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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: P7N0
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 **02/22/2017** (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:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* 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 02/20/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 04/20/2017 (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

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245619

April 20, 2017

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

Dear Ms. Barthel:

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

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

Effective February 10, 2017 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
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

April 20, 2017

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

RE: Project Number S5619004

Dear Ms. Barthel:

On January 23, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard completed on January 6, 2017. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On February 22, 2017, 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 January 6, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 10, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 6, 2017, effective February 10, 2017 and therefore remedies outlined in our letter to you dated January 23, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245619		2/22/2017

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0156 Reg. # 483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) LSC	Correction Completed 02/10/2017	ID Prefix F0157 Reg. # 483.10(g)(14) LSC	Correction Completed 02/10/2017	ID Prefix F0225 Reg. # 483.12(a)(3)(4)(c)(1)-(4) LSC	Correction Completed 02/10/2017
ID Prefix F0226 Reg. # 483.12(b)(1)-(3), 483.95(c)(1)-(3) LSC	Correction Completed 02/10/2017	ID Prefix F0246 Reg. # 483.10(e)(3) LSC	Correction Completed 02/10/2017	ID Prefix F0280 Reg. # 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) LSC	Correction Completed 02/10/2017
ID Prefix F0282 Reg. # 483.21(b)(3)(ii) LSC	Correction Completed 02/10/2017	ID Prefix F0323 Reg. # 483.25(d)(1)(2)(n)(1)-(3) LSC	Correction Completed 02/10/2017	ID Prefix F0332 Reg. # 483.45(f)(1) LSC	Correction Completed 02/10/2017
ID Prefix F0371 Reg. # 483.60(i)(1)-(3) LSC	Correction Completed 02/10/2017	ID Prefix F0441 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 02/10/2017	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 (INITIALS) GD/kfd	DATE 4/20/2017	SIGNATURE OF SURVEYOR 35993	DATE 2/22/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/6/2017	☐ 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

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Facility ID: 27752

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

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(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 **01/06/2017** (L34)

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2 AOA 3 Other

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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)

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A. In Compliance With Program Requirements Compliance Based On:
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X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* 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 :
Glenora Souther, HFE NE II 01/30/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 02/01/2017 (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
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07/16/2013
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

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(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

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 23, 2017

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

RE: Project Number S5619004

Dear Ms. Barthel:

On January 6, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

Remedies - 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;

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

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

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
gloria.derfus@state.mn.us
Telephone: (651) 201-3792 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 15, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions

are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that

substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 6, 2017 (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 July 6, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

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 ______	01/06/2017

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 156 SS=D	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting	F 156		2/10/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 01/27/2017

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.

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 ______	01/06/2017

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 156	Continued From page 1	F 156		

Continued From page 1

personal funds, under paragraph (f)(10) of this section;

(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.

(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and

(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42

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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 156	Continued From page 2 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:	F 156		

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(i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and

(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.

(g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident’s stay.

(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and

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regulations governing resident conduct and responsibilities during the stay in the facility.

(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.

(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;

(g)(17) The facility must--

(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-

(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;

(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and

(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section.

(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident’s stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the

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F 156	Continued From page 5 facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the appropriate liability notice to 1 of 3 residents (R90) reviewed who were discharged from Medicare services.	F 156	R90 has discharged from the facility. Facility wide audit was completed on all Medicare Denials that were to be given since 1/6/17.	

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F 156	Continued From page 6 Findings include: R90's admission Minimum Data Set dated 8/26/16, indicated R90 received physical and occupation therapy during their stay at the facility. R90 was admitted to the facility on 8/19/16, with admitting diagnoses Parkinson's disease, edema, and weakness obtained from the Progress Notes printed 1/5/17. On 1/6/17, at 9:00 a.m. the associate administrator provided two notices and a sheet with R90's progress notes and stated that was all she would find. During review of the paperwork for R90 provided the following was revealed: -General Note dated 9/23/16, at 12:24 p.m. "Writer called son, to discuss Medicare last cover day of 9/26/16. Denial was reviewed and son stated he understood. Son will come in to sign paperwork today..." Plan was to discharge to another facility pending availability. In addition, note indicated the writer would continue to be in contact with resident and family to further discuss plan. -General note dated 9/23/16, at 3:21 p.m. indicated "Son signed denial and continuation of stay form stating understanding of being private pay starting 9/27/16. Villa has not stated they are ready for his move in. Social worker will be available for family to discuss further discharge plans." The medical record I;acked evidence of an actual Medicare Denial Notice. On 1/6/17, at 10:45 a.m. the executive director (ED) approached when surveyor asked if there was an actual Notice of Medicare Non-Coverage provided to resident or legal representative, ED stated that was all they would find.	F 156	The Medicare A Program Policy was reviewed. Re-education on the policy completed with the social service and admission staff will be completed by 2/10/17. Audits will be completed randomly of residents weekly for 90 days to ensure compliance and results will be reported to the QA Committee meeting and will determine the need for ongoing monitoring. Administrator or designee is responsible for compliance.	

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F 156	Continued From page 7 The facility Medicare A Program policy dated July 2013, directed "1. When the facility determines that the resident is no longer coverable, the Notice of Medicare Non-Coverage will be prepared, delivered and communication to the patient or authorized representatives and appropriate departments..."	F 156		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)	F 157		2/10/17

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F 157	Continued From page 8 (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the resident's representative was notified when the plan of care was altered due to recent medical conditions for 1 of 1 resident (R87) reviewed for notification of change. Findings include: The communication/hearing care plan dated 7/21/16, indicated resident was hard of hearing, chose not to wear hearing aids. R87's quarterly Minimum Data Set dated 10/13/16, indicated the resident had intact cognition. R87 was able to make needs known and was able to understand what was being said to her. R87's diagnoses included glaucoma, hypertension, weakness, ataxia, and osteoarthritis obtained from the	F 157	R87 s Resident representative was notified of xray, UA results, increased pain and condition change when identified by MDH and documented in the medical record. Resident was placed on hospice and has since expired. Notification of change in condition policy was reviewed and revised. Education for change in condition and shift to shift reporting will be completed by 2/10/17. Daily audits of progress notes and nurse communication book will be completed to	

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Admission Record dated 1/5/17.

A general nursing note dated 1/4/17, at 10:40 a.m. indicated the resident had complained of left shoulder pain and had received schedule Tylenol (a mild analgesic) with slight relief. The note also indicated the nurse practitioner (NP) had been updated on "change of condition" and new orders to do Xray and urinalysis/urine culture (UA/UC). The medical record lacked documentation the family/legal representative/primary contact had been notified of the change in condition and treatment changes.

On 1/4/17, at 1:01 p.m. during an interview the resident stated, "I don't have complaints of care, but my arm hurts. Honey, they are working on getting an x-ray for me. I fell a while ago on this arm. I have never felt like this before. They are going to xray it." In addition, the resident indicated that the facility was going to obtain a urine sample and would have liked her daughter to have been called.

On 1/4/17, at 1:10 p.m. licensed practical nurse (LPN)-A was approached and asked about resident pain and what was going on, and LPN-A stated, "[R87] fell last week I was told. We are waiting on an x-ray ordered waiting to come take it. [R87] started complaining of pain beginning of shift and wanted Tylenol and had been given." LPN-A further stated a UA/UC had been ordered also as resident had been noted to be forgetful that day.

On 1/4/17, at 1:34 p.m. a family member (F)-B was observed go into resident room when registered nurse (RN)-A came by and stated the resident was lying in bed at the time because she

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ensure notification of condition change on all residents x 2 weeks and then weekly for 90 days with results reviewed at the Quality Assurance Committee which will determine the need for ongoing monitoring.

Director of Clinical Services or designee is responsible for ensuring compliance.

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F 157		F 157		

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was experiencing a lot of pain in the left arm and was going to have an x-ray done. F-Bstated she was not aware of that.

On 1/4/17, at 1:48 p.m. when asked if R87's family or legal representative was updated/notified of resident change in treatment plan due to increased pain, LPN-A stated she had not called the family. LPN-A stated the family had been notified when the resident fell. LPN-A stated usually she did not call the family to notify them of orders, did not call family if nothing was broken and only called if something was broken. LPN-A indicated the NP had been notified and had given orders.

On 1/4/17, at 1:56 p.m. F-B was approached and when asked about if the facility staff had notified her of resident increased pain, x-ray and UA/UC orders, F-B stated she had just found out when walking into R87's room. F-B stated she had just came by to visit the resident and would have preferred staff to have notified her of the pain and all the tests ahead.

Review of the PPX x-ray results findings completed on 1/4/16, the following was revealed for findings:
"Bones: It is difficult to evaluate because of the considerable deformity but there may be a new chip fracture at the superior margin of the deformed humeral head. There is an old left second rib fracture.
Joints: The deformed humeral head appears to be subluxed medial to the glenoid
Soft tissue: Unremarkable.
Other findings: There is considerable deformity of the left humeral head appears to be old trauma..."

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On 1/5/17, at 9:01 a.m. RN-A stated family was supposed to be notified right away for any resident change in treatment plan. RN-A also stated family was supposed to be notified when x-rays had been ordered and results after even if the result was negative. When asked if R87's family had been alerted of the increased pain and the tests/procedures that had been ordered, RN-A stated she would hope the nurse would have addressed the concerns with family before an x-ray leading up to the increased pain.

On 1/5/17, at 11:53 p.m. when asked what the findings of the x-ray were RN-A stated "it was not a definitive fracture."

On 1/6/17, at 9:25 a.m. the director of clinical service (DCS) stated when asked about notification of change for R87, DCS stated she thought the RN-A had notified the family about resident treatment change and increased pain. The surveyor informed DCS there was no documentation in the medical record. DCS stated she would follow up if there was documentation. DCS also stated it was the facility standard of practice for the nurse to call the family and update them on changes with treatment.

On 1/6/17, at 9:59 a.m. via telephone R87's F-B stated the facility had called to given an update of the x-ray and UA results and the plan of treatment for pain management. F-B stated the resident was able to comprehend however if staff had told her of the plan of treatment for the pain however resident would have asked the staff if the family member had been told so she would be around. F-B stated she would have appreciated being updated ahead of time of the x-ray and UA/UC being done. Even though R87 had intact

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F 157	Continued From page 12 cognition, R87's F-B had not been notified of the medical changes in R87's left shoulder regarding the pain and xray. In addition, F-B was not informed of the UA/UC orders.	F 157		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS (a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment,	F 225		2/10/17

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F 225	Continued From page 13 including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to submit a timely report of an allegation of abuse for 1 of 5 residents (R94) and failed to report and thoroughly investigate a pattern of injuries of unknown origin for 1 of 1 resident (R116) reviewed. Findings include:	F 225	R116 will be comprehensively assessed, chart reviewed, incidences investigated and care plan updated by the Clinical Director. R94 has expired. Re-education completed on NA-D on VA	

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R94's Minimum Data Set (MDS) annual assessment dated 11/4/16, indicated R94's cognition was intact.

Review of R94's care plan dated 11/29/15, identified R94 required extensive assistance of one staff member for toileting and personal cares.

Review of Vulnerable Adult (VA) reports identified a report submitted to the State agency (SA) on 11/25/16. The report included R94's allegation of abuse by nursing assistant (NA)-D on 11/24/16, during cares.

A five day investigation report submitted to the SA on 12/1/16, included NA-D continued to work on 11/24/16, including with R94 and was suspended on 11/25/16, during the investigation of the allegation of abuse, received VA training on reporting and corrective action. The five day report further included the Adult Protection Agency on 11/25/16 and that police were contacted on 12/2/16.

NA-D's employee file was reviewed and did not include corrective action, retraining, education or review of the resident allegation from 11/24/16. The file did not include documentation of NA-D's suspension or return to work.

On 1/6/16, at 9:43 a.m. R94 indicated on Thanksgiving Day he was hit by staff. R94 stated he was "in the bathroom and didn't do what the girl wanted him to do and she kind of pushed me. " R94 indicated there was another employee who "was there and she saw it happen, but she won't say anything. " R94 went on to say "that's about the only time anyone did damage to me, it didn't

F 225

policy.

Re-education was provided to Clinical Coordinator regarding documentation of incident per policy and review VA policy for reporting.

Incident reporting policy reviewed and revised to include if an injury of unknown origin is found must be called to the on call RN immediately.

VA policy reviewed.

Nursing staff re-educated on both policies by 2/10/17.

Audits to be completed on all incidents daily x2 weeks to ensure timely reporting and follow up is completed per policy then weekly for 90 days with results reviewed at the Quality Assurance Committee which will determine the need for ongoing monitoring.

Clinical Director/designee is responsible for ensuring compliance.

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	245619	A. BUILDING ______ B. WING ______	01/06/2017

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 225	Continued From page 15 make me feel very well, that someone would do that to me here, I thought this was a safe place. " When asked if this was reported to staff R94 answered "I told someone, but they didn't do much about it. " On 1/6/16 at 11:35 a.m. housekeeping employee (H)-A was interviewed and stated she remembered working on 11/24/16, and was collecting laundry in R94's room. H-A stated R94 was "really upset; not clear what he was saying. He was shaking and yelling with the aide (NA-D) standing next to him trying to calm him down. I couldn't understand if he said hit or hate. I didn't see anything happen, he was sitting on the toilet and the aide (NA-D) was trying to calm him down. " An interview with registered nurse (RN)-A on 1/6/16, at 11:52 a.m. confirmed RN-A found out about R94's 11/24/16, allegation of abuse on 11/25/16, while reading through the Progress Notes on 11/25/16. RN-A confirmed she was the nurse on-call on 11/24/16, and was not called by the facility. RN-A stated she questioned RN-G and licensed practical nurse (LPN)-B who were working on 11/24/16, and provided corrective action due to the lack of reporting. RN-A went on to say she heard R94 was on the toilet and NA-D was assisting him. During the cares, R94 accused NA-D of hitting him. During that time H-A walked into R94's bathroom during the accusation. Following the cares, NA-D reported to LPN-B that R94 accused her of hitting him. R94 also reported to LPN-B that NA-D had hit him during cares. H-A told LPN-B she did not witness NA-D hit R94 however heard the words "hit or hate" and did not understand what R94 was saying when she entered the room. LPN-B	F 225		

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F 225	Continued From page 16 reported the allegation to RN-G who directed NA-D should be supervised the remainder of the shift. RN-A indicated she met with licensed social worker (LSW)-B who interviewed R94 and did not feel the allegation was substantiated. RN-A stated they added two staff to care for R94 to his care plan and indicated staff was re-trained on how to perform cares for R94. RN-A confirmed NA-D had returned to work and continued to work on the same floor as R94. RN-A was not aware of NA-D being retrained and felt NA-D should be supervised. RN-A further confirmed she had not watched or supervised NA-D providing care. LSW-B was also interviewed on 1/6/16, at 11:52 a.m. and stated she interviewed R94 on 11/25/16, and stated R94 "was pretty disgruntled. " LSW-B states she asked R94 about his previous day and R94 stated someone hit him. LSW-B went on to say during R94's interview he stated "Thanksgiving was terrible. " LSW-B completed a BIMS on R94 on 11/25/16, which indicated a score of 15/15 (which indicated intact cognition), however LSW-B felt R94 was confused. LSW-B further interviewed R94 and asked him if he was hit by staff. R94 stated yes and pointed to his chest. LSW-B stated R94 felt safe at the facility and did not show any signs of anxiety, fearfulness and had no bruising in the area in which he indicated he was hit. LSW-B indicated R94 displayed no signs of trauma. LSW-B stated she was not concerned with the care NA-D provided and did not believe the allegation to be substantiated. When asked if she had followed up with R94 since the allegation, LSW-B stated she had talked with R94 however had not again asked about the allegation of abuse. An interview with the administrator on 1/6/16, at	F 225		

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F 225	Continued From page 17	F 225		

1:03 p.m. confirmed the allegation of abuse was reported to the SA one day later on 11/25/16, when administrative staff became aware of the allegation. The administrator confirmed her expectation was for staff to immediately report to the administrator and director of clinical services (DCS) any allegation of maltreatment so it can be immediately reported to the SA. The administrator went on to say NA-D should have been sent home and placed on suspension on 11/24/16, when the LPN-B and RN-G became aware of the allegation of abuse. The administrator further indicated VA training was provided to all staff after that incident on the timeliness of reporting allegations of maltreatment. The Administrator confirmed there was no evidence of retraining, education or further supervision provided to NA-D after the 11/24/16, allegation of abuse or when NA-D returned to work on 12/2/16. The administrator later found VA training that was completed with NA-D on 12/3/16, which the administrator confirmed was directed at the timeliness of reporting allegations of maltreatment. Additionally, the administrator confirmed there was no documentation in NA-D employee file regarding further education provided, retraining or corrective action related to the 11/24/16, incident.

A facility Vulnerable Adult Policy dated 11/28/16, included "any staff member who observes or suspects maltreatment of a tenant is required to report such an incident immediately to the Administrator of Designee. "

R116's Quarterly MDS dated 11/23/16, indicated she was severely cognitively impaired and required extensive assistance for all activities of

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F 225	Continued From page 18 daily living. R116's care plan dated 12/18/16, identified a risk for bruising due to thin skin and indicated R116 was unable to state where her bruises come from. A review of Oxbow Lake Care Center Progress Notes identified the following: - On 11/21/16, nursing assistant found bruise on R116's right hip during her shower. Resident was unable to verbalize how it happened. Bruise measured 5 centimeters (cm) x 7 cm, purplish/bluish in color "but mostly yellow and reddish." An untitled facility incident report was completed on 11/21/16. The bruise was not reported to the SA. - On 12/3/16, family called staff over to look at R116's right hand and thumb. Thumb in joint area of hand black and blue and swollen. Received order for x-ray. X-ray result returned with no acute fracture or dislocation. No facility incident report was completed for that injury nor was the injury reported to the SA. - On 12/6/16, a new order for x-ray (the Progress Note did not indicate area to be x-rayed). A review of a St Therese at Oxbow Lake Physician Order form dated 12/6/16, indicated x-ray of right hip/pelvis and right knee due to pain. No facility incident report was completed for that injury nor was the injury reported to the SA. During an interview on 1/5/16, at 8:28 a.m., RN-A stated when the bruise was found on R116's right hip in November of 2016 and an Incident Report form was completed. She stated when injuries or bruising of unknown origin occur staff are directed to fill out a facility Incident Report. RN-A stated following the report the staff comes up with different interventions and look for anything out of the ordinary. She stated because R116 was not	F 225		

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F 225	Continued From page 19 able to speak about or demonstrate how things happen, "we have to think outside the box." She further stated no Incident Report was completed for the injury to R116's right hand on 12/3/16, or the brushing on the right hip noted on 12/7/16. RN-A stated in regard to reporting injuries of unknown origin, "you have to look at them and if it is something you can't explain away" it gets reported to the SA. She stated the DCS or the administrator direct staff when to report to the SA. During an interview on 1/5/16, at 10:32 a.m., the DCS stated there were no incident/investigative reports completed for R116's bruises on her hand or on her right hip. She stated any injury that requires and x-ray should be investigated and reported to the SA. The DCS stated either herself or the administrator determine what is reportable and what is not. A facility policy titled St. Therese Vulnerable Adult, Reporting Maltreatment of, dated September 2, 2016 indicated the following: The purpose is to have an overall proactive approach for the detection and prevention of abuse and neglect. The policy directed staff to report unexplained injuries, defined as: an injury which is not associated with an explainable current medical condition and includes fractures, skin tears and bruising.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that:	F 226		2/10/17

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F 226	Continued From page 20 (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow policies and procedures related to reporting allegations of abuse for 1 of 5 residents (R94) reviewed for abuse prohibition and of injuries of unknown origin to the designated state agency (SA) for 1 of residents (R116). Findings include:	F 226	R116 will be comprehensively assessed, chart reviewed, incidences investigated and care plan updated by the Clinical Director. R94 has expired. Re-education completed on NA-D on VA policy.	

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F 226	Continued From page 21 R94: A facility Vulnerable Adult Policy dated 11/28/16, included "any staff member who observes or suspects maltreatment of a tenant is required to report such an incident immediately to the Administrator of Designee". R94's Minimum Data Set (MDS) annual assessment dated 11/4/16, indicated R94's cognition was intact. Review of R94's care plan dated 11/29/15, identified R94 required extensive assistance of one staff member for toileting and personal cares. Review of Vulnerable Adult (VA) reports identified a report submitted to the State agency (SA) on 11/25/16. The report included R94's allegation of abuse by nursing assistant (NA)-D on 11/24/16, during cares. A five day investigation report submitted to the SA on 12/1/16, included NA-D continued to work on 11/24/16, including with R94 and was suspended on 11/25/16, during the investigation of the allegation of abuse, received VA training on reporting and corrective action. The five day report further included the Adult Protection Agency on 11/25/16 and that police were contacted on 12/2/16. NA-D's employee file was reviewed and did not include corrective action, retraining, education or review of the resident allegation from 11/24/16. The file did not include documentation of NA-D's suspension or return to work. On 1/6/16, at 9:43 a.m. R94 indicated on Thanksgiving Day he was hit by staff. R94 stated	F 226	Re-education was provided to Clinical Coordinator regarding documentation of incident per policy and review VA policy for reporting. Incident reporting policy reviewed and revised to include if an injury of unknown origin is found must be called to the on call RN immediately. VA policy reviewed. Nursing staff re-educated on both policies by 2/10/17. Audits to be completed on all incidents daily x2 weeks to ensure timely reporting and follow up is completed per policy then weekly for 90 days with results reviewed at the Quality Assurance Committee which will determine the need for ongoing monitoring. Clinical Director/designee is responsible for ensuring compliance.	

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F 226	Continued From page 22	F 226		

he was "in the bathroom and didn't do what the girl wanted him to do and she kind of pushed me. " R94 indicated there was another employee who "was there and she saw it happen, but she won't say anything. " R94 went on to say "that's about the only time anyone did damage to me, it didn't make me feel very well, that someone would do that to me here, I thought this was a safe place. " When asked if this was reported to staff R94 answered "I told someone, but they didn't do much about it. "

On 1/6/16 at 11:35 a.m. housekeeping employee (H)-A was interviewed and stated she remembered working on 11/24/16, and was collecting laundry in R94's room. H-A stated R94 was "really upset; not clear what he was saying. He was shaking and yelling with the aide (NA-D) standing next to him trying to calm him down. I couldn't understand if he said hit or hate. I didn't see anything happen, he was sitting on the toilet and the aide (NA-D) was trying to calm him down. "

An interview with registered nurse (RN)-A on 1/6/16, at 11:52 a.m. confirmed RN-A found out about R94's 11/24/16, allegation of abuse on 11/25/16, while reading through the Progress Notes on 11/25/16. RN-A confirmed she was the nurse on-call on 11/24/16, and was not called by the facility. RN-A stated she questioned RN-G and licensed practical nurse (LPN)-B who were working on 11/24/16, and provided corrective action due to the lack of reporting. RN-A went on to say she heard R94 was on the toilet and NA-D was assisting him. During the cares, R94 accused NA-D of hitting him. During that time H-A walked into R94's bathroom during the accusation. Following the cares, NA-D reported to

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F 226	Continued From page 23 LPN-B that R94 accused her of hitting him. R94 also reported to LPN-B that NA-D had hit him during cares. H-A told LPN-B she did not witness NA-D hit R94 however heard the words "hit or hate" and did not understand what R94 was saying when she entered the room. LPN-B reported the allegation to RN-G who directed NA-D should be supervised the remainder of the shift. RN-A indicated she met with licensed social worker (LSW)-B who interviewed R94 and did not feel the allegation was substantiated. RN-A stated they added two staff to care for R94 to his care plan and indicated staff was re-trained on how to perform cares for R94. RN-A confirmed NA-D had returned to work and continued to work on the same floor as R94. RN-A was not aware of NA-D being retrained and felt NA-D should be supervised. RN-A further confirmed she had not watched or supervised NA-D providing care. LSW-B was also interviewed on 1/6/16, at 11:52 a.m. and stated she interviewed R94 on 11/25/16, and stated R94 "was pretty disgruntled. " LSW-B states she asked R94 about his previous day and R94 stated someone hit him. LSW-B went on to say during R94's interview he stated "Thanksgiving was terrible. " LSW-B completed a BIMS on R94 on 11/25/16, which indicated a score of 15/15 (which indicated intact cognition), however LSW-B felt R94 was confused. LSW-B further interviewed R94 and asked him if he was hit by staff. R94 stated yes and pointed to his chest. LSW-B stated R94 felt safe at the facility and did not show any signs of anxiety, fearfulness and had no bruising in the area in which he indicated he was hit. LSW-B indicated R94 displayed no signs of trauma. LSW-B stated she was not concerned with the care NA-D provided and did not believe the allegation to be	F 226		

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substantiated. When asked if she had followed up with R94 since the allegation, LSW-B stated she had talked with R94 however had not again asked about the allegation of abuse.

An interview with the administrator on 1/6/16, at 1:03 p.m. confirmed the allegation of abuse was reported to the SA one day later on 11/25/16, when administrative staff became aware of the allegation. The administrator confirmed her expectation was for staff to immediately report to the administrator and director of clinical services (DCS) any allegation of maltreatment so it can be immediately reported to the SA. The administrator went on to say NA-D should have been sent home and placed on suspension on 11/24/16, when the LPN-B and RN-G became aware of the allegation of abuse. The administrator further indicated VA training was provided to all staff after that incident on the timeliness of reporting allegations of maltreatment. The Administrator confirmed there was no evidence of retraining, education or further supervision provided to NA-D after the 11/24/16, allegation of abuse or when NA-D returned to work on 12/2/16. The administrator later found VA training that was completed with NA-D on 12/3/16, which the administrator confirmed was directed at the timeliness of reporting allegations of maltreatment. Additionally, the administrator confirmed there was no documentation in NA-D employee file regarding further education provided, retraining or corrective action related to the 11/24/16, incident.

R116:
A facility policy policy titled St. Therese Vulnerable Adult, Reporting of Maltreatment dated

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September 2, 2016, indicated the following: The purpose is to have an overall proactive approach for the detection and prevention of abuse and neglect. The policy directed staff to report unexplained injuries, defined as: an injury which is not associated with an explainable current medical condition and includes fractures, skin tears and bruising.

R116's Quarterly MDS dated 11/23/16, indicated she was severely cognitively impaired and required extensive assistance for all activities of daily living. R116's care plan dated 12/18/16, identified a risk for bruising due to thin skin and indicated R116 was unable to state where her bruises come from.

A review of Oxbow Lake Care Center Progress Notes identified the following:
- On 11/21/16, nursing assistant found bruise on R116's right hip during her shower. Resident was unable to verbalize how it happened. Bruise measured 5 centimeters (cm) x 7 cm, purplish/bluish in color "but mostly yellow and reddish." An untitled facility incident report was completed on 11/21/16. The bruise was not reported to the SA.
- On 12/3/16, family called staff over to look at R116's right hand and thumb. Thumb in joint area of hand black and blue and swollen. Received order for x-ray. X-ray result returned with no acute fracture or dislocation. No facility incident report was completed for that injury nor was the injury reported to the SA.
- On 12/6/16, a new order for x-ray (the Progress Note did not indicate area to be x-rayed). A review of a St Therese at Oxbow Lake Physician Order form dated 12/6/16, indicated x-ray of right hip/pelvis and right knee due to pain. No facility

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F 226	Continued From page 26 incident report was completed for that injury nor was the injury reported to the SA. During an interview on 1/5/16, at 8:28 a.m., RN-A stated when the bruise was found on R116's right hip in November of 2016 and an Incident Report form was completed. She stated when injuries or bruising of unknown origin occur staff are directed to fill out a facility Incident Report. RN-A stated following the report the staff comes up with different interventions and look for anything out of the ordinary. She stated because R116 was not able to speak about or demonstrate how things happen, "we have to think outside the box." She further stated no Incident Report was completed for the injury to R116's right hand on 12/3/16, or the brushing on the right hip noted on 12/7/16. RN-A stated in regard to reporting injuries of unknown origin, "you have to look at them and if it is something you can't explain away" it gets reported to the SA. She stated the DCS or the administrator direct staff when to report to the SA. During an interview on 1/5/16, at 10:32 a.m., the DCS stated there were no incident/investigative reports completed for R116's bruises on her hand or on her right hip. She stated any injury that requires and x-ray should be investigated and reported to the SA. The DCS stated either herself or the administrator determine what is reportable and what is not.	F 226		
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the	F 246		2/10/17

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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 246	Continued From page 27 resident or other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to honor bathing preferences for 1 of 1 resident (R135) reviewed for choices. Findings include: During an interview on 1/3/17, at 4:22 p.m., R135 stated, "I would like daily showers but I cannot have them. I have asked the nursing assistants." R135's admission Minimum Data Set (MDS) dated 12/1/16, indicated R135 was moderately cognitively impaired and rarely/never understood. R135's MDS indicated he required physical assist of one staff member to shower. R135's care plan printed 12/20/16, indicated R135 had self-care deficit related to Parkinson's disease with Lewy body dementia and directed staff to wash hair and provide assistance with washing his upper and lower body. The care plan did not identify R135's desired frequency for showers. During an interview on 1/4/17, at 11:50 a.m., registered nurse (RN)-G stated, when a resident admits to the facility she completes the initial nursing assessment. RN-G stated, "We do not ask about past practice for bathing, the residents get a shower once a week." She stated Social services does the preference sections of the MDS when it is due." During an interview on 1/4/17, at 12:37 p.m., RN-D stated, Sometimes therapy gives extra showers and stated residents can have extra	F 246	R135 was interviewed as to bathing preferences and care plan/care guide updated. An audit completed of all residents in the facility to ensure that their preferences were identified and care plans/care guides updated. Bathing preferences will be asked upon admission. Staff re-educated on resident preferences. Interviews will be completed on 10% of residents weekly for 90 days to ensure preferences are met/offered. Compliance and results will be reported to the QA Committee meeting and will determine the need for ongoing monitoring. Resident preferences will be reviewed quarterly by Social Services with the MDS schedule. Clinical Director or designee responsible for ongoing compliance.	

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F 246	Continued From page 28 showers but the residents would have to initiate the request. RN-D stated R135 has not asked for an extra shower and she had never asked him how often would like to shower. During an interview on 1/4/17, at 1:19 p.m., family member (F)-A stated, R135 took a shower every day in the morning at home. FM-A further stated the facility did not ask how many times a week R135 would like a shower, they just said his shower day would be Saturday mornings. FM-A said, "I would like him to be offered a shower daily especially since he said he would like it. It might make him feel better." During an interview on 1/4/17, at 1:34 p.m., nursing assistant (NA)-B said, "we have care plans in everyone's room that tell us when to give a shower and stated R135 does not talk much. "I don't think he could request a shower." NA-B stated she did know how the showers were assigned. During an interview on 1/4/17, at 1:40 p.m., NA-C stated the baths are on the nurse's sheet and stated each resident has a set bath day once a week unless they ask for more. During an interview on 1/5/17, at 1:48 p.m., social worker (SW)-A stated, the admission nurse asks about preferences on admission and she (SW-A) asks during the MDS assessment. SW-A stated she was not sure how often the residents received showers and stated ,that is a nursing decision." During interview on 1/5/17, at 1:57 p.m., RN-C stated baths were automatically set up and stated each room had a scheduled day and time. She	F 246		

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F 246	Continued From page 29 stated if a resident wants more baths they can have them but stated they would have to ask us, we do not offer. During an interview on 1/5/17, at 2:32 p.m., the director of clinical services (DCS) stated, the residents are scheduled for a bath one time a week. She stated, "Typically I believe it is asked what type of bath, what time of day and how frequently on admission" and stated nursing should be asking on admission. The DCS further stated she expected staff to ask the resident how often, and what type of bath/shower and stated "it's a standard of care." Policy regarding frequency of showers requested but not provided.	F 246		
F 280 SS=E	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items	F 280		2/10/17

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F 280	Continued From page 30 included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F 280		

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F 280	Continued From page 31 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan to include interventions to prevent bruising for 1 of 3 residents (R116) reviewed for accidents. In addition, the facility failed to revise the care plan to include interventions for positioning and bed mobility for 4 of 12 residents (R141, R142, R144, R145) reviewed. Findings include: Bruises: R116's Quarterly Minimum Data Set dated 11/23/16, indicated she was severely cognitively impaired and required extensive assistance for all activities of daily living. R116's care plan dated 12/18/16 identified a risk for bruising due to thin skin and directed staff to Monitor skin with cares	F 280	R116 was comprehensively assessed, chart reviewed and revised to include interventions to prevent injury by the Clinical Director. R141 reassessed, care plan reviewed and updated for positioning devices. R142, R144, and R145 have discharged from the facility. Care plan policy reviewed. Re-education will be completed by 2/10/17. A facility audit will be completed on all resident incidences to ensure	

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F 280	Continued From page 32 and report concerns, turn and reposition every two hours and apply lotion to skin as needed. A review of Oxbow Lake Care Center Progress Notes identified the following: On 11/21/16, nursing assistant found bruise on R116's right hip during her shower. Resident was unable to verbalize how it happened. Bruise measured 5 centimeters (cm) x 7 cm, purplish/bluish in color "but mostly yellow and reddish." An 11/23/16, Progress Note indicated bruising may have occurred with transfer, bumping or rolling into the side rail during cares. On 12/3/16, the noted depicted the family called staff over to look at R116's right hand and thumb. The thumb in joint area of hand was black and blue and swollen. The facility received order for x-ray. The X-ray result returned with no acute fracture or dislocation. A 12/6/16, Progress Note identified a new order for x-ray the progress note did not indicate area to be x-rayed however, a review of a St Therese at Oxbow Lake Physician Order form indicated x-ray of right hip/pelvis and right knee due to pain. Another 12/6/16, Progress Note indicated, "Having side rail down will help." However, that was not added to R116's care plan. On 12/7/16, a Progress Note indicated resident was using an extended wheel chair pedal to assist her with her leg and writer wonders if resident pushed against the pedal while then leaning forward causing a bruise to her backside on the right hip. During an observation on 1/5/16, at 8:07 a.m., nursing assistant (NA)-D and NA-E assisted R116 out of bed using a ceiling lift. R116 was cooperative during the transfer. When lifting R116 out of bed, staff assisted her out the left side of the bed and into the bathroom. Attached to the	F 280	interventions are care planned per facility policy. Ongoing audits will be completed per MDS schedule to ensure compliance. Results will be reviewed with the QA Committee which will determine the need for ongoing monitoring. Clinical Director or designee responsible for ongoing compliance.	

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bathroom wall, next to the toilet was a metal grab bar. The grab bar was on R116's left side while she was seated on the toilet.

During an interview on 1/5/16, at 8:07 a.m., NA-D stated she had never seen R116 hit her arms or legs on the side rail or wheelchair during transfers.

During an interview on 1/5/16, at 8:28 a.m., registered nurse (RN)-A stated R116 "is an easy bruiser." She stated when staff assist R116 into the lift sling she gets "grabby" and due to her cognition she touches everything. RN-A stated R116 hits the grab bars with her hands. RN-A also stated R116 "might bang her hands on the table" when seated. She stated when injuries or bruising of unknown origin occur staff are directed to fill out a facility incident report. RN-A stated following the report the staff comes up with different interventions and look for anything out of the ordinary.

During an interview on 1/5/16, at 10:32 a.m., the director of clinical services stated RN-A was responsible for updating the care plan and stated no new interventions were implemented.

R116 sustained three separate injuries resulting in bruising between 11/21/16 and 12/7/16. The care plan did not identify and interventions to prevent bruising after 10/20/16, and while the bruise identified on 11/21/16, it was determined to be a result of bumping the side rail during a transfer or during cares, R116's care plan was not updated to include keeping the side rail down during transfers.

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F 280	Continued From page 34 Bed mobility/positioning: R141's Oxbow Lake Care Center Admission Record indicated R141 admitted to the facility on 12/31/16. A facility document (temporary plan of care) labeled Saint Therese, dated 1/2/17, indicated R141 required assistance with bed mobility and transfers and used assistive devices that included a walker, wheel chair and transfer belt. The care plan did not identify the use of side rails. During an observation of R141's room on 1/6/17, at 10:48 a.m., the bed had two upper half side rails in the up position. An Admission/Readmission/Annual Clinical Review, undated, identified the use of half side rails for positioning. The review indicated R141 was able to demonstrate safe use of side rails on her bed to aide in bed mobility, cares and transfers. R142's Oxbow Lake Care Center Admission Record indicated R142 admitted to the facility on 12/24/16. A facility document (temporary plan of care) labeled Saint Therese, dated 1/5/17, identified R142 required assistance with all activities of daily living and used assistive devices which included a wheel chair and a transfer belt. The care plan did not identify the use of side rails. During interview on 1/3/17, at 4:13 p.m., R142 was observed lying in bed. There were bilateral upper half side rails attached to the bed. The side rails were in the raised position. During the	F 280		

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interview, R142 stated, the side rails were on the bed when she admitted to the facility and stated she did not usually use the right rail but used the top of the bed and the left rail sometimes.

An Admission/Readmission/Annual Clinical Review, undated, indicated R142 used assistive devices and indicated devices were used to promote mobility or positioning. The assessment indicated R142 was able to demonstrate use of half side rails for bed mobility and transfers.

R144's Oxbow Lake Care Center Admission Record indicated R144 admitted to the facility on 12/31/16.

A facility document (temporary plan of care) labeled Saint Therese, dated 1/4/17, indicated R144 required assistance with bed mobility and transfers and used assistive devices that included a wheel chair and transfer belt. The care plan did not identify the use of side rails.

During an interview on 1/6/17, at 10:45 a.m., R144 was sitting in chair next to bed. She stated some came to her room earlier that day and asked her if she wanted the side rails that were on her bed but stated no one had discussed the risk of side rail use with her.

An Admission/Readmission/Annual Clinical Review, undated, identified the use of half side rails for positioning. The review indicated R144 was able to demonstrate safe use of side rails on her bed to aide in bed mobility and transfers.

R145's Oxbow Lake Care Center Admission

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Record indicated R145 admitted to the facility on 1/5/17.

A facility document (temporary plan of care) labeled Saint Therese, dated 1/5/17, indicated R145 required assistance with bed mobility and transfers but did not identify the use of side rails.

During an observation of R145's room on 1/6/17, at 10:48 a.m., the bed had two upper half side rails in the up position.

An Admission/Readmission/Annual Clinical Review, undated, identified the use of half side rails for positioning. The review indicated R145 was able to demonstrate safe use of side rails to aide in bed mobility.

During interview on 1/5/17, at 2:46 p.m. the director of clinical ervice said expected device assessment to be completed at time of admission. The DCS verified the facility was not attempting interventions prior to placing side rails on beds on the transitional care unit as all beds on that unit have side rails on them.

During an interview on 1/6/17, at 2:16 p.m., RN-C stated, "I just added side rails to all of the care plans today when you requested the care plans." She stated, side rails were not on the care plans when we spoke this morning.

A facility policy titled Proper Use of Side Rails, dated October 2010, instructed staff, the purpose of these guidelines are to ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's medical symptoms. The use of side rails as an assistive

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F 280	Continued From page 37 device will be addressed in the resident care plan.	F 280		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents (R87) who was experiencing pain was appropriately transferred according to the plan of care. Finding include: R87's transferring care plan dated 11/8/16, indicated resident needed help to get back and forth from the bed to wheelchair due to weakness and ataxia. The care plan directed staff to encourage resident to use the grab bars, and provide extensive assist of one staff with gait belt to transfer as resident ability varied. A general nursing note dated 1/4/17, at 10:40 a.m. indicated the resident had complained of left shoulder pain and had received schedule Tylenol (a mild analgesic) with slight relief. The note also indicated the nurse practitioner (NP) had been updated on "change of condition" and with new orders to do an xray and an urinalysis/urine culture (UA/UC).	F 282	R87 has passed away. Corrective action and re-education provided to the na/r identified. Transfer policy reviewed. Nursing staff re-educated on policy by 2/10/17. Random audits of will be completed to ensure services are being completed per care plan weekly x 90 days. Results reviewed at the QA Committee which will determine the need for ongoing monitoring. Clinical Director/designee is responsible for ensuring compliance.	2/10/17

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Review of the PPX x-ray results findings completed on 1/4/16, the following was revealed for findings:
"Bones: It is difficult to evaluate because of the considerable deformity but there may be a new chip fracture at the superior margin of the deformed humeral head. There is an old left second rib fracture.
Joints: The deformed humeral head appears to be subluxed medial to the glenoid
Soft tissue: Unremarkable.
Other findings: There is considerable deformity of the left humeral head appears to be old trauma..."

On 1/5/17, at 7:40 a.m. nursing assistant (NA)-A was observed go to resident room after resident call light was on. At 7:43 a.m. the resident was observed lying in bed, on her back, and covered. When approached and asked how she had slept, the resident stated she was in pain all night even after she was given a new pain medication. NA-A applied gloves asked resident what pants, socks, shirt she wanted to wear then applied the socks, shoes and pants to the knees. NA-A then indicated to resident she was going to sit her by the edge of bed. NA-A then proceeded to reach out her right hand and grabbed the resident's right hand and was observed to pull the resident forward to a sitting position. However, the resident was pulling back and not able to hold herself up. At that time R87 asked NA-A, as she was attempting to sit up, "Honey do you have a transfer belt?" NA-A stated, "Yes" then applied the transfer belt at that time around the waist. NA-A then moved R87's legs to the edge of the bed and then pulled the resident out of bed towards her. Again NA-A grabbed R87's right hand not using the transfer belt. After the resident was

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seated on edge of the bed, NA-A cued the resident to stand to transfer to wheelchair. The resident held the grab bar with left hand, NA-A then cued resident she was going to assist her. As NA-A attempted to transfer resident holding onto the side of the transfer belt, the resident was unsteady and then sat back down on the edge of bed. On the second attempt, the resident was observed to give NA-A a bear hug as NA-A held the back of transfer belt and was able to transfer resident into the wheelchair with pants still hanging below the knees.

On 1/5/17, at 8:33 a.m. licensed practical nurse (LPN)-A stated the NA's or staff that was assisting residents with transfers were supposed to use the transfer belt and not to pull the resident by hand(s).
-At 8:40 a.m. NA-A stated she had pulled resident up because she was assisting her to sit on the edge of bed and had not used the belt. When asked if she was aware resident had been experiencing a lot of pain, NA-A stated, "I did not know that." NA-A did not follow the plan of care as NA-A did not utilize the transfer belt when NA-A assisted R87 to a seated position.

On 1/5/17, at 11:53 p.m. registered nurse (RN)-A stated NA-A was not supposed to grab resident by the hand and was supposed to use the transfer belt. RN-A stated NA-A was supposed to the follow the plan of care for each resident.

On 1/6/17, at 9:25 a.m. the director of clinical service (DCS) stated staff was supposed to use the transfer belt as that was part of their uniform. When asked if NAs were given report DCS stated the nurses gave report to NAs.

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F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to investigate a pattern of unknown injuries for 1 of 3 residents (R116) reviewed for accidents. The facility also failed to ensure proper transferring technique for 1 of 3 residents (R87) reviewed for activities of daily living who was experiencing pain. In addition, the facility failed to obtain informed consent for the use of side rails for 12 of 12 residents (R138,	F 323	R116 will be comprehensively assessed, chart reviewed, incidences investigated and care plan updated by the Clinical Director. Re-education was provided to Clinical Coordinator regarding documentation of incident per policy.	2/10/17

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F 323	Continued From page 41 R127, R142, R25, R69, R50, R143, R140, R139, R141, R144, R145) newly admitted to the facility. Findings include: R116 Quarterly Minimum Data Set (MDS) dated 11/23/16, indicated she was severely cognitively impaired and required extensive assistance for all activities of daily living. R116's care plan dated 12/18/16 identified a risk for bruising due to thin skin and directed staff to Monitor skin with cares and report concerns, turn and reposition every two hours and apply lotion to skin as needed. A review of Oxbow Lake Care Center Progress Notes identified the following: On 11/21/16, nursing assistant found bruise on R116's right hip during her shower. The resident was unable to verbalize how it happened. Bruise measured 5 centimeters (cm) x 7 cm, purplish/bluish in color "but mostly yellow and reddish." An 11/23/16, Progress Note indicated bruising may have occurred with transfer, bumping or rolling into the side rail during cares. On 12/3/16, the noted depicted the family called staff over to look at R116's right hand and thumb. The thumb in joint area of hand was black and blue and swollen. The facility received order for x-ray. The X-ray result returned with no acute fracture or dislocation. A 12/6/16, Progress Note identified a new order for x-ray the progress note did not indicate area to be x-rayed however, a review of a St Therese at Oxbow Lake Physician Order form indicated x-ray of right hip/pelvis and right knee due to pain. Another 12/6/16, Progress Note indicated, "Having side rail down will help." However, that was not added to R116's care plan. On 12/7/16, a Progress Note indicated resident was using an extended wheel chair pedal to	F 323	Incident reporting policy reviewed and revised to include if an injury of unknown origin is found must be called to the on call RN immediately. Audits to be completed on all incidents daily x2 weeks to ensure timely reporting and follow up is completed per policy then weekly for 90 days with results reviewed at the Quality Assurance Committee which will determine the need for ongoing monitoring. Resident #87 has expired. Corrective action and re-education provided to the NA-A. Transfer policy reviewed and all nursing staff re-educated. Random care audits to be completed weekly x 90 days with results reviewed at the Quality Assurance Committee which will determine the need for ongoing monitoring. R138 was reassessed for alternative devices. Care plan and care guide were updated. R139, 144, 142, 145, 143, 50, 127 and 25 all discharged back to home. R69, 140, 141 were reassessed for alternatives to siderails. Facility audit completed for use of alternative devices on beds with siderails.	

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F 323	Continued From page 42 assist her with her leg and writer wonders if resident pushed against the pedal while then leaning forward causing a bruise to her backside on the right hip. No facility incident report was completed for this injury. During an observation on 1/5/16, at 8:07 a.m., nursing assistant (NA)-D and NA-E assisted R116 out of bed using a ceiling lift. R116 was cooperative during the transfer. When lifting R116 out of bed, staff assisted her out the left side of the bed and into the bathroom. Attached to the bathroom wall, next to the toilet was a metal grab bar. The grab bar was on R116's left side while she was seated on the toilet. During an interview on 1/5/16, at 8:07 a.m., NA-D stated she had never seen R116 hit her arms or legs on the side rail or wheelchair during transfers. During an interview on 1/5/16, at 8:28 a.m., registered nurse (RN)-A stated R116 "is an easy bruiser." She stated when staff assist R116 into the lift sling she gets "grabby" and due to her cognition she touches everything. RN-A stated R116 hits the grab bars with her hands. RN-A also stated R116 "might bang her hands on the table" when seated. She stated when the bruise was found on R116's right hip in November and incident report form was completed. She stated when injuries or bruising of unknown origin occur staff are directed to fill out a facility incident report. RN-A stated following the report the staff comes up with different interventions and look for anything out of the ordinary. She stated because R116 is not able to speak about or demonstrate how things happen, "we have to think outside the box." She further stated no incident report was	F 323	Random side rail audits will be completed on 10% of residents weekly x 90 days. Results reviewed at the Quality Assurance Committee which will determine the need for ongoing monitoring. Clinical Director/designee is responsible for ensuring compliance.	

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completed for the injury to R116's right hand on 12/3/16, or the bruising on the right hip noted on 12/7/16.

During an interview on 1/5/16, at 10:32 a.m., the director of clinical services (DCS) stated there were no incident/investigative reports completed for R116's bruises on her hand or on her right hip. She stated any injury that requires and x-ray should be investigated.

While R116 sustained three separate injuries between 11/21/16 and 12/7/16, two of which required x-rays to rule out fractures, the facility did not investigate the bruises or attempt to identify any patterns related to the injuries. Further, while the bruise identified on 11/21/16, was determined to be a result of bumping the side rail during a transfer or during cares, R116's side rail was on the left side of her bed, and all three bruises were on the right side of her body.

A facility policy for investigation requirements was requested but not received.
R87's activities of daily living (ADL) Care Area Assessment (CAA) dated 7/21/16, indicated resident was at this facility after having a bowel obstruction that resulted in a sigmoid resection and colostomy and due to decrease in ADL function and inability to take care of colostomy resident was staying at this facility for long term care.

R87's quarterly MDS dated 10/13/16, indicated resident had intact cognition.

R87's transferring care plan dated 11/8/16, indicated resident needed help to get back and forth from the bed to wheelchair due to weakness

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and ataxia. The care plan directed staff to encourage resident to use the grab bars, and provide extensive assist of one staff with gait belt to transfer as resident ability varied.

A general nursing note dated 1/4/17, at 10:40 a.m. indicated the resident had complained of left shoulder pain and had received schedule Tylenol (a mild analgesic) with slight relief. The note also indicated the nurse practitioner (NP) had been updated on "change of condition" and with new orders to do an xray and an urinalysis/urine culture (UA/UC).

Review of the PPX x-ray results findings completed on 1/4/16, the following was revealed for findings:
"Bones: It is difficult to evaluate because of the considerable deformity but there may be a new chip fracture at the superior margin of the deformed humeral head. There is an old left second rib fracture.
Joints: The deformed humeral head appears to be subluxed medial to the glenoid
Soft tissue: Unremarkable.
Other findings: There is considerable deformity of the left humeral head appears to be old trauma..."

R87's diagnoses included volvulus, anemia, glaucoma, hypertension, weakness, ataxia, atrial fibrillation and osteoarthritis obtained from the Admission Record dated 1/5/17.

On 1/5/17, at 7:40 a.m. NA-A was observed go to resident room after resident call light was on. At 7:43 a.m. the resident was observed lying in bed, on her back, and covered. When approached and asked how she had slept, the resident stated she was in pain all night even after she was given

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a new pain medication. NA-A applied gloves asked resident what pants, socks, shirt she wanted to wear then applied the socks, shoes and pants to the knees. NA-A then indicated to resident she was going to sit her by the edge of bed. NA-A then proceeded to reach out her right hand and grabbed the resident's right hand and was observed to pull the resident forward to a sitting position. However, the resident was pulling back and not able to hold herself up. At that time R87 asked NA-A, as she was attempting to sit up, "Honey do you have a transfer belt?" NA-A stated, "Yes" then applied the transfer belt at that time around the waist. NA-A then moved R87's legs to the edge of the bed and then pulled the resident out of bed towards her. Again NA-A grabbed R87's right hand not using the transfer belt. After the resident was seated on edge of the bed, NA-A cued the resident to stand to transfer to wheelchair. The resident held the grab bar with left hand, NA-A then cued resident she was going to assist her. As NA-A attempted to transfer resident holding onto the side of the transfer belt, the resident was unsteady and then sat back down on the edge of bed. On the second attempt, the resident was observed to give NA-A a bear hug as NA-A held the back of transfer belt and was able to transfer resident into the wheelchair with R87's pants still hanging below the knees.

On 1/5/17, at 8:33 a.m. licensed practical nurse (LPN)-A stated the NAs or staff that was assisting residents with transfers was supposed to use the transfer belt and not to pull the resident by hand.
-At 8:40 a.m. NA-A stated she had pulled resident up because she was assisting her to sit on the edge of bed and had not used the belt. When asked if she was aware resident had been experiencing a lot of pain, NA-A stated "I did not

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know." NA-A did not follow the plan of care as NA-A did not utilize the transfer belt when NA-A assisted R87 to a seated position.

On 1/5/17, at 11:53 p.m. RN-A stated NA-A was not supposed to grab resident by the hand and was supposed to use the transfer belt. RN-A stated NA-A was supposed to the follow the plan of care for each resident. When asked if the NAs were supposed to be updated of resident pain she stated the facility had a system and the nurse was supposed to update the NAs on report from the 24 hour report. When asked if resident had a fracture RN-A stated "it was not a definitive fracture."

On 1/6/17, at 9:25 a.m. the DCS stated staff was supposed to use the transfer belt as that was part of there uniform. When asked if NA's were given report DCS stated the nurses gave report to NAs.

R138's Oxbow Lake Care Center Mission Record indicated R138 admitted to the facility on 12/21/16, with diagnosis that included a compression fracture of the lumbar vertebra, pain, and chronic obstructive pulmonary disease.

A facility document (temporary plan of care) labeled Saint Therese and dated 12/21/16, identified a need for assistance with bed mobility and transfers. Upon initial review of the document the assistive device section was blank but was later updated to include two siderails to enhance mobility.

During an observation on 1/3/17, at 6:59 p.m., R138 was lying in bed with the head of the bed up. R138's bed had half side rails secured to the

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F 323	Continued From page 47 upper half that were in the raised position. There were two side rails attached to the lower half of the bed that were flush against the bed. During an observation on 1/6/17, at 10:00 a.m., R138 was lying in bed with the head of the bed raised. Both upper side rails were raised. With the facility administrator present, R138 stated, "I don't know why they [the side rails] are still on, I told them [nursing staff] I did not want them." R138 stated she told them the day before and stated, they asked me if I wanted them and I said no. She stated, they told me I could get hurt and said, "I don't want to get hurt any more." A review of a facility Positioning Device Evaluation was completed on 1/5/17 (15 days after R138 was admitted), and identified the use of half side rails. The evaluation indicated the side rails did not place R138 at risk for falls, strangulation, loss of muscle tone, pressure sores, decreased mobility/stiffness, agitation/frustration, loss of dignity, or incontinence/constipation. The Comment section of the evaluation noted: Late Entry: Resident has been in unit before. Resident understands the use of side rails. Resident needs assistance with putting the side rails up and down occasionally. The Positioning Device Evaluation lacked evidence that R138 had been informed of the risks of side rail usage, lacked evidence of alternative interventions attempted prior to installation and lacked evidence of informed consent for use. During an interview on 1/5/17, at 8:50 a.m., RN-D verified R138's clinical record lacked evidence of a consent for side rails usage. She stated she was unaware of interventions attempted prior to installing the side rails and stated, all of the beds	F 323		

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on the unit have side rails and the rails are all raised at night.

During and interview on 1/5/17, at 9:40 a.m., RN-C stated she was unaware a consent for side rails was needed if the rails did not restrict access to the residents body and did not prevent them from getting out of bed independently.

R127's Oxbow Lake Care Center Admission Record indicated R127 admitted to the facility on 12/30/16.

During an interview on 1/6/17, at 10:44 a.m., R127 was observed sitting on a chair next to her bed. Attached to her bed were two half side rails observed in the raised position. R127 stated no one had asked her if she wanted side rails, nor had anyone discussed risk factors for side rails with her. She stated, "I don't have side rails at home, I would have said no."

During an interview on 1/6/17, at 10:50 a.m., RN-C verified R127 had bilateral half side rails since admission. RN-C stated a risk and benefit for the use of side rails had not been completed not had the facility obtained consent for their use.

R142's Oxbow Lake Care Center Admission Record indicated R142 admitted to the facility on 12/24/16.

A facility document (temporary plan of care) labeled Saint Therese, dated 1/5/17, identified R142 required assistance with all activities of daily living and used assistive devices which included a wheel chair and a transfer belt. The

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F 323	Continued From page 49 care plan did not identify the use of side rails. During interview on 1/3/17, at 4:13 p.m., R142 was observed lying in bed. There were bilateral upper half side rails attached to the bed. The side rails were in the raised position. During the interview, R142 stated, the side rails were on the bed when she admitted to the facility and stated she did not usually use the right rail but used the top of the bed and the left rail sometimes. An Admission/Readmission/Annual Clinical Review, undated, indicated R142 used assistive devices and indicated devices were used to promote mobility or positioning. the assessment indicated R142 was able to demonstrate use of half side rails for bed mobility and transfers. The assessment did not include evidence that R142 had been informed of the risks of side rail usage or evidence of alternative interventions attempted prior to installation. During interview on 1/6/17, at 10:50 a.m. RN-C verified R142 was admitted on 12/24/16, and had bilateral half side rails. RN-C stated a review of the risks and benefits of side rail use had not been completed nor had the facility received an informed consent. R25's Oxbow Lake Care Center Admission Record indicated R25 admitted to the facility on 11/29/16. A facility document (temporary plan of care) labeled Saint Therese, dated 1/1/17, indicated R25 required assistance with transferring and bed mobility and identified the use of assistive devices. The care plan directed staff to use two	F 323		

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F 323	Continued From page 50 side rails in the up position while in bed to facilitate bed mobility and transfers. On 1/3/17, at 7:19 p.m., R25 was observed lying in bed with bilateral upper half side rails attached to the bed and in the up position. A Positioning Device Evaluation dated 12/5/16, indicated R25 used half side rails and indicated the side rails did not place R25 at risk for falls, strangulation, loss of muscle tone, pressure sores, decreased mobility/stiffness, agitation/frustration, loss of dignity, or incontinence/constipation. The evaluation indicated R25 had demonstrated use of half rails to aid in bed mobility and cares. The Positioning Device Evaluation lacked evidence that R25 had been informed of the risks of side rail usage, lacked evidence of alternative interventions attempted prior to installation and lacked evidence of informed consent for use. During interview on 1/6/17, at 10:50 a.m. RN-C verified R25 had bilateral half side rails attached to her bed. RN-C stated a review of the risks and benefits of side rail use had not been completed nor had the facility received an informed consent. R69's Oxbow Lake Care Center Admission Record indicated R69 admitted to the facility on 11/29/16. A facility document (temporary plan of care) labeled Saint Therese, dated 1/1/17, indicated R69 required assistance with bed mobility and transfers. The care plan identified the use of assistive devices and indicate two side rails up in bed to facilitate bed mobility and transfers.	F 323		

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During an observation of R69's room on 1/6/17, at 10:48 a.m., the bed had two upper half side rails attached. The rails were in the raised position.

An Admission/Readmission/Annual Clinical Review, undated, indicated R69 was able to demonstrate safe use of assistive devices but did not identify the type of device used. The assessment indicated patient to be evaluated.

During an interview on 1/6/17, at 10:50 a.m., RN-C verified R69 had bilateral half side rails. RN-C stated a review of the risks and benefits of side rail use had not been completed nor had the facility received an informed consent.

R50's Oxbow Lake Care Center Admission Record indicated R50 admitted to the facility on 12/6/16.

A facility document (temporary plan of care) labeled Saint Therese, dated 12/10/16, indicated R50 required assistance with bed mobility and transfers and used assistive devices. The care plan directed staff to use two side rails up in bed to facilitate bed mobility and transfers.

During an observation on 1/6/17, at 10:47 a.m., R50 was lying in bed with head of bed at 30 degrees. There were two half side rails on the upper portion of the bed. R50 stated she had a vertical bar that goes from the floor to the ceiling at home and stated her therapist at home said it was safer than side rails. R50 said no one here had talked to her about the risk related to side rail use.

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SAINT THERESE AT OXBOW LAKE	**5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443**

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F 323	Continued From page 52 During interview on 1/6/17, at 10:50 a.m. RN-C stated a review of the risks and benefits of side rail use had not been completed nor had the facility received an informed consent for R50. R143's Oxbow Lake Care Center Admission Record indicated R143 admitted to the facility on 12/20/16. A facility document (temporary plan of care) labeled Saint Therese, dated 12/26/16, indicated R143 required assistance with bed mobility and transfers and used assistive devices. The care plan directed staff to use two half side rails up while in bed to facilitate transfer and bed mobility. During an observation of R143's room on 1/6/17, at 10:48 a.m., the bed had two upper half side rails in the up position. An Admission/Readmission/Annual Clinical Review, undated, indicated R143 was able to demonstrate safe use of side rails on her bed to aide in bed mobility, cares and transfers. During an interview on 1/6/17, at 10:50 a.m., RN-C stated a review of the risks and benefits of side rail use had not been completed nor had the facility received an informed consent for R143. R140's Oxbow Lake Care Center Admission Record indicated R140 admitted to the facility on 12/21/16. A facility document (temporary plan of care) labeled Saint Therese, dated 12/24/16, indicated	F 323		

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R140 required extensive assistance from two staff for bed mobility and did not transfer. The care plan directed staff to use two side rails up in bed to facilitate bed mobility and transfers.

During an observation on 1/6/17, at 10:48 a.m., R140's bed was noted to have two upper half side rails. The rails were in the raised position.

An Admission/Readmission/Annual Clinical Review, undated, indicated R140 was able to demonstrate safe use of side rails on her bed to aide in bed mobility, cares and transfers.

During interview on 1/6/17 at 10:50 a.m., RN-C verified had bilateral half side rails. RN-C stated a review of the risks and benefits of side rail use had not been completed nor had the facility received an informed consent for R140.

R139's Oxbow Lake Care Center Admission Record indicated R139 admitted to the facility on 12/22/16.

A facility document (temporary plan of care) labeled Saint Therese, dated 1/1/17, indicated R139 required assistance with bed mobility and transfers and used assistive devices. The care plan directed staff to use two half side rails up while in bed to facilitate transfer and bed mobility.

During an observation of R139's room on 1/6/17, at 10:48 a.m., the bed had two upper half side rails in the up position.

An Admission/Readmission/Annual Clinical Review, undated, indicated R139 was able to demonstrate safe use of side rails on her bed to

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aide in bed mobility, cares and transfers.

During interview on 1/6/17, at 10:50 a.m., RN-C verified R139 had bilateral half side rails. She stated a risk for the use of side rails had not been reviewed with R139, nor had the facility obtained consent for their use.

R141's Oxbow Lake Care Center Admission Record indicated R141 admitted to the facility on 12/31/16.

A facility document (temporary plan of care) labeled Saint Therese, dated 1/2/17, indicated R141 required assistance with bed mobility and transfers and used assistive devices that included a walker, wheel chair and transfer belt. The care plan did not identify the use of side rails.

During an observation of R141's room on 1/6/17, at 10:48 a.m., the bed had two upper half side rails in the up position.

An Admission/Readmission/Annual Clinical Review, undated, identified the use of half side rails for positioning.. The review indicated R141 was able to demonstrate safe use of side rails on her bed to aide in bed mobility, cares and transfers.

During interview on 1/6/17, at 10:50 a.m., RN-C verified R141 had bilateral half side rails. She stated a risk for the use of side rails had not been reviewed with R141, nor had the facility obtained consent for their use.

R144's Oxbow Lake Care Center Admission

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Record indicated R144 admitted to the facility on 12/31/16.

A facility document (temporary plan of care) labeled Saint Therese, dated 1/4/17, indicated R144 required assistance with bed mobility and transfers and used assistive devices that included a wheel chair and transfer belt. The care plan did not identify the use of side rails.

During an interview on 1/6/17, at 10:45 a.m., R144 was sitting in chair next to bed. She stated some came to her room earlier that day and asked her if she wanted the side rails that were on her bed but stated no one had discussed the risk of side rail use with her.

An Admission/Readmission/Annual Clinical Review, undated, identified the use of half side rails for positioning. The review indicated R144 was able to demonstrate safe use of side rails on her bed to aide in bed mobility and transfers.

During interview on 1/6/17, at 10:50 a.m., RN-C verified R144 had bilateral half side rails. She stated a risk for the use of side rails had not been reviewed with R144, nor had the facility obtained consent for their use.

R145's Oxbow Lake Care Center Admission Record indicated R145 admitted to the facility on 1/5/17.

A facility document (temporary plan of care) labeled Saint Therese, dated 1/5/17, indicated R145 required assistance with bed mobility and transfers but did not identify the use of side rails.

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During an observation of R145's room on 1/6/17, at 10:48 a.m., the bed had two upper half side rails in the up position.

An Admission/Readmission/Annual Clinical Review, undated, identified the use of half side rails for positioning. The review indicated R145 was able to demonstrate safe use of side rails to aide in bed mobility.

During interview on 1/6/17, at 10:50 a.m., RN-C verified R145 had bilateral half side rails. She stated a risk for the use of side rails had not been reviewed with R145, nor had the facility obtained consent for their use. RN-C stated she had started reviewing the the risks of side rail use with residents on the unit earlier today including the risk for entanglement, injury up to and including death and risk for fractures. She stated she also discussed the benefits of the enhanced mobility, bed mobility and transfers and told them if they want to use the grab bars she would need to have a consent. RN-C stated the facility did not have a form for consent and she had not yet documented she had this morning.

During interview on 1/5/17, at 2:46 p.m. the DCS said expected device assessment to be completed at time of admission. The DCS stated she was not aware that informed risks and benefits needed to be completed and she verified the facility was not attempting interventions prior to placing side rails on beds on the transitional care unit as all beds on that unit have side rails on them.

While the facility assessed the residents on the transitional care unit for their ability to use the side rails for positioning, there was no evidence

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F 323	Continued From page 57 the facility attempted appropriate alternatives prior to implementing the side rails. Further the facility did not expand the risks related to the us of side rails or obtain consent for their use prior to installing side rails to all of the beds on the unit. A facility policy titled Proper Use of Side Rails, dated October 2010, instructed staff, the purpose of these guidelines are to ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's medical symptoms. Side rails are only permissible if they are used to treat a resident's medical symptoms or to assist with mobility and transfer of residents. An assessment will be made to determine the resident's symptoms or reason for using side rails. When used for mobility or transfer, an assessment will include a review of the resident's: Bed mobility; and ability to change positions, transfer to and from bed or chair and to stand and toilet. The use of side rails as an assistive device will be addressed in the resident care plan. Documentation will indicate if less restrictive approaches are not successful, prior to considering the use of side rails. The risks and benefits of side rails will be considered for each resident. Consent for side rail use will be obtained from the resident or legal representative, after presenting potential benefits and risks.	F 323		
F 332 SS=D	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater;	F 332		2/10/17

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F 332	Continued From page 58 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 8 residents (R127, R37) were free of medication errors. This resulted in a facility medication error rate of 12%. Findings include: R127's admission Minimum Data Set (MDS) dated 10/29/16, indicated R127 was cognitively intact with diagnoses of high blood pressure and arthritis in both knees. R127's MDS indicated R127 had occasional pain rated as five on a scale of zero to ten. R127's January 2017 Medication Administration Record (MAR) instructed staff to give R127 acetaminophen tablet 500 milligram (mg) one tablet every six hours as needed (PRN) for pain rated as one to five and give two tablets by mouth every six hours PRN for pain rated six to ten. R127's Physician Order dated 1/3/17, instructed staff to give R127 "Metoprolol [a medication to treat elevated blood pressure, chest pain and abnormally fast pulse] 25 mg 1 p.o. [by mouth] BID [twice a day] may increase to 50 mg on 1/4[17] if heart rate above 90 and BP [blood pressure] above 150." During a medication pass observation on 1/3/17, at 6:11 p.m., registered nurse (RN)-F asked R127 to rate her pain level. R127 stated her pain was a four out of 10 (0 equals no pain and 10 equals the worse pain ever). R127 requested two pain pills. RN-F gave R127 two tablets of acetaminophen 500 milligrams (mg). RN-F did not explain to R127 that the Physician's Order was for one	F 332	Medication error forms completed on R 127, R37 and notifications completed per policy. R127 discharged. Medication identified for R37 was discontinued per MD upon clarification to change the order. RN re-educated immediately. Medication Error policy and Medication Administration policy reviewed. All staff responsible for passing medication will be re-educated on medication administration by 2/10/17. MD order transcription policy reviewed and revised. Licensed staff and Clinical Support staff will be re-educated on policy by 2/10/17. Medication/order transcription audits will be completed on 5% of residents weekly x 90 days. Results reviewed at the QA Committee which will determine the need for ongoing monitoring. Clinical Director/designee is responsible for ensuring compliance.	

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tablet at that pain level.

During the medication pass observation on 1/3/17, at 6:16 p.m., RN-F explained to R127 that the doctor had started R127 on a new medication for blood pressure and pulse. RN-F explained the parameters for metoprolol 25 mg if pulse was less than 90 and BP was less than 150. RN-F told R127 that if the pulse or blood pressure were above these limits (R127) would receive 50 mg of metoprolol. RN-F informed R127 that her pulse was 106 and blood pressure was 171/89 so RN-F would be giving her 50 mg of metoprolol. R127 should have received 25 mg of the metoprolol on 1/3/17, according to the Physician's Order.

During interview on 1/3/17, at 6:24 p.m., RN-F verified the order in the chart was for metoprolol 25 mg may increase to 50 mg on 1/4/17 if heart rate was greater than 90 and blood pressure was greater than 150. RN-F verified that was R127's first dose of metoprolol. RN-F verified resident was also on Dyazide (a medication for high blood pressure and fluid retention) 37.5-25 mg in the morning. RN-F verified acetaminophen order was for one tablet for pain rated one to five and two tablets for pain six to ten but stated R127 had asked for two tablets. RN-F acknowledged not explaining to R127 that the Physician Order was for one tablet for a pain level of four.

During an interview on 1/5/17, at 8:59 a.m., the nurse practitioner stated she would have expected the staff to give Metoprolol 25 mg twice on January third as ordered. She stated the medications are to be given as ordered and if there is a concern the staff should call and have the order clarified.

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R37's January's 2017 MAR instructed staff to give one tablet of "Multivital [Multiple Vitamins-Minerals]" a day. R37's January's MAR indicated R37 had a diagnosis of anemia.

During a medication pass observation on 1/5/17, at 7:46 a.m., RN-E gave R37 one multivitamin, not a multivitamin with minerals as ordered.

During an interview on 1/5/17, at 7:57 a.m., RN-E verified R37's order from Order Summary Report signed by R37's primary physician on 12/20/16. The order was as follows: MultiVital Tablet give one tablet by mouth one time a day. RN-E verified that she had given R37 a multivitamin that did not contain minerals. RN-E said that was a medication error.

During an interview on 1/5/17, at 1:45 p.m., The consulting pharmacist stated he reviews all medication error forms and stated the facility did not have a lot of them. The consulting pharmacist further state, medications are to be given as ordered and there was a problem staff should call the doctor or nurse practitioner.

During an interview on 1/5/17, at 2:52 p.m., the director of clinical services said, "Staff are to follow the six rights of medication administration [right resident, right medication, right dose, right time, right route, and right documentation]. She stated she expected staff to give the medications the doctor ordered and if there is a problem with the order call and get the order clarified. The director of clinical services stated the order for the multivitamin was correct but was entered into the computer incorrectly. She agreed that if the doctor signed the order for multivitamin with

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F 332	Continued From page 61 mineral that was what was to be given. A facility Medication Administration Policy dated August 2012, indicated Medication administration will be completed safely and therapeutically following industry standards and maintaining regulatory compliance. The policy directed staff to use the 5 rights of medication administration : Right time, Right route, Right resident, Right medication, and Right dose.	F 332		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced	F 371		2/10/17

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F 371	Continued From page 62 by: Based on observation, interview, and document review, the facility failed to follow equipment sanitation procedures that would minimize the possibility of food borne illness in 2 of 3 kitchenette's. This had the potential to affect 28 of 61 residents in the facility, who were served food out of the kitchenette's. Findings include: During the initial tour to the facility kitchenettes the following sanitation problems were observed and confirmed on 1/3/17, at 12:23 p.m. by the chef manager (CM). The Transitional Care Unit (TCU) kitchenette flat top stove was observed with heavy buildup of a black substance on the cooking surface and along the edges of the stove. CM verified stated the stove was cleaned daily and a deep clean on the weekend which would take care of the edge stuff off. When asked for the cleaning log the CM reviewed it with the surveyor verified cleaning the flat stove was not in the list, however, stated staff always did a run through to make sure everything was clean daily. -At 12:27 p.m. toured the long term care (LTC) unit upstairs kitchenette and the flat top stove was observed clean and the chef verified how clean it looked compared to the TCU stated it was not used as much. The Memory Care Unit kitchenette observed the oven with heavy black baked on substance on the bottom of the oven inside. When asked who and when it had been cleaned, CM stated it was used by the activity department and would be find out more and get back to the surveyor.	F 371	TCN kitchen grill and memory care kitchenette oven have been deep cleaned. Cleaning checklist updated to include grill top and kitchenette ovens. Cleaning procedures reviewed and updated. Staff educated on updated cleaning checklist and cleaning procedures. Audits will be completed weekly on cleaning procedures and results will be reported to the QA Committee meeting, action plans developed as needed, and will determine the need for ongoing monitoring. Dining Director and/or designee responsible for ongoing compliance.	

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F 371	Continued From page 63 On 1/3/17, at 4:53 p.m. during a follow up visit to the TCU kitchenette the flat top stove observed to have been cleaned however, still observed to have the thick black baked on patches all around the edges. On 1/5/17, at 9:30 a.m. during a follow up tour with CM he verified the black baked on matter was still left on some parts on the edge stated he had reviewed the cleaning log and seen it was there however was not specific "Clean out drip trays under stove and wipe down entire oven..." CM acknowledged even though the staff signed off, the flat stove clearly had at least a weeks worth of heavy baked on matter. -At 9:35 a.m. when asked for the facility equipment cleaning policy CM stated he did not have one and the staff was to follow the logs and were supposed to sign off after the cleaning. When asked who was responsible for cleaning the Memory Care Unit oven CM stated activity department used it however housekeeping cleaned it and "we are supposed to follow up with it as it is a kitchen equipment." During review of the Good Life/TCN Cook's Daily Cleaning Schedule logs for dates 12/16, through 1/2/17, it was revealed the staff signed off the logs however on the spot "Clean out Drip stove & wipe down entire oven" did not indicate if the ovens in the Memory Care Unit and the flat top stove had been cleaned.	F 371		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program.	F 441		2/10/17

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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 441	Continued From page 64	F 441		

The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the

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	245619	A. BUILDING ______ B. WING ______	01/06/2017

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SAINT THERESE AT OXBOW LAKE	**5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443**

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F 441	Continued From page 65 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper hand hygiene and glove use was provided for 2 of 3 residents (R75, R87) reviewed for activities of daily living (ADL's). Findings include: R75 was observed being wheeled to the room on 1/4/17, at 12:29 p.m. by nursing assistant (NA)-F. NA-F then applied the transfer belt, wheeled the resident close to the toilet, cued the resident to use the grab bars, then cued her to keep turning as she pulled the pants off and guided the resident to sit on the toilet. NA-F then told	F 441	Staff identified during observations were re-educated and given corrective action on infection control practices. Handwashing and gloving policy reviewed. Nursing staff re-educated on the policy. Random weekly audits will be completed for 90 days and results will be reviewed for ongoing compliance at the quarterly QAA. Clinical Director/designee is responsible for ensuring compliance.	

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F 441	Continued From page 66 resident she was going to be waiting outside the door. At 12:34 p.m. the resident stated "I think am done. I did not go." NA-F then went in assisted resident to stand told resident "you went a little." Then was observed provide pericare. The wipes were noted to have feces on them. NA-F tossed the soiled wipes in the trash, never removed the soiled gloves or washed the hands. NA-F adjusted the resident's clothing, sat the resident back in the wheelchair, and touched the wheelchair with the same soiled gloves. NA-F then flushed the toilet, removed the soiled gloves and did not wash the hands. NA-F turned the wheelchair to face the door, and then offered the resident a wet wipe to wipe their hands. NA-F wheeled the resident to the bedside, applied the foot pedals and then wheeled resident out of the room in front of the television. At 12:39 a.m. NA-A then went over to the nursing station and washed hands at that time. -At 12:40 p.m. when asked what the facility policy was for hand washing NA-F stated she was going to wash her hands before assisting another resident and acknowledged she would have washed her hands at the entry way sink before leaving resident room. She indicated she had not removed the gloves after providing pericare because she wanted to make sure the resident was situated to prevent her from falling. R87's call light was observed light on 1/5/17, at 7:40 a.m. when NA-A was observed go to resident room. At 7:43 a.m. the resident was observed lying in bed, on her back, and covered. When approached and asked how she had slept, the resident stated she was in pain all night even after she was given a new pain medication. NA-A then asked resident what she wanted her to do	F 441		

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F 441	Continued From page 67 for her, the resident got frustrated and stated, "What do you normally do for me?" NA-A then applied gloves and asked resident what pants, socks, shirt she wanted to wear. NA-A then applied the socks, shoes and pants to the knees then indicated to resident she was going to sit her by the edge of bed. NA-A cued resident to stand to transfer to wheelchair. NA-A then wheeled the resident into the bathroom, cued her to stand using the grab bars, resident stood up. NA-A asked the resident to pivot turn, NA-A removed the wet soiled incontinent pad, then the resident sat on the toilet. NA-A then told resident she was going to stay with her so she did not fall. NA-A ran the water in faucet however, never washed hands after removing the gloves. NA-A then washed resident up as she sat on the toilet applied lotion and applied the shirt. At 8:04 a.m. NA-A applied a clean pad then cued resident to stand, resident stood up she provided pericare, resident stated she would not stand any longer. NA-A then told resident to sit back on toilet, still wearing the same gloves, she had provided pericare with, NA-A then cued resident to stand again to adjust the pad. The resident stated her nose was runny. NA-A got a Kleenex wiped the resident's nose with the same soiled gloves. At 8:09 a.m. NA-A asked surveyor to get another staff member to assist with the transfer. The surveyor left room briefly came back with licensed practical nurse (LPN)-A. At 8:13 a.m. After the transfer, NA-A then removed the soiled gloves and came over to the bedside, and re-applied another pair. NA-A did not wash their hands. NA-A was observed to straighten the bed after went back to bathroom removed gloves and finally washed hands. NA-A then came back to resident put the call light at reach went to bathroom to wash the resident's glasses. NA-A came back to bedside, and the	F 441		

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resident stated she had not brushed her teeth. NA-A offered to go assist and get her back to the bathroom.

On 1/5/17, at 8:30 a.m. when interviewed about the gloves NA-A acknowledged she had not removed the gloves she provided peri-care with and had not washed her hands.
-At 8:33 a.m. LPN-A stated the NA's was supposed to wash their hands each time after removing gloves and before and after providing cares to any resident.

On 1/5/17, at 11:53 p.m. registered nurse (RN)-A stated when asked about gloving and hand washing, RN-A stated the staff was supposed to wash hands after removing gloves and change gloves after pericare.

On 1/6/17, at 9:11 a.m. when asked about glove use and hand washing the director of clinical services (DCS) stated per facility policy staff was to remove gloves after peri care and wash hands. DCS further stated the staff was supposed to take gloves off and wash hands prior to leaving a residents room.

The facility Infection Control: Personal Protective Equipment dated August 2012, directed "C. Gloves will be changed between tasks and procedures on the same resident after contact with material that may contain a high concentration of microorganism..."

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

F5619004

FORM APPROVED
OMB NO. 0938-0391

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	245619	A. BUILDING 01 - MAIN BLDG B. WING ______	01/05/2017

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety,Fire Marshal Division on January 05, 2017. At the time of this survey, Saint Therese at Oxbow Lake was found in compliance with the requirements for participation in Medicare/Medicaid, 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101 , Life Safety Code (LSC), Chapter 19 Existing Health Care. 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 61 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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.