DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ES5O

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 27752

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245619**

2.STATE VENDOR OR MEDICAID NO.
(L2) **753490000**

3. NAME AND ADDRESS OF FACILITY
(L3) **SAINT THERESE AT OXBOW LAKE**
(L4) **5200 OAK GROVE PARKWAY**
(L5) **BROOKLYN PARK, MN** (L6) **55443**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/5/2014** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
06/13

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **64** (L18)

13.Total Certified Beds **64** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	64			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Unit Supervisor 12/08/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/08/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
07/16/2013
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/24/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245619

December 8, 2014

Ms. Brandi Barthel, Administrator
Saint Therese At Oxbow Lake
5200 Oak Grove Parkway
Brooklyn Park, Minnesota 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 November 28, 2014 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

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

December 8, 2014

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

RE: Project Number S5619002

Dear Ms. Barthel:

On November 3, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 23, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 5, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 23, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 28, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 23, 2014, effective November 28, 2014 and therefore remedies outlined in our letter to you dated November 3, 2014, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245619	A. Building B. Wing	12/5/2014

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **11/28/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **11/01/2014**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **11/28/2014**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **11/28/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____ **State Agency**	**Reviewed By** GD/KFD	**Date:** 12/08/2014	**Signature of Surveyor:** 18623	**Date:** 12/05/2014
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 10/23/2014	_____	**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245619	01 - MAIN BLDG	11/19/2014

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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0020	10/31/2014	ID Prefix Reg. # NFPA 101 LSC K0043	11/06/2014	ID Prefix Reg. # NFPA 101 LSC K0077	10/23/2014
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/KFD	12/08/2014	28120	11/19/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/22/2014			

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ES5O

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 27752

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245619**

2.STATE VENDOR OR MEDICAID NO.
(L2) **753490000**

3. NAME AND ADDRESS OF FACILITY
(L3) **SAINT THERESE AT OXBOW LAKE**
(L4) **5200 OAK GROVE PARKWAY**
(L5) **BROOKLYN PARK, MN** (L6) **55443**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/23/2014** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
06/13

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **64** (L18)

13.Total Certified Beds **64** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	64			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Kathy Sass, HPR Dietary Specialist 11/21/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 11/24/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
____

22. ORIGINAL DATE OF PARTICIPATION
07/16/2013
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: November 3, 2014

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

RE: Project Number S5619002

Dear Ms. Barthel:

On October 23, 2014, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), 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

Informal Dispute Resolution - 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, Gayle Lantto, and Sue Reuss
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: gloria.derfus@state.mn.us
Telephone: (651) 201-3792

Email: gayle.lantto@state.mn.us
Telephone: (651) 201-3794

Email: susanne.reuss@state.mn.us
Telephone: (651) 201-3793

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 December 2, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 2, 2014 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

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.

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 January 23, 2015 (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 April 23, 2015 (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
Division of Compliance Monitoring
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 electronic 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:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions about this electronic notice.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245619	A. BUILDING _____ B. WING _____	10/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic 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.	F 000		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		11/28/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245619	A. BUILDING _____ B. WING _____	10/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor for potential side effects of antidepressant and antianxiety medications for 3 of 5 residents (R43, R72, R12) reviewed for unnecessary medications. Findings include: R43 was not monitored for potential side effects related to use of Celexa (an anti-depressant) R43's diagnoses included orthostatic hypotension, abnormal gait, muscle weakness, depression, anxiety, history of fall, Parkinson's disease, osteoporosis, and anemia obtained from significant Minimum Data Set (MDS) dated 9/19/14. On 10/22/14, at 8:36 a.m. licensed practical nurse (LPN)-D was observed to wheel R43 to the dining room (DR) for breakfast. -At 8:37 a.m. overheard the LPN-D ask R43 if she wanted coffee and R43 stated "Yes please." -At 8:40 a.m. to 9:00 a.m. R43 remained in the DR table during observation R43 had several interactions with several staff and other residents seated at the DR table which were appropriate. On 10/23/14, at 7:05 to 8:13 a.m. R43 was observed to have continuous twitching to both her legs when seated on the toilet and wheelchair during morning cares observation.	F 329	R43, R72, and R12 had side effects and target behavior monitoring immediately initiated upon notification during survey. An audit was completed on all residents for side effects and target behavior monitoring for anti-depressant and anti-anxiety medications. Ongoing compliance review will be completed per RAI schedule by Clinical Coordinator or designee and reported to the Director of Clinical Services. The policy and procedure related to the use of psychoactive medications and behavior monitoring has been reviewed and updated. Licensed staff will be re-educated on the policy by 11/28/14 and is ongoing. Audits will be completed on 10% of residents weekly for 2 months 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. Director of Clinical Services and/or designee will be responsible for ongoing compliance.	

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F 329	Continued From page 2 R43's significant change MDS dated 9/19/14, identified R43 received both anti-depressants and anti-psychotic medications seven days a week. Care Area Assessment (CAA) for psychotropic Drug use dated 10/2/14, indicated R43 received Celexa for depression and indicated R43 was to be monitored for medication side effects. R43's behavior care plan dated 4/15/14, also indicated R43 was on Celexa for depression. Review of R43's Order Summary Report dated 10/7/14, indicated R43 had orders for Seroquel (anti-psychotic) 6.25 Milligram (mg) by mouth every AM for dementia with delusions, Seroquel 12.5 mg one time a day at 5 p.m., Seroquel 37.5 mg at bedtime, Trazodone (anti-depressant) 25 mg as needed for sleep bedtime (HS) and Celexa (anti-depressant) 10 mg daily for depression. During review of the Target Behavior Form dated 9/1/14, through 10/23/14, it was revealed R43's anti-psychotic was being monitored for side effects but the anti-depressants were not being monitored. Monthly Medication Regimen Review revealed the consultant pharmacist had reviewed R43's medications on dates 1/23/14, through 9/17/14, but had not indicated side effect monitoring documentation was lacking for the antidepressants R43 was receiving. When interviewed on 10/23/14, at 7:43 a.m. LPN-A indicated the side effects of some of the medications would be at the back of the form as she was pointing to the Target Behavior Form. When asked about the side effect monitoring for	F 329	Correction date for certification is 11/28/2014.	

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F 329	Continued From page 3 R43's antidepressants LPN-A stated she would not know and directed surveyor to the registered nurse (RN)-A and also stated "During my shift I would be watching for the side effects and would document them if they happened." When asked where the side effects for the antidepressant would be documented RN-A stated it would be documented at the bottom of the Target Behavior Forms in the blue three ring binder as she pointed at the bottom of one of the Behavior Monitoring Form where the staff documented the side effects. When asked about the specific side effects monitoring for the antidepressants that R43 received, RN-A stated she was going to look for the information for surveyor as she was not able to locate any after going through the binder. R72 was not monitored for potential side effects related to use of Remeron (anti-depressant) and Ativan (antianxiety) medications. R72's diagnoses included dementia, depressive disorder and psychosis obtained from the Admission Record face sheet. The quarterly MDS dated 9/29/14, noted the resident had severely impaired cognition, exhibited disorganized thinking, did not exhibit hallucinations or delusions and demonstrated verbal and physical behavioral symptoms directed toward others. CAAs were requested but not provided. R72's care plan with revision date of 9/30/14, indicated R72 was on Remeron and Ativan and to monitor/observe for identified side effects of each medication. On 10/20/14, at 5:33 p.m. dining was observed in	F 329		

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F 329	Continued From page 4	F 329		

the memory care unit for the dinner meal. R72 was observed to throw a napkin on her plate after it was placed in front of her. LPN-E explained to R72 that her food is here but R72 appeared obsessed with a glass containing thickened liquid for another resident (R122), telling R122 that she did not need it and trying to take it away. R122 told R72 to be quiet because she was scaring her. Staff then sat next to each resident, redirected and each resident calmed down.

On 10/22/2014, at 7:22 a.m. R72 was observed calmly reading a newspaper in the dayroom and interacting appropriately with staff.
- At 1:46 p.m. R72 was sitting quietly with a staff member in the dayroom, was approached by another nursing aide. R72 started getting agitated, the aide stopped, R72 was redirected at which time R72 calmed down.

The current Medication Administration Record (MAR) dated 10/1/14 through 10/31/14, indicated R72 was receiving Remeron 7.5 mg oral (by mouth) 9;00 p.m. to 10:00 a.m. for depression, insomnia and decreased appetite and Ativan 0.5 mg by mouth every two hours as needed for anxiety/SOB (shortness of breath).

Monthly Medication Regimen Review revealed the consultant pharmacist had reviewed R72's medications on dates 1/23/14 through 9/17/14, but had not indicated side effect monitoring was lacking for the antidepressant and antianxiety medications R72 was receiving.

During an interview on 10/23/14, at 9:37 a.m. RN-B stated R72 had target behaviors and side effect monitoring for Seroquel (anti-psychotic) but there was no side effect monitoring for Remeron

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F 329	Continued From page 5 and Ativan. "I would have expected side effect monitoring for the Ativan, not necessarily for the Remeron." R12 was not monitored for potential side effects for the use of an anti-depressant (Sertraline HCL 75mg). R12's Admission Record printed on 10/23/14, indicated R12 had a diagnosis to include depressive disorder with an onset date written as 7/27/14. Doctor's progress notes dated 10/15/14, indicated R12 was started on Zoloft related to recent loss of two people close to her. The doctor's Order Summary Report for R12 as of 10/23/14, indicated R12 was on Sertraline HCL (Zoloft) tab 75mg by mouth once a day for depression. The Mood section of R12's care plan dated 10/17/14, identified R12 to have restlessness at night and poor appetite related to " slow progression." The care plan directed staff to monitor for increase in signs and symptoms (s/s) of mood disturbance and to continue medication management as ordered by the physician. The Behaviors section of R12's care plan indicated R12 was on Zoloft for depression and goals were for R12 to " remain free from adverse behaviors	F 329		

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F 329	Continued From page 6 and have decreased s/s of depression." A review of R12's MAR for 10/14, revealed R12 had been taking Zoloft 75mg daily from 10/10/14 to 10/23/14. On 10/23/14, at 7:47 a.m. Nursing assistant (NA)-A denied having observed any behavior or depressive symptoms for R12. NA-A described R12 as pleasant and cooperative with cares. NA-A stated he was not aware to monitor any signs of depression or side effects of antidepressant for R12. -At 7:48 a.m. LPN-B stated she was not aware of any depressive symptoms for R12. LPN-B added target behaviors were monitored every shift daily but LPN-B verified there were no side-effects monitoring sheet initiated for R12. -At 8:34 a.m. RN-B stated she expected signs of depression and side effects of the anti-depressant (Zoloft) should have been monitored for R12. -At 9:02 a.m. R12 was observed to be calm and was pleasant during the interview. R12 stated the anti-depressant was ordered " before " because of deaths in the family but added was ready to move on and " do not need " the anti-depressant. R12 further asked who to talk to in order to have the medication stopped. Surveyor informed R12 that facility staff should help. -At 10:00 a.m. LPN-B initiated a target behavior and side effects monitoring form for R12. On 10/23/14, at 9:02 a.m. RN-A stated the consultant pharmacist had indicated the side effect monitoring was supposed to be documented at the bottom of the behavior sheets. -At 9:18 a.m. RN-A stated the facility had acknowledged it was a problem and was going to	F 329		

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F 329	Continued From page 7 fix it. On 10/23/14, at 9:08 a.m. the director of nursing (DON) stated she checked on current practice for the use of anti-depressants and anti-anxiety acknowledged that both should be monitored for resident-specific symptoms and side-effects. Behavior and Psychological Symptoms of Dementia and Psychotropic Medications and Monitoring policy dated February 2013, directed "Side effect monitoring will be completed for all residents with psychotropic medications orders." The policy did not address monitoring of side effects for anti-depressants and the policy did not indicate who was responsible to ensure adequate monitoring was being documented for other medications such was anti-depressants.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:	F 356		11/1/14

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F 356	Continued From page 8 o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the required daily nurse staffing information included the name of the facility, the actual shift hours worked by staff and each category of licensed and unlicensed nursing staff was broken down. This had the potential to affect all 62 residents currently residing in the facility, as well as family members, and the general public. Findings include: On 10/20/14, at approximately 11:48 a.m. during the initial tour, Report of Nursing Staff Hours Directly Responsible for Resident Care staff posting dated 10/20/14, was observed stored in a red three ring binder on top of the receptionist desk to the left. The posting was observed to have lacked the name of the facility, the specific shift hours worked by staff and the posting was observed to have both registered nurses (RN) and licensed practical nurses (LPN) not broken down into separate categories.	F 356	Nursing staff hours posting has been updated to include the name of the facility, specific shift hours worked by staff and RN/LPN hours broken down into separate categories. Policy has been reviewed and updated. Clinical Support Specialists and Licensed staff will be educated on the policy by 11/28/14 and is ongoing. Random audits will be completed weekly for 2 months to ensure compliance. Results will be reviewed at the QA Committee meeting, action plans developed as needed, and determine the need for ongoing monitoring. Administrator or designee is responsible for ongoing compliance. Correction date for certification is 11/1/14.	

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F 356	Continued From page 9 On 10/21/14, at 8:00 a.m. to 4:30 p.m. the staff posting remained the same and on consecutive days of the survey 10/22/14, 7:00 a.m. to 3:31 p.m. and on 10/23/14, at 7:00 a.m. to 12:00 p.m. When interviewed on 10/23/14, at 11:55 a.m. clinical support specialist who was in charge of preparing the staff posting verified and acknowledged the staff posting lacked the facility name, shift time hours worked by staff, and the broken down in categories was lacking in the posting. When interviewed on 10/23/14, at 1:13 p.m. the campus administrator verified and acknowledged the staff posting was incorrect and stated "Will be any easy fix." Staffing: Posting of Nursing hours policy dated April 2014, indicated the posting was to include the facility name, total number and actual hours worked by the categories broken down to registered nurses, licensed practical nurses, nursing assistants and trained medication aid.	F 356		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate	F 425		11/28/14

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F 425	Continued From page 10 acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to administer the proper medication and ensure the pharmacy filled it correctly for 1 of 5 residents (R134) reviewed for unnecessary medications. Findings include: R134 received vitamin (vit) B1 in place of vitamin B12 which was ordered by the physician. R134 was admitted on 10/19/14, for rehabilitation. Diagnoses included aftercare following joint replacement, hypertension (high blood pressure) and Type II diabetes obtained from the Order Summary Report dated 10/23/14. Review of the Physician Prders dated 10/20/14, indicated "vit B12 100 micrograms [mcg] po daily for vit B12 deficiency." Review of the Order Summary Report dated 10/23/14, indicated "Vitamin B1 Tablet (Thiamine Mononitrate) Give 100 mcg by mouth one time a day for B-12 deficiency."	F 425	R134's physicians order was immediately verified with the MD upon notification, and per facility policy and procedure a medication error form completed. The medication was removed from the resident's medication cabinet and the appropriate medication was ordered from the pharmacy. The MD/NP and family were notified per facility protocol. Pharmacy consultant was notified of dispensing B1 for dx of B12 deficiency. All residents physician orders were audited for accuracy. Facility policy for transcription of Physician Orders was reviewed and updated. Licensed staff will be education on the policy by 11/28/14 and is ongoing. Audits will be completed weekly for 2 months by the Clinical Coordinator or designee to ensure compliance. Results will be reviewed at the QA Committee	

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F 425	Continued From page 11 Review of the Medication Administration Record (MAR) dated 10/1/14 through 10/31/14, indicated Vitamin B1 Tablet (Thiamine Mononitrate) 100 mcg by mouth one time a day for B-12 Deficiency, start date 10/21/14, and discontinued date of 10/23/14. The MAR indicated R134 received the Vitamin B1 on 10/23/14. Review of the prescription bottle label dated 10/22/14, indicated, "Take 1 tablet by mouth once daily, Vitamin B1 Thiamine 100 mg Tab Major." During interview on 10/23/14, at 8:25 a.m. the consultant pharmacist (CP) verified that the wrong medication was given "it's a med error." CP stated "vitamin B1 doesn't come in mcg, it comes in milligrams [mg]." During interview on 10/23/14, at 8:28 a.m. registered nurse (RN)-B verified R134 should have gotten vitamin B12 100 mcg po (by mouth) daily and that the medication in R134's room was Vitamin B1 100 mg tab. The nurse also acknowledged he had received one dose on 10/23/14. R134 had refused the medication on the previous two days. RN-B stated there are three checks by staff, typically the household unit coordinator (HUC) puts the order in, it was then checked by the floor nurse and was checked by a third person. During interview on 10/23/14, at 8:33 a.m. clinical support specialist (CSS) stated the medication was put in the computer by the HUC, the floor nurse verified it and then monthly, usually at the end of the month, the clinical coordinator reviewed medications with the nurse practitioner (NP) on rounds. RN-B acknowledged that if the	F 425	meeting, action plans developed as needed, and determine the need for ongoing monitoring. Director of Clinical Services and/or designee will be responsible for ongoing compliance. Correction date for certification is 11/28/2014.	

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F 425	Continued From page 12 nurse did not find the error and if the medication was ordered at the beginning of the month, the residents could potentially receive the wrong medication for much longer. During interview on 10/23/14, at 8:44 a.m. the director of nursing (DON) stated it was a transcription error and the nurse should have caught it when she checked it and the pharmacy should have clarified the order. During interview on 10/23/14, at 9:27 a.m. the CP stated "I would have expected the pharmacy to verify the order because B1 is not given for a vit B12 deficiency. I am going back to the pharmacy today to find out what happened." During interview on 10/23/14, at 2:36 p.m. the NP stated she was made aware that morning that R134 was not getting Vitamin B12 as ordered. NP stated R134 had been taking a 100 mcg maintenance dose of Vitamin B12 for about a year now for severe vitamin B12 deficiency. "He has history of frequent severe nose bleeds." NP further stated "Yes, I would have expected him to be getting the vitamin B12." A policy/procedure for medication ordering/administration accuracy was requested but not provided.	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to	F 428		11/28/14

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 13 the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the consultant pharmacist identified irregularities for potential side effect monitoring for 3 of 5 residents (R43, R72, R12) reviewed for unnecessary medications. Findings include: R43 was not monitored for potential side effects related to use of Celexa (an anti-depressant) R43's diagnoses included orthostatic hypotension, abnormal gait, muscle weakness, depression, anxiety, history of fall, Parkinson's disease, osteoporosis, and anemia obtained from significant Minimum Data Set (MDS) dated 9/19/14. On 10/22/14, at 8:36 a.m. licensed practical nurse (LPN)-D was observed to wheel R43 to the dining room (DR) for breakfast. -At 8:37 a.m. overheard the LPN-D ask R43 if she wanted coffee and R43 stated "Yes please." -At 8:40 a.m. to 9:00 a.m. R43 remained in the DR table during observation R43 had several interactions with several staff and other residents seated at the DR table which were appropriate. On 10/23/14, at 7:05 to 8:13 a.m. R43 was	F 428	R43, R72, R12 had side effects and target behavior monitoring immediately initiated upon notification during survey and will be reviewed for side effects and unnecessary medications by the Pharmacy Consultant. The policy and procedure related to the use of psychoactive medications and behavior monitoring has been reviewed and updated. Licensed staff and Pharmacy Consultant will be re-educated on the policy by 11/28/14 and is ongoing. Pharmacy Consultant will audit psychotropic side effect monitoring during monthly visits to ensure that all residents are reviewed quarterly and will report findings to the Director of Clinical Services. Results will be reviewed at the quarterly QA Committee meeting and action plans will be initiated as needed. Director of Clinical Services and/or designee will be responsible for ongoing compliance.	

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F 428	Continued From page 14 observed to have continuous twitching to both her legs when seated on the toilet and wheelchair during morning cares observation. R43's significant change MDS dated 9/19/14, identified R43 received both anti-depressants and anti-psychotic medications seven days a week. Care Area Assessment (CAA) for psychotropic Drug use dated 10/2/14, indicated R43 received Celexa for depression and indicated R43 was to be monitored for medication side effects. R43's behavior care plan dated 4/15/14, also indicated R43 was on Celexa for depression. Review of R43's Order Summary Report dated 10/7/14, indicated R43 had orders for Seroquel (anti-psychotic) 6.25 Milligram (mg) by mouth every AM for dementia with delusions, Seroquel 12.5 mg one time a day at 5 p.m., Seroquel 37.5 mg at bedtime, Trazodone (anti-depressant) 25 mg as needed for sleep bedtime (HS) and Celexa (anti-depressant) 10 mg daily for depression. During review of the Target Behavior Form dated 9/1/14, through 10/23/14, it was revealed R43's anti-psychotic was being monitored for side effects but the anti-depressants were not being monitored. Monthly Medication Regimen Review revealed the consultant pharmacist had reviewed R43's medications on dates 1/23/14, through 9/17/14, but had not indicated side effect monitoring documentation was lacking for the antidepressants R43 was receiving. When interviewed on 10/23/14, at 7:43 a.m. LPN-A indicated the side effects of some of the	F 428	Correction date for certification is 11/28/2014.	

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F 428	Continued From page 15	F 428		

medications would be at the back of the form as she was pointing to the Target Behavior Form. When asked about the side effect monitoring for R43's antidepressants LPN-A stated she would not know and directed surveyor to the registered nurse (RN)-A and also stated "During my shift I would be watching for the side effects and would document them if they happened."

When asked where the side effects for the antidepressant would be documented RN-A stated it would be documented at the bottom of the Target Behavior Forms in the blue three ring binder as she pointed at the bottom of one of the Behavior Monitoring Form where the staff documented the side effects. When asked about the specific side effects monitoring for the antidepressants that R43 received, RN-A stated she was going to look for the information for surveyor as she was not able to locate any after going through the binder.

R72 was not monitored for potential side effects related to use of Remeron (anti-depressant) and Ativan (antianxiety) medications.

R72's diagnoses included dementia, depressive disorder and psychosis obtained from the Admission Record face sheet. The quarterly MDS dated 9/29/14, noted the resident had severely impaired cognition, exhibited disorganized thinking, did not exhibit hallucinations or delusions and demonstrated verbal and physical behavioral symptoms directed toward others. CAA's were requested but not provided.

R72's care plan with revision date of 9/30/14 indicated R72 was on Remeron and Ativan and to monitor/observe for identified side effects of each

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F 428	Continued From page 16	F 428		

medication.

On 10/20/14, at 5:33 p.m. dining was observed in the memory care unit for the dinner meal. R72 was observed to throw a napkin on her plate after it was placed in front of her. LPN-E explained to R72 that her food is here but R72 appeared obsessed with a glass containing thickened liquid for another resident (R122), telling R122 that she did not need it and trying to take it away. R122 told R72 to be quiet because she was scaring her. Staff then sat next to each resident, redirected and each resident calmed down.

On 10/22/2014, at 7:22 a.m. R72 was observed calmly reading a newspaper in the dayroom and interacting appropriately with staff.
- At 1:46 p.m. R72 was sitting quietly with a staff member in the dayroom, was approached by another nursing aide. R72 started getting agitated, the aide stopped, R72 was redirected at which time R72 calmed down.

The current Medication Administration Record (MAR) dated 10/1/14 through 10/31/14, indicated R72 was receiving Remeron 7.5 mg oral (by mouth) 9:00 p.m. to 10:00 p.m. for depression, insomnia and decreased appetite and Ativan 0.5 mg by mouth every two hours as needed for anxiety/SOB (shortness of breath).

Monthly Medication Regimen Review revealed the consultant pharmacist had reviewed R72's medications on dates 1/23/14 through 9/17/14, but had not indicated side effect monitoring was lacking for the antidepressant and antianxiety medications R72 was receiving.

During an interview on 10/23/14, at 9:37 a.m.

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F 428	Continued From page 17 RN-B stated R72 had target behaviors and side effect monitoring for Seroquel (anti-psychotic) but there was no side effect monitoring for Remeron and Ativan. "I would have expected side effect monitoring for the Ativan, not necessarily for the Remeron." R12 was not monitored for potential side effects for the use of anti-depressant (Zoloft). R12's Admission Record printed on 10/23/14, indicated R12 had a diagnosis to include depressive disorder with an onset date as 7/27/14. Doctor's progress notes dated 10/15/14, indicated R12 was started on Zoloft related to recent loss of two people close to her. The doctor's Order Summary Report for R12 as of 10/23/14, indicated R12 was on Sertraline HCL (Zoloft) tab 75 mg by mouth once a day for depression. The Mood section of R12's care plan dated 10/17/14, identified R12 to have restlessness at night and poor appetite related to "slow progression." The care plan directed staff to monitor for increase in signs and symptoms (s/s) of mood disturbance and to continue medication management as ordered by the physician. The Behaviors section of R12's care plan indicated R12 was on Zoloft for depression and goals were for R12 to "remain free from adverse behaviors and have decreased s/s of depression." A review of R12's MAR for 10/14, revealed R12 had been taking Zoloft 75 mg daily from 10/10/14 to 10/23/14.	F 428		

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F 428	Continued From page 18 On 10/23/14, at 7:47 a.m. Nursing assistant (NA)-A denied to have observed any behavior or depressive symptoms for R12. NA-A described R12 as very pleasant and cooperative with cares. NA-A stated he was not aware to monitor any signs of depression or side effects of antidepressant for R12. -At 7:48 a.m. LPN-B stated she was not aware of any depressive symptoms for R12. LPN-B added target behaviors were monitored every shift daily but LPN-B verified there was no specific target behavior and side-effects monitoring sheet initiated for R12. -At 8:34 a.m. RN-B stated she expected signs of depression and side effects of the anti-depressant (Zoloft) should have been monitored for R12. -At 9:02 a.m. R12 stated the anti-depressant was ordered "before" because of deaths in the family but added was ready to move on and "do not need" the anti-depressant. R12 further asked who to talk to in order to have the medication stopped. Surveyor informed R12 that facility staff should help. -At 9:08 a.m. the director of nursing (DON) stated she checked on current practice for the use of anti-depressants and agreed R12 should be monitored for resident-specific symptoms and side-effects for the use of Zoloft. -At 10:00 a.m. LPN-B initiated a target behavior monitoring form for R12. During an interview on 10/23/14, at 9:02 a.m. RN-A stated the consultant pharmacist had indicated the side effect monitoring was supposed to be documented at the bottom of the behavior sheets. -At 9:18 a.m. RN-A stated the facility had	F 428		

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F 428	Continued From page 19 acknowledged it was a problem and was going to fix it. On 10/23/14, at 9:08 a.m. the DON stated she checked on current practice for the use of anti-depressants and anti-anxiety medications and acknowledged that both should be monitored for resident-specific symptoms and side-effects. During an interview on 10/23/14, at 9:27 a.m. the consultant pharmacist stated her expectation was the facility was supposed to monitor the side effects for the antidepressant at the bottom of the behavior sheets and thought the facility did those with exception. She further stated the facility had an audit tool that was used to verify the required documentation which included the side effects. Behavior and Psychological Symptoms of Dementia and Psychotropic Medications and Monitoring policy dated February 2013, directed "Side effect monitoring will be completed for all residents with psychotropic medications orders." The policy did not address monitoring of side effects for anti-depressants and the policy did not indicate who was responsible to ensure adequate monitoring was being documented for other medications such was anti-depressants.	F 428		

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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. 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. 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 By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Electronically Signed — 11/14/2014

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.

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K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Oxbow Lake Care Center is a 2-story building with a basement. The building was constructed in 2012 and was determined to be of Type II (111) construction. It is automatic fire sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitor for fire department notification. The facility has a capacity of 64 beds with a census of 62 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 020 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least two hours connecting four stories or more. (One hour for single story building and sprinklered buildings up to three stories in height.) 18.3.1.1.	K 020		10/31/14

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K 020	Continued From page 2 An atrium may be used in accordance with 8.2.2.3.5. This STANDARD is not met as evidenced by: Based on observations and interview, the facility has penetrations betweens floors that are not properly separated in accordance with NFPA 101 "The Life Safety Code" (2000) Section 18.3.5.4. This deficient practice could affect the residents. Findings include: On facility tour between 9:45 AM and 12:00 PM on 10/22/2014, observations revealed that the stair door leading from the TCU unit does not have a fire rated label. This deficient practice was verified by the administrator at the time of the inspection.	K 020	The door leading to the Transitional Care Neighborhood stairway has proper fire rating markings installed to show compliance. This door had proper fire rating tags installed on 10/31/2014. Plant Operations Director is responsible for monitoring these practices to perform random monthly audits of fire rated doors.	
K 043 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Patient room doors are arranged so that patients can open the door from inside without using a key. (Special door locking arrangements are permitted in mental health facilities.) 18.2.2.2.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has failed to maintain the door locks in accordance with Life Safety Code Section 18.2.2.4. This deficient practice could affect the residents.	K 043	The emergency button is both a mag release and a mag re-lock control button. To make the button positioning obvious on 11/6/14 a lighted LED light was installed to indicate the positioning of the mag locks	11/6/14

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K 043	Continued From page 3 Findings include: On facility tour between 9:45 AM and 12:00 PM on 10/22/2014, observation revealed that the memory care perimeter doors automatically relock. There is no means to manually relock the doors. This deficient practice was verified by the administrator at the time of the inspection.	K 043	and button, as either on or off. Plant Operations Director is responsible for the ongoing compliance with monthly trainings to occur after each fire drill.	
K 077 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Piped in medical gas systems comply with NFPA 99, Chapter 4. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to properly install and maintain the piped medical gas system in accordance with NFPA 99. This deficient practice could affect all residents. Findings include: On facility tour between 9:45 AM and 12:00 PM on 10/22/2014, observation revealed that the piped medgas system is currently using the reserve bank with the primary bank is empty and shut-off. An interview with the Plant Operations Director revealed that he was notified at 8:00 PM on 10/21/2014 that the oxygen system was on reserve. The reserve bank was at 900psi at the time of the inspection. The facility does have a ready supply of emergency cylinders as well as several "K" cylinders in storage.	K 077	The facility reviewed and updated the policy and procedure on 10/23/14 to increase the monitoring of the oxygen tanks each even evening, by maintenance staff to ensure tanks would not expire after hours. Plant Operations Director is responsible to ensure ongoing compliance fore resident continuous available oxygen. Weekly audits of maintenance staff oxygen check practices will be reviewed at the monthly Safety Committee meeting and action plans developed as needed.	10/23/14

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K 077	Continued From page 4 This deficient practice was verified by the administrator at the time of the inspection.	K 077		