repair wall and wall scratches near the		Plant Operations Director and/or or is responsible for ongoing complia		

Minnesota Department of Health STATE FORM

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				-		
		27752	B. WING		12/0	4/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SAINT T	HERESE AT OXBOW	IAKE	CGROVE PA YN PARK, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21665	Continued From pa	ge 38	21665			
	R60's annual MDS indicated R60 had i	assessment dated 9/25/15, moderate cognitive impairment sive one to two person				
	R40's bathroom toilet riser was observed with bowel movement smears on the seat.					
	out when the room and indicated toilet toilets were cleaned	a.m. HS stated he would find was scheduled for cleaning risers, surfaces, all around d. In addition, executive d it would be cleaned.				
	indicated R40 did n	quired extensive one person				
	R52's scooter's foo stained yellow.	t area was observed to be				
	privately owned and	a.m. HS stated scooters were d indicated R44 recently D stated it would be cleaned.				
	indicated R52 was	assessment dated 10/21/15, cognitively intact and required to person assistance with most				
	odor, there were se colored stains were entryway, a short g	ed was observed to have urine everal four to six inch light e dripping down room wall near ray line on the wall near head om floor had red/brown colored				
		a.m. POD stated gray wall lchair and would be repaired.				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		27752	B. WING		12/0	4/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SAINT T	HERESE AT OXBOW I		C GROVE PA (N PARK, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21665	ED stated stains wo wall would be spot processed to spot processed	build be cleaned and HS stated bainted. S assessment dated 11/15/15, cognitively intact and required assistance with most ADL's. If had been observed on the ertical lines on wall across from 0 stated these would be Same of the ertical lines on wall across from 0 stated these would be Simum Data Set (MDS) dated (R25 had severe cognitive uired extensive one to two with most activities of daily It with long scratch marks on a compart of the ertical lines on the ertical lines on wall across from 0 stated these would be	21665	DEFICIENCY)		
	R19's admission MI	DS dated 9/9/15, indicated rintact and required extensive				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		27752	B. WING		12/0	4/2015
	PROVIDER OR SUPPLIER	5200 OAK	DRESS, CITY, S GROVE PA 'N PARK, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21665	one to two person at On 11/30/15, at 6:2 was observed with lon 12/3/15, at 9:45 repaired. R19's admission MIR19 was cognitively one to two person at R71's annual MDS indicated R71 had and required extensional assistance with most observed with black several gouges on the Company of the Com	assistance with most ADL's. 7 p.m. R19's bedroom wall long scratch mark in entryway. a.m. POD stated it would be DS dated 9/9/15, indicated intact and required extensive assistance with most ADL's. assessment dated 8/28/15, severe cognitive impairment sive one to two person st ADL's. a.m. R71's bathroom wall interest line across from sink and wall. tated repairs would be made. Il observed with gouges in it.	21665			
	walk-through's with	ely did daily building staff. He also did weekly and ılk-through's with his				

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED						
		27752	B. WING		12/0	4/2015					
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE							
SAINT THERESE AT OXBOW LAKE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443											
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ION SHOULD BE COMPLETE THE APPROPRIATE DATE						
21665	Continued From page 41		21665								
	periodic painting ma reported nursing an concerns. He stated system for mainten	a.m. POD stated he did aintenance, including any d housekeeping staff d the facility used Micromain ance. Staff entered a work ince picked up and resolved									
	think it acceptable to only once a week. Streason for houseke	0 a.m. ED stated she did not hat room toilets were cleaned the further stated that was the eping closets on each unit, to a toilet when it was dirty.									
	life specialists (CLS between weekly roo On 12/3/15, at 12:2 walk-through's to ol On 12/4/15, at 8:50 stated if he had a hwould call the HS a not working or he h concern, he would and maintenance. 12/4/15 at 8:55 a.m housekeeping or m	2 a.m. HS stated community s) should be spot cleaning in om cleanings. 5 p.m. POD stated he did daily be serve for any issues. a.m. registered nurse (RN)-C, ousekeeping concern he and report it. If call lights were ad another maintenance update the clinical coordinator. CLS-(C), stated if she had a aintenance concern, she eping or maintenance.									
	indicated "policy: to are attended to in a Micromain work ord maintenance staff r communication reg. orders and who is v none are missed fo Work order request repairs policy dated	arding the status of work vorking on the work order so									

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED							
		27752	B. WING		12/0)4/201 5						
NAME OF			DDECC CITY (CTATE ZID CODE	1 12/0	77/2013						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY												
SAINT THERESE AT OXBOW LAKE BROOKLYN PARK, MN 55443												
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE						
21665	through Micromain Preventative mainted dated 9/10, indicated conduct regular inspidentify maintenance services to remedy maintain a sanitary, interior. Procedure: will be scheduled or follow-up random a plant operations directly ensure proper complepartment Housel policy indicated "reson a regular basis." SUGGESTED MET director of facility or revise the policies, and identify trends of The director of nursi reporting environments.	software system." enance inspections policy of "plant operations staff will bections of the facility to e issues and provide repair all issues. Purpose: to orderly and comfortable D) all areas for inspections n a quarterly basis. E) udits will be conducted by the ector on a quarterly basis to	21665									

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