



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 19, 2025

Licensee

Saint Therese Of Oxbow Lake
5200 Oak Grove Parkway
Brooklyn Park, MN 55443

RE: Project Number(s) SL30544016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 9, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility.**

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

resident(s)/employee(s) identified in the correction order.

- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

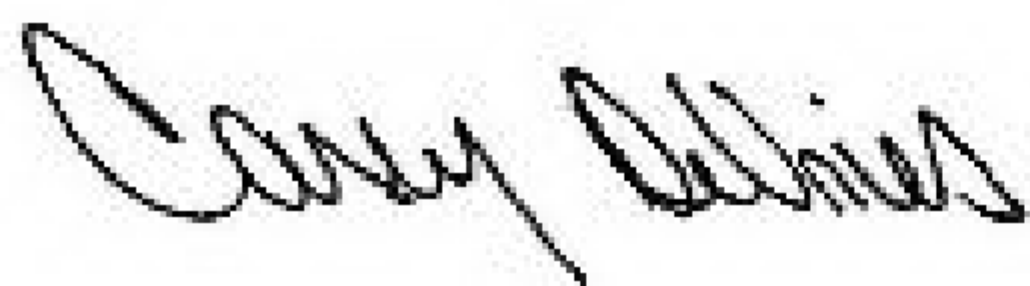
<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor

State Evaluation Team

Email: casey.devries@state.mn.us

Telephone: 651-201-5917 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30544	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER SAINT THERESE OF OXBOW LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30544016-0 On January 6, 2025, through January 9, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 61 residents all of whom received services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is 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. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30544	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER SAINT THERESE OF OXBOW LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30544	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER SAINT THERESE OF OXBOW LAKE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 6, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30544	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER SAINT THERESE OF OXBOW LAKE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480			
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure required orientation training documentation was included in employee records for two of two employees (unlicensed personnel (ULP)-B, registered nurse (RN)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30544	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER SAINT THERESE OF OXBOW LAKE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 650	Continued From page 4 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired by licensee on May 20, 2024, to provide direct care to residents. ULP-B's employee record lacked the following required orientation content: - overview of assisted living statutes, and - evidence of TB Training upon hire. RN-C RN-C was hired by licensee on February 5, 2024, to provide direct care to residents. RN-C's employee record lacked the following required orientation content: - overview of assisted living statutes; - principles of person-centered planning/service delivery; and - evidence of TB Training upon hire. On January 8, 2025, at 9:30 a.m., RN-C stated they completed their orientation before starting to provide direct care to the licensee's residents. On January 8, 2025, at 10:00 a.m., licensed assisted living director (LALD)-D stated all the licensee's employees completed TB training during orientation and before starting to provide direct resident cares. LALD-D also stated they did not know ULP-B and RN-C's record missed the TB training documentation.	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30544	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER SAINT THERESE OF OXBOW LAKE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 650	Continued From page 5 On January 8, 2025, at 1:30 p.m., LALD-D stated all the licensee's employees undergo orientation training before starting to provide direct resident cares. LALD-D also stated they did not know how ULP-B and RN-C's record missed the orientation training documentation. The licensee's Assisted Living with Dementia Care Orientation - All Staff dated November 2, 2022, indicated infection control training will incorporate TB prevention and control. The licensee's Assisted Living with Dementia Care Orientation - All Staff policy indicated newly hired staff will receive orientation and training on topics required for assisted living organizations including the topics above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current State Fire Code in Minnesota Rules, chapter 7511. This had the potential to directly affect all residents, staff, and visitors.	0 775			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30544	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER SAINT THERESE OF OXBOW LAKE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 775	Continued From page 6 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On January 8, 2025, from 10:00 a.m. to 12:30 p.m., the surveyor toured the facility with plant operations director (POD)-E and vice president of operations (VPO)-F. The surveyor made the following observations of non-compliance with current Minnesota Fire Code provisions: FIRE RESISTANT RATED DOORS The fire-rated electrical room doors inside the housekeeping closets on third floor and second floor did not close and positively latch. The fire-rated closet door inside the memory care office on first floor did not close and positively latch. The fire-rated housekeeping closet door inside the laundry room on first floor did not close and positively latch. Fire resistant rated doors are required to automatically close and latch to prevent the spread of flame and smoke in the event of a fire or similar emergency in accordance with Minnesota State Fire Code. POD-E and VPO-F visually verified these	0 775			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30544	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER SAINT THERESE OF OXBOW LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 775	Continued From page 7 deficient findings at the time of discovery. On January 8, 2025, POD-E and VPO-F stated they did not know the doors listed above were not functioning as designed. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30544	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER SAINT THERESE OF OXBOW LAKE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 810	Continued From page 8 every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and to provide the required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 8, 2025, plant operations director (POD)-E provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Safety and Emergency Plan", dated January 2021, failed to include the following: The FSEP included a resident roster that indicated the evacuation level of each resident but lacked instructions for staff on how to provide	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30544	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER SAINT THERESE OF OXBOW LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 810	Continued From page 9 assistance during a fire or evacuation to any residents identified as needing assistance. On January 8, 2025, at 1:30 p.m., POD-E stated they did not have instructions to staff on how to provide assistance to residents and did not have a tool or system in place for staff to quickly identify which residents needed assistance with movement or evacuation in the event of a fire or similar emergency. TRAINING: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. POD-E lacked documentation showing any training was offered or training was scheduled for a future date for employees on the fire safety and evacuation plan. On January 8, 2025, at 1:30 p.m., POD-E stated they reviewed the fire safety policy with staff at the time of each fire drill, but lacked documentation indicating that all staff received the required amount of training on the FSEP. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by:	01770			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30544	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER SAINT THERESE OF OXBOW LAKE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01770	Continued From page 10 Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R5's diagnoses included essential hypertension, atrial fibrillation, type II diabetes, and chronic kidney disease. R5's Individualized Service Plan dated October 11, 2024, indicated R5 received medication management services. R5's medication administration record (MAR) dated between January 1, 2025, and January 8, 2025, indicated R5 received the following medications: allopurinol oral tablet 100 milligram (mg), give two tablets by mouth daily, donepezil hcl oral tablet 10 mg, give one tablet by mouth daily, glipizide oral tablet 2.5 mg give three tablets by mouth one time daily, hydrochlorothiazide oral tablet 25 mg, give one tablet by mouth in the morning, lisinopril oral tablet 40 mg give one tablet by mouth one time daily, metoprolol tartrate oral tablet 100 mg give one tablet two times daily, Eliquis oral tablets 5 mg give one tablet by mouth two times daily, and vitamin D3 oral tablet 50 microgram (mcg) tablet give one tablet by mouth	01770			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30544	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER SAINT THERESE OF OXBOW LAKE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01770	Continued From page 11 one time daily. On January 8, 2025, at 8:05 a.m., the surveyor observed unlicensed personnel (ULP)-B take medications from a set pill box and administer the oral medications to R5. ULP-B stated the medications were set up by the registered nurse (RN) weekly. R5's record lacked documentation of medication set up to include: - dates of medication setup; and - name of person completing medication setup. On January 8, 2025, at 1:30 p.m., clinical nurse supervisor (CNS)-A stated the RN used R5's current electronic medication administration record (eMAR) to set up the medication. CNS-A also stated that there was no further documentation in the resident record and that there were more residents who received medication set up services and that the procedure was the same for all of them. The licensee's Medication, Treatment and Therapy Reminders policy dated October 2022, indicated the nurse who sets up the medications in the dosage box will monitor the medication reminder documentation and compliance and will initial that this has been done. The medication regimen will also be updated and reviewed at the same time of medication set up. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30544	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER SAINT THERESE OF OXBOW LAKE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01820	Continued From page 12	01820			
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a written or electronically recorded prescription was obtained for one of four residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R5's diagnoses included essential hypertension, atrial fibrillation, type II diabetes, and chronic kidney disease. R5's Individualized Service Plan dated October 11, 2024, indicated R5 received medication management services. R5's medication administration record (MAR) dated between January 1, 2025, and January 8, 2025, indicated R5 received the following medications: allopurinol oral tablet 100 milligram (mg), give two tablets by mouth daily, donepezil hcl oral tablet 10 mg, give one tablet by mouth	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30544	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER SAINT THERESE OF OXBOW LAKE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01820	Continued From page 13 daily, glipizide oral tablet 2.5 mg give three tablets by mouth one time daily, hydrochlorothiazide oral tablet 25 mg, give one tablet by mouth in the morning, lisinopril oral tablet 40 mg give one tablet by mouth one time daily, metoprolol tartrate oral tablet 100 mg give one tablet two times daily, Eliquis oral tablets 5 mg give one tablet by mouth two times daily, and vitamin D3 oral tablet 50 microgram (mcg) tablet give one tablet by mouth one time daily. R5's provider orders signed and dated October 1, 2024, indicated hydrochlorothiazide oral capsule 12.5 mg, give one capsule by mouth daily. R5's unsigned after visit summary printed on November 9, 2024, indicated hydrochlorothiazide oral tablet 25 mg, give one tablet by mouth daily. On January 8, 2025, at 1:30 p.m., clinical nurse supervisor (CNS)-A stated R5's new dosage script was sent to the pharmacy and the licensee only received the after-visit summary. CNS-A also stated it was an oversight on their part to follow up with the provider to write them a signed order. The licensee's Medication & Treatment Orders: Receiving, Renewal, Implementation, and Reordering policy dated April 2024, indicated all medication and treatment orders must be signed by the prescriber either by hand or by a legal electronic signature. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30544	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER SAINT THERESE OF OXBOW LAKE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01890	Continued From page 14	01890			
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure expired medications were discarded for two of five residents (R6, R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On January 7, 2025, at 9:43 a.m., the surveyor observed the medication cart in the memory care unit, and the following medications were expired: R6 - hydrocort cream 1% expired October 3, 2024; - nystatin cream usp expired November 12, 2024; - quetiapine tablet 25 milligram (mg) take one-quarter tablet (6.26 mg) by mouth daily as needed expired December 28, 2024; and - acetaminophen tablet 500 mg one tablet by mouth three times daily not to exceed 4000	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30544	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER SAINT THERESE OF OXBOW LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01890	Continued From page 15 mg/24 hours as needed for pain expired December 13, 2024. R7 - lubricant eye drops instill one drop into both eyes as needed for dry eyes expired April 19, 2024; and - advanced antacid take twice daily as needed for stomach pain expired June 20, 2024. On January 7, 2025, at 10:30 a.m., registered nurse (RN)-C stated they completed medication cart audits weekly. RN-C also stated probably they were not paying close attention to the as needed medications and that they checked medication dosage more closely than expiration dates. The licensee's Expired Medications policy dated January 2024, indicated expired medications will be disposed of per the disposition or disposal of medication policy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			

Type: Full
Date: 01/07/25
Time: 12:45:09
Report: 1004251005

Food and Beverage Establishment Inspection Report

Page 1

Location:

Saint Therese Of Oxbow Lake
5200 Oak Grove Parkway
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:

ID #: 0038716
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634937000
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

2-100 Supervision**2-102.12AMN**

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO CURRENT STATE CERTIFIED FOOD PROTECTION MANAGER. KITCHEN MANAGER HAS TAKEN FOOD SAFETY COURSE BUT DID NOT APPLY WITH THE STATE FOR CERTIFICATION. INFORMATION PROVIDED WITH REPORT.

Comply By: 01/07/25

4-500 Equipment Maintenance and Operation**4-501.11AB**

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

FRONT PREP LINE HAD MULTIPLE SECTIONS THAT WERE NOT CURRENTLY WORKING. KITCHEN STAFF WERE USING TIME AS A PUBLIC HEALTH CONTROL AND LIMITING FOOD STOCKED IN THE PREP LINE TO 2 HOURS AND THEN DISCARDING. *WORK ORDER HAS BEEN PUT IN FOR REPAIR.

Comply By: 01/07/25

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit

Location: WIPING CLOTH BUCKET

Violation Issued: No

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit

Location: WIPING CLOTH BUCKET

Violation Issued: No

Type: Full
Date: 01/07/25
Time: 12:45:09
Report: 1004251005
Saint Therese Of Oxbow Lake

Food and Beverage Establishment Inspection Report

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

Wash Temp. Gauge: = at 155 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Rinse Temp. Gauge: = at 195 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Utensil Surface Temp.: = at 176 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: TACO MEAT
Temperature: 178 Degrees Fahrenheit - Location: STEAM WELL
Violation Issued: No

Process/Item: BROCCOLI CHEESE SOUP
Temperature: 125 Degrees Fahrenheit - Location: STEAM WELL *TAPHC
Violation Issued: No

Process/Item: DICED TOMATO
Temperature: 50 Degrees Fahrenheit - Location: COLD PREP LINE *TAPHC
Violation Issued: No

Process/Item: CHICKEN
Temperature: 210 Degrees Fahrenheit - Location: COOK TEMP
Violation Issued: No

Process/Item: HAM
Temperature: 38 Degrees Fahrenheit - Location: PREP TOP COOLER
Violation Issued: No

Process/Item: CORNED BEEF
Temperature: 40 Degrees Fahrenheit - Location: PREP TOP COOLER
Violation Issued: No

Process/Item: CHICKEN
Temperature: 36 Degrees Fahrenheit - Location: REACH-IN PREP COOLER
Violation Issued: No

Process/Item: PEARS
Temperature: 40 Degrees Fahrenheit - Location: ARCTIC AIR STANDING COOLER
Violation Issued: No

Process/Item: NAVY BEAN SOUP
Temperature: 38 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Type: Full
Date: 01/07/25
Time: 12:45:09
Report: 1004251005
Saint Therese Of Oxbow Lake

Food and Beverage Establishment Inspection Report

Process/Item: FRENCH ONION SOUP
Temperature: 112 Degrees Fahrenheit - Location: WALK-IN COOLER *COOLING 1HR
Violation Issued: No

Process/Item: CUT LETTUCE
Temperature: 39 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: CUT LETTUCE
Temperature: 38 Degrees Fahrenheit - Location: BASEMENT WALK-IN COOLER
Violation Issued: No

Process/Item: BROCCOLI CHEESE SOUP
Temperature: 143 Degrees Fahrenheit - Location: MEMORY CARE SOUP WELL
Violation Issued: No

Process/Item: MILK
Temperature: 38 Degrees Fahrenheit - Location: MEMORY CARE REFRIGERATOR
Violation Issued: No

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		0	0	2

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY BENARD NYANGENA.

- DISCUSSED:
- EMPLOYEE ILLNESS POLICY AND LOG
 - HANDWASHING
 - SANITIZER USE AND TEST KITS
 - VEGETABLE WASH USE AND TESTING
 - CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
 - HIGH TEMPERATURE SANITIZING DISH MACHINE TEMPERATURE VERIFICATION
 - DATE MARKING PROCEDURES
 - COOLING PROCEDURES
 - REHEATING PROCEDURES
 - THERMOMETER USE AND CALIBRATION
 - SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
 - VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
 - FOOD SOURCE
 - RECEIVING DELIVERIES PROCEDURES
 - FOOD SERVICE PROCEDURES
 - PEST CONTROL
 - PHYSICAL FACILITIES AND MAINTENANCE

*REPORT WAS DISCUSSED WITH OPERATORS ON SITE AND WITH THE NURSE EVALUATOR, BENARD.

*MEMORY CARE KITCHEN HAS RESIDENTIAL CABINETRY AND APPLIANCES. AREA IS ONLY USED AS A SERVICING STATION: ALL MEALS ARE PLATED IN THE MAIN KITCHEN AND DELIVERED FOR SERVICE.

Type: Full
Date: 01/07/25
Time: 12:45:09
Report: 1004251005
Saint Therese Of Oxbow Lake

Food and Beverage Establishment Inspection Report

*IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE RESIDENT. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1004251005 of 01/07/25.

Certified Food Protection Manager NONE

Certification Number: _____ Expires: ____/____/____

Inspection report reviewed with person in charge and emailed.

Signed: _____
JOSH ANDERSON

Signed: Molly Dougherty
Molly Dougherty
Public Health Sanitarian
Metro District Office
651-201-3978
molly.dougherty@state.mn.us