DEPARTMENT OF HEALTH	I AND HUMA	N SERVICES		CENTERS FOR MEDICARE & MEDICAID SERVICES				
			1EDICAID CERTIFICATION AND TRANSMITTA					
	PART I -	TO BE COMPL	LETED BY T	THE STAT	FE SURVEY AGENCY	Facility ID: 27752		
1. MEDICARE/MEDICAID PROVIDER (L1) 245619	R NO.	3. NAME AND AD (L3) SAINT THE			ΧE	4. TYPE OF ACTION: <u>7 (</u> L8) 1. Initial 2. Recertification		
2.STATE VENDOR OR MEDICAID NO	D.	(L4) 5200 OAK G	ROVE PARK	WAY		3. Termination 4. CHOW		
(L2) 753490000		(L5) BROOKLYN PARK, MN			(L6) 55443	5. Validation 6. Complaint 7. On-Site Visit 9. Other		
5. EFFECTIVE DATE CHANGE OF O (L9)	WNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint		
6. DATE OF SURVEY 04/10/	2014 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF			
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/III	D 15 ASC	FISCAL YEAR ENDING DATE: (L35)		
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	06/13		
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:				
From (a):		A. In Complian				The Following Requirements:		
To (b):		Program Requirements Compliance Based On:			2. Technical Personnel 3. 24 Hour RN	 6. Scope of Services Limit 7. Medical Director 		
12.Total Facility Beds	64 (L18)	1. Ao	cceptable POC		4. 7-Day RN (Rural SN 5. Life Safety Code			
13.Total Certified Beds	64 (L17)		pliance with Prog ents and/or Appli			(L12)		
14. LTC CERTIFIED BED BREAKDOW	VN				15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
64 (L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMA	RKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION I	DATE):				
See Attached Remarks								
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:		
Lou Anne Page, HFE-NE	II	0	06/09/2014 (L19) Anne Kleppe, Enfor			ement Specialist 06/09/2014		
PAR	T II - TO BE	COMPLETED E	BY HCFA RE	EGIONAI	L OFFICE OR SINGLE S			
19. DETERMINATION OF ELIGIBILI	ТҮ	20. COM	PLIANCE WITH	H CIVIL	21. 1. Statement of Finar	ncial Solvency (HCFA-2572)		
_X 1. Facility is Eligible to Pa			ITS ACT:		2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)			
2. Facility is not Eligible	incipate				3. Both of the Above :			
=: · · · · · · · · · · · · · · · · · ·	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	. LTC AGREEN	/IENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION 07/16/2013	BEGINNING	G DATE	ENDING DAT	ГЕ	<u>VOLUNTARY</u> <u>00</u> 01-Merger, Closure	<u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse			
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	on <u>OTHER</u>		
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change		
(L27)	B. Rescind S	uspension Date:	(L44)			00-Active		
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE				
	(L32)	03/03/2014		(L33)	DETERMINATION APPI	ROVAL		

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN#: 24-5619

On 04/10/14, a second Post Certification Revisit (PCR) was completed by the Department of Health. Based on the PCR, it has been determined that the facility had achieved substantial compliance pursuant to the standard 01/10/14 survey, effective 04/09/14. Refer to the CMS 2567B for both health and life safety code.

Effective 04/09/14, the facility is certified for 64 skilled nursing facility beds.



Protecting, Maintaining and Improving the Health of Minnesotans CMS Certification Number (CCN): 24-5619

June 9, 2014

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

Dear Ms. Martin:

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 April 9, 2014, the above facility is certified for:

64 - Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

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,

Are Klegese

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Telephone: (651) 201-4124 Fax: (651) 215-9697



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered: April 11, 2014

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

RE: Project Number S5619001

Dear Ms. Martin:

On April 9, 2014, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective April 12, 2014. (42 CFR 488.422)

On April 9, 2014, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective April 24, 2014. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in our letter of April 9, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 24, 2014.

This was based on the deficiencies cited by this Department for a standard survey completed on January 10, 2014, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on March 19, 2014. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On April 10, 2014, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on March 19, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 9, 2014. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on March 19, as of April 9, 2014. As a result of the revisit findings, the Department is rescinding the Category 1 remedy of state monitoring effective April 9, 2014.

Saint Therese at Oxbow Lake April 11, 2014 Page 2

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of April 9, 2014. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective April 24, 2014, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective April 24, 2014, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective April 24, 2014, is to be rescinded.

In our letter of April 9, 2014, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 24, 2014, due to denial of payment for new admissions. Since your facility attained substantial compliance on April 9, 2014, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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 about this e-Notice.

Sincerely,

Are Klegepe

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

State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 27752	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 4/10/2014
Name	e 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 State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

Completed NB Prefix Completed Q409/2014 ID Prefix Completed NR Reg. # ID Prefix Completed Reg. # ID Prefix Completed LSC ID Prefix Completed LSC ID Prefix Completed LSC ID Prefix Completed LSC ID Prefix Correction Completed Correction Completed Correction LSC Correction Completed Correction LSC Correction LSC Correction LSC Correction Completed	(Y4) Item		(Y5)	Date	(Y4) Item	(Y5)	Date	(Y4)	ltem		(Y5)	Date
Reg. # NN Rule 4658.1350 Subp. Reg. # LSC Reg. # LSC	ID Prefix	21630	Co	ompleted	ID Prefix				ID Prefix			Correction Completed
Correction ID Prefix Correction Completed Correction ID Prefix Correction Reg.# Correction LSC Correction LSC Correction Completed Correction ID Prefix Correction Completed Correction Completed Correction Completed Correction Completed Correction ID Prefix Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction ID Prefix Correction Completed Corre					Reg. #							
ID Prefix	LSC				LSC				LSC			
Completed	Reg. #		Co		Reg. #		Completed		Reg. #			
Completed Completed Completed Completed Completed Completed ID Prefix Completed ID Prefix Reg. # Completed ID Prefix Reg. # LSC Correction Correction <td>Reg. #</td> <td></td> <td>Co</td> <td></td> <td>Reg. #</td> <td></td> <td>Completed</td> <td></td> <td></td> <td></td> <td></td> <td></td>	Reg. #		Co		Reg. #		Completed					
Completed Completed Completed Completed Completed Completed ID Prefix	Reg. #		Co		Reg. #		Completed		Dog #			Correction Completed
Reviewed By Reviewed By Date: Signature of Surveyor: Date: State Agency GD/AK 06/09/2014 18622 04/10/2014 Reviewed By Reviewed By Date: Signature of Surveyor: Date: CMS RO Reviewed On: Check for any Uncorrected Deficiencies. Was a Summary of Date:	Reg. #		Co		Reg. #		Completed		Reg. #			
State Agency GD/AK 06/09/2014 18622 04/10/2014 Reviewed By Reviewed By Date: Signature of Surveyor: Date: CMS RO Followup to Survey Completed on: Check for any Uncorrected Deficiencies. Was a Summary of												
Reviewed By Reviewed By Date: Signature of Surveyor: Date: CMS RO Followup to Survey Completed on: Check for any Uncorrected Deficiencies. Was a Summary of Date:	Reviewed E	By Revie	ewed By	y	Date:	Signature of Sur	veyor:				Date:	
CMS RO Followup to Survey Completed on: Check for any Uncorrected Deficiencies. Was a Summary of	State Agen	cy GD	/AK		06/09/2014				18	622	04/	10/2014
		By Revie	ewed By	y	Date:	Signature of Sur	veyor:				Date:	
1/10/2014 Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO STATE FORM: REVISIT REPORT (5/99) Page 1 of 1 Event ID: RNX613		1/10/2014		2)	0	Uncorrected Defic				the Facility?		

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245619	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 4/10/2014
Nam	e of Facility		Street Address, City, State, Zip Code	
SAINT THERESE AT OXBOW LAKE			5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443	

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

(Y4) Item		(Y5)	Date	(Y4) Item	(Y5)	Date	(Y4)	Item		(Y5)	Date
ID Prefix	F0425	С	orrection ompleted I/09/2014	ID Prefix		Correction Completed		ID Prefix			Correction Completed
Reg. # LSC	483.60(a),(b)			Reg. # LSC				Reg. # LSC			
Reg. #		C	orrection ompleted	Reg. #		Correction Completed		Pog #			Correction Completed
ID Prefix Reg. # LSC		C	orrection ompleted			Correction Completed					Correction Completed
ID Prefix Reg. # LSC		C	orrection ompleted	_ "		Correction Completed					Correction Completed
Reg. #		C	orrection ompleted					D "			
Reviewed B	By Rev	/iewed B	у	Date:	Signature of Sur	vevor:				Date:	
State Agen		D/AK		06/09/2014	•			18	622		10/2014
Reviewed E CMS RO		/iewed B	у	Date:	Signature of Sur	veyor:				Date:	
Followup t	o Survey Comple 1/10/201				Check for any Unco Uncorrected Defic					YES	NO

DEPARTMENT OF HEALTH AND HUMA	N SERVICES	CENTERS FOR MEDICARE & MEDICAID SERVICES			
	ARE/MEDICAID CERTIFICATION				
PART I -	TO BE COMPLETED BY THE STA	TE SURVEY AGENCY	Facility ID: 27752		
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245619	3. NAME AND ADDRESS OF FACILITY (L3) SAINT THERESE AT OXBOW LAI	KE	 TYPE OF ACTION: <u>7 (</u>L8) Initial Recertification 		
2.STATE VENDOR OR MEDICAID NO.	(L4) 5200 OAK GROVE PARKWAY		3. Termination4. CHOW		
(L2) 753490000	(L5) BROOKLYN PARK, MN	(L6) 55443	5. Validation6. Complaint7. On-Site Visit9. Other		
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIER CATEGORY01 Hospital05 HHA09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint		
6. DATE OF SURVEY 03/19/2014 (L34)	02 SNF/NF/Dual 06 PRTF 10 NF	14 CORF	ERCALVEAD ENDING DATE: (1.25)		
8. ACCREDITATION STATUS: (L10)	03 SNF/NF/Distinct 07 X-Ray 11 ICF/III		FISCAL YEAR ENDING DATE: (L35)		
0 Unaccredited 1 TJC 2 AOA 3 Other	04 SNF 08 OPT/SP 12 RHC	16 HOSPICE	06/13		
11LTC PERIOD OF CERTIFICATION	10.THE FACILITY IS CERTIFIED AS:				
From (a):	A. In Compliance With	And/Or Approved Waivers Of			
To (b):	Program Requirements Compliance Based On:	2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit 7. Medical Director		
12.Total Facility Beds 64 (L18)	1. Acceptable POC	4. 7-Day RN (Rural SN 5. Life Safety Code			
13.Total Certified Beds 64 (L17)	X B. Not in Compliance with Program Requirements and/or Applied Waivers:		(L12)		
14. LTC CERTIFIED BED BREAKDOWN		15. FACILITY MEETS			
18 SNF 18/19 SNF 19 SNF	ICF IID	1861 (e) (1) or 1861 (j) (1):	(L15)		
64 (L37) (L38) (L39)	(L42) (L43)				
16. STATE SURVEY AGENCY REMARKS (IF APPLICA	BLE SHOW LTC CANCELLATION DATE):				
See Attached Remarks					
17. SURVEYOR SIGNATURE	Date :	18. STATE SURVEY AGENCY	APPROVAL Date:		
Patrick Sheehan, Supervisor, SFMO	04/08/2014 (L19)	Anne Kleppe, Enforcement Specialist 06/09/2014			
PART II - TO BE	COMPLETED BY HCFA REGIONAL	L OFFICE OR SINGLE ST			
19. DETERMINATION OF ELIGIBILITY	20. COMPLIANCE WITH CIVIL	21. 1. Statement of Finan	cial Solvency (HCFA-2572)		
X 1. Facility is Eligible to Participate	RIGHTS ACT:	 Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
2. Facility is not Eligible					
(L21)					
22. ORIGINAL DATE 23. LTC AGREEM	MENT 24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION BEGINNINC 07/16/2013	DATE ENDING DATE	VOLUNTARY 00 01-Merger, Closure 00			
(L24) (L41)	(L25)	02-Dissatisfaction W/ Reimburse	•		
25. LTC EXTENSION DATE: 27. ALTERNATI	VE SANCTIONS	03-Risk of Involuntary Termination	n <u>OTHER</u>		
A. Suspension	n of Admissions:	04-Other Reason for Withdrawal	07-Provider Status Change		
(L27) B. Rescind Su	(L44) Ispension Date:		00-Active		
	(L45)				
28. TERMINATION DATE: 29	. INTERMEDIARY/CARRIER NO.	30. REMARKS			
	03001				
(L28)	(L31)				
31. RO RECEIPT OF CMS-1539 32	. DETERMINATION OF APPROVAL DATE				
(L32)	03/03/2014 (L33)	DETERMINATION APPR	ROVAL		

DEPARTMENT OF HEALTH AND HUMAN SERVICES	CENTERS FOR MEDICARE & MED	ICAID SERVICES
MEDICARE/MEDICAID CERTIFICATION AN	D TRANSMITTAL	ID: RNX6
PART I - TO BE COMPLETED BY THE STATE	SURVEY AGENCY	Facility ID: 27752

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN#: 24-5619

On 03/19/14, a Post Certification Revisit (PCR) was completed by the Minnesota Department of Health and on 02/12/14, the Minnesota Department of Public Safety completed a PCR. Based on these PCRs, it has been determined that the facility has not achieved substantial compliance pursuant to the 01/10/14 standard survey. Refer to the CMS 2567 (For health), CMS 2567B for both health and life safety code.



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered: April 9, 2014

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

RE: Project Number S5619001

Dear Ms. Martin:

On January 28, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 10, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 19, 2014, the Minnesota Department of Health and on February 12, 2014, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 10, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 19, 2014. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on January 10, 2014.

At the time of this revisit, we identified the following deficiency:

• 0425-Pharmaceutical Svc - Accurate Procedures, Rph-483.60(a),(b)

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

• State Monitoring effective April 12, 2014 (42 CFR 488.422)

However, as we notified you in our letter of January 28, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is

Saint Therese at Oxbow Lake April 9, 2014 Page

prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 10, 2014.

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective April 24, 2014. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective April 10, 2014. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 10, 2014. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Saint Therese At Oxbow Lake is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective January 10, 2014. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division Attention: Karen R. Robinson, Director 330 Independence Avenue, SW Cohen Building, Room G-644 Saint Therese at Oxbow Lake April 9, 2014 Pag&

Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

Telephone: (651) 201-3792 Fax: (651) 201-3790 Email: <u>gloria.derfus.state.mn.us</u>

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

Saint Therese at Oxbow Lake April 9, 2014 Page

> ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

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

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

• 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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

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 10, 2014 (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

Saint Therese at Oxbow Lake April 9, 2014 Page

informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

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

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

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

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

Telephone: (651) 201-7205 Fax: (651) 215-0541 Email: <u>pat.sheehan@state.mn.us</u>

Feel free to contact me if you have questions.

Sincerely,

Ane Klegge

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

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245619	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 3/19/2014
Name	e of Facility		Street Address, City, State, Zip Code	
SAINT THERESE AT OXBOW LAKE			5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443	

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

(Y4) Item		(Y5) Date	(Y4) Item	(Y5)	Date	(Y4) Item		(Y5) I	Date
	F0157 483.10(b)(11)	Correction Completed 02/19/2014		F0167 483.10(g)(1)	Correction Completed 02/19/2014				
ID Prefix Reg. # LSC	F0226 483.13(c)	Correction Completed 02/19/2014	ID Prefix		Correction Completed 02/19/2014	ID Prefix Reg. # LSC	483.20(d)(3), 4	483.10(k)	Correction Completed 02/19/2014 (2)
ID Prefix Reg. # LSC	F0309 483.25	Correction Completed 02/19/2014	ID Prefix Reg. # LSC	F0325 483.25(i)	Correction Completed 02/19/2014	ID Prefix Reg. # LSC	F0329 483.25(I)		Correction Completed 02/19/2014
	F0428 483.60(c)	Correction Completed 02/19/2014		F0431 483.60(b), (d), (e)	Correction Completed 02/19/2014	ID Prefix Reg. # LSC			
ID Prefix Reg. # LSC			– <i>– –</i>						
State Agen	cy (eviewed By GD/AK eviewed By	Date: 06/09/20 Date:	Signature of Su 14 Signature of Su	•	1	8622	Date: 03/1 Date:	9/2014
Followup	o Survey Comp 1/10/20			Check for any Unco Uncorrected Defi				YES	NO

State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 27752	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 3/19/2014
Name	e 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 State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item		(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item		(Y5)	Date
0	20265 MN Rule 4658		0	Correction Completed 02/19/2014 IN Rule 4658.0405 Subp.	•	_20570 MN Rule 465		
ID Prefix		Correction Completed 02/19/2014	ID Prefix	Correction Completed	ID Prefix			Correction Completed 02/19/2014
ID Prefix Reg. # LSC	21535 MN Rule4658.			Correction 21980 02/19/2014 IN St. Statute 626.557 Sul		22000 MN St. Statu		
ID Prefix Reg. # LSC			ID Prefix Reg. # 	Correction Completed	Reg. #			
ID Prefix Reg. # LSC			Reg. #	Correction Completed	Reg. #			Correction Completed
Reviewed E State Agen Reviewed E	cy	Reviewed By GD/AK Reviewed By	Date: 06/09/201 Date:	4 Signature of Surveyor: 4 Signature of Surveyor:	18	8622	Date: 03/1 Date:	9/2014
	o Survey Com 1/10/2 RM: REVISIT RE	2014		Check for any Uncorrected Defic Uncorrected Deficiencies (CN Page 1 of 1				NO

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245619	(Y2) Multiple Construction A. Building B. Wing 01 - MA	(Y3) Date of Revisit 2/12/2014	
Name of Facility		Street Address, City, State, Zip Code	
SAINT THERESE AT OXBOW LAKE		5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443	

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

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
ID Prefix		Co	rrection mpleted /11/2014	ID Prefix			Correction Completed 01/20/2014		ID Prefix			Correction Completed 02/05/2014
	NFPA 101				NFPA 101					NFPA 101		
-	K0050			-	K0052					K0071		
			rrection				Correction					Correction
ID Prefix			mpleted /04/2014	ID Prefix			Completed 01/21/2014		ID Prefix			Completed
Reg. #	NFPA 101				NFPA 101							
	K0140			LSC	K0144				LSC			
ID Prefix		Co	rrection mpleted	ID Prefix			Correction Completed		ID Prefix			Correction Completed
Reg. # LSC									Reg. #			
Reg. #		Co	rrection mpleted				Correction Completed					Correction Completed
ID Prefix Reg. #		Cc	rrection mpleted	ID Prefix			Correction Completed		ID Prefix			Correction Completed
	.			Deter								
Reviewed I State Agen	DC	iewed By /AK	1	Date: 04/08/20	Signatur 14	e ot Sur	veyor:		28	3120	Date: 2/12	2/2014
	-	iewed By	1	Date:	Signatur	e of Sur	veyor:				Date:	
Followup t	o Survey Complet 1/15/201									Summary of the Facility?	YES	NO

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			ľ		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-		0	MB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	COM	E SURVEY IPLETED
		245619	B. WING	;			R 1 9/2014
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	00/	13/2014
	HERESE AT OXBOW				5200 OAK GROVE PARKWAY		
SAINT II	HERESE AT OXBOW				BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENT	rs	{F 0	00]	}		
F 425 SS=D	on March 19, 2014. determined the faci compliance with Fe following deficiency	RMACEUTICAL SVC -	F 4	425	5		4/9/14
	drugs and biologica them under an agre §483.75(h) of this p unlicensed personn	ovide routine and emergency als to its residents, or obtain eement described in part. The facility may permit hel to administer drugs if State by under the general ensed nurse.					
	(including procedur acquiring, receiving	drugs and biologicals) to meet					
	a licensed pharmad	nploy or obtain the services of cist who provides consultation e provision of pharmacy ity.					
	by: Based on interview facility failed to ens patch) used to cont manner to prevent	NT is not met as evidenced and document review, the ure Fentanyl patches (narcotic rol pain were destroyed in a potential diversion for 1 of 2 ho utilized Fentanyl patches.					
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed					4/09/20	014

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.

PRINTED: 04/10/2014

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES				OMB NO. 0938-0391 (X3) DATE SURVEY	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				E SURVEY PLETED
			A. BUILDI	NG		r	R
		245619	B. WING				、 19/2014
NAME OF F	PROVIDER OR SUPPLIER		·	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	HERESE AT OXBOW			Ę	5200 OAK GROVE PARKWAY		
				E	BROOKLYN PARK, MN 55443		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTIO		(X5) COMPLETION
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		DATE
					DEFICIENCY)		
			1				
F 425	Continued From pa	ge 1	F 4	25	;		
	Findings includes						
	Findings include:						
		ility provided a document for					
		n of Correction Education					
		Licensed staff (no date)					
		pain patches need to be nurses via the sewer system.					
		to independently place a note					
	in the progress note	es that the patch was removed					
		he sewer system and who was					
		g to review of the facility's cumentation, each of the					
		urses had received training					
		rough 2/17/14, related to the					
		tion, and required record					
	keeping, related to	Fentanyl patches.					
	R134 was admitted	to the facility on 3/9/14, after					
		p replacement. R134 had a					
		ated 3/9/14, for a Fentanyl					
		ns (mcg) per hour which was					
		dermally (on the skin) every ess note dated, 3/14/14,					
		ent rated the pain as moderate					
		0 (10 being the worse pain)					
		cated pain management was					
	effective on the cur	rent schedule.					
	The narcotic sign o	ut book was reviewed with					
		N)-A on 3/19/14, at 9:45 a.m.					
	R134 had received	a Fentanyl patch on 3/12/14,					
		14, at 9:20 a.m. and 3/18/14,					
		tion, according to the narcotic					
	correct.	entanyl patch count was					
		progress note dated 3/12/14, eviewed and indicated: "Late					

If continuation sheet Page 2 of 4

PRINTED: 04/10/2014

		AND HUMAN SERVICES				FORM	04/10/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245619	B. WING				R 1 9/2014
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
SAINT T	HERESE AT OXBOW	LAKE			200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	Entry. Writer and C Fentanyl patch in a staff had not docum information to indica the destruction of th been removed prior A nursing progress p.m. included: "Fen flushed down sewe licensed staff involv the necessary verifi destruction of the F removed prior to ap addition, although th applied at 9:20 a.m not been document and 10 minutes late A nursing progress 3/18/14 at 4:00 p.m wasted this a.m., ne documentation was minutes after the Fe applied to the reside staff witnessing the path had not both s the destruction. RN-A was interview and confirmed the to dated 3/12/14, 3/15 include documentation the Fentanyl patch of confirmed the documing The director of nurs	linical coordinator destroyed .m. on 3/12/14." The licensed nented the appropriate ate they had both witnessed he Fentanyl patch which had r to applying the new patch. note dated 3/15/14, at 10:30 tanyl patch removed and r with [RN-B and RN-C]". The yed had not both documented ication of having witnessed the entanyl patch which had been oplying the new patch. In he Fentanyl patch had been ., a progress note entry had ted until 10:30 p.m., 11 hours er. note in R134's record, dated ., included: "Fentanyl patch ew patch applied at 9:45." The swritten six hours and 13 entanyl patch had been ent. In addition, the licensed destruction of the Fentanyl igned to indicate verification of yed on 3/19/14, at 9:45 a.m. three nursing progress notes /14, and 3/18/14, failed to tion to verify the witnessing of destruction, and RN-A mentation had not been	F 4	425			

If continuation sheet Page 3 of 4

		AND HUMAN SERVICES				FORM	04/10/2014 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED R		
		245619	B. WING				≺ 19/2014	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-		
SAINT THERESE AT OXBOW LAKE				-	200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 425	for destruction of na prevent diversion o DON confirmed the witnesses to verify facility policy. The facility did not o were wasted which	ge 3 not followed the facility's policy arcotic patches to minimize or r accidental exposure. The late entries and failure of both destruction, went against the ensure the Fentanyl patches involved a secure and safe on and/or accidental exposure	F 4	125				

Facility ID: 27752

If continuation sheet Page 4 of 4

Minnesota Department of Health						
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		27752	B. WING		F 03/1	₹ 9/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SAINT T	HERESE AT OXBOW	IAKF	K GROVE PA YN PARK, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{2 000}	Initial Comments		{2 000}			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided that the Department with	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	licensing orders iss	rS: npleted to verify correction of ued at the time of the January he following licensing orders				
	Medications; Destru	0 Subp. 2 A.B. Disposition of uction	{21630}			4/9/14
LABORATOR	epartment of Health Y DIRECTOR'S OR PROVID ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

6899

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 27752		CONSTRUCTION	- (X3) DATE SURVE COMPLETED - R - 03/19/201		
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
SAINT TI	HERESE AT OXBOW	LAKE					
			YN PARK, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
{21630}	Continued From pa	age 1	{21630}				
	remaining in the nu discharge of a resid prescribed, or any discontinued perma manner recommen or the consultant pl pharmacist must fu instructions and for kept on file in the n B. Unused por drugs remaining in death or discharge were prescribed or discontinued perma according to part 6 be returned to the p 6800.2700, subpar destruction listing t medication, prescri	tions of controlled substances ursing home after death or dent for whom they were controlled substance anently must be destroyed in a nded by the Board of Pharmacy harmacist. The board or the urnish the necessary rms, a copy of which must be uursing home for two years. tions of other prescription the nursing home after the of the resident for whom they					
	by: Based on interview facility failed to ens patch) used to con- manner to prevent	ent is not met as evidenced and document review, the sure Fentanyl patches (narcotic trol pain were destroyed in a potential diversion for 1 of 2 tho utilized Fentanyl patches.	;				
	Findings include:						
	review entitled, Pla	sility provided a document for n of Correction Education r Licensed staff (no date)					

STATE FORM

RNX612

STATEME	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED	
		27752	B. WING		R 03/19/2014		
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S				
SAINT T	HERESE AT OXBOW	LAKE	K GROVE PAR YN PARK, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
{21630}	indicated "Narcotic destroyed with two Each nurse needs t in the progress note and destroyed via th present." According education roster do facility's licensed nu between 2/10/14 th appropriate destruct keeping, related to R134 was admitted having a total left hi physician's order da patch 75 microgram to be applied transo three days. A program to be applied transo three days. A program indicated the reside on a scale of 1 to 1 was a 5. R134 indic effective on the cur The narcotic sign o registered nurse (R R134 had received at 10:00 a.m. 3/15/ at 9:47 a.m. In addi book records, the F correct. However, a nursing at 10:57 a.m. was r Entry. Writer and C Fentanyl patch in a staff had not docum information to indicated the destruction of the	pain patches need to be nurses via the sewer system. to independently place a note es that the patch was removed he sewer system and who was g to review of the facility's cumentation, each of the urses had received training rough 2/17/14, related to the tion, and required record Fentanyl patches. to the facility on 3/9/14, after p replacement. R134 had a ated 3/9/14, for a Fentanyl hs (mcg) per hour which was dermally (on the skin) every ess note dated, 3/14/14, ent rated the pain as moderate 0 (10 being the worse pain) cated pain management was					

RNX612

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		27752	B. WING			R 1 9/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	HERESE AT OXBOW	5200 OA	K GROVE PAR	KWAY		
		BROOK	LYN PARK, MN	55443		-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
{21630}	Continued From pa	age 3	{21630}			
	p.m. included: "Fer flushed down sewe licensed staff involve the necessary verife destruction of the F removed prior to an addition, although the applied at 9:20 a.m. not been document and 10 minutes late A nursing progress 3/18/14 at 4:00 p.m. wasted this a.m., ne documentation was minutes after the F applied to the reside staff witnessing the path had not both se the destruction.	note in R134's record, dated a., included: "Fentanyl patch ew patch applied at 9:45." The s written six hours and 13 entanyl patch had been ent. In addition, the licensed e destruction of the Fentanyl signed to indicate verification o				
	and confirmed the dated 3/12/14, 3/15 include documenta the Fentanyl patch	ved on 3/19/14, at 9:45 a.m. three nursing progress notes 5/14, and 3/18/14, failed to tion to verify the witnessing of destruction, and RN-A mentation had not been hented.				
	3/19/14, at 4:45 p.r licensed staff had r for destruction of na prevent diversion o DON confirmed the	sing (DON) was interviewed or n. and confirmed the identified not followed the facility's policy arcotic patches to minimize or r accidental exposure. The late entries and failure of both destruction, went against the				

If continuation sheet 4 of 5

Minnesc	linnesota Department of Health						
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP		
		27752	B. WING		R 03/1	2 9/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
SAINT T	HERESE AT OXBOW		K GROVE PA YN PARK, M				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETE DATE	
{21630}	Continued From pa	ige 4	{21630}				
{21630}	were wasted which	involved a secure and safe on and/or accidental exposure	{21630}				
Minnocata D	epartment of Health						
wiii iii esula D							

RNX612



Protecting, Maintaining and Improving the Health of Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Electronically Delivered: April 9, 2014

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

Re: Project Number: S5619001

Dear Ms. Martin:

On March 19, 2014, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 10, 2014 with orders received by you January 30, 2014.

State licensing orders issued pursuant to the last survey completed on January 10, 2014 and found corrected at the time of this March 19, 2014 revisit, are being submitted to you electronically via the ePOC Web Portal.

State licensing orders issued pursuant to the last survey completed on January 10, 2014, found not corrected at the time of this March 19, 2014 revisit and subject to penalty assessment are as follows:

• 21630 - MN Rule 4658.1350 Subp. 2 A.B. - Disposition Of Medications; Destruction - \$300.00

The details of the violations noted at the time of this revisit completed on March 19, 2014 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically sign and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of **\$300.00** per day beginning on the day you receive this notice.

The fines shall accumulate daily until written notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered to the Department at the address below or to , Minnesota Department of Health, Licensing and Certification Program, Division of Compliance Monitoring, Po Box 64900 St Paul Mn

Saint Therese at Oxbow Lake Hand Delivered - DATE Page 2

55164-0900.

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Division of Compliance Monitoring, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

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.

Sincerely,

Are Klegge

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

cc: Shellae Dietrich, Licensing and Certification Program Penalty Assessment Deposit Staff

		AND HUMAN SERVICES & MEDICAID SERVICES		F	ORM APPROVED 8 NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			3) DATE SURVEY COMPLETED
		245619	B. WING		R 03/19/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
SAINT TI	HERESE AT OXBOW	LAKE		5200 OAK GROVE PARKWAY	
				BROOKLYN PARK, MN 55443	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
{F 000}	INITIAL COMMENT	ſS	{F 000)}	
F 425 SS=D	on March 19, 2014. determined the faci compliance with Fe following deficiency 483.60(a),(b) PHAR	RMACEUTICAL SVC -	F 42	5	4/9/14
	drugs and biologica them under an agre §483.75(h) of this p unlicensed personn	ovide routine and emergency als to its residents, or obtain eement described in art. The facility may permit bel to administer drugs if State by under the general ensed nurse.			
	(including procedur acquiring, receiving	drugs and biologicals) to meet			
	a licensed pharmad	nploy or obtain the services of sist who provides consultation e provision of pharmacy ity.			
	by: Based on interview facility failed to ensi patch) used to cont manner to prevent residents (R134) wi	NT is not met as evidenced y and document review, the ure Fentanyl patches (narcotic rol pain were destroyed in a potential diversion for 1 of 2 ho utilized Fentanyl patches.		A. Corrective action for residents involved: Nurse identified as being responsible not following facility policy for the destruction of fentanyl patches was	
LABORATOR	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE

TITLE

PRINTED: 06/09/2014

Electronically Signed

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.

		AND HUMAN SERVICES			FORM	APPROVED
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI		MB NO. 0938-0391 (X3) DATE SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:	· · /			PLETED
					F	र
		245619	B. WING _		03/1	9/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SAINT TH	HERESE AT OXBOW	LAKE		5200 OAK GROVE PARKWAY		
				BROOKLYN PARK, MN 55443		
(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I	BE	(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	DATE
			1			
F 425	Continued From pa	ge 1	F 42	5		
		-		disciplined.		
	Findings include:			B. How to identify other residents		
	On 3/19/14 the fac	ility provided a document for		potentially affected: All nurses and clinical coordinators	were	
		n of Correction Education		notified to alert Director of Clinical		
		Licensed staff (no date)		Services when any orders were rece	eived	
		pain patches need to be nurses via the sewer system.		for fentanyl patches. C. Measure/Systemic changes to e	oncuro	
	5	o independently place a note		deficient practice will not reoccur:	ensure	
	in the progress note	es that the patch was removed		All narcotic pain patches will be rem		
		he sewer system and who was g to review of the facility's		destroyed by two licensed nurses vi sewer system, and both nurses will	a the	
		cumentation, each of the		document as soon as possible in the	е	
	facility's licensed nu	urses had received training		electronic health record the destruct		
		rough 2/17/14, related to the		the patch. All licensed staff will be	manal	
	keeping, related to	tion, and required record Fentanyl patches.		reeducated on the procedure for dis of narcotic pain patches during the		
				of April 7, 2014.		
		to the facility on 3/9/14, after		D. How to monitor:		
		p replacement. R134 had a ated 3/9/14, for a Fentanyl		All residents with narcotic pain patcl will be audited weekly for the next to		
		ns (mcg) per hour which was		months, then monthly for three mon		
		lermally (on the skin) every		then quarterly for appropriate dispos		
		ess note dated, 3/14/14, Int rated the pain as moderate		documentation of disposal of narcot patches. Audits will be received by		
		0 (10 being the worse pain)		Director of Clinical Services and rev		
		ated pain management was		by clinical coordinators. Trends and	d audit	
	effective on the cur	rent schedule.		results will be reviewed at facility qu	ality	
	The narcotic sign of	ut book was reviewed with		improvement committee meetings. Director of Clinical Services is respo	onsible	
	registered nurse (R	N)-A on 3/19/14, at 9:45 a.m.		for compliance.		
		a Fentanyl patch on 3/12/14,				
		14, at 9:20 a.m. and 3/18/14, tion, according to the narcotic				
		entanyl patch count was				
	correct.					
	However a pureing	progress note dated 2/12/14				
		progress note dated 3/12/14, eviewed and indicated: "Late				

PRINTED: 06/09/2014

		AND HUMAN SERVICES				FORM	06/09/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245619	B. WING				R 1 9/2014
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SAINT T	HERESE AT OXBOW	LAKE			200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 425	Entry. Writer and C Fentanyl patch in a staff had not docum information to indica the destruction of th been removed prior A nursing progress p.m. included: "Fen flushed down sewe licensed staff involv the necessary verifi destruction of the F removed prior to ap addition, although th applied at 9:20 a.m not been document and 10 minutes late A nursing progress 3/18/14 at 4:00 p.m wasted this a.m., ne documentation was minutes after the Fe applied to the reside staff witnessing the path had not both s the destruction. RN-A was interview and confirmed the to dated 3/12/14, 3/15 include documentation the Fentanyl patch of confirmed the documing The director of nurs	Junical coordinator destroyed .m. on 3/12/14." The licensed nented the appropriate ate they had both witnessed he Fentanyl patch which had r to applying the new patch. .note dated 3/15/14, at 10:30 atanyl patch removed and r with [RN-B and RN-C]". The ved had not both documented ication of having witnessed the fentanyl patch which had been oplying the new patch. In he Fentanyl patch had been ., a progress note entry had ted until 10:30 p.m., 11 hours er. .note in R134's record, dated h., included: "Fentanyl patch ew patch applied at 9:45." The s written six hours and 13 entanyl patch had been ent. In addition, the licensed e destruction of the Fentanyl signed to indicate verification of ved on 3/19/14, at 9:45 a.m. three nursing progress notes 5/14, and 3/18/14, failed to tion to verify the witnessing of destruction, and RN-A umentation had not been	F 4	425			

If continuation sheet Page 3 of 4

		AND HUMAN SERVICES				FORM	06/09/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		245619	B. WING				२ 1 9/2014
NAME OF F	PROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE		
SAINT TI	HERESE AT OXBOW	LAKE		-	200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 425	for destruction of na prevent diversion o DON confirmed the witnesses to verify facility policy. The facility did not o were wasted which	age 3 not followed the facility's policy arcotic patches to minimize or r accidental exposure. The a late entries and failure of both destruction, went against the ensure the Fentanyl patches involved a secure and safe on and/or accidental exposure	F 4	125			

If continuation sheet Page 4 of 4

Minneso	ta Department of He	alth			-	_
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		27752	B. WING		F 03/1	₹ 9/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SAINT TI	HERESE AT OXBOW		K GROVE PA YN PARK, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{2 000}	Initial Comments		{2 000}			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defict herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance.	hether a violation has been compliance with all e rule provided at the tag ule number indicated below. ns several items, failure to the items will be considered Lack of compliance upon				
	result in the assess	ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	licensing orders iss	rS: npleted to verify correction of ued at the time of the January he following licensing orders				
	Medications; Destru	0 Subp. 2 A.B. Disposition of uction	{21630}			4/9/14
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

6899

	ta Department of He	ealth				APPROVED	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 27752			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
						R	
		B. WING			9/2014		
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE			
SAINT TI	HERESE AT OXBOW	IAKF	K GROVE PA				
a.a. 1 -			YN PARK, M				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
{21630}	Continued From pa	age 1	{21630}				
	remaining in the nu discharge of a resid prescribed, or any of discontinued perma manner recommen or the consultant pl pharmacist must fu instructions and for kept on file in the n B. Unused por drugs remaining in death or discharge were prescribed or discontinued perma according to part 6 be returned to the p 6800.2700, subpar destruction listing t medication, prescri	tions of controlled substances irsing home after death or dent for whom they were controlled substance anently must be destroyed in a ided by the Board of Pharmacy harmacist. The board or the irnish the necessary ms, a copy of which must be ursing home for two years. tions of other prescription the nursing home after the of the resident for whom they	/				
	by: Based on interview facility failed to ens	ent is not met as evidenced and document review, the ure Fentanyl patches (narcotic		A. Corrective action for resider involved:			
	manner to prevent	trol pain were destroyed in a potential diversion for 1 of 2 ho utilized Fentanyl patches.		Nurse identified as being respon not following facility policy for the destruction of fentanyl patches v disciplined.	9		
	Findings include:			 B. How to identify other resider potentially affected: 	nts		
	review entitled, Pla	ility provided a document for n of Correction Education r Licensed staff (no date)		All nurses and clinical coordinate notified to alert Director of Clinic Services when any orders were	al		

STATE FORM

RNX612

If continuation sheet 2 of 5

	ota Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 27752		LE CONSTRUCTION	(X3) DATE S COMPL R 03/19	ETED
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	00,10	
		5200 OAK	GROVE PA			
SAINT T	HERESE AT OXBOW		N PARK, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLE ⁻ DATE
{21630}	destroyed with two Each nurse needs t in the progress note and destroyed via th present." According education roster do facility's licensed nu- between 2/10/14 th appropriate destruct keeping, related to R134 was admitted having a total left hi physician's order da patch 75 microgram to be applied transo three days. A progra- indicated the reside on a scale of 1 to 10 was a 5. R134 indic effective on the curr The narcotic sign or registered nurse (R R134 had received at 10:00 a.m. 3/15/ at 9:47 a.m. In addi book records, the F correct. However, a nursing at 10:57 a.m. was r Entry. Writer and C Fentanyl patch in a. staff had not docum information to indica the destruction of th	pain patches need to be nurses via the sewer system. to independently place a note es that the patch was removed he sewer system and who was g to review of the facility's cumentation, each of the urses had received training rough 2/17/14, related to the tion, and required record Fentanyl patches. to the facility on 3/9/14, after p replacement. R134 had a ated 3/9/14, for a Fentanyl hs (mcg) per hour which was dermally (on the skin) every ess note dated, 3/14/14, ent rated the pain as moderate 0 (10 being the worse pain) cated pain management was	{21630}	for fentanyl patches. C. Measure/Systemic changes t deficient practice will not reoccur: All narcotic pain patches will be re destroyed by two licensed nurses sewer system, and both nurses w document as soon as possible in electronic health record the destri- the patch. All licensed staff will b reeducated on the procedure for of narcotic pain patches during th of April 7, 2014. D. How to monitor: All residents with narcotic pain pa- be audited weekly for the next two months, then monthly for three m then quarterly for appropriate disp documentation of disposal of narc patches. Audits will be received to Director of Clinical Services and r by clinical coordinators. Trends a results will be reviewed at facility improvement committee meeting: Director of Clinical Services is res for compliance.	emoved, via the rill the uction of e disposal e week tches will o onths, posal and cotic pain by the eviewed ind audit quality s.	

RNX612

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 27752			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		B. WING			R 1 9/2014	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	TATE, ZIP CODE		
ΔΙΝΤ ΤΙ	HERESE AT OXBOW	1 AKE 5200 OA	AK GROVE PAR	KWAY		
		BROOK	LYN PARK, MN	55443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
{21630}	Continued From pa	age 3	{21630}			
	p.m. included: "Fer flushed down sewe licensed staff involv the necessary verif destruction of the F removed prior to ap addition, although t applied at 9:20 a.m not been document and 10 minutes late A nursing progress 3/18/14 at 4:00 p.m wasted this a.m., n documentation was minutes after the F applied to the resid staff witnessing the	note dated 3/15/14, at 10:30 ntanyl patch removed and er with [RN-B and RN-C]". The yed had not both documented ication of having witnessed th Fentanyl patch which had been oplying the new patch. In the Fentanyl patch had been i., a progress note entry had ted until 10:30 p.m., 11 hours er. note in R134's record, dated n., included: "Fentanyl patch ew patch applied at 9:45." The s written six hours and 13 entanyl patch had been lent. In addition, the licensed e destruction of the Fentanyl signed to indicate verification of	e			
	and confirmed the dated 3/12/14, 3/15 include documenta the Fentanyl patch	ved on 3/19/14, at 9:45 a.m. three nursing progress notes 5/14, and 3/18/14, failed to tion to verify the witnessing of destruction, and RN-A imentation had not been hented.				
	3/19/14, at 4:45 p.n licensed staff had n for destruction of na prevent diversion o DON confirmed the	sing (DON) was interviewed o n. and confirmed the identified not followed the facility's policy arcotic patches to minimize or or accidental exposure. The late entries and failure of bot destruction, went against the				
	The facility did not	ensure the Fentanyl patches				

RNX612

Minnesc	ta Department of He	ealth				
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		27752	B. WING		F 03/1	२ 9/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SAINT T	HERESE AT OXBOW		K GROVE PA YN PARK, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
{21630}	Continued From pa	ige 4	{21630}			
{21630}	were wasted which	involved a secure and safe on and/or accidental exposure	{21630}			
Minnesota D	epartment of Health		μ	l		1

RNX612

DEPARTMENT OF HEALTH	AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: RNX6
	PART I -	TO BE COMPL	ETED BY T	'HE STA'	FE SURVEY AGENCY	Facility ID: 27752
1. MEDICARE/MEDICAID PROVIDE (L1) 245619	R NO.	3. NAME AND AD (L3) SAINT THE			KE	4. TYPE OF ACTION: <u>2</u> (L8) 1. Initial 2. Recertification
2.STATE VENDOR OR MEDICAID NO (L2) 753490000).	(L4) 5200 OAK G (L5) BROOKLYN		WAY	(L6) 55443	3. Termination4. CHOW5. Validation6. Complaint
5. EFFECTIVE DATE CHANGE OF O (L9)	WNERSHIP	7. PROVIDER/SU	PPLIER CATEG	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 01/10/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IIE 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 06/13
11. LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:		·
From (a):		A. In Complian	nce With		And/Or Approved Waivers Of	The Following Requirements:
To (b):		Program Re Compliance	equirements e Based On:		2. Technical Personnel	6. Scope of Services Limit
12. Total Facility Beds	64 (L18)	1	cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	 7. Medical Director IF)8. Patient Room Size 9. Beds/Room
13.Total Certified Beds	64 (L17)	X B. Not in Com Requireme	pliance with Prog ents and/or Applie		* Code: B *	(L12)
14. LTC CERTIFIED BED BREAKDOW	٧N				15. FACILITY MEETS	
18 SNF 18/19 SNF 64	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMA See Attached Remarks	RKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION I	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Angela Richey, HFE-NE	II	02	2/19/2014	(L19)	Anne Kleppe, Enforc	ement Specialist 02/25/2014 (L20)
PAR	T II - TO BE	COMPLETED B	BY HCFA RE		L OFFICE OR SINGLE S	
19. DETERMINATION OF ELIGIBILI	ГҮ	20. COM	PLIANCE WITH ITS ACT:		21. 1. Statement of Finan	ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible	(L21)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	. LTC AGREEM	IENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 07/16/2013	BEGINNING	G DATE	ENDING DAT	ſE	<u>VOLUNTARY</u> <u>00</u> 01-Merger, Closure	INVOLUNTARY 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	ement 06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	on <u>OTHER</u>
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change 00-Active
(L27)	B. Rescind S	uspension Date:	(L44)			00-Active
			(L45)			
28. TERMINATION DATE:	29). INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE		
	(L32)			(L33)	DETERMINATION APPI	ROVAL

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: RNX6

PART	I - TO BE COMPLETED BY THE STATE SURVEY AGENCY	Facility ID: 27752
C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS	

CCN#: 24-5619

At the time of the standard survey completed January 15, 2014, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8279

January 28, 2014

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

RE: Project Number S5619001

Dear Ms. Martin:

On January 15, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55108-2970 Telephone: (651) 201-3792 Fax: (651) 201-3790

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 19, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by February 19, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,
- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, 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.

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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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 10, 2014 (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.

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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 10, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Cedar Street, Suite 145 St. Paul, Minnesota 55101-5145 Telephone: (651) 201-7205 Fax: (651) 215-0541 Saint Therese At Oxbow Lake January 28, 2014 Page 6 Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske Downing

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

Enclosure

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			C	MB NO.	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY PLETED
		245619	B. WING			01/	10/2014
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
SAINT TI	HERESE AT OXBOW				200 OAK GROVE PARKWAY		
				Ŗ	ROOKLYN PARK, MN 55443		
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	as your allegation o Department's accept bottom of the first p be used as verifcati Upon receipt of an a revisit of your facility validate that substare gulations has beet your verification. 483.10(b)(11) NOTI (INJURY/DECLINE/ A facility must immer consult with the resist known, notify the re or an interested fam accident involving the injury and has the p intervention; a signif physical, mental, or deterioration in heal status in either life the clinical complication significantly (i.e., a re existing form of trea consequences, or to treatment); or a deci the resident from the §483.12(a). The facility must also and, if known, the re	of correction (POC) will serve of compliance upon the otance. Your signature at the age of the CMS-2567 form will on of compliance. acceptable POC an on-site y may be conducted to ntial compliance with the on attained in accordance with FY OF CHANGES	FO		Corrective action for residents volved: The nurse practitioner f was updated on 11/4/13 and ar was received for an Xray of har acute fracture was noted in Xra Resident remained comfortable the use of as needed pain med and ice to hand. A report was f with the appropriate state agen injury to hand was investigated remains at stable and has not f change in condition. How identify other residents poily affected: All residents could p tially be affected. Measure/Systemic changes to a deficient practice will not reoccu- licensed staff will receive educat the week of February 10, 2014 gards to when the physician ne- be updated. Facility policy titled NP notification regarding chang resident's condition was reviewed updated. Licensed staff were re- cated on policy during education sions.	or R35 n order nd. No iy. with ication iled cy and R35 ad a tential- ooten- ensure ir: All tion in re- eds to I MD/ e of ed and eedu-	2/19/14
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	specified in §483.15	ō(e)(2); or a change in					
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Will deficience	statement anding with a	nastorisk (*) dototog a dofisionau whis	h tha inati		h may be excused from correcting and dimension		ibod that
her safeguar llowing the d	rds provide sufficient prote ate of survey whether or the date these document	ection to the patients. (See instructions not a plan of correction is provided. Fo	 Except nursing I 	for r hom	h may be excused from correcting providing i nursing homes, the findings stated above are es, the above findings and plans of correction e cited, an approved plan of correction is requ	disclosabl ı are disclo	e 90 days osable 14

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 27752

	OF DEFICIENCIES	& MEDICAID SÈRVICES	(X2) MULTIDI	LE CONSTRUCTION		. 0938-039 E SURVEY
	DF CORRECTION	IDENTIFICATION NUMBER:				E SURVEY IPLETED
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NAME OF	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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F 157	regulations as spect this section. The facility must ret the address and philegal representative This REQUIREMEN by: Based on interview facility failed to noti manner for 1 of 3 ret a skin tear, bruising hand. Findings include: R35's diagnoses inthistory of a close fra- end humerus obtain Minimum Data Set MDS indicated R35 Status (BIMS-tool u status) score was 1 cognitive status).	age 1 er Federal or State law or cified in paragraph (b)(1) of cord and periodically update ione number of the resident's e or interested family member. NT is not met as evidenced y and document review, the fy the physician in a timely esidents (R35) who sustained and swelling injury to the right cluded osteoporosis and acture unspecified part upper hed from the quarterly (MDS) dated 10/3/13. The 's Brief Interview of Mental sed to measure cognitive 5 (which indicated intact	F 157	How to monitor: A random samp progress notes will be audited a reviewed monthly for three mon then quarterly. Progress noted reviewed to assure physicians w updated timely and appropriate! Audit results will be reviewed wi rector of Clinical services and cl coordinators. Director of Clinical vices is responsible for complian RECEIVED FEB – 7 2014 COMPLIANCE MONITORING DIVIS LICENSE AND CERTIFICATION	nd ths will be vere y. th Di- inical I Ser- nce	2/19/14
	measuring 2 centim R35 had reported si walker was noted. S the note indicated s -On 10/20/13, R35's red, swollen, warm remained intact. R3 indicated staff would	n tear to the right wrist eter (cm) x 1.5 cm was and ne bumped her hand over her Steri-strips were applied and taff would continue to monitor. a right hand was noted to be to touch and the Steri-strips 5 denied pain and the note a continue to monitor. of R35's right hand was				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION	(>	(X3) DATE SURVEY COMPLETED	
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F 157	skin tear and the ha tender to touch. R3 exactly what happe she was constantly something. Ice was times during the sh noted. The note ind monitor R35's need -On 11/3/13, two no remained swollen/p tender to touch and Scheduled pain me administered and R -On 11/4/13, an ear R35's right hand wa swollen. Later that s noted to be dark rea and was swollen all R35 reported pain w pressure. The nurse updated and an x-ra R35's medical reco evidence the physic the right hand injury tear occurred and/o bruising and swellin On 1/10/14, at 11:11 services (DCS) was not updated when th 10/19/13, and on 11 to go back and revia stated she expected "If injury with pain, in anything out of the explained when the	ne Steri-strip from a previous and was bruised, swollen and 5 was not able to explain ned when asked and stated bumping the hand on applied to R35's hand two ifft, with decreased swelling icated staff would continue to ls. tes indicated R35's right hand uffy, bruised, warm, and R35 reported pain. dication and ice were 35 reported relief. lier note indicated the top of as bruised, reddened and same day, the bruise was d, measured 35 cm x 15 cm, the way down to the fingers. with range of motion and with e practitioner (NP) was ay was ordered. rd lacked documented bian (MD) or NP was notified of a until 16 days after the skin r two days after the right hand	F	157			

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FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 27752

If continuation sheet Page 3 of 62

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	TIPLE CONSTRUCTIO	N		(3) DATE SURVEY COMPLETED	
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F 157	hand injury. On 1/10/14, at 12:1 facility was suppose change in condition baseline immediate working, or if it was facility was to call the treatment. Additionate expected the nurse issues that would n NP stated she would working day. NP fur- updated regarding 11/4/13, and stated rule out a possible fa and pain. The licensed practice worked with R35 or 1/10/14, at 12:33 p. able to re-call the b Note dated 11/2/13. more swelling than updated the next sh LPN-C confirmed n the supervisor were the right hand. The MD/NP and/or Regarding a change policy dated Februate were to be kept infor health status so that made.	5 p.m. the NP stated the ed to update her of any a, new complaint, or change off ely. NP stated if she was not during the weekend, the ne on-call provider for ally, the NP stated she s to leave a voice message for ot need immediate attention. Id follow up on her next rther stated she recalled being R35's bruised right hand on she had ordered an x-ray to fracture due to the swelling cal nurse (LPN)-C who had n 11/2/13, was interviewed on m. via telephone. LPN-C was ruising incident and Progress . LPN-C also added there was bruising at the time and had nift to continue to monitor. either the physician, NP nor e notified about the condition of Resident/Family Notification e of Resident's Condition ary 2013, indicated the MD/NP ormed of change in current it a medical decision can be T TO SURVEY RESULTS -	F 1					
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: RNX611		Facility ID: 27752	If continual	tion sheet	Page 4 of 62	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		
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	the most recent sur Federal or State sur correction in effect w The facility must ma examination and ma accessible to reside their availability. This REQUIREMEN by: Based on observati review, the facility fa results in an area ea and visitors. This ha of 60 residents in th Findings include: During the initial fac a.m. a sign posted a indicated the survey the desk. A red threa a corner behind the previous survey resu On 1/9/14, at 9:10 a president (R10) accor receptionist desk. R indicated where the stated she would no results from her whe ask staff to see the s	ight to examine the results of vey of the facility conducted by rveyors and any plan of with respect to the facility. ake the results available for ust post in a place readily ents and must post a notice of IT is not met as evidenced ion, interview and document ailed to post prior survey asily accessible to residents ad the potential to affect all 60 e facility and visitors. ility tour on 1/7/14, at 10:15 at the receptionist desk results were available behind e ring binder was observed in desk which included the ults. .m. the resident counsel ompanied the surveyor to the 10 was shown the sign which survey results were kept. R10 t be able to reach the survey eelchair and would have to survey results. In addition, Id not want to have to ask	Fi	 67 Corrective action for residents involved: The red binder containing the marcent survey results will be plated top of the reception desk at the trance of the facility, clearly visit accessible to all residents and we tors. The sign posted on the redesk noting the location of the redesk noting the location be the sected. Measure/Systemic changes to endeficient practice will not reoccul. All staff will be educated of this change through staff meetings a Plan of Correction education he the week of February 10, 2014. Cation will also be provided at the dent council held on February 4 and the family meeting on February 11, 2014. 	nost iced on en- ble and visi- ception red nounce cential- e af- ensure ir: and Id on Edu- ie resi- , 2014	2/19/14

Facility ID: 27752

If continuation sheet Page 5 of 62

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TAG REQULATORY OR LISC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY DM F 167 Continued From page 5 F 167 F 167 Continued From page 5 2/19 On 1/9/14, at 10:08 a.m. the red binder with the survey results was observed on top of the receptionist desk. The administrator verified the survey results were not posted anywhere else, could not be reached behind the desk and stated they would now be kept to top of the receptionist desk instead of behind the desk. F 167 How to monitor: This change is now part of the recep- tionist's daily tasks to ensure proper location and will be monitored through facility QA process. Findings of monthly audit will be reported at facili- ty quality improvement committee meeting. Administrator is responsible for compliance. F 225 F 225 483.13(c)(1)(ii). (ii). (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS F 225 The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law, or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misapropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitnees for service as a nurse aide registry or licensing authorities. F The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of the facility and image to the administrator of the facility and Inthefacility and the adminis		F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY IPLETED
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PREERX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREERX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 2/19 F 167 Continued From page 5 F 167 F 167 How to monitor: 2/19 On 1/9/14, at 10:08 a.m. the red binder with the survey results was observed on top of the receptionist desk. The administrator verified the survey results ware not posted anywhere else, could not be reached behind the desk and stated the yould now be kept on top of the receptionist desk instead of behind the desk. F 167 This change is now part of the recep- tionist's daily tasks to ensure proper location and will be monitored through facility QA process. Findings of monthly audit will be reported at facili- ty quality improvement committee meeting. Administrator is responsible for compliance. F 225 F 225 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS F 225 The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law, or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfiltness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. F 225 The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, inclouding injuries of unknown source and imec			LAKE	5	200 OAK GROVE PARKWAY	, ,	
 On 1/9/14, at 10:08 a.m. the red binder with the survey results was observed on top of the receptionist desk. The administrator verified the survey results were not posted anywhere else, could not be reached behind the desk and stated they would now be kept on top of the receptionist desk instead of behind the desk. On 1/9/14, at 3:15 p.m. the administrator stated the facility did not have a policy and procedure for posting the survey results and used the regulation as a guide. F 225 F 225 F 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and 	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETION DATE
 survey results was observed on top of the receptionist desk. The administrator verified the survey results were not posted anywhere else, could not be reached behind the desk and stated they would now be kept on top of the receptionist desk instead of behind the desk. On 1/9/14, at 3:15 p.m. the administrator stated the facility did not have a policy and procedure for posting the survey results and used the regulation as a guide. F 225 483.13(c)(1)(ii)-(iii), (c)(2) - (4) SS=D INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law gainst an employee, which would indicate unfitness for service as a nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law gainst an employee, which would indicate unfitness. The facility must noter that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and 	F 167	Continued From pa	ige 5	F 167			2/19/14
The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report 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 to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and		survey results was receptionist desk. T survey results were could not be reache they would now be desk instead of beh On 1/9/14, at 3:15 p the facility did not h posting the survey as a guide. 483.13(c)(1)(ii)-(iii), INVESTIGATE/REF	observed on top of the The administrator verified the a not posted anywhere else, ed behind the desk and stated kept on top of the receptionist hind the desk. c.m. the administrator stated ave a policy and procedure for results and used the regulation (c)(2) - (4) PORT	F 225	This change is now part of the re- tionist's daily tasks to ensure pro- location and will be monitored to facility QA process. Findings of monthly audit will be reported a ty quality improvement committo meeting. Administrator is response	roper hrough f t facili- ee	
involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and		The facility must no been found guilty of mistreating resident had a finding entere registry concerning of residents or misa and report any know court of law against indicate unfitness fo other facility staff to	t employ individuals who have f abusing, neglecting, or ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a an employee, which would or service as a nurse aide or the State nurse aide registry	х х		-	
to other officials in accordance with State law through established procedures (including to the State survey and certification agency).		involving mistreatme including injuries of misappropriation of immediately to the a to other officials in a through established	ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law procedures (including to the				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 01/28/2014 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION	(X3) DATE COMF	SURVEY
		245619	B. WING		01/1	0/2014
SAINT T	PROVIDER OR SUPPLIER	·····		STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		з.
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
	The facility must ha violations are thorou prevent further pote investigation is in pr The results of all inv to the administrator representative and t with State law (inclu certification agency) incident, and if the a appropriate correction This REQUIREMEN by: Based on observati review, the facility fa injuries of unknown to the administrator agency (SA); in addi ensure a resident wa investigation of alleg	ve evidence that all alleged ughly investigated, and must initial abuse while the rogress. vestigations must be reported or his designated to other officials in accordance ding to the State survey and o within 5 working days of the alleged violation is verified ve action must be taken. IT is not met as evidenced on, interview and document iled to immediately report origin (bruises and skin tears) and the designated State tion, the facility failed to	F 225		ought to Clinical y report- uary 9, dminis- d to the the n. estigat- d inter- educe by staff d at unaware oruises. vith the	2/19/14
	were not immediatel	nown origin to both forearms y reported to the diately reported to the SA or		been reported. Care plan was viewed for R35 to assure curre up to date. Resident has had changes in ADLs or condition to bruise and swelling to hand	re- ent and no related	·
	have several dark pu			lilty ID: 27752 If continuat	on sheet Pa	

PRINTED: 01/28/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED
		245619	B. WING	r	01/	10/2014
	PROVIDER OR SUPPLIER	LAKE		STREET ADDRESS, CITY, STATE, ZIP CO 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		HOULD BE	.(X5) COMPLETION DATE
F 225	dining room table e assistant (NA)-B wa other resident cuino observed to acknow bruises. On 1/8/14, at 2:27 g any resident with br nurse immediately the bruising. Althou report bruises immediately the bruising. Althou reported. On 1/9/14, at 7:30 a sitting on the couch eyes closed. The ar- be reading the pape other residents. The R75; R75's forearm visible during the ar- administrator was p clearly visible, the c documented evider R75's significant ch (MDS) dated 9/20/1 included Alzheimer degeneration of the R75 had severe co extensive assistand living. The Pressure (CAA) dated 10/3/1 for pressure ulcers always being able t lacked R75's risk for wanderer.	was observed sitting at the pating independently. A nursing as sitting between R75 and g her to eat. NA-B was not wledge or asked R75 about the p.m. NA-B stated if she noticed ruises, she would report to the to ensure the nurse assessed ugh NA-B stated she would ediately, the clinical record e observed bruises were a.m. R75 was observed to be n in the middle lounge with her dministrator was observed to er outloud to R75 and four e administrator sat next to ns and the bruises were clearly ctivity. Although the present and the bruises were clinical record lacked nee the bruises were identified. hange Minimum Data Set 13, indicated R75's diagnoses 's disease and macular e retina. The MDS indicated gnitive impairment and require ce for all activities of daily e Ulcer Care Area Assessment 3, indicated R75 was at risk related to dementia, not o verbalize needs. The CAA or bruising due to being a		 Incident with R30 had pre- reported. R30 remains sa further incidents have bee Nursing assistant involved had been disciplined and was provided to prevent fi- dents How identify other resider ly affected:All residents co- tially be affected. Measure/Systemic chang- deficient practice will not r minders and education wa to staff addressing the fac- ble Adult policy to report in all allegations involving m neglect or abuse, includin unknown source. Survey reviewed with Clinical and Coordinator and reminded mediate reporting. All sta- cated on vulnerable adult during education sessions February 10, 2014. 	afe and no en reported. d in incident education urther inci- nts potential- ould poten- es to ensure reoccur: Re- as provided ility Vulnera- mmediately istreatment, g injuries of results were Household I about im- ff were edu- reporting the week of	
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: RNX61	1	Facility ID: 27752 If c	ontinuation shee	t Page 8 of 62

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION		E SURVEY PLETED
	у.	245619	B. WING			01/*	10/2014
	PROVIDER OR SUPPLIER	LAKE		5	STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	integrity, "[R75 was integrity due to alwa bladder and occasi risk and self-care d care plan did not id but directed to "mod baths/showers, dur the nurse." Althoug R75 had potential f macular degenerati identified R75 wand other resident room R75 was at risk for Review of R75's Pr 11/25/13, 12/2/13, a been noted on both Progress Note date been brought to the surveyor), indicated arms. The note indi the bruises were as - right upper forearm - right mid forearm - right wrist 2 cm x - below right index f - at base of right the - left upper forearm - left mid forearm 5 - area to left wrist/to Although the condit documented on the record lacked evide were assessed and to prevent further b On 1/9/14, at 8:40 a	ed 11/20/12, identified for skin] At risk for impaired skin ays being incontinent of onally incontinent of bowel, fall eficit related to dementia." The entify R75's risk for bruising, nitor for skin changes during ing am/pm cares and notify h the vision focus identified or change in vision related to ion; the behavior focus dered around the unit and into its, neither focus included how injury or bruising. ogress Notes revealed on and 12/16/13, old bruising had of R75's forearms. A nursing ed 1/9/14 (after concern had a attention of facility staff by the d R75 had eight bruises to both icated the measurements of a follows: m 6 centimeter (cm) x 8 cm; 3 cm 1 cm; 2.5 cm; finger 4 cm x 2.5 cm; umb 3 cm x 1 cm; 5 cm x 5.5 cm; cm x 3 cm; op of hand 5 cm x 3 cm. ion of bruising was above dates, the medical ence R75's current bruises I measures were put in place	F2	225	How to monitor: A sample of we skin check progress notes will b dited monthly to assure bruises investigated and addressed per Also on a monthly basis a visua sessment of resident's skin will I conducted. Vulnerable adult rep and trending will be reviewed at facility quality improvement com meetings every three months ar reviewed monthly at facility staff ings to assure appropriate steps been taken with each investigati Director of Clinical Services is re sible for compliance.	e au- are policy. l as- be ports the mittee ad also meet- b have on.	2/19/14
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: RNX611		Fa	cility ID: 27752 If continuat	ion sheet	Page 9 of 62

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FORM API	PROVED
OMB NO 09	38-0391

STATEMENT	OF DEFICIENCIES		(X2) MUI	TIPLE		(X3) DAT	E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILC	ING _		COM	IPLETED
	к. 	245619	B. WING			01/	10/2014
	PROVIDER OR SUPPLIER	LAKE		52	REET ADDRESS, CITY, STATE, ZIP CODE 00 OAK GROVE PARKWAY ROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	clinical services- Dr immediately. For the the nurses are supp and start the invest residents skin was weekly with bath/sh supposed to docum with cares. RN-D sineeded to be addres confirmed both of F bruises and verified and stated the bruise healing. On 1/9/14, at 9:42 a were supposed to be and if the bruise was stated she was sup immediately or as sis she was to be notificall. DSC further st supposed to let the update the care plate every shift until rest On 1/9/14, at 2:10 p (RN)-D stated she bruises. RN-D state may have bumped causing the bruise aware of the bruise investigation imme- to the administrator	ified and my boss [director of CS], of any bruises or falls the bruises of unknown origin, posed to measure, document igation." She further stated all supposed to be checked nower and the nurses were nent the resident skin condition tated if anything was noted it essed immediately. The RN-D R75's forearms had dark purple d after looking at both forearms ses were at different stages of a.m. DSC stated all bruises be documented by the nurses as of unknown origin, the DSC uposed to be notified soon as possible. DSC stated ied even when she was on ated the nurses were clinical coordinator know to an and monitor the skin issue olved. b.m. clinical coordinator was not aware R75 had the ed R75 "was a wanderer" and or "ran into something"	F	2225			

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OMB NO 0938-0391

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION IG	(X3) DAT	E SURVEY IPLETED
		245619	B. WING	à		01/	10/2014
	PROVIDER OR SUPPLIER	LAKE			STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	Continued From pa and the bruising wa	-	F	22	5		
	10/19/13, redness a on 10/20/13, and bi unknown origin on	in tear to the right wrist on and swelling to the right hand ruising to the right hand of 11/2/13; none of the injuries eported to the administrator					
	R35's diagnoses in history of a close fr. end humerus. The Interview of Mental measure cognitive indicated intact cog addition indicated F extensive physical activities of daily liv as being unsteady	dated 10/3/13, indicated cluded osteoporosis and acture unspecified part upper MDS indicated R35's Brief Status (BIMS-tool used to status) score was 15 (which nitive status). The MDS in R35 required limited to assist of one staff with ing (ADL's), R35 was identified with balance with transitions, th without assist and used a lichair.					
	following: -On 10/19/13, a ski measuring 2 centim and R35 had report over her walker. Ste note indicated staff -On 10/20/13, R35's red, swollen, warm remained intact. R3 indicated staff woul -On 11/2/13, R35's observed to have o skin tear and hand	ress Notes revealed the n tear to the right wrist neter (cm) x 1.5cm was noted ed she had bumped her hand eri-strips were applied and the would continue to monitor. s right hand was noted to be to touch and the Steri-strips 5 denied pain and the note d continue to monitor. top of right hand was ne Steri-strip from previous was bruised, swollen and 5 was not able to explain					

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PRINTED:	01/28/2014
FORM A	PPROVED
OMB NO (038-0301

		a MEDICAID SERVICES			Ŭ		0000 0001
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION		E SURVEY PLETED
		245619	B. WING	à		01/	10/2014
	PROVIDER OR SUPPLIER	LAKE		:	STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	she was constantly something. Ice was during the shift with revealed staff would needs. -On 11/3/13, two no remained swollen/p tender to touch and Scheduled pain me administered and F -On 11/4/13, an ear hand was bruised, that same day the B red, measured 35 of the way down to the with range of motio nurse practitioner (was ordered. The x indicated there was injury. On 1/10/14, at 11:1 have liked both her have been notified DCS verified the ad notified immediatel On 1/10/14, at 12:3 nurse (LPN)-C was LPN-C confirmed h verified he recalled able to recall the nu day. LPN-C stated bruising at the time the next shift to cor hand. LPN-C confir	ned when asked and stated bumping the hand on applied to hand two times decreased swelling. The note d continue to monitor R35's oftes indicated R35's right hand ouffy, bruised, warm, and R35 reported pain. dication and ice were R35 reported relief. dier note indicated top of right reddened and swollen. Later bruise was noted to be dark cm x 15 cm, was swollen all e fingers. R35 reported pain n and with pressure. The NP) was updated and an x-ray c-ray results dated 11/4/13, a no evidence of acute bony 1 a.m. DCS stated she would self and the administrator to of the right hand injury. The dministrator should have been y. B p.m. the licensed practical interviewed via telephone. we worked with R35 on 11/2/13, the bruising incident and was ursing Progress note from that there was more swelling, than and stated he had updated ontinue to monitor the right med he did not update the e condition of R35's right	F	225			
	nand. LPN-C stated	d he asked the NA assigned to					

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245619	B. WING	i		01/	/10/2014
	PROVIDER OR SUPPLIER	LAKE		52	REET ADDRESS, CITY, STATE, ZIP CODE 200 OAK GROVE PARKWAY ROOKLYN PARK, MN 55443	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 225	and the NA both the "by the vanity." LPN she went to the toil probably had bump VERBAL ABUSE A R30 was not protect alleged verbal abus A vulnerable adult (indicated R30 had (NA) who had work before (on 6/26/13) indicated R30 repo yelled at R30 that h R30 was "not blind. An email dated 6/2 household coordina "reported to me jus her get to bed last discribed the abusi screaming at her [F eyes are okay and Although the email reported to the DS0 evidence the allega administrator imme and lacked evidence documented in the The quarterly MDS R30's diagnoses in kidney disease. R3 Status (BIMS-tool to	skin issue. LPN-C stated he ought the bruise was caused N-C stated R35 had told him et "back and forth" and bed herself "on something." LLEGATION ted during an investigation of se. (VA) report dated 6/27/13, reported a nursing assistant ted with R30 the evening was abusive. The report rted the NA screamed and her (R30's) eyes were okay and " 7/13, at 3:45 p.m. from the ator to DSC indicated R30's t now" a [NA staff] "who helped hight was 'abusive." The email ve behaviors of "yelling and R30]and telling her that her that she [R30] is not blind." indicated the allegation was C, the clinical record lacked titon was reported to the ediately, reported to the SA, se the incident was	F	225			

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FORM APPROVED
OMB NO 0938-0391

	13 I ON MEDIOANE				<u> </u>		0920-0291
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		LE CONSTRUCTION		E SURVEY IPLETED
		245619	B. WING	à		01/	10/2014
	PROVIDER OR SUPPLIER	LAKE		:	STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	Continued From pa	ge 13	F	225	5		
	had decreased visid degeneration and w function CAA dated with an impairment blindness and dem On 1/10/14, at 10:5 incident was called (versus online repo have a Medicare pr (and could not com After the DCS revie the administrator ha on 6/27/13, at 4:50 incident and stated and review the incid investigation, "That care of her [R30]." investigation the N/ her [R30] too" and t the unit. When aske R30 was safe from they continued worl during the investiga R30 was protected. household coordina the complaint in the actual report, what and that he had rep immediate supervis Review of the VA lo had been notified o indicated earlier by On 1/10/14, at 11:50	vas legally blind. The visual 2/5/13, also identified R30 with risk factors including entia. 8 a.m. DCS stated the in by telephone to the SA rting) as the facility did not ovider number at the time plete online reports to SA). we the VA log, DCS stated ad been notified the same day p.m. DCS recalled the she would need to "go back" dent. DCS stated during the NA was asked not to take DCS further stated during the NA was asked not to take DCS further stated during the A "went back and apologized to the NA continued to work on ed how the facility ensured the alleged perpetrator while ked on the same unit as R30 tion, DCS was unclear how DCS confirmed the tor should have documented the follow up at the time was norted the incident to his					

Facility ID: 27752

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU		LE CONSTRUCTION	1	E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245619	B. WING	à		01/	10/2014
NAME OF PROVIDER OR SUPPLIER SAINT THERESE AT OXBOW LAKE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES				STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	have been interview this had been done The administrator a expected the employ with R30 providing provided. The adm not know if a reside investigation if the a unit unless she was further stated the fa during an investiga R30 was not protect The administrator whave been docume should have include notification, details been done. On 1/10/14, at 12:1 coordinator stated basics on the incide send an email and supervisors" who wa administrator. The the allegation and i the DSC, was not crecord. The housel should have docum The Incident Repor policy dated Augus was completed who an unusual situatio matt, (unless it is o intentionally places bruises greater tha vulnerable areas ie	tated she expected R30 to wed. The administrator stated by the clinical coordinator. added she would have oyee in question not to work direct care until education was inistrator verified she would ent was protected during the staff continued to work in the s "sitting right there." She acility had suspended staff tion in the past and verified oted during the investigation. verified R30's incident should ented in the clinical record and ed: the initial complaint, of the incident and what had 6 p.m. the household usually he would document the ent/report, who he spoke with, immediately report to "my	F	225			

FORM CMS-2567(02-99) Previous Versions Obsolete

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			(<u>)MB NO.</u>	0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
	• · ·	245619	B. WING		·	01/	10/2014
NAME OF I	PROVIDER OR SUPPLIER	· / · · · · · · · · · · · · · · · · · ·		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	HERESE AT OXBOW			52	200 OAK GROVE PARKWAY		
SAINT D		LARE		В	ROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIOI DATE
F 225 F 226 SS=D	ABUSE/NEGLECT The facility must de policies and proced mistreatment, negle and misappropriation This REQUIREMEN by: Based on docume facility failed to imp policy regarding im skin tear injuries of administrator, imme agency (SA) and to injury to rule out po addition, the facility (R30) during invest for 3 of 4 residents abuse prohibition. Findings include: The facility Vulnera Maltreatment of pol abuse as, "An act a constitutes a violati aiding, and abetting defined unexplaine source) as, "An inju with an explainable The policy identified fractures as reporta	counted injuries. P/IMPLMENT , ETC POLICIES evelop and implement written	F 2	225	Corrective action for residents volved: Bruises noted on R75 were bro the attention of the Director of Services and were immediately ed to the administrator on 1/9/ on review with the administrato bruises were reported to the st agency on 1/9/14 due to the br were of unknown origin. Bruise documented, investigated, care was updated, and interventions put in place to reduce further in R75 was noted by staff to amb independently and at times bur things being unaware of surrou Family and physician were upd immediately of bruises. Investi report was filed with the state a Injury to R35's hand had previo been reported. Care plan was viewed for R35 to assure curre up to date. Resident has had r changes in ADLs or condition re to bruise and swelling to hand.	ought to Clinical v report- 4. Up- or the ate uises es were plan s were jury. ulate np into ndings. ated gative gency. ously re- nt and	2/19/14

Facility ID: 27752

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` <i>´</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	~	245619	B. WING	i		01/	10/2014	
NAME OF PROVIDER OR SUPPLIER SAINT THERESE AT OXBOW LAKE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF	5 B	TREET ADDRESS, CITY, STATE, ZIP CODE 200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION		
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		DATE	
F 226	to the appropriate of administrator immediately to the SA further directed, "e. abuse/neglect the of (DCS) would review externally to the SA further directed, "e. abuse/neglect is su involved supervisor department head if should be placed of based on the potent abuse/neglect and/ environment. The enotice of investigation investigation by the INJURIES OF UNK R75's bruises of unvertigate administrator and S On 1/7/14 and 1/9/ eight clearly visible different stages of 1 was unable to expla- and a facility staff w observations. The of the bruises were id immediately to the clinical record lacked thoroughly investigate Review of R75's Pr 12/2/13, and 12/16/ bruises noted on bo On 1/9/14, at 3:03	department head and the diately. The procedure also wing an oral or written report of director of clinical services wit and determine if to report it mediately. The policy If staff to resident respected, determine with the and/or appropriate the named employee(s) in investigative suspension tial of further resident or disruption of the work employee(s) will be given a ve leave pending supervisor." (NOWN SOURCE known origin to both forearms ed and reported to the SA. 14, R75 was observed to have dark purple bruises at nealing to both forearms. R75 ain how she got the bruises vas present during the clinical record lacked evidence entified and/or reported administrator and SA; the ed evidence the bruises were ated. ogress Notes dated 11/25/13, (13, indicated R75 had old	F	226	Incident with R30 had previousl reported. R30 remains safe and further incidents have been reported. Nursing assistant involved in indi- had been disciplined and educat was provided to prevent further dents. How identify other residents pot- ly affected: All residents could potentially be fected. Measure/Systemic changes to e- deficient practice will not reoccu. Reminders and education was p- ed to staff addressing the facility nerable Adult policy to report im ately all allegations involving mi- ment, neglect or abuse, including ries of unknown source. Survey sults were reviewed with Clinica Household Coordinator and rem about immediate reporting. All s- were educated on vulnerable ac- reporting during education sessi- the week of February 10, 2014.	d no orted. cident ition inci- eential- eeaf- ensure r: orovid- / Vul- medi- streat- g inju- / re- l and ninded staff lult	2/19/14	

Facility ID: 27752

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATI	E SURVEY PLETED	
		245619	B. WING			01/	10/2014
NAME OF PROVIDER OR SUPPLIER SAINT THERESE AT OXBOW LAKE			520	REET ADDRESS, CITY, STATE, ZIP CODE 00 OAK GROVE PARKWAY ROOKLYN PARK, MN 55443			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	aware of the bruise investigation imme- to the administrator further stated an in- and the bruising wa R35 skin tear to rig hand of unknown o facility administrator R35's nursing Prog 10/19/13, 10/20/13 tear to the right wris bruising, swelling a noted. The medical evidence the skin to origin had been rep SA for 16 days sinc been identified on Progress Note date right hand was brui Later that same da dark red, measured swollen all the way reported pain with n pressure. The nurs updated and an x-r results dated 11/4/- evidence of acute to On 1/10/14, at 11:1 have liked both her have been notified DCS verified the ac notified immediatel On 1/10/14, at 11:4	 s. DSC stated if she had been s, she would have started an diately, reported it immediately r and immediately to SA. DSC vestigation had been started as reported to SA. ht wrist and bruise to right rigin were not reported to the r and SA. ress Notes indicated on , 11/2/13, and 11/3/13 a skin st and the right hand redness, nd warm to touch had been record lacked documented ear and bruising of unknown borted to the administrator and the first time the issue had 10/19/13. The nursing ed 11/4/13, indicated top of the sed, reddened and swollen. y the bruise was noted to be d 35 cm x 15 cm and was down to the fingers. R35 range of motion and with e practitioner had been ay was ordered. The x-ray 13, indicated there was no bony injury. 1 a.m. DCS stated she would self and the administrator to of the right hand injury. The dministrator should have been y. 	F 2	226	How to monitor: A sample of weekly skin check gress notes will be audited mon assure bruises are investigated addressed per policy. Also on a monthly basis a visual assessm resident's skin will be conducted nerable adult reports and trendi be reviewed at the facility qualit provement committee meetings three months and also reviewed monthly at facility staff meetings assure appropriate steps have be taken with each investigation. It tor of Clinical Services is respon for compliance.	thly to and a eent of d. Vul- ng will y im- every d s to been Direc-	2/19/14
FORM CMS-25	She was supposed	to be notified "Right away" of Obsolete Event ID: RNX61	1	Facili	ity ID: 27752 If continuati	on sheet	Page 18 of 62

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	0038-0301

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB	CLIA (X2)	,	PLE CONSTRUCTION	0	(X3) DATE	SURVEY
		245619	B. W	B. WING			01/1	0/2014
	NAME OF PROVIDER OR SUPPLIER SAINT THERESE AT OXBOW LAKE		•		STREET ADDRESS, CITY, STATE, ZI 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 5544			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD HE APPROPF	BE	(X5) COMPLETION DATE
F 226	issues. She added any VA issues such neglect, bruising, a immediately. She fi have been notified have contacted her The administrator v origin should have the root cause anal would not be starte completed. ALLEGATION OF V R30 was not protect alleged verbal abus A Vulnerable Adult indicated R30 had assistant (NA) who before 6/26/13, was NA was screaming eyes were okay and During further docu R30 had reported t on 6/27/13, at 3:45 correspondence to coordinator never of the clinical resident On 1/10/14, at 10:5 stated during the in assistant was aske (resident)." DCS fu investigation the stat to her (R30) too" ar on the unit. DCS was the resident was pr	building, resident or stat the staff are to notify he as any suspicion of at nything they report to the urther stated the DCS is on 11/2/13, and DCS is which had not been do verified skin tears of un been investigated to de lysis and verified invest d until after reporting he VERBAL ABUSE sted during an investigate ted during an investigate se. (VA) report dated on 6/ reported to staff a nurs had worked with her e is abusive. R30 reported and yelling at her that he d that she was not blind ument review, it was revorted to the household coording p.m. through e-mail the DSC. The household cocumented R30's com	er of buse, he State should hould bone. known etermine igation as been ation of 27/13, ing vening d the her d. vealed nator bld plaint in iewed ng er blogized b work sured erson	F 226				
FORM CMS-25	67(02-99) Previous Versions	Obsolete Ever	it ID: RNX611	Fa	acility ID: 27752	If continuation	on sheet P	age 19 of 62

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

PRINTED: 01/28/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245619	B. WING			01/*	10/2014
NAME OF PROVIDER OR SUPPLIER SAINT THERESE AT OXBOW LAKE			5	STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 226 F 279 SS=D	have documented record including the up at the time was incident to his imm On 1/10/14, at 11:5 interviewed verified protected during th continued to work is sitting right there. S suspended pending verified the R30 was investigation. The a incident should hav clinical record, incl notification, details been done which w 483.20(d), 483.20(COMPREHENSIV A facility must use to develop, review comprehensive pla The facility must de plan for each resid objectives and time medical, nursing, a needs that are ider assessment. The care plan must to be furnished to a highest practicable psychosocial well-I §483.25; and any s	 household coordinator should the complaint in the clinical e actual report, what the follow and that he had reported the ediate supervisor and herself. 66 a.m. the administrator was a she would not know R30 was e investigation if the staff n the unit unless she was She further stated facility had g investigation in the past and as not protected during the administrator verified the ve been documented in the uding initial complaint, of the incident and what had vas lacking. k)(1) DEVELOP E CARE PLANS the results of the assessment and revise the resident's 		226		27 d- ms, if sleep i up- odone elated ven- nonitor ention	2/19/14

Facility ID: 27752

If continuation sheet Page 20 of 62

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		E SURVEY PLETED
		245619	B. WING			01/1	10/2014
NAME OF PROVIDER OR SUPPLIER SAINT THERESE AT OXBOW LAKE			52	REET ADDRESS, CITY, STATE, ZIP CODE 00 OAK GROVE PARKWAY ROOKLYN PARK, MN 55443		10/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	due to the resident §483.10, including under §483.10(b)(4 This REQUIREME by: Based on interview facility failed to dew sleep problems, sle of Trazodone for 1 for un-necessary m Findings include: R27 received sche without developme the use of the med with the medication interventions, such Physician's orders received Trazodon mouth (PO) twice of of sleep (HS). The diagnoses to includ dementia without b Alzheimer's diseas The care plan date use of Trazodone f sleep and non-pha promote sleep. In a direction for monito sleep patterns and medication. On 1/9/14, at 2:01	s exercise of rights under the right to refuse treatment b). NT is not met as evidenced v and document review, the relop a care plan to address eep monitoring and/or the use of 5 residents (R27) reviewed hedications. duled Trazodone for sleep nt of a care plan to address ication, risk factors associated h and non-pharmacological as for sleep. dated 11/7/13, indicated R27 e HCL 25 milligrams (mg) by daily and 50 mg PO every hour orders identified R27's de unspecified psychosis, hehavioral disturbance, and	F	279.	How identify other residents polly affected: All other resident care plan and guides who are receiving a sleet were reviewed and updated to rusage of sleep aid, non-pharmacological interventions fi sleep, side effects of sleep aid, intervention for monitoring sleet terns and medication use. Faci policy for psychotropic medicati monitoring was reviewed and uped. Measure/Systemic changes to a deficient practice will not reoccu. Education provided to all license in regards to policy and procedu care planning and development comprehensive care plans was ed during plan of correction edu sessions during the week on Fe 10,2014. Care plans and care g are to be updated every two we per set schedule and as needed reflect changes in resident's abi or needs. Licensed staff to upd Clinical Coordinator if care plan not accurately reflect the resider needs, abilities, medication usa	care p aid eflect or and o pat- lity on and pdat- ensure ir: ed staff ure for of provid- ication bruary guides eks d to lities ate does nt's	2/19/14

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245619	B. WING			01/	10/2014	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	19 T		
	IEREAE AT AVRAU			52	200 OAK GROVE PARKWAY			
SAINT H	HERESE AT OXBOW	LAKE		В	ROOKLYN PARK, MN 55443			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 279	consultant pharma- telephone and verificare planned the u On 1/10/14, at 9:04 services (DCS) ver sleep problems sho The facility's Psych Monitoring policy a identified pertinent medications, include the policy directed of psychotropic me monitoring and ass	Trazodone. At 2:31 p.m. the cist (CP)-F was interviewed via fied the facility should have	F2	279	How to monitor: A sample of residents care guide care plans that receive psychotr medication or sleep aides, will b dited monthly for three months, quarterly for one year. A summ the audit will be given to the Dire of Clinical Services. Trending a audit reports will be reviewed even three months at the Quality Imp ment committee meeting. Direc Clinical Services is responsible compliance.	opic e au- than ary of ector nd very rove- tor of	2/19/14	
F 280 SS=D	planning psychotro 483.20(d)(3), 483.1 PARTICIPATE PLA The resident has the incompetent or othe incapacitated under participate in plann changes in care an A comprehensive of within 7 days after comprehensive assist interdisciplinary tea physician, a register for the resident, and disciplines as deter and, to the extent p the resident, the re- legal representative	pic medications. 0(k)(2) RIGHT TO NNING CARE-REVISE CP ne right, unless adjudged erwise found to be r the laws of the State, to ing care and treatment or	F:	280	Corrective action for residents in volved: Daughter present during R63's s uled bath time and reported R63 extreme anxiety when brought to tub room. R63 brought to room given a complete bed bath, accor to daughter R63 showed decrea anxiety with complete bed bath even thanked the CLS staff. Co versed with daughter and receive okay to give R63 bed baths only Care plan and care guide updat reflect R63 receives bed baths of weekly bath days. Educated sta new plan of care for R63 relating weekly bath.	sched- 3 had o the and ording ased and on- ved v. ed to only on aff on	2/19/14	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION		ATE SURVEY OMPLETED	
	•	245619	B. WING			01/	10/2014	
NAME OF PROVIDER OR SUPPLIER SAINT THERESE AT OXBOW LAKE				52	TREET ADDRESS, CITY, STATE, ZIP CODE 200 OAK GROVE PARKWAY ROOKLYN PARK, MN 55443			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 280	each assessment. This REQUIREMEN by: Based on observat review, the facility f was revised regard of 5 residents (R63 medications. In ado a plan of care for 1 bruises on unknown	NT is not met as evidenced tion, interview and document ailed to ensure the care plan ing bathing preferences for 1) reviewed for unnecessary dition the facility failed to revise of 3 residents (R75) with n origin and risk for bruising	F 2	280	Care plan for R75 was updated identify bruises noted on arms. plan was also updated with risk tors and interventions to prevent ther injury. How identify other residents pote ly affected: Care plans were reviewed for th residents with identified bruises residents receiving psychotropic cation.	Care fac- t fur- ential- ose and	2/19/14	
	Findings include: The Admission Rec included diagnoses depression. The Order Summar revealed R63 was p every bedtime and to be given before t mornings. The ever dated 8/13/13, inclu- bath/sponge bath in The bathing care pl R63 had a history of very agitated and u and identified R63 of The care plan direc psychotropic medic not to wash R63's f provide a calm app	ressure skin conditions. cord for R63 dated 12/4/13, of dementia, aphasia, and ry Report dated 1/9/14, prescribed Seroquel 25mg 25mg every Friday for anxiety path/shower on Friday ry Friday Seroquel orders uded directions of may try bed hstead. an dated 11/6/13, indicated of refusing showers, becoming pset during the shower activity did not like water on her head. ted staff to administer a sation prior to shower, directed hair with the bath, directed to roach and offer reassurance The care plan directed to			Measure/Systemic changes to e deficient practice will not reoccu Education provided to all license the week of February 10,2014 in gards to the policy; Charting: Do mentation/updating and reviewin care plans. Care plans will be up as needed and every two weeks set schedule. Licensed staff to u clinical coordinator if changes ar needed and possibility of signific change in status. Care plans wi reviewed and updated by Clinica Household coordinators every th months with RAI review.	r: ed staff n re- ocu- ng odated s per update re cant II be al and		

Facility ID: 27752

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OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 245619 B. WING 01/10/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **5200 OAK GROVE PARKWAY** SAINT THERESE AT OXBOW LAKE **BROOKLYN PARK, MN 55443** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION DATE ID (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 280 Continued From page 23 F 280 How to monitor: 2/19/14 re-approach at a later time if R63 became agitated or upset. The care plan did not include A sample of resident's care plans and direction to offer a bed bath to R63. care guides will be audited monthly for When interviewed on 1/8/14, at 9:03 a.m. family three months then guarterly for one member (FM)-A reported R63 had problems with year. Findings will be reviewed with bathing and did not like to take baths or showers. the licensed staff. A summary of the FM-A stated R63 would become very upset findings will be given to the Director of during and after bathing. FM-A further stated R63 used to take showers regularly without problems Clinical Services. Director of Clinical and did not know what had caused the change. Services is responsible for compliance. On 1/9/14, at 9:24 a.m. nursing assistant (NA)-A stated R63 did not like water and would scream, kick, yell and call angry names with showers. NA-A reported noting no difference in R63's behaviors since Seroguel was started and stated R63 now needed two staff members to assist with a shower. NA-A further stated when she gave R63 a bed bath, R63 was "happy." At 9:34 a.m. registered nurse (RN)-A stated R63 would get very upset, verbally and physically abusive during baths, and verified the behavior had not improved since the Seroquel was started on 8/13/13. RN-A stated R63 was much calmer with a bed bath. On 1/9/14, at 9:57 a.m. the clinical coordinator (RN)-B stated R63's family had requested Ativan (an anti-anxiety medication), but the staff wanted to use Seroquel. RN-B stated she had not seen any notes about behaviors with baths and if staff "doesn't tell" her, she "doesn't know." RN-B reported R63 got a shower weekly versus a bed bath per her family's request. On 1/9/14, at 12:27 p.m. FM-A was interviewed again and stated it was not a family request R63 got a shower every week and stated she did not know a bed bath was an option. FM-A reported FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: RNX611 Facility ID: 27752 If continuation sheet Page 24 of 62

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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FORM APPROVED

PRINTED:	01/28/2014
FORM	APPROVED
OMB NO	0938-0391

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245619	B. WING			01/	10/2014
NAME OF PROVIDER OR SUPPLIER SAINT THERESE AT OXBOW LAKE			:	STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 280	visited the day after On 1/9/14, at 12:39 services (DCS) stat need to have a sho more comfortable fi choice." The DCS is alternatives to be u antipsychotic for ba On 1/9/14, at 1:44 g stated he ordered S did not like the side MD-A further stated that was what he us MD-A stated he wore explain things to res comfort before star behavior. R75's care plan was bruising and the bru On 1/7/14, at 1:44 g have several dark p at different stages of On 1/9/14, at 7:30 a on a couch in the mini- closed. The administ newspaper to R75 a forearms and bruise The significant char dated 9/20/13, indic included Alzheimer's degeneration of reti	 still very upset when she r her showers. p.m. the director of clinical ted weekly residents do not wer and if a bed bath was or them that was "their stated she would expect sed prior to using an thing. p.m. R63's physician (MD)-A Geroquel for R63 because he effects of benzodiazepines. I he used Seroquel because sually used in nursing homes. uld expect facility staff to sidents to increase their ting any medications for s not revised for risk of uises on both forearms. p.m. R75 was observed to burple bruises to both forearms 	F	280			

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

PRINTED: 01/28/2014 FORM APPROVED OMB NO: 0938-0391

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
•		245619	B. WING			01/	10/2014
	NAME OF PROVIDER OR SUPPLIER SAINT THERESE AT OXBOW LAKE				STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	living. R75's care plan dat integrity, "[R75 was integrity due to alw bladder and occasi risk and self-care d care plan did not id but directed to "mo baths/showers, dur the nurse." Althoug R75 had potential f macular degenerat identified R75 wan other resident room R75 was at risk for factors. Review of R75's Pr 11/25/13, 12/2/13, 12	ted 11/20/12, identified for skin as being incontinent of onally incontinent of bowel, fall leficit related to dementia." The entify R75's risk for bruising, nitor for skin changes during ing am/pm cares and notify h the vision focus identified or change in vision related to ion; the behavior focus dered around the unit and into ns, neither focus included how injury or bruising with the risk togress Notes revealed on and 12/16/13, old bruising had n of R75's forearms. Although bocumented occassionally in the 5's care plan did not address y the new bruising, such as erventions in place to prevent a.m. the clinical coordinator RN)-D after looking at R75's ied R75's had dark purple the bruises were at different a.m. DCS stated the nurses et the clinical coordinator know	F 2	280			
	, at		I				

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	13 FUR MEDIUARE		-		Ŭ	IVID INO.	0920-0291
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245619	B. WING	à		01/	10/2014
NAME OF PROVIDER OR SUPPLIER SAINT THERESE AT OXBOW LAKE				5	STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			iX à	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	(X5) COMPLETION DATE	
F 280	aware she would h The Skin Care Pro- if bruises are noted weekly skin check nursing) will be upo the policy indicated will be provided ba- and application of t resident identified a integrity. The policy to revise the care p had been assessed	age 26 bruising and stated if she was ave updated the care plan. tocol dated May 2013, directed I during daily cares or during the clinical or DON (director of lated immediately. In addition, resident care interventions sed on nursing assessment he nursing process for the as being at risk for altered skin v lacked who was responsible blan when any resident's skin d and noted to have an issue.	F	280			•
F 309 SS=D	policy dated Septer purpose was to pro- interdisciplinary tea and implement an i evaluate the effecti treatment on an on indicated this proce resident to achieve level. The policy lac plan of care on goin identified with new the MDS's. 483.25 PROVIDE (HIGHEST WELL B Each resident must provide the necess or maintain the high mental, and psycho	mber 2012, indicated the ovide a means for the individualized care plan, and veness of their care and going basis. The policy ess was used to assist each /maintain an optimal functional cked information on revising a ng when any resident was issues or risk factors between CARE/SERVICES FOR	F	309	Corrective action for residents ir volved: R75 care plan and care was reviewed on 1/9/14 to reflect rent level of care. Physician and ly were notified of skin alteration Care plan and care guide update with current risk factors and inte tions were put in place including sleeves to bilateral arms.	guide ct cur- l Fami- l. ed rven-	2/19/14

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY . COMPLETED	
	245619		B. WING	ì	- · · · · · · · · · · · · · · · · · · ·	01/10/2014		
NAME OF PROVIDER OR SUPPLIER			52	TREET ADDRESS, CITY, STATE, ZIP CODE 200 OAK GROVE PARKWAY ROOKLYN PARK, MN 55443				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 309	by: Based on observative review, the facility f root cause and pro- prevent bruising four reviewed for non-p Findings include: On 1/7/14, at 1:44 have several dark p at different stages explain how she go - At 5:22 p.m. R75 dining room table e assistant (NA)-B sa resident cuing her On 1/8/14, at 2:27 (NA)-B stated if she bruises she would to ensure the nurse Although NA-B stat to the nurse immed lacked evidence R assessed. On 1/9/14, at 7:30 couch in the middle forearms and bruis R75's diagnoses in history of falls, Alzt	NT is not met as evidenced tion, interview and record ailed to identify, assess for vide preventative measures to r 1 of 3 residents (R75) pressure related skin issues p.m. R75 was observed to purple bruises to both forearms of healing but was not able to ot the bruises. was observed sitting at the pating independently. A nursing at between R75 and other	F	309	DEFICIENCY) How identify other residents polly affected: Current incident reports involvine bruises were reviewed to assume bruises were identified on plane care, assessed for root cause, a preventative measures were pul- place. Measure/Systemic changes to a deficient practice will not reoccu Education provided to staff durine week of February 10, 2014 in m to skin alteration policy. Care p will be updated as needed and two weeks per schedule to assu accurate reflection of current ne risks, and interventions. Licens staff was reeducated to update coordinator if changes are need and possibility of significant chan status.	ng e of and t in ensure ur: ng the egards lans every ure seds, sed clinical ed	2/19/14	
	significant Minimur	n Data Set dated 9/20/13. The 5 to had severe cognitive						

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245619	B. WING			01/-	01/10/2014	
	PROVIDER OR SUPPLIER	LAKE		52	REET ADDRESS, CITY, STATE, ZIP CODE 200 OAK GROVE PARKWAY ROOKLYN PARK, MN 55443		·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 309	all activities of daily Assessment (CAA) was at potential ris needing extensive times. The CAA ind dementia and was needs known. The R75's risk for bruis The skin integrity c identified R75 was integrity due to alw bladder and occasi The care plan iden had self care defici goal indicated, "Sk directed to "monito baths/showers, dur the nurse." Review of R75's Pr 11/25/13, 12/2/13, been noted on bott Progress Note date been brought to the surveyor), indicated arms. The note ind the bruises were as - right upper forearm - right wrist 2 cm x - below right index - at base of right th - left upper forearm - area to left wrist/t Although the condi	quire extensive assistance for <i>l</i> living. The Care Area dated 10/4/13, indicated R75 k for pressure ulcers related to assist with bed mobility at dicated R75 had a diagnosis of not always able to make her Pressure Ulcer CAA lacked ing due to being a wanderer. are plan dated 11/20/12, at risk for impaired skin ays being incontinent of ionally incontinent of bowel. tified R75 was a fall risk and ts related to dementia. The in will remain intact" and r for skin changes during ring am/pm cares and notify rogress Notes revealed on and 12/16/13, old bruising had n of R75's forearms. A nursing ed 1/9/14 (after concern had e attention of facility staff by the d R75 had eight bruises to both licated the measurements of s follows: m 6 centimeter (cm) x 8 cm; 3 cm 1 cm; 2.5 cm; finger 4 cm x 2.5 cm; umb 3 cm x 1 cm; n 5 cm x 5.5 cm;		309	How to monitor: A sample of weekly skin check gress notes will be audited mor assure bruises are assessed fo cause, plan of care is updated, preventative measures were pu place. A sample of incident rep will also be reviewed monthly to sure appropriate follow up and i gation has occurred. Audit resu be reviewed by Director of Clinic Services. Reports and trending reviewed at the facility quality in provement committee meetings three months. Director of Clinic Services is responsible for com ance.	hthly to r root and t in orts as- nvesti- ults will cal will be n- every cal	2/19/14	
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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245619	B. WING _			01/10/2014	
	PROVIDER OR SUPPLIER	LAKE		STREET ADDRESS, C 5200 OAK GROVE F BROOKLYN PARK	PARKWAY		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI> TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD RENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	were assessed and to prevent further b On 1/9/14, at 8:40 a clinical coordinator supposed to be not clinical services, Du immediately. For th the nurses are supp and start the invest residents skin was weekly with bath/sh supposed to docum with cares. RN-D sineeded to be addre confirmed both of F bruises and verified stages of healing. On 1/9/14, at 9:42 a are supposed to be She further stated f the clinical coordina plan and monitor th resolved. On 1/9/14, at 2:10 not aware R75 had sure R75 was a wa or ran into somethil stated if she was an the care plan. On 1/9/14, at 3:03 stated she was not soon as the bruisin	ence R75's current bruises I measures were put in place	F 3	09			
FORM CMS-25	interventions have		1	Facility ID: 27752	If continuati	on sheet I	Page 30 of 62

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		245619	B. WING	i		01	/10/2014
				5	STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	if bruises are noted weekly skin check t	ocol dated May 2013, directed during daily cares or during he clinical or DON will be	F	309			
F 325 SS=D	updated immediate indicated a residem provided based on application of the n identified as being a 483.25(i) MAINTAIN UNLESS UNAVOID Based on a residem assessment, the fa resident - (1) Maintains accep status, such as boo unless the resident demonstrates that t (2) Receives a ther nutritional problem. This REQUIREMEN by: Based on observat review, the facility fa	Iy. In addition, the policy t care interventions will be nursing assessment and ursing process for the resident at risk for altered skin integrity. N NUTRITION STATUS DABLE t's comprehensive cility must ensure that a stable parameters of nutritional ly weight and protein levels, s clinical condition his is not possible; and apeutic diet when there is a	F	325	Corrective action for residents in- volved: R99's diet was changed in the ele tronic medical record per physicia order. A new report was printed of 1/9/14 to assure all staff aware of change to diet. How identify other residents poter ly affected: All resident's could potentially be a fected. A new diet report was pos for all neighborhoods to assure all staff had most accurate information Measure/Systemic changes to ens deficient practice will not reoccur: Training was provided to dining su visors to access diet reports in ele tronic medical record and to check	n on atial- af- ted n. sure uper- c-	2/19/14
					email frequently to obtain new resident diet orders and updates in die orders, training was completed on 1/31/14. All clinical staff were reed cated on diet order process during plan of education the week of 2/10	et du-	

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		AND HUMAN SERVICES			FO	ED: 01/28/2014 RM APPROVED VO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3)	DATE SURVEY COMPLETED
		245619	B. WING			01/10/2014
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE		
SAINT TH	IERESE AT OXBOW	LAKE		5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 325	facility due to weigh index (BMI, a numb weight and height u identify possible we R99's weight was 8 16.8 on 1/8/14. Acc Disease Control (C 1/10/14, a BMI of b to be underweight. A Physician's Order R99 a nutritional su diet. On 1/9/14, at 12:25 dining room at a lar socializing. R99 has served was tomato and a cookie. R99 the the tomato soup, 10 and 25% of the fres On 1/9/14, at 12:30 was asked how the the correct diet, DA chart, taped to the each residents nam was listed as requir sodium/fat/choleste DA-A confirmed R9 diet. On 1/9/14, at 12:44 (LPN)-A checked th medical record and limited diet with reg	to be at nutritional risk by the at loss and a low body mass ber calculated from a person's used as a screening tool to bight problems for adults). Be pounds and the BMI was bording to the Centers for DC) website, date of reference elow 18.5 indicates a person r dated 1/7/14, directed to give applement and,ok for regular be p.m. R99 was observed in the ge table eating lunch and d milk and water. The meal soup with crackers, fresh fruit was observed to eat 100% of 00% of the milk and cookie sh fruit. P.m. the dietary aide (DA)-A y ensured residents received I-A showed the surveyor a wall in the kitchen, which listed the and prescribed diet. R99	F 32		complete a mple of diet or- iree months ther s in clinical recor curacy with diet of diet order au- facility Quality ttee. A summary to the Director Director of Dinin	d /
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		24561	9	B. WING		-	01/10/2014		
	PROVIDER OR SUPPLIER	LAKE			5200 OAK (DRESS, CITY, STATE, Z GROVE PARKWAY (N PARK, MN 5544			ï
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOL TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)		FION SHOULD	BE	(X5) COMPLETION DATE		
F 325	Continued From parstated she would has 12:57 p.m. LPN-A do been receiving a restarting on 1/7/14. A (MD)-A clarified and regular starting on A nutritional assess R99's low BMI as a ideal body weight rassessment also n with intake and door were fair (50%). The provide diet as order 0 n 1/9/14, at 1:50 provide diet as order was changed to a restricten still had R9 diet. DCS stated shorder was not yet in about the process of the electronic medidiet orders also we a "diet order group" director. On 1/9/14, at 1:55 was asked about F changed to a regular order of the electronic medidiet order group director. On 1/9/14, at 1:55 was asked about F changed to a regular order of the changed to a regular or the facility Diet Changed to a regular of the the facility Diet Changed to the the changed to a regular of the the facility Diet Changed to the the changed to a regular of the the facility Diet Changed to the the changed to a regular of the the facility Diet Changed to the the	ave to clarify the o confirmed R99 sho gular diet with reg At 1:01 p.m. R99's d confirmed the di 1/7/14. sment dated 1/6/14 concern and ider ange as 95-115. T oted R99 was inde cumented intakes te assessment ince ered." p.m. the director o s made aware R99 regular diet on 1/7, 9 listed as needin- te would investiga nplemented. Whe of getting new ord CS stated new ord CS stated new ord cal record. DCS s re communicated ' which included th p.m. the dietary di (99's diet order no ar diet and not bei 7/14, DD stated, " eck the email."	buld have ular texture physician et order was 4, noted htified their he ependent at meals luded "will f clinical 9's diet order (14, and the g a limited te why the en asked ers ders go into tated new via emails to he dietary rector (DD) t being ng To be honest	F 3	25	DEFICIENC	ςγ)		
	2013, indicated it w and nursing depart keep all diet orders change. The policy	ments would com current, whether indicated all diet	municate to initial or a changes						
FURINI GMS-28	567(02-99) Previous Versions	Ousolete	Event ID: RNX611	1	Facility ID: 277	U2	n continuati	on sneet i	Page 33 of 62

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245619	B. WING			01	1/10/2014	
	PROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE 200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION _ DATE	
F 325 F 329 SS=D	department in a tim responsible for trar send an email to fa policy indicated wh new diet report was kitchen and staff fo 483.25(I) DRUG RH UNNECESSARY D Each resident's dru unnecessary drugs drug when used in duplicate therapy); without adequate n indications for its u adverse consequer should be reduced combinations of the Based on a compre- resident, the facility who have not used given these drugs u therapy is necessa as diagnosed and o record; and resider drugs receive grad behavioral interven contraindicated, in drugs.	ated to the dining services hely manner. The staff scribing the new order would cility diet order group. The en a diet order changed, a s printed by dietary for the r the neighborhood kitchens. EGIMEN IS FREE FROM ORUGS or gregimen must be free from . An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of nces which indicate the dose or discontinued; or any			Corrective action for residents in- volved: Physician was contacted R27's per chotropic medications. Haldol was discontinued and Seroquel was de creased. Physician note dated 1/10/2014 states "as patient stable decrease dose of Seroquel advise watch behavior closely. May need consider stopping Trazodone in fur especially the PRN dose." Nursin order written to monitor behavior a update MD as needed. Physician address diagnoses for psychotrop use and provide appropriate diagn ses. R27's Target Behavior monit ing form and care plan reviewed a updated to reflect R27 specific beh iors. Care plan for R27 reviewed a updated with Trazodone in focus statement, sleep related goal, slee related interventions, and intervent for monitoring sleep patterns and medication use. R63's daughter i volved in interventions to decrease anxiety during weekly bath.	sy- s e- e will e to d to iture g and to ic or- nd nav- and p tion n-	2/19/14	

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		245619	B. WING	i	د 	01/ ⁻	10/2014	
NAME OF	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
	HERESE AT OXBOW			5	200 OAK GROVE PARKWAY			
SAINTI	HERESE AT OXBOW			B	BROOKLYN PARK, MN 55443			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 329	review, the facility f clinical indications f Seroquel (Quetiapii and as needed (PF antipsychotic), faile failed to assess for reduction (GDR) of the facility failed to use of Trazodone (used to treat sleep failed to assess an scheduled Seroque (R27, R63) in the s un-necessary medi Findings include: R27 received scher Haldol without appr ongoing use, lacke monitoring and lack potential GDR for t was warranted; alth R27's sleep, the fact to determine the ef Trazodone use. Physician's orders received quetiapine milligrams (mg) by of sleep (HS); Hald "Agitation/restlessr sublingual (under th PRN; Trazodone H 50 mg PO every HS identified R27's dia psychosis, dement	tion, interview and document ailed to ensure appropriate for the ongoing use of ne Fumarate, an antipsychotic) (N) Haldol (haloperidol, an d to monitor for efficacy and a potential gradual dosage the antipsychotic medications; evaluate sleep for the ongoing an antidepressant medication problems) (R27); the facility d monitor the ongoing use of el (R63); for 2 of 5 residents ample reviewed for	F		Daughter present during R63's so uled bath time and reported R63 extreme anxiety when brought to tub room. R63 brought to room a given a complete bed bath, accor to daughter R63 showed decreas anxiety with complete bed bath at even thanked the CLS staff. Con versed with daughter and receive okay to give R63 bed baths only. Care plan and care guide updated reflect R63 receives bed baths on weekly bath days. Educated staff new plan of care for R63 relating weekly bath. Physician contacted regarding ineffective psychotropic fore bath and bed bath is tolerated well. Order obtained to discontinu scheduled Seroquel prior to week bath. R63 no longer exhibits beha iors related to bathing, it does not need to be addressed on the targe behavior form at this time. How identify other residents poter ly affected: Target behavior forms care plans reviewed and updated all resident receiving a psychotrop medication that requires Target m toring forms to be completed, to re- resident specific behaviors.	had the ind ind ed nd - d d to ily on f on to f on to i s be- d ue ly av- et ntial- and for pic oni-	2/19/14	

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		245619	B. WING		0-	01/10/2014	
	NAME OF PROVIDER OR SUPPLIER SAINT THERESE AT OXBOW LAKE			STREET ADDRESS, CITY, STATE, Z 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 5544			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 329	dated 6/6/13, ident cognitive impairme problems and indic with all activities of - The Care Area As psychotropic drug of "Resident receives for a diagnosis of p antidepressant for Dementia and psyc resident has had a abusive behaviors, exhibited since adr medication side eff reduction [GDR] as indicated the diagn Seroquel, the CAA specific behaviors such as paranoia of diagnoses for the u include sleep/insor identified Alzheime and psychosis as t antidepressant. Th which warranted a indications to warra The clinical record GDR was consider - The CAA for ADL Potential dated 6/1 had declined, she n ADLs and R27 hac from Hospice. - The CAA for falls had sustained no falls	inge Minimum Data Set (MDS) ified R27 had moderate int, no mood or behavior sated R27 was independent daily living (ADLs). ssessment (CAA) for use dated 6/11/13, indicated, an antipsychotic medication osychosis and an a diagnosis of Alzheimer's chosis. Per previous facility gitation, restlessness and which none have been mission here. Will monitor tects and look at gradual dose indicated." Although the CAA osis of psychosis was used for did not address resident associated with the diagnosis, or hallucinations. The use of Trazodone did not nnia and inappropriately r's (not a psychiatric condition) he diagnoses for the e CAA did not identify factors potential GDR, such as lack of ant the use of the medication. lacked further evidence a	F 3	Measure/Systemic chan deficient practice will not ucation provided to all lid regards to psychotropic monitoring, target behav documenting on behavic ual dose reduction. Edu to monitor and observer behaviors and update Cl nator if new or worsening are noted. Clinical Coor continue to evaluate psy medications quarterly an and approach the MD if reduction is indicated. How to monitor: All resid tion will be reviewed for i by the Consultant Pharm ly. A sample of Target B toring forms and care pla audited monthly for three then quarterly for one yea Target behaviors are res and care plan is in congr Target Behavior monitori sample of target behavio forms and assessments w ed monthly for three mon quarterly for one year to e ual dose reduction is add	t reoccur: Ed- censed staff in medication ior forms, ors, and grad- cated all staff esidents for inical Coordi- g behaviors dinator will chotropic d as needed gradual dose lent's medica- rregularities acist month- ehavior moni- ins will be months and ar to ensure ident specific uence with ng forms. A r monitoring will be audit- ths and then ensure grad-	2/19/14	

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED		
		245619	B. WING	·		01/10/2014		4	
	ROVIDER OR SUPPLIER	LAKE	•	5	TREET ADDRESS, CITY, STATE, ZIP CODE 200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLE DATE	TION	
F 329	Trazodone through contribute to falls for for side effects." - The CAA for cogn 6/19/13, identified I indicated, "Resider dementia and cogn R27's physician's F - On 9/5/13, the nu R27 and, "Patient of complaints." The nu Mood, memory, aff The note further ind [sic] PRN and Que for sleepSince las removed from hosp - On 10/11/13, the R27 and identified, normal. Dementia: isses [sic] noted. P have haldol [sic]" A from 9/5/13, identif Hospice, the MD P on hospice no new - On 11/22/13, the new complaints, R2 sometimes that thin [the facility]." The r behaviors reported any previous visits 'Have people been Although the physic appropriately review psychiatric data, th of indication for the medication. The no	at also takes scheduled out the day which could or resident. Staff is monitoring hitive loss/dementia dated R27's decline in cognition and at does have a diagnosis of hition fluctuates." Progress Notes indicated: rse practitioner (NP) had seen offers no concerns or ote indicated, "Psychiatric: ect and judgement normal." dicated, "Currently on haldol tiapine. Uses trazaDCSe [sic] st visit, patient has been bice [sic]." medical doctor (MD) had seen "Psychiatric: Her behavior is Stable no behavioural [sic] t [patient] does not to [sic] Ithough the Progress Note ied R27 was no longer on rogress Note contradicted, "Pt concerns." NP indicated R27 offered no 27 felt "discouraged ngs are so slow around here note indicated, "Dementia - No from staff. Pt unable to recall from MD or NP, however. meeting behind my back?"" cian's progress notes wed R27's mood, behavior and e documentation reflected lack ongoing use of antipsychotic ites lacked review of R27	F	329	A summary of these audits will be en to the Director of Clinical Serv Audits and trends will be reviewe Quality Improvement committee n ing. Director of Clinical Services responsible for compliance.	ices. d at meet-	2/19/1	14	
EOBM CMS-25	sleep and Trazodou		1	Far	cility ID: 27752 If continuat	ion sheet	Page 37	of 62	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 01/28/2014 FORM APPROVED OMB NO 0938-0391

STATEMENT	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CL (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER	IA (X2) N		PLE CONSTRUCTION G	0	(X3) DAT	E SURVEY IPLETED
		245619	B. WI	NG			01/	10/2014
	PROVIDER OR SUPPLIER	LAKE			STREET ADDRESS, CITY, STATE, ZIP 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULI SC IDENTIFYING INFORMATION	L PR	ID EFIX AG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD	BE	(X5) COMPLETION DATE
F 329	Continued From pa	age 37		F 329	9			
	changes in R27's c problem of "feeling had the behavior of days during the ass remained independ The Psychotropic N 11/26/13, identified medications were S behaviors and occu medications were, occurrence on day evening shift, and r The indications for were, "Agitation/Re on day shift, one oc no occurrences on indicated R27 had ne effects when last as the review indicated the behaviors were antipsychotic use a indications for use. review identified low behaviors, the revie GDR of the antipsy Review of the Cher dated 11/26/13, ind - The assessment reviewed was "Traz goal of, "Diagnosis decrease agitation asleep, stay asleep restful sleep hours. - Indications for the	Medication Review dated R27's current psychotro Seroquel and Haldol. The Irrences listed for both "Refusal of cares: One shift, no occurrences on no occurrences on night use for both medications stlessness: No occurren currence on evening shi night shift." The assess no involuntary movemen sessed on 10/22/13. Alt d a review of the behavior not appropriate for nd did not reflect approp In addition, although the w numbers of the target aw did not address a pote chotic medications. mical Restraint assessme icated the following: identified the medication caDCSe," with the therap is sleep/agitation. Goal i and increase ability to fa , and increase the numb	rgy;" 1-3 pic shift." ces ff, and nent t side hough rrs, riate ential ent being eutic s to Il er of					
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event I	D:RNX611	F	acility ID: 27752	continuatio	on sheet f	Page 38 of 62

CENTER	<u>AS FOR MEDICARE</u>	<u>= & MEDICAID SERVICES</u>	_		(<u>JVIB INO.</u>	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
		245619	B. WIN	IG		01/	10/2014
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SAINT TI	HERESE AT OXBOW	LAKE			5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443	- <u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	address the indicat medication were "1 feelings, redirection environment for sle - The efficacy secti indicated, "No nursi describes agitation - The GDR section "Will address with 1 - The resident input "Resident offers no sleep or feeling tire The assessment in plan updates "at th Although the asses GDR with the physi evidence the physi potential GDR for lacked evidence th Haldol were assess restraints or if a GI antipsychotic medi clinical record lack a GDR was clinica addition, the asses antipsychotic indica verbal aggression, of Trazodone (an a The care plan date at risk for behavior insomnia, and agit Alzheimer's demer I [R27] currently re manage these beh personality and try	" cological interventions to tions for the use of the 1:1, reassurance, validation n, provide quiet, dark eep." ion of the assessment sing documentation noted th nor sleeplessness." nof the assessment indicate the physician this quarter." ut/education section indicate to c/o [complaints of] inability ed/not rested in the morning indicated R27 required no ca is time." ssment referred to address sician, the clinical record lac ician was consulted regardi Trazodone. The clinical record ne use of Seroquel and PRN sed as potential chemical	of nat ed, ed, ite are the ked ng a ord l why In ded use was is, id, "	- 329			
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID:	RNX611	Fa	acility ID: 27752 If continua	tion sheet	Page 39 of 62

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	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUC			E SURVEY PLETED
		245619	B. WING	B. WING		01/1	10/2014
	PROVIDER OR SUPPLIER	LAKE	STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EAC	OVIDER'S PLAN OF CORRECTIO H CORRECTIVE ACTION SHOULE REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	information regardi and/or care." The c "Monitor/Observe fi insomnia, and susp paranoia and notify doctor/nurse practi if I resist ADL care MD/NP as needed which could lead to as needed when I a residents. Remind information about c Chemical Restraint plan update was wa care plan did not id sleep, lacked a foc non-pharmacologic sleep. In addition, t for monitoring and patterns. Although for behaviors" of pa insomnia, and agita did not identify curr use of antipsychotic specific behaviors t diagnoses. During all dates of 1/10/14, R27 was of concerns, was plea appropriately with s Review of the Medi (MARs) from Janua 2013 indicated the - The September, (December 2013 M.	that I cannot receive ing other residents health care plan directed, for restlessness, agitation, piciousness/fearfulness r/t y nurse and MD/NP [medical itioner] as needed. Notify Nurse or I refuse to eat. Notify if I resist taking medications, o medical decline. Redirect me ask questions about other me that I cannot receive other residents." Although the t assessment indicated no care farranted on 11/26/13, R27's dentify the use of Trazodone for tus for sleep and cal interventions to promote the care plan lacked direction evaluation of R27's sleep the care plan identified a "risk aranoia, restlessness, ation diagnoses; the care plan rent behaviors warranting the ic medication or resident to reflect the above listed the survey 1/7/14, through observed to have no behavioral asant and interacted staff and other residents.		329			
FORM CMS-25	567(02-99) Previous Versions	s Obsolete Event ID: RNX61	1	Facility ID: 27752	If continuat	ion sheet F	Page 40 of 62

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	TS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPI		(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPL		PLETED		
		245619	B. WING	-		01/	10/2014
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SAINT T	HERESE AT OXBOW	LAKE			5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	"Sleep/Agitation." 1 medications were a PRN Haldol doses - The January 2014 Seroquel and Traz administered as or 1/1/14, at 5:00 a.m administered. The PRN antipsychotic Review of the Trea (TARs) from Janua 2013 indicated beg Sleep" was monito included the numb 2:45 p.m. and 10:4 R27 occasionally s rarely slept by 2:45 hours of sleep doc clinical record lack patterns, such as e usually sleeping fo R27's nursing Prog from 9/4/13, throug following: - On 9/4/13, at 4:59 of Sleep, Did not s [twice] to void, and a.m.]. Offers no co states 'one of those [sic] well'" At 7:27 "Resident was eas identified R27 aske facility and R27 sta note indicated the updated and the ho	zodone was offered for Fhe MARs indicated both administered as ordered. No	F	329			

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<u> </u>	15 FUR MEDICARE	& MEDICAID SERVICES			<u> </u>	MP NO.	0920-0291
	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		245619	B. WING	i		01/	10/2014
	PROVIDER OR SUPPLIER	LAKE		5	STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	said she was not hu accepted her show behaviors. - On 9/5/13, at 1:46 weight taken. - On 9/18/13, at 4:5 "Resident refused shave it tomorrow. V clinical record did m received the next d - On 10/23/13, at 10 refused the shower - On 11/20/13, at 10 refused the shower - On 12/4/13, at 10 refused the shower - On 12/4/13, at 10 refused the shower - On 12/4/13, at 10 refused the shower - On 1/1/14, at 5:01 medication adminis Administration Note Administration was identify the PRN mu the medication was effe The clinical record of clinical indication antipsychotic medic On 1/9/14, at 1:13 p nurse (LPN)-B state was documented in "LH Nursing Docum of the binder includ documentation of ta R27 indicated the r	e, R27 grew "agitated and ungry." The note indicated R27 er and had no further 5 p.m. R27 refused to have her 5 p.m. a note indicated, shower tonight. Said she will (SS [vital signs stable]." The iot indicate if the shower was ay. 0:48 p.m. a note indicated R27 5. 0:53 p.m. a note indicated R27 7. 0:6 p.m. a note indicated R27 7. 1. 1. 1. 1. 2. Effective." The note did not edicated, "PRN 1. Effective." The note did not edication administered, why 1. 2. Effective. The note did not edication administered, why 2. administered and how the ective. 1. 1. 2. D.m. the licensed practical ed target behavior monitoring 1. a light blue binder labeled nentation." The Behaviors tab ed Target Behavior Forms for arget behaviors. The forms for esident was monitored for the lated to "Seroquel/Haldol" use. rs information included nent freq [frequency] per shift.":	F	329			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 01/28/2014 FORM APPROVED OMB NO 0938-0391

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILC		LE CONSTRUCTION	(X3) DATI	(X3) DATE SURVEY COMPLETED	
		245619	B. WING		01/	10/2014		
_	PROVIDER OR SUPPLIER	LAKE		5	STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROF DEFICIENCY)		BE	(X5) COMPLETION DATE	
F 329	documented for "Agevening shift; a "+" of care" on the day "+" indicated the bedocumentation did times the behavior documentation for the R27 had no further September. - In both October and documentation indi- target behaviors of "Agitation/Restlessed behaviors identified November. - In December 2013 all hash marks for be month. Although or "Agitation/Restlessed target behaviors be documentation indi- marks and initialed specified for R27. Sehaviors were blan- identified in the moo- - In January 2014, I of cares and agitati- indicated no documentation indi- specified for R27. Sehaviors were blan- identified in the moo- - In January 2014, I of cares and agitati- indicated no documentation indi- specified for R27. Sehaviors January 2014. The target behaviors January 2014. The target behaviors 2013 through Januar	cated a "+ [plus sign]" was gitation/restlessness" on the was documented for "Refusal shift of 9/5/13. Although the abavior occurred, the not include the number of occurred (frequency). The the rest of the month indicated behaviors for the month of and November 2013, the cated all hash marks for both "Refusal of cares" and ness." R27 had no target l in the months of October and 8, the documentation indicated both target behaviors the entire ally "Refusal of cares" and ness" were identified as the ing monitored, the cated staff documented hash for target behaviors not Spaces for both target the. No target behaviors were the of December. R27 was monitored for refusal on/restlessness. The form entation for any shift from "-" (hash mark) was dically the rest of the month; were identified in early " monitoring indicated R27 had al problems since September ary 2014 (for approximately d not support the ongoing use	F	329				

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CENTER	RS FOR MEDICARE	<u> & MEDICAID SERVICES</u>			(<u>)MR NO.</u>	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED
		245619	B. WING	i		01/	10/2014
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
SAINT TH	HERESE AT OXBOW	LAKE			5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	coordinator (RN)-B - When asked if R2 both staff verified F to R27 on 1/1/14. - When LPN-B was were monitored in a antipsychotic media would "look for agit described these as antsy." LPN-B furth restlessness as "pa all sorts of things;" R27 as being "upse "non-verbal commu something with you - When asked wha administering PRN there was a note in the medication was clinical record did r warranting the use - When asked then the documentation, was a "negative" and behavior occurred on it." - RN-B verified the behavior the faci had an order for Ha discontinued." - RN-B verified she assessed for GDR RN-B stated GDRs "Chemical Restrain"	p.m. LPN-B and the clinical , were interviewed together. 27 had received PRN Haldol, PRN Haldol was administered a asked what target behaviors relation to the use of the cations, LPN-B stated staff ation, restlessness," and , "If she's [R27's] getting her gave examples for acing, rummaging, getting into for agitation LPN-B described et" and staff would observe for unication" such as "doing ir hands." t the indication for Haldol was, LPN-B verified the clinical record identifying s "effective," LPN-B verified the not include a behavior of the drug. meaning of the hash marks in , LPN-B stated the hash mark in a "plus sign [+]" indicated a and we "put a progress note indications for use and target g were not resident specific, ons for the use of PRN Haldol pecific. RN-B stated R27 was lity enrolled in Hospice and aldol which was "not was unclear when R27 was with the use of antipsychotics. were addressed either on the	F	329			

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE				X3) DATE SURVEY COMPLETED	
		245619	B. WING			01/	10/2014	
	PROVIDER OR SUPPLIER	LAKE		5	STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		BE	(X5) COMPLETION DATE	
F 329	did not indicate a G indicate if the physi GDR and verified th clinical rational why contraindicated. - RN-B verified R27 unclear which facilit monitor and evalua efficacy of the Traze clinical record lacke R27's sleep or the to been evaluated. On 1/9/14, at 2:31 p (CP)-F was contact the indications for th Seroquel should be she had alerted the monitoring needed verified restlessness enough of a clinical the reasons should CP-F stated indicat monitoring and dete the pharmacy, but v included in the audi monitoring should F determine the ongo On 1/10/14, at 9:04 services (DCS) stat indications for use o she would "look at 1" "what she [R27] wa affected her or othe specific target behaver verified restlessness resident specific incoments.	ge 44 DR was attempted, did not cian was notified of a potential ne clinical record lacked a GDR was clinically "s sleep was tracked, but was ty staff were supposed to te the sleep data to determine odone. RN-B verified the ed documented evidence use of Trazodone had ever o.m. the consultant pharmacist red via telephone and verified he use of PRN Haldol and "expanded on." CP-F stated facility Target Behavior to be "expanded on." CP-F s and agitation was not indication for use and stated have been noted on review. ions for use, target behavior ermining GDR was audited by was unclear if R27 was t. CP-F verified the sleep have been evaluated to sing efficacy of Trazodone. a.m. the director of clinical red when determining of a psychotropic medication, the behaviors" and determine s doing" and "how it [behavior] ers" and agitation were not dications for the ongoing use th Haldol. DCS confirmed	F	329				

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OMB NO 0938-0391

CENTER	AS FUR MEDICARE	& MEDICAID SERVICES					0300-0031	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	l		E SURVEY IPLETED	
		245619	B. WING			01/1	0/2014	
NAME OF F	PROVIDER OR SUPPLIER	1		STREET ADDRESS,	CITY, STATE, ZIP CODE			
	ICDEOC AT OVDOW			5200 OAK GROVE	PARKWAY			
SAINT II	HERESE AT OXBOW	LAKE		BROOKLYN PAR	RK, MN 55443			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CO	ER'S PLAN OF CORRECTIOI RRECTIVE ACTION SHOULD ERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 329	Haldol on 1/1/14, s target behavior mo the clinical coordina assessments and b periods, target beh reviewed by the nu behaviors documen use of the antipsyc Trazodone sleep lo quarterly to determ and verified the clir for R27. The facility's Psych Monitoring policy a identified all reside alter behavior" wer diagnosis" and "rea medication. The po a "therapeutic goal - The policy further should be administ possible only after interventions to cor been attempted." T appropriate non ph attempt, directed to therapeutic goal" a related to the beha - The procedure dir behaviors to monit specific and approp Agitation, anxiety, a explicit behaviors is procedure directed antipsychotic media	administration of the PRN hould have been documented; nitoring should be reviewed by ator quarterly during the MDS between the MDS assessment avior monitoring should be rses. DCS verified R27 had no need to warrant the ongoing hotics. DCS verified egs should be evaluated ine efficacy of the medication nical record lacked evaluation hotoropic Medications and nd procedure dated 8/2012, nts receiving a medication "to e to have an "approved ason for use" of the blicy indicated there should be , and symptoms monitored." indicated, "The drug chosen ered in the lowest dose non pharmaceutical htrol/alter the behavior have The procedure identified harmaceutical interventions to o obtain "an approved nd diagnosis from MD/NP "as vior altering medication." rected to determine target or and "B. Behaviors must be oriate to the drug ordered. abusive, etc. need further dentified." In addition, the l, "C. Behaviors for use of cation must potentially be ful to self or others" and listed physical aggression "(hitting,	F3					
FORM CMS-28	567(02-99) Previous Versions	s Obsolete Event ID: RNX61	1	Facility ID: 27752	It continuat	ion sneet l	Page 46 of 62	

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FORM APPROVED
OMB NO. 0938-0391

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		245619	B. WING		,	01/1	0/2014
	PROVIDER OR SUPPLIER	LAKE		STREET ADDRESS, CITY, STAT 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN X (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD	BE	(X5) COMPLETION DATE
F 329	kicking, hurting self property, physical s non-aggression bel trying to leave with agitated behaviors sexual advances, e document on the "t and identified the "u responsible to eval and the Psychotrop Review would be u psychotropic medic - The policy indicat antidepressant use addressed on the C antidepressants sh RAI (Resident Asse CAAs) and docume - The policy indicat psychoactive medic per "regulation;" co pharmacy review, o and/or the family. T	F or others, destroying sexual advances)," physical haviors "(pacing, disrobing, but authorization)," verbally "(screaming, cursing, verbal etc.)" The procedure directed to arget behavior form" each shift Clinical Coordinator" would be uate the target behavior forms bic Medication Quarterly tilized to assess the effect of cations. ed, "F. Symptom(s) for must be identified and	F 3	329			
	the facility failed to for ongoing use of The Admission Red	quel 25 mg every Friday and identify, assess and monitor the medication. cord for R63 dated 12/4/13, s of dementia, aphasia, and					
FORM CMS-2	depression. The Order Summa revealed R63 was every bedtime and	ry Report dated 1/9/14, prescribed Seroquel 25mg 25mg every Friday for anxiety bath/shower on Friday	1	Facility ID: 27752	If continuat	ion sheet F	Page 47 of 62

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<u>CENTER</u>	IS FOR MEDICARE	A MEDICAID SERVICES			Ĺ	<u>IND NO.</u>	0920-0291
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245619	B. WING	I		01/-	0/2014
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	HERESE AT OXBOW	LAKE		5200 OAK GROVE PARKWAY			
				B	BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	dated 8/13/13, inclubath/sponge bath in physician 's order' medication) 0.25m, to dental procedure R63's annual MDS R63 had severely in daily decision maki communication onl one person for tran MDS indicated reje The Care Area Ass dated 11/5/13, indic dementia with agita with daily cares and Seroquel use. The statements of staff dead when staff att medications and no bathing. The psych 11/5/13, indicated F dementia with agita any non-pharmaco used for R63. The 11/5/13, indicated F make her needs kr The bathing care p R63 had a history of very agitated and u and identified R63 The care plan direc psychotropic medic not to wash R63's I provide a calm app during the shower.	ry Friday Seroquel orders uded directions of may try bed nstead. R63 also had a for Ativan (an anti-anxiety g for anxiety 30 minutes prior e. dated 11/5/13, established mpaired cognitive skills for ing, responded to simple direct ly, required physical help of nsfer only with bathing. The ection of care did not occur. sessment (CAA) for behaviors cated R63 had a diagnosis of ation, R63 had some behaviors d behaviors that required CAA noted R63 would make trying to kill her or wanting her tempted to give her oted some anxiety in regards to notropic medication CAA dated R63 was receiving Seroquel for ation. The CAA did not address logical interventions being communication CAA dated R63 was not always able to		329			
FORM CMS-25	67(02-99) Previous Versions	s Obsolete Event ID: RNX61	1	Fac	cility ID: 27752 If.continua	tion sheet I	Page 48 of 62

PRINTED:	01/28/2014
FORM	APPROVED
OMB NO	0038-0301

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245619	B. WING	à		01/	10/2014
	PROVIDER OR SUPPLIER	LAKE			STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	direction to offer a la Review of R63's Pr following: - On 7/26/13, the to get very agitated seemed very distre - On 8/2/13, the agitated during the aggressive to staff - On 8/3/13, the upset all shift, the w resident she "felt st shower "on evening nurse practitioner [I Ativan would be app reduce agitation an - On 8/9/13, the receive shower, beam mention of shower, go to bed after supp getting worse each - On 8/16/13, noi physically aggressiv The note indicated R63 every week. - On 8/23/13, the was given; resident swearing and strikin - On 9/13/13, the of Seroquel was giv not given, R63 was aggressive at menti R63 refused to ente got me last time, no - On 9/20/13, the given prior to R63's	he care plan did not include bed bath to R63. ogress Notes indicated the e note indicated R63 continued during the shower and ssed at the mention of shower. note indicated R63 was very shower, verbally very assisting with shower. note indicated R63 seemed vriter gathered from listening to aff hated her" since receiving shift last night." "Will update NP] to see if a small dose of propriate before showers to d anxiety." note indicated R63 did not came anxious and agitated at pleaded with writer to let her ber. Noted anxiety for shower week. ted R63 to be verbally and ve with staff during shower. the shower was upsetting for e note indicated R63's shower was very upset after shower, ng out at staff. note indicated an extra dose ren to R63. The shower was "very agitated and verbally on of shower," and indicated er spa room and told staff "you	F	329			

Facility ID: 27752

If continuation sheet Page 49 of 62

PRINTED: 01/28/2	2014
FORM APPRO	VED
OMB NO 0938-0	391

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245619	B. WING			01/1	0/2014
	PROVIDER OR SUPPLIER	LAKE		STREET ADDRESS, C 5200 OAK GROVE BROOKLYN PAR			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH COF	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD RENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	 given at 5:00 p.m., verbally aggressive On 10/4/13, the given prior to the sl R63 became "very and physically aggr R63 as very upset the point she starte. The note indicated her further. The not when staff left her a - On 10/25/13, th given a shower and noted. A physician Progre a nursing concern with cares, was get noted R63 had bee changes. A nurse practitione noted staff reported bathing and noted every bedtime, 12.3 and 25mg prior to v. The Target Behavid January 2014, indic of increased rambl and yelling out. Bel included for monito: When interviewed member (FM)-A rep bathing and did not 	e note indicated Seroquel was R63 was still physically and a. e note indicated Seroquel was nower. At mention of shower anxious," restless and verbally ressive. The note described after the shower and crying to ad having emesis (vomited). attempts to calm R63 agitated te indicated R63 calmed down alone. ne note indicated R63 was d verbal aggression was still ss Note dated 9/6/13, indicated of non-cooperative behavior tting aggressive at times and en on Seroquel with no r Progress Note dated 10/8/13, d behavioral issues with R63 received Seroquel 25 mg 5mg as needed for agitation weekly bath. or Forms from August 2013 - cated R63 had target behaviors ing speech, verbally agitated, naviors with bathing were not	F۵	329			
FORM CMS-28	567(02-99) Previous Versions	Obsolete Event ID: RNX61	1	Facility ID: 27752	lf continuati	on sheet F	Page 50 of 62

PRINTED: 01/28/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245619	B. WING	à	01	/10/2014	
	PROVIDER OR SUPPLIER	LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		JLD BE	(X5) COMPLETION DATE	
F 329	during and after bat used to take showe and did not know w On 1/9/14, at 9:24 a stated R63 did not 1 kick, yell and call ar NA-A reported notin behaviors since Set R63 now needed tw a shower. NA-A furt R63 a bed bath, R6 registered nurse (R very upset, verbally baths, and verified t since the Seroquel stated R63 was mu On 1/9/14, at 9:57 a (RN)-B stated R63's (an anti-anxiety me to use Seroquel. RN any notes about bel "doesn't tell" her, sh reported R63 got a bath per her family's On 1/9/14, at 12:27 again and stated it w got a shower every know a bed bath was she noted R63 was visited the day after On 1/9/14, at 12:39 services (DCS) stat need to have a show more comfortable for	thing. FM-A further stated R63 rs regularly without problems hat had caused the change. a.m. nursing assistant (NA)-A ike water and would scream, ngry names with showers. ng no difference in R63's roquel was started and stated to staff members to assist with ther stated when she gave 3 was "happy." At 9:34 a.m. N)-A stated R63 would get and physically abusive during the behavior had not improved was started on 8/13/13. RN-A ch calmer with a bed bath. a.m. the clinical coordinator is family had requested Ativan dication), but the staff wanted N-B stated she had not seen haviors with baths and if staff ie "doesn't know." RN-B shower weekly versus a bed is request. p.m. FM-A was interviewed was not a family request R63 week and stated she did not as an option. FM-A reported still very upset when she	F3	329			

Facility ID: 27752

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PRINTED: 01/28/2014 FORM APPROVED OMB NO. 0938-0391

UENTER	13 FUR MILDIUARL						0000 0001
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` <i>'</i>		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245619	B. WING	i	·	01/	10/2014
	PROVIDER OR SUPPLIER	LAKE		52	TREET ADDRESS, CITY, STATE, ZIP CODE 200 OAK GROVE PARKWAY ROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329 F 428 SS=D	antipsychotic for ba On 1/9/14, at 1:44 J stated he ordered S did not like the side MD-A further stated that was what he us MD-A stated he wo explain things to re comfort before star behavior. 483.60(c) DRUG R IRREGULAR, ACT The drug regimen of reviewed at least of pharmacist. The pharmacist muthe attending physi	sed prior to using an thing. c.m. R63's physician (MD)-A Seroquel for R63 because he effects of benzodiazepines. d he used Seroquel because sually used in nursing homes. uld expect facility staff to sidents to increase their ting any medications for EGIMEN REVIEW, REPORT		428	Corrective action for residents in- volved: Consultant pharmacist reviewed F medications for irregularities. Hal PRN was discontinued and Seroc was decreased. Care plan and ta behaviors were updated to accura reflect need for medication. Diago for medication was reviewed by p cian and updated. Will continue to monitor effectiveness of medication	ldol quel arget ately nosis hysi- o	2/19/14
	by: Based on interview facility's consultant irregularities with th Haldol (both antips	NT is not met as evidenced w and document review, the pharmacist failed to identify the use of Seroquel and PRN ychotic medications) for 1 of 5 he sample reviewed for cations.			How to identify other residents po- tially affected: All residents receiving psychotrop medications will be reviewed for a proved diagnosis, appropriate targ behaviors, care plan up to date an include non-pharmacy intervention	ic p- get	
			1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RNX611

Facility ID: 27752

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PRINTED: 01/28/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245619	B. WING			01/	10/2014
	PROVIDER OR SUPPLIER	LAKE		52	TREET ADDRESS, CITY, STATE, ZIP CODE 200 OAK GROVE PARKWAY ROOKLYN PARK, MN 55443		·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	Physician's orders received quetiapine milligrams (mg) by of sleep (HS); Hald "Agitation/restless sublingual (under th PRN. The Physicia diagnoses to incluc dementia without b Alzheimer's disease The Psychotropic N 11/26/13, identified medications were, behaviors and occu medications were, occurrence on day evening shift, and r The indications for were, "Agitation/Re on day shift, one oc no occurrences on indicated R27 had effects when last at Review of the Cher dated 11/26/13, ind - The assessment reviewed was "Traz therapeutic goal of Goal is to decrease to fall asleep, stay number of restful s - Indications for the "Sleeplessness, ag inability to redirect. - The non-pharmac	dated 11/7/13, indicated R27 a fumarate (Seroquel) 50 mouth (PO) daily at the hour ol 0.25 milliliters (ml) PO for ess/abusive behaviors" ne tongue) every four hours n's Orders identified R27's le unspecified psychosis, ehavioral disturbance, e, and encephalopathy. Medication Review dated R27's current psychotropic Seroquel and Haldol. The urrences listed for both "Refusal of cares: One shift, no occurrences on no occurrences on night shift." use for both medications stlessness: No occurrences ccurrence on evening shift, and night shift." The assessment no involuntary movement side ssessed on 10/22/13. mical Restraint assessment icated the following: dentified the medication cadone [sic]," with the "Diagnosis is sleep/agitation. a agitation and increase ability asleep, and increase the leep hours."	F	428	Measure/Systemic changes to endeficient practice will not reoccur: All resident's medication will be reviewed for irregularities by the Cosultant Pharmacist monthly. Eduction provided to nurses during placorrection education sessions the week of February 10, 2014 in regito monitoring for behaviors, approdiagnosis for medication and asserinterventions are in place and door mented. How to monitor: All resident's medications will be riviewed for irregularities by the Cosultant Pharmacist monthly. Recomendations will be given to the ating physician and the Director of Ning for review. Consultant pharmacist's quarterly reports will be reviewed at the facility quality improment committee meetings every the months and also reviewed by the cal coordinators. Director of Clinic Services is responsible for compliance.	e- on- ca- n of ards oved uring cu- e- n- m- tend- Nurs- a- ve- nree clini- cal	2/19/14

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F428 Continued From page 53 F 428 F 428 Continued From page 53 F 428 The efficiency section of the assessment indicated, "No nursing documentation noted that describes agitation or sleeplesmes." • The efficiency • The officiency section of the assessment indicated, "No nursing documentation noted that describes agitation or sleeplesmes." • The efficiency • The officiency section of the assessment indicated, "Will address with the physician this quarter." • The officiency of inability to sleep or feeling tired/not rested in the morning." • The assessment indicated R27 required no care plan updates "at this time." Although the assessment referred to address the GDR with the physician, the clinical record lacked evidence the physician, was consulted regarding a potential GDR. The clinical record lacked evidence a GDR for the use of Seroquel or Haldol was attempted or a reduction was clinically contraindicated. The care plan dated 12/13/13, identified R27 was at risk for behaviors of "(paranoia, restlessness, insomnia, and agitation) r/1 (related to] AZbeimer's dementia." The care plan identified, "I [R27] currently receive Seroquel every HS to manage these behaviors. I have a strong personality and try to become involved in other residents personal business at times. I do not		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SU IDENTIFICATIO			TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SAINT THERESE AT OXBOW LAKE STREET ADDRESS, CITY, STATE, ZIP CODE (M4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG IP ORTIFICATION (F4 20) (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG IP ORTIFICATION F 428 Continued From page 53 feelings, redirection, provide quiet, dark environment for sleep." F 428 - The efficacy section of the assessment indicated, "No nursing documentation noted that describes agitation or sleeplesenses." F 428 - The efficacy section of the assessment indicated, "Will address with the physician this quarter." F 428 Orden to Step." - The resident input/education section indicated, "Resident offers no c/o (complaints of) inability to sleep or feeling itred/no trested in the morning." The assessment indicated R27 required no care plan updates "at this time." Although the assessment referred to address the GDR with the physician was consulted regarding a potential GDR. The clinical record lacked evidence the physician was consulted regarding a potential GDR. The clinical record lacked evidence a GDR for the use of Seroquel or Haldol was attempted or a reduction was clinically contraindicated. The care plan dated 12/13/13, identified R27 was at risk for behaviors of "(paranoia, restlessness, insomnia, and agitation) rif (related to) Alzheimer's dementa." The care plan identified, " 11 [R27] currently receive Seroquel every HS to manage these behaviors. I have a strong personal business at times. I do not			245	619	B. WING			01/1	0/2014
PREPX TAG (EACH ODRECTIVE ACTION SHOULD BE REQULATORY OR LSC IDENTIFYING INFORMATION) PREFX TAG CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY COMPLETION DEFICIENCY F 428 Continued From page 53 feelings, redirection, provide quiet, dark environment for sleep." - The efficacy section of the assessment indicated, "No nursing documentation noted that describes agitation or sleeplessness." - The GDR section of the assessment indicated, "Will address with the physician this quarter." - The resident input/education section indicated, "Resident offers no c/o [complaints of] inability to sleep or feeling tired/not rested in the morning." The assessment indicated R27 required no care plan updates "at this time." Although the assessment referred to address the GDR with the physician was consulted regarding a potential GDR. The clinical record lacked evidence the physician was consulted regarding a potential GDR. The clinical record lacked evidence a GDR for the use of Seroquel or Haldol was attempted or a reduction was clinically contraindicated. The care plan dated 12/13/13, identified R27 was at risk for behaviors. I have a strong personality and try to become involved in other residents personal business at times. I do not			LAKE			5200 OAK GROVE	PARKWAY		
 feelings, redirection, provide quiet, dark environment for sleep." The efficacy section of the assessment indicated, "No nursing documentation noted that describes agitation or sleeplessness." The GDR section of the assessment indicated, "Will address with the physician this quarter." The resident input/education section indicated, "Resident offers no c/o [complaints of] inability to sleep or feeling tired/not rested in the morning." The assessment indicated R27 required no care plan updates "at this time." Although the assessment referred to address the GDR with the physician was consulted regarding a potential GDR. The clinical record lacked evidence the physician was consulted regarding a potential GDR. The use of Seroquel or Haldol was attempted or a reduction was clinically contraindicated. The care plan dated 12/13/13, identified R27 was at risk for behaviors of "(paranoia, restlessness, insomnia, and agitation) r/t [related to] Alzheimer's dementia. The care plan identified, " 1 [R27] currently receive Seroquel every HS to manage these behaviors. I have a strong personality and try to become involved in other residents personal business at times. I do not 	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECED	ED BY FULL	PREFI	X (EACH COF	RECTIVE ACTION SHOULD ERENCED TO THE APPROPI	BE	COMPLETION
always understand that I cannot receive information regarding other resident 's health and/or care." The care plan directed, "Monitor/Observe for restlessness, agitation, insomnia, and suspiciousness/fearfulness r/t paranoia and notify nurse and MD/NP [medical doctor/nurse practitioner] as needed. Notify Nurse if I resist ADL care or I refuse to eat. Notify MD/NP as needed if I resist taking medications, which could lead to medical decline. Redirect me as needed when I ask questions about other FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: RNX611		feelings, redirection environment for sle - The efficacy secti- indicated, "No nurs describes agitation - The GDR section "Will address with t - The resident inpur "Resident offers no sleep or feeling tire The assessment in plan updates "at the Although the asses GDR with the physi- evidence the physi- evidence the physi- evidence a GDR for was attempted or a contraindicated. The care plan date at risk for behaviors insomnia, and agita Alzheimer's demen I [R27] currently red manage these behaviors information regardi and/or care." The c "Monitor/Observe fi insomnia, and susp paranoia and notify doctor/nurse practi- if I resist ADL care MD/NP as needed which could lead to as needed when I a	h, provide quiet, ep." on of the assess ing documentat or sleeplessness of the assessm he physician thi t/education sect c/o [complaints d/not rested in t dicated R27 rec is time." sment referred ician, the clinica clan was consul clinical record r the use of Ser reduction was d 12/13/13, iden s of "(paranoia, ation) r/t [related tia." The care p ceive Seroquel e aviors. I have a to become invol business at time that I cannot re ng other resider are plan directe or restlessness, biciousness/fear nurse and MD/ tioner] as neede or I refuse to ea if I resist taking medical decline ask questions al	sment ion noted that ss." ent indicated, s quarter." ion indicated, s of] inability to he morning." quired no care to address the l record lacked ted regarding a lacked oquel or Haldol clinically htified R27 was restlessness, I to] lan identified, " every HS to strong lved in other es. I do not ceive ht ' s health ed, agitation, fulness r/t /NP [medical ed. Notify Nurse it. Notify medications, e. Redirect me bout other					Deco. 54 of 62

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 245619 B. WING 01/10/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 01/10/2014 SAINT THERESE AT OXBOW LAKE STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH ODEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH ODEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETION PATE F 428 Continued From page 54 residents. Remind me that I cannot receive information about other residents." The care plan did not identify the use of Trazodone for sleep, lacked a focus for sleep and non-pharmacological interventions to promote sleep. In addition, the care plan lacked direction for monitoring and F 428			a MEDICAID SERVICES				. 0300-0031
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SAINT THERESE AT OXBOW LAKE STREET ADDRESS, CITY, STATE, ZIP CODE SOUD OAK GROVE PARKWAY BROOKLYN PARK, MN 55443 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX CROSS-REFERENCED TO THE APPROPRIATE COMPLETION PATE DEFICIENCY) F 428 Continued From page 54 F 428 F 428 F 428 Continued From page 54 F 428 residents. Remind me that I cannot receive information about other residents." The care plan did not identify the use of Trazodone for sleep, lacked a focus for sleep and non-pharmacological interventions to promote sleep. In addition, the F 428							
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SAINT THERESE AT OXBOW LAKE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE F 428 Continued From page 54 residents. Remind me that I cannot receive information about other residents." The care plan did not identify the use of Trazodone for sleep, lacked a focus for sleep and non-pharmacological interventions to promote sleep. In addition, the F 428			245619	B. WING	à	01	/10/2014
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLÉTION DATE F 428 Continued From page 54 residents. Remind me that I cannot receive information about other residents." The care plan did not identify the use of Trazodone for sleep, lacked a focus for sleep and non-pharmacological interventions to promote sleep. In addition, the F 428			LAKE		5200 OAK GROVE PARKWAY	•	
residents. Remind me that I cannot receive information about other residents." The care plan did not identify the use of Trazodone for sleep, lacked a focus for sleep and non-pharmacological interventions to promote sleep. In addition, the	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF	IX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	ULD BE	(X5) COMPLETION DATE
evaluation of R27s sleep patterns. Review of the Medication Administration Records (MARs) from January 2014 through September 2013 indicated the following: - The September, October, November and December 2013 MARs indicated Seroquel was offered for the diagnoses of "Alzheimer's Dementia" and Trazodone was offered for "Sleep/Agitation." The MARs indicated both medications were administered. - The January 2014 MAR indicated scheduled Seroquel and Trazodone medications were both administered as ordered. MAR indicated on 1/1/14, at 5:00 a.m. R27 had PRN Haldol administered. Review of the Treatment Administration Records (TARs) from January 2014 through September 2013 indicated beginning on 5/28/13, "Hours of Sleep" was monitored. The documentation included the number of hours slept by 6:45 a.m., rarely slept 2:45 p.m. and Usably by 6:45 a.m., rarely slept 2:45 p.m. and Usably had eight hours of sleep documented at 10:45 p.m The Clinical record lacked evaluation of R27s sleep patterns, such as efficacy of Trazodone and R27 usually sleeping for eight hours during the night. R27's nursing Progress Notes were reviewed from 9/4/13, through 1/8/14 and revealed the		residents. Remind information about o did not identify the u lacked a focus for s interventions to pro care plan lacked din evaluation of R27's Review of the Medii (MARs) from Janua 2013 indicated the - The September, C December 2013 M/ offered for the diage Dementia" and Traz "Sleep/Agitation." T medications were a PRN Haldol doses - The January 2014 Seroquel and Trazc administered as orc 1/1/14, at 5:00 a.m. administered. Review of the Treat (TARs) from Januar 2013 indicated begi Sleep" was monitor included the numbe 2:45 p.m. and 10:45 R27 occasionally sl rarely slept 2:45 p.n of sleep documente record lacked evalu such as efficacy of sleeping for eight ho	me that I cannot receive ther residents." The care plan use of Trazodone for sleep, sleep and non-pharmacological mote sleep. In addition, the rection for monitoring and sleep patterns. cation Administration Records ry 2014 through September following: Dctober, November and ARs indicated Seroquel was noses of "Alzheimer's zodone was offered for he MARs indicated both idministered as ordered. No were administered. MAR indicated scheduled bodone medications were both dered. MAR indicated on R27 had PRN Haldol ment Administration Records ry 2014 through September inning on 5/28/13, "Hours of ed. The documentation er of hours slept by 6:45 a.m., 5 p.m. The TARs indicated ept 0.5-1 hour 6:45 p.m., n. and usually had eight hours ed at 10:45 p.m. The clinical lation of R27s sleep patterns, Trazodone and R27 usually ours during the night. ress Notes were reviewed	F	428		

Facility ID: 27752

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CENTER	15 FOR MEDICARE	& MEDICAID SERVICES			<u>U</u>		0000-0001
IDENTIFICATION NUMPER:		(X2) MU A. BUILE			(X3) DATE SURVEY COMPLETED		
		245619	B. WING	ì		01/10/2014	
	PROVIDER OR SUPPLIER	LAKE		5	TREET ADDRESS, CITY, STATE, ZIP CODE 200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		
			1		1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 428	of Sleep Did not sle [twice] to void, and a.m.]. Offers no cou- states 'one of those [sic] well '" At 7:: "Resident was easi identified R27 aske facility and R27 sta note indicated the of updated and the ho to" R27. R27 refuse re-approached twic said she was not h accepted her show behaviors. - On 9/5/13, at 1:46 weight taken. - On 9/18/13, at 4:5 "Resident refused shave it tomorrow. V clinical record did r received the next of - On 10/23/13, at 1 refused the shower - On 11/20/13, at 10 refused the shower - On 12/4/13, at 10 refused the shower - On 11/14, at 5:01 medication adminis Administration Note Administration was identify the PRN m the medication was eff The clinical record	a.m. a note indicated, "Hours eep very well tonight. Up x2 incontinent at 0430 [4:30 mplaints of pain, discomfort, enights that cannot fall sleep 27 p.m. a note indicated, ly agitated today" and d for "bath soap" from the ting she "pays the bills." The clinical coordinator was buse supervisor "came to talk ed supper after being ee, R27 grew "agitated and ungry." The note indicated R27 er and had no further 5 p.m. R27 refused to have her 5 p.m. a note indicated, shower tonight. Said she will /SS [vital signs stable]." The not indicate if the shower was ay. 0:48 p.m. a note indicated R27 c. 066 p.m. a note indicated R27 c. 1 a.m. an "eMAR [electronic stration record]-Medication e indicated, "PRN : Effective." The note did not edication administered, why a administered and how the	F	428			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245619	B. WING			01/10/2014	
NAME OF PROVIDER OR SUPPLIER SAINT THERESE AT OXBOW LAKE				5200 C	T ADDRESS, CITY, STATE, ZIP CODE DAK GROVE PARKWAY DKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 428	antipsychotic media The Monthly Medic indicated from 4/23 consultant pharma- regiment. On 4/23/ (Seroquel) and Tra 11/20/13, the consu PRN Haldol was ac 11/19/13, and to ch documentation in of consultant pharma- identify irregularitie regimen. On 1/9/14, at 2:31 (CP)-F was contac the indications for t Seroquel should be she had alerted the monitoring needed verified restlessness enough of a clinica the reasons should Stated indications for the pharmacy, but included in the aud monitoring should determine efficacy On 1/10/14, at 9:04 services (DCS) ver review target beha "they've [consultan past." DCS verified member of the Qua	cations. ation Regimen Review k/13, to 12/18/13, the cist reviewed R27's medication 13, the use of Quetiapine zodone were identified. On ultant pharmacist identified no dministered from 11/1/13 - teck the psychotropic one to two months. The cist documentation did not s with R27's medication p.m. the consultant pharmacist ted via telephone and verified he use of PRN Haldol and e "expanded on." CP-F stated a facility the Target Behavior to be "expanded on." CP-F ss and agitation was not l indication for use and stated I have been noted on review. for use, target behavior ermining GDR was audited by was unclear if R27 was lit. CP-F verified the sleep have been evaluated to	F	128			

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
245619		B. WING	B. WING		01/10/2014		
NAME OF PROVIDER OR SUPPLIER SAINT THERESE AT OXBOW LAKE				STREET ADDRESS, CITY, STATE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55	ľ,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		ACTION SHOULD E	BE CO	(X5) MPLETION DATE
F 428	Monitoring policy a identified all resider alter behavior" wer diagnosis" and "rea medication. The policy a "therapeutic goal - The policy further should be administ possible only after interventions to cor been attempted." T appropriate non ph attempt, directed to therapeutic goal" a related to the beha - The procedure dii behaviors to monite specific and approp Agitation, anxiety, a explicit behaviors is procedure directed antipsychotic medii distressful or harm examples such as kicking, hurting sel property, physical s non-aggression be trying to leave with agitated behaviors sexual advances, e document on the "t and identified the " responsible to eval and the Psychotrop Review would be u psychotropic medio - The policy indicat antidepressant use	abortopic Medications and nd procedure dated 8/2012, nts receiving a medication "to e to have an "approved ason for use" of the blicy indicated there should be , and symptoms monitored." indicated, "The drug chosen ered in the lowest dose non pharmaceutical htrol/alter the behavior have The procedure identified harmaceutical interventions to botain "an approved nd diagnosis from MD/NP "as vior altering medication." rected to determine target or and "B. Behaviors must be priate to the drug ordered. abusive, etc. need further dentified." In addition, the I, "C. Behaviors for use of cation must potentially be ful to self or others" and listed physical aggression "(hitting, f or others, destroying sexual advances)," physical haviors "(pacing, disrobing, out authorization)," verbally "(screaming, cursing, verbal etc.)" The procedure directed to target behavior form" each shift Clinical Coordinator" would be luate the target behavior forms bic Medication Quarterly utilized to assess the effect of cations. ted, "F. Symptom(s) for a must be identified and		Facility ID: 27752		n sheet Para	58 of 62
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID: RNX6	11	Facility ID: 27752	If continuation	on sheet Pag	e 58 of 62

		AND HUMAN SERVICES				APPROVED
	RS FOR MEDICARE	IPLE CONSTRUCTION		0938-0391 E SURVEY		
		l` '	NG		PLETED	
ı.		245619	B. WING _		01/	10/2014
NAME OF F	PROVIDER OR SUPPLIER		Τ	STREET ADDRESS, CITY, STATE, ZIP CODE		
SAINT TI	HERESE AT OXBOW	LAKE		5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 428	addressed on the C antidepressants sh RAI (Resident Asse CAAs) and docume - The policy indicate psychoactive medic per "regulation;" co pharmacy review, c and/or the family. T "does not agree to rationale will be doo 483.60(b), (d), (e) I LABEL/STORE DR The facility must er a licensed pharmac of records of receip controlled drugs in accurate reconcilia records are in orde controlled drugs is reconciled. Drugs and biologic labeled in accordar professional princip appropriate access instructions, and th applicable. In accordance with facility must store a locked compartme	CPL (care plan); ould be evaluated with each essment Instrument, MDS and ented in the residents' chart. ed dosage reductions of cations would be attempted uld be initiated by MD/NP, ease manager, the resident 'he policy indicated if MD/NP dosage reduction, the cumented by the MD/NP." DRUG RECORDS, BUGS & BIOLOGICALS mploy or obtain the services of cist who establishes a system of and disposition of all sufficient detail to enable an tion; and determines that drug r and that an account of all maintained and periodically als used in the facility must be note with currently accepted oles, and include the tory and cautionary e expiration date when State and Federal laws, the all drugs and biologicals in nts under proper temperature it only authorized personnel to	F 4	 28 31 Corrective action for residents volved: Narcotic pain patches will be removed and destroyer nurses in sewer system. How to identify other residents tially affected: Currently no oth dents in facility with narcotic p patch. Measure/Systemic changes to deficient practice will not reoco Medication: controlled substar cy was updated on narcotic pain patches. All narcotic pain patch be removed and destroyed by licensed nurses. All licensed swere educated on new proceed disposal during plan of correct 	for R27 d by two s poten- ner resi- ain o ensure cur: nce poli- ain ches will two staff lure for ion edu-	2/19/14
		ovide separately locked, d compartments for storage of		cation session during the weel February 10, 2014.	< of	
FORM CMS-2	567(02-99) Previous Versions	S Obsolete Event ID: RNX61		Facility ID: 27752 If conti	nuation sheet	Page 59 of 62

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CENTER	AS FOR MEDICARE	& MEDICAID SERVICES			0	VID INU.	0920-0291		
				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		245619	B. WING			01/	10/2014		
	PROVIDER OR SUPPLIER	LAKE	STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 431	Comprehensive Dri Control Act of 1976 abuse, except when package drug distri quantity stored is m be readily detected	ted in Schedule II of the ug Abuse Prevention and and other drugs subject to n the facility uses single unit bution systems in which the ninimal and a missing dose can	F 4	31	How to monitor: All residents with narcotic pain pares will be audited monthly for the three months then quarterly for a priate disposal and documentation disposal of narcotic pain patches. Audits will be received by the Direction of the	next opro- n of	2/19/14		
-	by: Based on observat review, the facility f patches (a narcotic	NT is not met as evidenced tion, interview and document ailed to ensure Fentanyl (s) used to control pain) were ner to prevent potential resident (R27).			of Clinical Services and reviewed clinical coordinators. Trends and dit results will be reviewed at facil quality improvement committee m ings. Director of Clinical Services responsible for compliance.	by au- ity eet-			
	following was rando On 1/9/14, at 7:28 a nurse (LPN)-B state patch and offer an used to control pair observed to remove from a box, two sea remain in the box. I and recorded the n and Percocet in the - At 7:33 a.m. LPN- date and initials on - At 7:39 a.m. LPN- explained the medi the Percocet, a full took the medication then retrieved glove	a.m. the licensed practical ed she had to apply a Fentanyl oral Percocet (a narcotic(s) n) to R27. LPN-B was e one sealed Fentanyl patch aled patches were observed to LPN-B counted the patches umber of Fentanyl patches a Individual Narcotic Record. B opened the patch, wrote							

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CENTER	AS FOR MEDICARE	& MEDICAID SERVICES			Ĺ	<u> NNP NO</u>	0938-0391
		(X2) MUI A. BUILE		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245619	B. WING	í		01/	10/2014
NAME OF PROVIDER OR SUPPLIER SAINT THERESE AT OXBOW LAKE				5	BTREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 431	area. LPN-B was o patch in the empty and returned to the cupboard under the spent patch and Fe Sharps container (a dispose of sharp ha used medication ne container was "full" Sharps container a nursing station. LPI over to neighboring placed the spent Fe container under the be alone and did ne witness the disposa - At 8:30 a.m. LPN- dispose of the Fent container and state facility policies to di differently, "I was to putting anything oth container." LPN-B y policy and stated st coordinator (RN)-B - At approximately LPN-B (with survey patch disposal. RN could dispose of the container alone. On 1/9/14, at 9:05 a the Medications: Co and procedure data indicated, "D. Narco removed from resides sharps container on	tch to the right shoulder/back bserved to place the spent package. LPN-B left the room nurse 's station, opened the e sink and bent to place the ontanyl patch package in a a plastic container used to azardous equipment such as bedles). LPN-B stated the and stated she would use the t the other second floor N-B carried the spent patch unit nursing station and entanyl patch in the Sharps e sink. LPN-B was observed to of seek out another nurse to al of the narcotic patch. B stated she was trained to anyl patch in the Sharps d she was aware of other spose of the patches old there could be fines for her than Sharps in the was unclear on the actual ne was going to ask the clinical	F	431			

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Facility ID: 27752

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245619	B. WING	l		01/	10/2014
	PROVIDER OR SUPPLIER	LAKE		STREET ADDRESS, CITY, STATE, ZIP 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORF PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE A DEFICIENCY)		OULD BE COMPLÉT	
F 431	to dispose of or des The policy directed verify the amount o disposal of "medica nurse/nurse or nurs aide] present to with On 1/9/14, at 12:27 pharmacist (CP)-F CP-F stated "it was "recommendation" "flushed" and "witne surveyor explained Controlled Substan stated she was not she had not seen th not go through me, assurance], and it ' verified she was not of Fentanyl patches same as any narco high risk for diversite medication left in th give affect/relief." On 1/9/14, at 12:42 services (DCS) veri be disposed of eithe "flush them." DCS s consulted when the CP-F was not the s the policy identified patches should be the facility had not r witness the destruct	but verified the policy directed stroy "narcotics" with two staff. to "request another nurse to f drug being wasted" and attion in the sewer system with se/TMA [trained medication	F	431			

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

	STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BLDG		(X3) DATE SURVEY COMPLETED	
			245619	B. WING_		01/15/2014	
		PROVIDER OR SUPPLIER HERESE AT OXBOW I	LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
j.	K 000	INITIAL COMMENT	S	K 00	0		
6		FIRE SAFETY					
20. 2,		ALLEGATION OF C DEPARTMENT'S AC SIGNATURE AT TH PAGE OF THE CMS VERIFICATION OF			POC 04 18 2-7-14		
Ŷ		ON-SITE REVISIT C CONDUCTED TO V SUBSTANTIAL COM REGULATIONS HAS	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE ALIDATE THAT MPLIANCE WITH THE S BEEN ATTAINED IN ITH YOUR VERIFICATION.				
\$1-01-1		Minnesota Departme time of this survey, S was found not in sub requirements for par Medicare/Medicaid, 4 Life Safety from Fire National Fire Protect	42 CFR, Subpart 483.70(a), , and the 2000 edition of ion Association (NFPA) Safety Code (LSC), Chapter		RECEIVED	51	
KY.		PLEASE RETURN T CORRECTION FOR DEFICIENCIES (K-1	THE FIRE SAFETY		FEB - 7 2014		
1)		Healthcare Fire Inspe State Fire Marshal Di 445 Minnesota St., S St. Paul, MN 55101-8	ivision ulte 145		MN DEPT. OF PUBLIC SAFE STATE FIRE MARSHAL DIVISIO	Śm	
		By emall to:	_				
Č	Ang ny deliciency	statement ending with an	R/SURPLIER REPRESENTATIVE'S SIGNA	The Institut	Executive Director lon may be excused from correcting providing it	- 2 7 14 Is determined that	
ol fo di	ther safeguar blowing the d	ids provide sufficient/prote ate of survey whether or n the date these documents	ction to the patients. (See Instructions. of a plan of correction is provided. For) Except for nursing hor	r nursing homes, the findings stated above are o mes, the above findings and plans of correction are cited, an approved plan of correction is requi	lisclosable 90 days are disclosable 14	

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Facility ID: 27752

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01/15/2014

(X6) COMPLETION DATE

CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BLDG 245619 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **5200 OAK GROVE PARKWAY** SAINT THERESE AT OXBOW LAKE **BROOKLYN PARK, MN 55443** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX TAG id Prefix (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) K-050 Fire Drill Schedule. K 000 Continued From page 1 K 000 The facility fire drill schedule was Marlan.Whitney@state.mn.us updated to include fire drills on all THE PLAN OF CORRECTION FOR EACH shifts for each quarter. A night shift DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: fire drill is to be conducted on February 11th, 2014. 1. A description of what has been, or will be, done to correct the deficiency. The schedule was updated on 2. The actual, or proposed, completion date. 1/15/14 and the missing night shift fire drill will be conducted on 3. The name and/or title of the person responsible for correction and monitoring to 2/11/14. prevent a reoccurrence of the deficiency. Roy Krueger, Plant Operations DI-Oxbow Lake Care Center Is a 2-story building rector is responsible to ensure comwith a basement. The building was constructed in 2012 and was determined to be of Type II (111) pletion and ongoing monitoring. construction. It is automatic fire sprinkler The facility Safety Committee is protected throughout. The facility has a fire alarm system with smoke detection in the corridors and overseen by Roy Krueger. The Safespaces open to the corridors that is monitor for

capacity of 64 beds with a census of 60 at the implement an audit practice to entime of the survey. sure ongoing compliance with the The requirement at 42 CFR, Subpart 483.70(a) is fire drill schedule that will be moni-NOT MET as evidenced by: tored by the Safety Committee in-NFPA 101 LIFE SAFETY CODE STANDARD K 050 K 050 their quarterly meetings. Education SS=F Fire drills are held at unexpected times under has been provided to the staff at varying conditions, at least quarterly on each shift. Safety Committee meetings to en-The staff is familiar with procedures and is aware that drills are part of established routine. sure ongoing awareness. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded

fire department notification. The facility has a

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Event ID: RNX621

Facility ID: 27752

ty Committee met on 1/28/14 to

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1	· O	(X3) DAT	e Survey Pleted
245619			A, BUILDING	a 01 - MAIN BLDG		
	PROVIDER OR SUPPLIER HERESE AT OXBOW			STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443	1 01/	15/2014
(X4) ID Prefix Taq	(EACH DEFICIENG	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL 8C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X6) Completion Date
K 052 SS=F	announcement ma alarms. 18.7.1.2 This STANDARD I Based on review o interview, it was de to vary the times ar in the last 12-month practice could affect of a fire. Improper r the safety of all resi Findings include: On facility tour betw 12:30 PM on 01/15/ that there was no ni quarter of 2013. This deficient practi administrator at the NFPA 101 LIFE SAI A fire alarm system installed, tested, and with NFPA 70 Nation 72. The system has	y be used instead of audible s not met as evidenced by: f reports, records and termined that the facility failed ad dates of numerous fire drills a period. This deficient t how staff react in the event eaction by staff would affect dents. The between 9:30 AM and 2014, record review revealed ght shift fire drill for the third ce was verified by the time of the inspection. FETY CODE STANDARD required for life safety is d maintained in accordance nal Electrical Code and NFPA an approved maintenance complying with applioable	K 050	K 052 Fire Alarm System Test Ban-Koe, contracted Fire Panel of erator, ran a smoke detector sen tivity test per requirements on 1/20/14. Sensitivity test is attack to this document. Mayer Electric the contracted company for the facilities low voltage smoke detector system and the UL device cou- was contacted on 1/15/14 and pr vided a new, updated UL Certifica for 1/23/14. The annual fire alar test will be completed going for-	ned C, C- Ints ro- ate m	
	This STANDARD is Based on observati	not met as evidenced by:		ward within 365 days. Mayer ele tric provided a computer generat report for the annual Fire Alarm Inspection report.		

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Event ID: RNX621

Facility ID: 27762

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TATEMEN	T OF DEFICIENCIES	E & MEDICAID SERVICES		LE CONSTRUCTION	(X3) DAT	0938-039
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED		
		245619	B. WING		01/	15/2014
NAME OF	PROVIDER OR SUPPLIEF	1		TREET ADDRESS, CITY, STATE, ZIP CODE		
SAINT T	HERESE AT OXBOW	/ LAKE		200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES 37 MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	JD PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X6) COMPLETIO DATE
K 052 K 071 SS=F	review, the facility system in accorda deficient practice of Findings include: During facility tour PM on 01/15/2014 1. There is no doc detector sensitivity 2. The device cour the fire alarm acce 08/14/2012 and th dated 09/04/2013 is smoke detectors, of devices. There is identifying why the counts 3. The annual fire is completed within th 4. The "Initiating ar Inspection" checkb NFPA 72 Fire Alarm 09/04/2013 are may which is inconsiste generated form and Page 4 of the repo These deficient pra administrator at the NFPA 101 LIFE SA Rubbish Chutes, Im	failed to maintain the fire alarm nce with NFPA 72. This could effect all residents. between 9:30 AM and 12:30 , record review revealed that: umentation of the smoke test its between the UL Certificate, ptance report dated e annual inspection report reflect different number(s) of duct detectors and supervisory no supporting documentation re is a difference in device alarm inspection was not he required 365 days nd Supervisory Device Test and ioxes located on Page 3 of the in Inspection Report dated irked with a blue ball point pen nt with the rest of the computer d associated signatures on	K 052	K 052 Fire Alarm System Test The dates for completion are list above: sensitivity test complete 1/20/14, UL Device counts on 1/23/14 and next scheduled Fire Alarm Inspection is scheduled fo 365 days from initial Install of sys- tem, August of 2014. Roy Krueger, Plan Operations Dif- tor is responsible for follow up al ongoing compliance of reports an inspections. Facility will require reports to be computer generate by contractor	on r s- nd nd all	
	Chutes (1) Any existing line pneumatic rubbish	en and trash chute, including and linen systems, that opens rridor is sealed by fire resistive				

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

	t of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - Main Bldg	(X3) DATE SURVEY COMPLETED	
		245619	B. WING		01/15/2014	
	PROVIDER OR SUPPLIEI			STREET ADDRESS, CITY, STATE, ZIP COU 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION 8) CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X6) COMPLETION DATE
K 071	 construction to previate a fire door as rating of 1 hour. A section 9.5. (2) Any rubbish che pneumatic rubbish with automatic rubbish with automatic ext accordance with 9 (3) Any trash chute collection room us protected in accord (4) Existing flue-feed 	event further use or is provided sembly having a fire protection and linen chute, including and linen systems, is provided inguishing protection in .7. e discharges into a trash ed for no other purpose and dance with 8.4. d inclnerators are sealed by fire on to prevent further use.	К 07	K 071 Rubbish Chutes All trash chute doors have p fire rating markings installed show compliance. The first trash chute closes and latch properly. Trash is removed below the trash chute on a d sistent basis throughout the ensure trash does not overfi- block the chute. The fusible the trash chute door was co to be in compliance. Trash chute doors had proper rating markings installed on The first floor trash chute was on 1/15/14. Trash removal	d to floor es from con- day to low and link on nnected er fire 2/5/14. as fixed	
	Based on observa has trash chutes the requirements of LS and NFPA 82. This all residents. Findings include: During facility tour i PM on 01/15/2014, 1. There are no fire doors 2. The first floor tra close and latch	is not met as evidenced by: tion and Interview, the facility iat do not meet the GC Sections 18.5.4, 9.5 and 8.4 deficient practice could affect between 9;30 AM and 12;30 observation revealed that rating on the trash chute sh chute door does not fully trash collection room, the		on 1/15/14. Trash removal of flow happened on 1/15/14 a check system by maintenance implemented on 1/15/14. The ble link on the trash chute we paired on 1/15/14. Roy Krueger, Plant Operation rector is responsible for ongo monitoring of these practices has made the trash removal facility QM Process to be auco monthly.	ind new ce was ne fusi- as re- ns DI- bing s and part of	

EvenI ID:RNX621

Facility ID: 27752

If continuation sheet Page 5 of 7

(2)

		AND HUMAN SERVICES			RINTED: 01/28/20 FORM APPROVE MB NO: 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION IG 01 - MAIN BLDG	(X3) DATE SURVEY COMPLETED
		245619	B. WING_		01/15/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
SAINT T	HERESE AT OXBOW	LAKE		5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CHOSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETIO
SS=F	the trash chute doo 4. The fusible link for collection room trass disconnected. These deficient prace administrator at the NFPA 101 LIFE SAI Master alarm panels and have audible ar high/low alarms for NFPA 99, 4.3.1.2.2 This STANDARD is Based on record re failed to maintain the accordance with NF could effect all resid medical gases. Findings include: During facility tour be PM on 01/15/2014, r	ng the dumpster preventing r from closing or the basement trash	K 07	1	; tis thly d
K 144 SS=F	This deficient practic administrator at the t NFPA 101 LIFE SAF	e was verified by the ime of the Inspection. ETY CODE STANDARD acted weekly and exercised	K 144		
	7(02-99) Previous Versions C	bsolete Event ID; RNX621	Fa		lon sheet Page 6 of 1

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Event ID: RNX621

Facility ID: 27752

If continuation sheet Page 6 of 7

PRINTED: 01/28/2014 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO, 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING D1 - MAIN BLDG COMPLETED 245619 B, WING 01/15/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5200 OAK GROVE PARKWAY** SAINT THERESE AT OXBOW LAKE **BROOKLYN PARK, MN 55443** SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (X5) COMPLET(ON (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) **CRO86-REFERENCED TO THE APPROPRIATE** DATE DEFICIENCY) K 144 Generator testing K 144 Continued From page 6 K 144 Monthly generator test schedule under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. was updated to reflect a monthly test within the exact month. Dates of test will occur mld-month to comply with this requirement. This practice will be reviewed by facility Safety Committee guarterly. Week-This STANDARD is not met as evidenced by: Based on observation and Interview, the facility ly generator tests began on 1/21/14 falled to maintain the emergency generator in and followed weekly. accordance with the requirements of NFPA 110-1999 edillon, Section 6-4. This deficient Generator monthly test schedule practice could affect all residents. was updated on 1/15/14 and week-Findings Include: ly inspections began on 1/21/14 On facility tour between 9:30 AM and 12:30 PM and followed weekly. on 01/15/2014, record review revealed that 1. The monthly generator test for May was Roy Krueger, Plant Operations DIconducted in June and the September test was rector is responsible to oversee the conducted in October 2. The emergency generator has not been ongoing compliance of required inspected on a weekly basis. inspections of the generator. The These deficient practices were verified by the Safety Committee will run audits of administrator at the time of the inspection. this practice to ensure ongoing compliance quarterly.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID: RNX621

Facility ID: 27752

If continuation sheet Page 7 of 7

INSPECTION, TESTING, AND MAINTENANCE

MAYER ELECTRIC	INSPECTION AND TESTING FORM
SYSTEM SERVICES	DATE:
Energy Management - Fire Protection - Voice - Data - Security	TIME: 7AM
SERVICE ORGANIZATION	PROPERTY NAME (USER)
Name: MAYER ELECTRIC CORPORATION	Name: ST. THERESE AT OXBOW LAKE
Address: 7224 WINNETKA AVE N.	Address: 9751 REGENT AVE N.
BROOKLYN PARK, MN 55428	BROOKLYN PARK, MN 55443
Representative: JIM MORRIS	Owner Contact: ROY KRUEGER
License No.: CA01205	Telephone: (763) 493-7070
Telephone: (763) 537-9357	
MONITORING ENTITY	APROVING AGENCY
Contact: W-H INTERNATIONAL RESPONSE CENTER	Contact: BROOKLYN PARK FIRE INSPECTOR
Telephone: (800) 858-7811	Telephone: (763) 493-8020
Monitoring Account Ref. No.: SS9312	5
TYPE TRANSMISSION	SERVICE
U Multiplex	Monthly Quarterly
Reverse Polarity	Semiannually
RF	Annuaily
Other (Specify)	Other (Specify)
Control Unit Manufacturer: _EST	Model No.: _ lo 500
Circuit Class - Styles: B - 4	Software Rev.:
Number of Circuits: 1 SLC CIRCUIT	Firmware Rev.: 3-3
Last Date System Had Any Service Performed: 8-16-2013	14
Last Date that Any Software or Configuration Was Revised: 8-16-2013	
ALARM-INITIATING DEVICES	AND CIRCUIT INFORMATION
Quantity Class - Style	а.
<u> </u>	Manual Fire Alarm Boxes (Pull Stations)
<u> </u>	Ion Detectors Photo Detectors
	Duct Detectors
<u>B-4</u>	Heat Detectors
<u> </u>	Waterflow Switches Supervisory Switches (3) SPRINKLER TAMPER, (1) PIV
<u> </u>	Other (Specify) (1) ANSUL FLOOR 1 KITCHEN
	(1) ANSUL FLOOR 2 KITCHEN
Alarm verification feature is disabled 🔀 enabled 🔲	
Chapter 10.6.2.3 Inspection and Testing	NFPA 72 (2002), 1 of 4
Chapter 10.6.2.3 Inspection and Testing	
MAYER ELECTRIC 7224 Winnetka Ave. N., Mir (763) 537-9357 • fa www.maye	nneapolls, MN 55428-1622 ix (763) 537-2309

ALARM NOTIFICATION APPLIAN	CE AND CIRCUIT INFORMATION
Circuit	
Quantity Class - Style 49 B - Y 29 B - Y 0 B - Y 0 B - Y 0 B - Y 0 B - Y 0 B - Y 0 B - Y 0 B - Y	Horn/Strobes Strobes Horns Chimes Bells Speaker/Strobes
B-Y	Other (Specify) FAAP: 2 @ F-1 NUR STAT, 2 @ F-2 NUR STAT
No. of alarm notification appliance circuits:	
Are circuits monitored for integrity: X Yes No	
SUPERVISORY SIGNAL-INITIATING D	EVICES AND CIRCUIT INFORMATION
Circuit Quantity Class - Style	÷
0 B-4 0 B-4	Bullding Temp. Site Water Temp.
0 B-4 B-4	Site Water Level
0 B-4	Fire Pump Power
<u> </u>	Fire Pump Running
<u> </u>	Fire Pump Auto Position Fire Pump or Pump Controller Trouble
0 B-4	Fire Pump Running
0 B-4	Generator In Auto Position
<u> </u>	Generator or Controller Trouble
	Switch Transfer Generator Engine Running
2 B-4	Other (Specify) ELEVATOR SHUNT TRIP
SIGNALING LINE CIRCUITS Quantity and style of signaling line circuits connected to system (see NFPA	
Quantity: 1 Class - Sty	yles: <u>B - 4</u>
SYSTEM POWER SUPPLIES	
(a) Primary – Main: Nominal Voltage 120VAC	Amps 2.0A
Overcurrent Protection: Type CIRCUIT BREAKER	Amps 20A
Location (of Primary Supply Panelboard): MEMORY CARE STORAG	
Disconnecting Means Location: _ELECTRIC PANEL (LP-11), BREAK	
	y: Amp-Hr. Rating18 AH
Calculated capacity to operate system, in hours: 24	 Engine-driven generator dedicated to fire alarm system:
Location of fuel storage:	
TYPE BATTERY	
Dry Cell Nickel-Cadmium Lead-Acid Other (Specify):	Sealed Lead-Acid
(c) Emergency or standby system used as a backup to primary power suppN/AEmergency system described in NFPA 70, ArticleN/ALegally required standby described in NFPA 70, AN/AOptional standby system described in NFPA 70, Aof Article 700 or 701.	9 700
Chapter 10.6.2.3 Inspection and Testing	NFPA 72 (2002), 2 of 4
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INSPECTION, TESTING, AND MAINTENANCE

	PRIOR T	O ANY TESTING		
NOTIFICATIONS ARE MADE Monitoring Entity Building Occupants Building Management Other (Specify) AHJ Notified of Any Impairments	Yes ⊠ ⊠ □ ⊠	No	Who WHIRC ST. THERESE ST. THERESE BROOK PARK	Time
TYPE Control Unit Interface Equipment Lamps/LEDS Fuses Primary Power Supply Trouble Signals Disconnect Switches Ground-Fault Monitoring	SYSTEM TES Visual X X X X X X X X X X	TS AND INSPECTIONS Functional	Cc	omments
SECONDARY POWER TYPE Battery Condition Load Voltage Discharge Test Charge Test Specific Gravity	Visual	Functional	Co	omments
TRANSIENT SUPPRESSORS REMOTE ANNUNCIATORS NOTIFICATION APPLIANCES Audible Visible Speakers Volce Clarity			 	
ΙΝΙΤΙΑΙ	ING AND SUPERVISOR	Y DEVICE TESTS AND	INSPECTIONS	
	Visual Functional Check Test Check C C C C C C C C C C C C C C C C C C C	Factory Setting	Measured Setting	Pass Fail Image: Constraint of the second
Comments: SMOKES (GROUP OF 10) C ONE OR MORE OF OF SMOKES 150 - 162 REPAIR: FAS PROGRAMMING CORRECT	CURRENTLY INITIATES	BELEVATOR RECALL.		
Chapter 10.6.2.3 Inspection and Testing		r.		NFPA 72 (2002), 3 of 4
	MAYER ELECT	RIC CORPORATION	4000	

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INSPECTION, TESTING, AND MAINTENANCE

EMERGENCY COMMUNICATIONS EQUIPMENT Phone Set Phone Jacks Off-Hook Indicator Amplifier(s) Tone Generator(s) Call-In Signal System Performance INTERFACE EQUIPMENT (Specify) N/A (Specify) N/A (Specify) N/A	Visual		nctional	Comments N/A Simulated Operation □ □
SPECIAL HAZARD SYSTEMS (Specify) N/A (Specify) N/A (Specify) N/A Special Procedure: N/A				
Comments: VISIBLE/AUDIBLE NAC DEVICES AUTO FACP REMAINS IN ALARM. REPAIR: FAS PROGRAMMING CHANGE MADE.	OMATICALLY	STOP FUN	ICTIONING AFT	ER 60 SECONDS.
SUPERVISING STATION MONITORING Alarm Signal Alarm Restoration Trouble Signal Supervisory Signal Supervisory Restoration	Yes X X X X	≥ □ □ □	Time	Comments
NOTIFICATIONS THAT TESTING IS COMPLETE Building Management Monitoring Agency Building Occupants Other (Specify)	Yeş X X	N₀ 	Who ST. THERESE WHIRC ST. THERESE	E
The following did not operate correctly: System restored to normal operation: Date:	1-23-2014 (Time:	1PM
THIS TESTING WAS PERFORMED IN ACCORDANCE V Name of Inspector: JORDAN KORAN Signature:			A STANDARDS 23-2014 (9-4-20	
7224 Winne	3) 537-9357 •	/Inneapolis	, MN 55428-162 37-2309	22

Pane	: el Name: el Version: ort Filter:		sttherese 1/20/2014 8:54 PANEL1.SEN 2.10.0 All Devices		Page: 1
Loop	Address	% Dirty	Sensitivity	CO Life Left Months	Message
1	1	0%	Least	N/A	SMOKE 1ST FL DINING ROOM BY 171 WEST
1	2	0%	Least	N/A	HEAT SOUTH ELEVATOR MACHINE ROOM
1	3	8%	Least	N/A	SMOKE SOUTH ELEVATORMACHINE ROOM
1	4	16%	Least	N/A	SMOKE SOUTH ELEVATORBASEMENT LOBBY
1	5	68%	Least	N/A	SMOKE SOUTH ELEVATOR 1ST FLOOR LOBBY
1	6	0%	Least	N/A	SMOKE 1ST FLOOR COFFEE SHOP
1	7	0%	Least	N/A	SMOKE 1ST FLOOR NORTH ELEV LOBBY FRT
1	8	0%	Least	N/A	SMOKE BASEMENT NORTHELEV LOBBY
1	9	0%	Least	N/A	HEAT BASEMENT ELEC ROOM NORTH ELEV.
1	10	0%	Least	N/A	SMOKE BASEMENT ELEC ROOM NORTH ELEV.
1	11	0%	Least	N/A	SMOKE 2ND FLOOR N. ELEV KITCHEN LOBBY
1	12	0%	Least	N/A	SMOKE 2ND FL NORTH ELEV HALL LOBBY
1	13	0%	Least	N/A	SMOKE 1ST FL SOUTH ELEV KITCHEN LOBBY
1	14	0%	Least	N/A	SMOKE -1 LEVEL STORAGE NEXT TO DATA
1	15	0%	Least	N/A	SMOKE -1 LEVEL DATA ROOM
1	16	0%	Least	N/A	SMOKE -1 LEVEL EDUCATION ROOM
1	17	0%	Least	N/A	SMOKE -1 LEVEL POOL EQUIPMENT ROOM
1	18	0%	Least	N/A	SMOKE -1 LEVEL MAIN ELECT RM SERVIC
1	19	0%	Least	N/A	SMOKE -1 LEVEL LAUNDRY ROOM
1	20	0%	Least	N/A	SMOKE -1 LEVEL WALK IN COOLER
1	21	0%	Least	N/A	SMOKE -1 LEVEL MECH. RM PUMP RM
1	22	0%	Least	<u>N/A</u>	SMOKE 1ST FL HALL BY BATHER
1	23	0%	Least	N/A	SMOKE 1ST FL HALL BY ROOM 150
1	24	0%	Least	N/A	SMOKE 1ST FL HALL BY ROOM 152
1	25	4%	Least	N/A	SMOKE 1ST FL HALL BY ROOM 154
1	26	0%	Least	N/A	SMOKE 1ST FL HALL BY ROOM 157
1	27	0%	Least	N/A	SMOKE 1ST FL HALL BY ROOM 158
1	28	0%	Least	N/A	SMOKE 1ST FL HALL BY ROOM 160
1	29	0%	Least	N/A	SMOKE 1ST FL HALL BY ROOM 162
1	30	0%	Least	N/A	SMOKE 1ST FL ELECT RM BY ROOM 162
1	31	0%	Least	N/A	SMOKE 1ST FL ENTRY WAY LOBBY
1	32	0%	Least	N/A	SMOKE 1ST FL LOBBY HALL BY STAIRS
1	33	0%	Least	N/A	SMOKE 1ST FL LOBBY HALL BY CONF
1	34	8%	Least	N/A	SMOKE -1 LEVEL GARBAGE ROOM
1	35	16%	Least	N/A	SMOKE 1ST FL HALL BY WELLNESS CENTER
1	36	0%	Least	N/A	SMOKE 1ST FL WELLNESCENTER BY DOOR A-150
1	37	0%	Least	N/A	SMOKE 1ST FL HALL BY STUDIO
1	38	0%	Least	N/A ·	SMOKE 1ST FL HALL BY DOOR B161A
1	39	0%	Least	N/A	SMOKE 1ST FL HALL WOMANS LOCKER
1	40	0%	Least	N/A	SMOKE 1ST FL LOBBY BY FACP
1 1	41 42	0% 0%	Least Least	N/A N/A	SMOKE 1ST FL HALLWAYWELLNESS CENTER SMOKE 1ST FL BY POOLDOOR IN POOL LOBBY

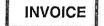
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Date	-		1/20/2014 8:54	:33 AM		Page: 2
	el Name: el Version:		PANEL1.SEN 2.10.0			
	ort Filter:		All Devices			
oop	Address			CO Life Left Months	Message	
1	43	0%	Least	N/A	1ST FL LOBBY	BY DOOR B166E
	44 .	0%	Least	N/A		NSIDE LINK BY DOOR B166B
	45	0%	Least	N/A	SMOKE 2ND FL	HALL BY ROOM 279
	46	0%	Least	N/A	SMOKE 2ND FL	HALL BY ROOM 277
	47	0%	Least	N/A	SMOKE 2ND FL	HALL BY ROOM 282
	48	0%	Least	N/A	SMOKE 2ND FL	HALL BY ROOM 284
	49	0%	Least	N/A	SMOKE 2ND FL	HALL BY ROOM 285
	50	0%	Least	N/A	SMOKE 2ND FL	BY NURSE STATION
	51	0%	Least	N/A	SMOKE 2ND FL	ELECTRICAL ROOM
	52	0%	Least	N/A	SMOKE 2ND FL	HALL BY ROOM 275
	53	0%	Least	N/A	SMOKE 2ND FL	DINE ROOM
	54	0%	Least	N/A	SMOKE 2ND FL	HALL BY ROOM 270
	55	0%	Least	N/A	SMOKE 2ND FL	LIVING ROOM FIRE DR
	56	0%	Least	N/A	SMOKE 2ND FL	HALL BY ROOM 253
	57	0%	Least	N/A	SMOKE 2ND FL	HALL BY ROOM 205
	58	0%	Least	N/A	SMOKE 2ND FL	HALL BY ROOM 257
	59	0%	Least	N/A	SMOKE 2ND FL	HALL BY ROOM 259
	60	0%	Least	N/A	SMOKE 2ND FL	HALL BY ROOM 260
	61	0%	Least	N/A	SMOKE 2ND FL	HALL BY ROOM 262
	62	0%	Least	N/A	SMOKE 2ND FL	HALL BY ROOM 264
	63	0%	Least	N/A	SMOKE 2ND FL	HALL BY ROOM 265
	64	0%	Least	N/A	SMOKE 2ND FL	HALL BY ROOM 254
	65	0%	Least	N/A	SMOKE 2ND FL	ELECTRICAL ROOM 220
	66	0%	Least	N/A	SMOKE 2ND FL	HALL BY DOOR B276
	67	12%	Least	N/A	SMOKE 2ND FL	HALL BY DOOR B276
	68	0%	Least	N/A	SMOKE 2ND FL	HALL BY ROOM 272
	69	0%	Least	N/A	SMOKE 2ND FL	TRASH ROOM
	70	0%	Least	N/A	SMOKE 2ND FL	LIV ROOM 2 BY TRASH
	71	0%	Least	N/A	SMOKE 2ND FL	HALL BY ROOM 251
	72	0%	Least	N/A	HEAT 2ND FL	KITCHEN
	73	0%	Least	N/A	SMOKE 1ST FL	DINE ROOM BY FIRE DR
_	74	0%	Least	N/A	SMOKE 1ST FL	HALL BY ROOM 178
	75	0%	Least	N/A	SMOKE 1ST FL	HALL BY ROOM 180
	76	0%	Least	N/A	SMOKE 1ST FL	HALL BY ROOM 182
_	77	0%	Least	N/A	SMOKE 1ST FL	HALL BY ROOM 184
	78	0%	Least	N/A	SMOKE 1ST FL	HALL BY ROOM 185
	79	0%	Least	N/A	SMOKE 1ST FL	BY NURSE STATION
	80	0%	Least	N/A	SMOKE 1ST FL	HALL BY ROOM 175
	81	0%	Least	N/A	SMOKE 1ST FL	HALL BY ROOM 177
	82	0%	Least	N/A	SMOKE 1ST FL	LIVING RM BY RM 173
	83	0%	Least	N/A	SMOKE 1ST FL	HALL BY ROOM 172

		P	anel Devi	ce Maintenance	e/Sensitivity Report
-	Project: sttherese Date: 1/20/2014 8:54:33 AM			Page	
Pan	Panel Name: PANEL1.SEN Panel Version: 2.10.0 Report Filter: All Devices				
Loop	Address	% Dirty	Sensitivity	CO Life Left Months	Message
1	85	0%	Least	N/A	SMOKE 1ST FL HALL BY ROOM 170
1	86	0%	Least ⁻	N/A	SMOKE 1ST FL HALL BY CLINICAL SE
1	87	0%	Least	N/A	SMOKE 1ST FL HALL BY DISH WASHI
1	88	0%	Least	N/A	SMOKE 1ST FL DINING RM BY ENTRY
1	89	0%	Least	N/A	HEAT 1ST FL KITCHEN
1	90	0%	Least	N/A	SMOKE 1ST FL HALLWAYWELLNESS CEN
1	91	0%	Least	N/A	SMOKE 1ST FL EAST LINK HALL 153
1	92	0%	Least	N/A	SMOKE 1ST FL MEM CARE KITCHEN
1	93	0%	Least	N/A	SMOKE 1ST FL MEM CARE LOUNGE



Mayer Electric Corp 7224 Winnetka Ave N Brooklyn Park, MN 55428 Phone: (763) 537-9357 Fax: (763) 537-2309



INVOICE NO 16916



CUST Saint Therese at Oxbow Lake 9751 Regent Ave N Brooklyn Park, MN 55443 SITE Saint Therese at Oxbow Lake 9751 Regent Ave N Brooklyn Park, MN 55443

ACCOUNT NO	INVOICE DATE	TERMS	DUE DATE	PAGE
SAITHE	01/23/2014	Net 30	02/22/2014	1

ORDER 7082, PO

ORDERED BY Roy Krueger

DESCRIPTION 2013 UL fire alarm test follow up.

RESOLUTION Followed up to check device locations.

ITEM NO	QUANTITY	DESCRIPTION	UNIT PRICE	EXTENDED
JKORAN	3.50	Jordan Koran	125.00	437.50*
TRUCK	1	Truck Charge	30.00	30.00*
	1	FAS SERVICE	177.00	177.00*
		"FAS RUNNER		
		SOW: DOWNLOAD SENSITIVITY		
		REPORT FROM FACP.		×

* means item is non-taxable

Fao	Dopt	Account	Ame:TOTAL	AMOUNT	644.50

l					
	Signat	ure	Dele		

File No: S24368 CCN: UUFX Service Center No: 1 Expires: 01/23/2019 Issued: 01/23/2014 Entry No: 5298954 Version: 7 **CENTRAL STATION - FIRE** FIRE ALARM SYSTEM CERTIFICATE DESCRIPTION FOR Certificate Serial No: FC46391268 Protected Property: Alarm Service Company: ST. THERESE AT OXBOW LAKE MAYER ELECTRIC CORPORATION 7224 WINNETKA AVE N 9751 REGENT AVE N **MINNEAPOLIS MN 55428-1622** BROOKLYN PARK, MN 55443 System Description: Area Covered: ENTIRE PREMISE Authority Having Jurisdiction: BROOKLYN PARK FIRE MARSHAL 763-493-8020 Responding Fire Department: BROOKLYN PARK Testing and Maintenance Contract date: 08/08/2012 SYSTEM DEVIATIONS FROM REFERENCED NFPA STANDARDS ANNUAL TESTING PER AHJ **Automatic Fire Detection and Alarm Service** Coverage is Selected Area 90 - Smoke Detectors: 0 - Ionization 90 - Photoelectric 2 - Duct Smoke Detectors : 0 - Ionization 2 - Photoelectric 4 - Heat Detectors : 0 - ROR (Rate of temperature rise) 0 - Fixed Temperature 4 - Combination Sprinkler System Waterflow Alarm and Supervisory Service Sprinkler System Type: Wet Pipe 1 - Waterflow Switch 4 - Sprinkler Valve Supervisory Services 4 - Other Devices : 2 ANSUL, 2 ELEV SHUNT TRIP Manual Fire Alarm and Guard's Tour Supervisory Service 9 - Manual Fire Alarm Boxes **Alarm Notification and Annunciation Devices** 29 - Visual Signals : Type - Strobe 49 - Audible/Visual Signals : Type - Strobe Control and Transmitter Unit EST IO500/SA-DACT **Remote Monitoring UL Listed Central Station** File: S7050, Service Center Number: 0 WH INTERNATIONAL RESPONSE CENTER 6800 ELECTRIC DR **PO BOX 330** ROCKFORD MN 55373-0330

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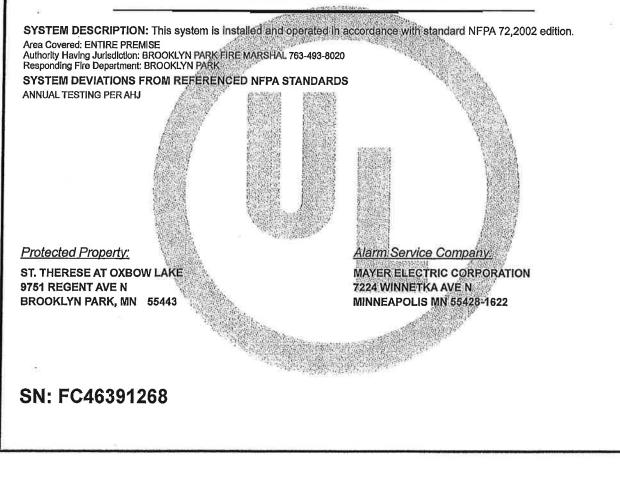
File No: S24368 CCN: UUFX Service Center No: 1 Expires: 01/23/2019 Issued: 01/23/2014

CENTRAL STATION - FIRE FIRE ALARM SYSTEM CERTIFICATE (NFPA 72)

THIS CERTIFIES that the *Alarm Service Company* is included by UL LLC in its Directory as qualified to use the *UL Listing Mark* in connection with the certificated *Alarm System*. This Certificate is the *Alarm Service Company*'s representation that the *Alarm System* including all connecting wiring and equipment has been installed and will be maintained in compliance with requirements established by UL. This Certificate does not apply in any way to the installation of any additional signaling systems, such as; fire, smoke, waterflow, burglary, holdup, medical emergency, or otherwise, that may be connected to or Installed along with the Certificated *Alarm System*. This Certificate does not apply in any way to the communication channel between the protected property and any facility that monitors signals from the protected property unless the use of a UL listed or Classified Alarm Transport Company is specified on the Certificate.

LIMITATION OF LIABILITY: UL LLC makes no representations or warranties, express or implied, that the Alarm System will in all cases prevent any loss by fire, smoke, water damage, burglary, hold-up or otherwise, or that the Alarm System will in all cases provide the protection for which it is installed or intended. By the Alarm Service Company providing this Certificate and the Protected Property acceptance of this Certificate, the Alarm Service Company and the Protected Property acknowledge and agree that UL does not assume or undertake to discharge any liability of the Alarm Service Company or any other party. UL is not an insurer and assumes no liability which may result directly or indirectly from inspection of the equipment, failure of the equipment, failure to conduct inspections, incorrect certification, nonconformity with requirements, failure to discover nonconformity with requirements, cancellation of the Certificate or withdrawal of the Alarm Service Company from inclusion in ULs Directory prior to the expiration date appearing on this Certificate.

OPERATIONAL REQUIREMENTS: The *Alarm Service Company* bears the responsibility for the correctness of the installation; maintenance of the system documentation; periodic system inspection and testing; maintaining and providing any necessary repairs. All operations and maintenance shall be conducted in the manner prescribed by the NFPA standard referenced. All required service is to be provided for in an appropriate contract. System documentation is defined to include any "As Built Drawings"; the records of any "Acceptance Testing"; and the records of all periodic system testing and maintenance.





 File No: S24368
 CCN: UUFX

 Service Center No: 1
 Expires: 01/23/2019

 Issued: 01/23/2014
 Version: 7

CENTRAL STATION - FIRE FIRE ALARM SYSTEM CERTIFICATE DESCRIPTION FOR Certificate Serial No: FC46391268

Alarm Retransmission to Fire Department

Public Telephone Network and Public Telephone Network Alarm Transmission Method: Digital Alarm Communicator



Annual Medical Gas Inspection-2014

Saint Therese at Oxbow Lake 5200 Oak Grove Pkwy Brooklyn Park, MN

Date Inspected: February 4th, 2014 Inspected by: David Alsop | ASSE 6030 Medical Gas Verifier

Medical Gas Terminal Count					
Oxygen	17				
Medical Air	0				
Medical Vacuum	0				
Waste Anesthetic Gas Disposal	0				
Nitrous Oxide	0				
Carbon Dioxide	0				
Nitrogen	0				
Helium	0				
Total Gas Terminals	17				



Total Area Alarms



Master Panels
Location 1
1st Floor Nurses Desk



Report Summary

Al Medical Gas, Inc Phone: 919-247-4728 Email: Almedgas@gmail.com

				Cor	ntamina	ints Evalu	uation			a lead of	
ocation	<u>Sample</u> <u>ID</u>	Gas	<u>% Gas</u>	<u>C0</u>	<u>CO2</u>	Gaseous Hydrocarbons	Halogenated	White Rag Test	Odor	<u>Total</u> Particulat	
Room 177	13-68	02	99.99% O2	<1 ppm	<5 ppm	<.7 ppm	<.1 ppm	Pass	N/D	<1 mg	
		TBD=Tc	be Determine	ed, data anal		EGEND KEY	N/D = None		s e ja	-	
		NFPA 2	005 Gas Cond		quirements	NFPA 2005 C	(A) (公司)(2) (2) (2) (2) (2) (2) (2) (2) (2) (2)	Irements (minimum)	-Medical		
		「主要なない」	Sas		Requirement	CO 10ppm (maxir	num allowable)		Assessment Super-		
			geometric and	1.0.0000	% 02	CO2 500ppm (maximum allowable)					
		Med	ical Air	19.5-23.5% O2		Gaseous Hydrocarbons as Methane 25ppm (max allowed)					
		~	-		6 N2O	Halogenated Hydrocarbons 2ppm (maximum allowable)					
			n Dioxide	0.041	6 CO2	Dew Point 39 ° F				1	
	20	INIU	rogen	>99% N2	or <1% O2	Odor-Shall show	no signs of non-stand	lard odor]	
				NFPA 2005	o Contaminar	nt Requirements- Medical	Positive Pressure Air	Gases, excluding			
			1	Dew Point 41 ° F	= (5°C) @ 50 ps	sig			-		
				CO 10ppm (max					1		
				Fotal Hydrocarb	ons as Methane	e 1ppm (maximum a	llowable)		1		
			LF I	Halogenated Hy	drocarbons 2pp	m (maximum allowa	able)		1		

Contaminants Evaluation

Al Medical Gas, Inc Phone: 919-247-4728 Email: david@a1medicalgas.com

Master Alarm Summary

Saint Therese at Oxbow Lake

Master Alarm Signal Summary						
Master Alarm 1	Location 1st Floor Nurse's Desk					
Gas/Vac:						
Туре:	Manifold without Reserve					
Signals						
LINE PRESSURE LOW	40					
LINE PRESSURE HIGH	60					
RESERVE IN USE						
EMERGENCY RESERVE IN USE						
RESERVE PRESSURE LOW	□.					
MAIN LIQUID LEVEL LOW						
RESERVE LIQUID LEVEL LOW						

Al Medical Gas, Inc Phone: 919-247-4728 Email: Almedgas@gmail.com

Master Alarms

Tested by: Robin Krause NFPA 99, 1999

Alarm Field Data

			Area	Alarms			
Area Alarm Location	Gas Type	Pressure Psig/In	Set Point High	Set Point Low	Condition	Manuf/Model	Notes
Near Nurses Desk; Controls	1					A	Combo Master / Area
Rooms: 170-186	02	52 psig	60 psig	40 psig	Good	Amico Alert	

Area Alarms

Al Medical Gas, Inc Phone: 919-247-4728 Email: Almedgas@gmail.com

Saint Therese at Oxbow Lake

There are no recommendations at this time.

Alarm Deficiencies

A1 Medical Gas, Inc Phone: 919-247-4728 Email: A1medgas@gmail.com

5

Zone Valve Field Data

		Zone	Valve Boxe	S
Zone Valve Location	Gas Type	Pressure Psig/In	Condition	Notes
Near Nurses Desk; Serves Rooms: 170- 186	1			
	02	52 psig	Good	

Zone Valve Boxes

Al Medical Gas, Inc Phone: 919-247-4728 Email: Almedgas@gmail.com

Zone Valve Box Deficiencies Information

Saint Therese at Oxbow Lake

There are no recommendations at this time.

Valve Deficiencies

Al Medical Gas, Inc Phone: 919-247-4728 Email: Almedgas@gmail.com

Medical Gas Outlet and Inlet Field Data

Medical Gas Inlets and Outlets								
Location	Gas Type	Flow Rate/SCFM	Standing Pressure	Flowing Pressure	Leaks Y/N?	Pass/Fail	Notes	
170	02	>3.5	54 psig	52 psig	N	Pass		
171	02	>3.5	54 psig	52 psig	N	Pass		
172	02	>3.5	54 psig	52 psig	N	Pass		
173	02	>3.5	54 psig	52 psig	N	Pass		
174	02	>3.5	54 psig	52 psig	N	Pass		
175	02	>3.5	54 psig	52 psig	N	Pass		
176	02	>3.5	54 psig	52 psig	N	Pass		
177	02	>3.5	54 psig	52 psig	N	Pass		
178	02	>3.5	54 psig	52 psig	N	Pass		
179	02	>3.5	54 psig	52 psig	N	Pass		
180	02	>3.5	54 psig	52 psig	N	Pass		
181	02	>3.5	54 psig	52 psig	N	Pass		
182	02	>3.5	54 psig	52 psig	N	Pass		
183	O2 '	>3.5	54 psig	52 psig	N	Pass		
184	02	>3.5	54 psig	52 psig	N	Pass		
185	02	>3.5	54 psig	52 psig	N	Pass		
186	02	>3.5	54 psig	52 psig	N	Pass		

Medical Gas Inlets and Outlets

Q.,

Al Medical Gas, Inc Phone: 919-247-4728 Email: Almedgas@gmail.com

Saint Therese at Oxbow Lake

There are no recommendations at this time.

Inlets and Outlets Deficiencies

Al Medical Gas, Inc Phone: 919-247-4728 Email: Almedgas@gmail.com

Oxygen Emergency Supply Manifold

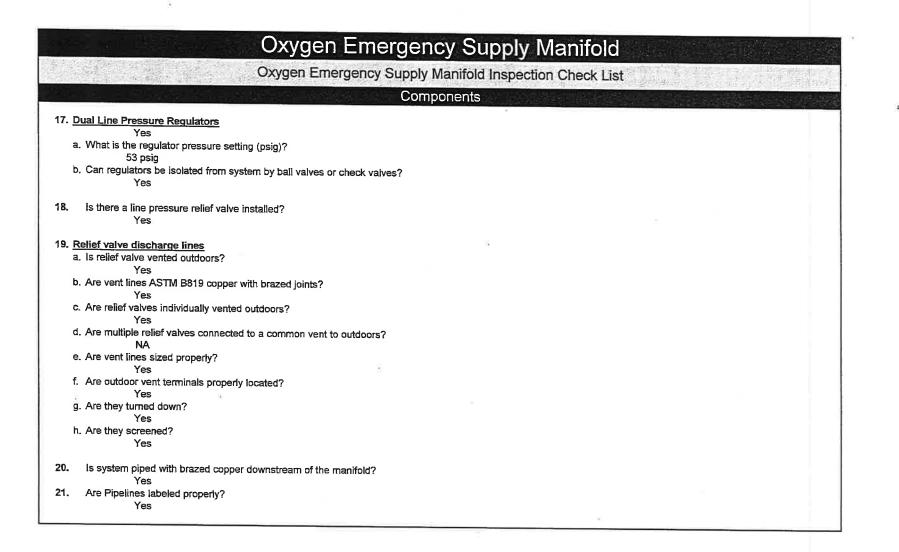
Saint Therese at Oxbow Lake

127.1	Internet Allow contractions and	ONYYCI	Lineigency	Supply Mani			
		Oxygen Eme	ergency Supply Mar	ifold Inspection Che	ck List		
1			General I	Data			
1.	Inspection Date:	2/4/2014					
2.	Gas System:	Oxygen					
3,	Gas or Liquid Source:	Gas					
4.	Location of Manifold:	Manifold Room Floor Level -1					
5.	Facility Area(s) served :	Entire Facility					
6.	Manifold Manufacturer:	Amico					
7.	Model Number.	UDHD-HH-U-OXY					
8.	Serial Number:	201213-D-A					
9.	Cylinders per bank:	4 x 4					
10.	Is there automatic alterna	tion?					
11.	Yes Are cylinder check valves Yes	installed?				5	
12.	Are there shut off valves Yes	for each side of manifold?			*		
13.	125 psig	ight bank changeover occurs (
14.	Pressure at which right to 125 psig	left bank changeover occurs ((kPa/psig).				
15.	ls manifold equipped with Yes						
16.	Is manifold on emergenc Yes	/ electrical power?		÷			
		Verified by whom? Engine	eering				

 (\mathbf{x})

Al Medical Gas, Inc Phone: 919-247-4728 Email: david@a1medicalgas.com

Saint Therese at Oxbow Lake



Oxygen Emergency Supply Manifold

Al Medical Gas, Inc Phone: 919-247-4728 Email: david@almedicalgas.com

Saint Therese at Oxbow Lake

	Oxygen Emergency Supply Manifold
	Oxygen Emergency Supply Manifold Inspection Check List
	Components (Continued)
22. 5	ource Valve
a	Is there a source valve installed?
	Yes
b	
C	Is it labeled for gas?
Ь	No Is it labeled for area(s) served?
ч	No
e	Is it labeled "DO NOT CLOSE EXCEPT IN EMERGENCY"? No
23.	Where there leaks detected in manifold piping?
~ .	No
24.	Is manifold area posted "No Smoking"?
25.	Yes Is area enclosed with lockable entry?
£J.	Yes
26.	Interior locations with mechanical ventilation, where required?
	Yes
27.	Interior locations with natural ventilation where permitted?
28.	Is are free from flammable liquids and gases?
	Yes
29.	Are all electrical switches and outlets above 5 feet in elevation? Yes
30.	Are cylinders individually chained or secured? Yes
31.	Is area not exposed to temperatures in excess of 130° F (54° C) or less than 20° F (-7° C)? Yes

Oxygen Emergency Supply Manifold

Al Medical Gas, Inc Phone: 919-247-4728 Email: david@a1medicalgas.com

Saint Therese at Oxbow Lake

	Oxygen Emergency Supply Manifold
有效 法公司 基本	Oxygen Emergency Supply Manifold Inspection Check List
	Comments
Source Valve Tags being sent to) facility.

Oxygen Emergency Supply Manifold

A1 Medical Gas, Inc Phone: 919-247-4728 Email: david@a1medicalgas.com

Oxygen Emergency Supply Manifold Deficiencies / Recommendations

Saint Therese at Oxbow Lake

There are no recommendations at this time.

Oxygen Emergency Supply Manifold Deficiencies / Recommendations Al Medical Gas, Inc Phone: 919-247-4728 Email: david@a1medicalgas.com



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8279

January 28, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5619001

Dear Ms. Martin:

The above facility was surveyed on January 6, 2014 through January 10, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health,

Gloria Derfus, Unit Supervisor Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55108-2970 Telephone: (651) 201-3792 Fax: (651) 201-3790

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Kumala Fiske Downing

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

Enclosure(s)

cc: Original - Facility Licensing and Certification File Saint Therese At Oxbow Lake January 28, 2014 Page 3

PRINTED: 01/28/2014 FORM APPROVED

Minnesota Department of Health								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
27752		B. WING		01/10/2014				
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	RESS, 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 SHOUL) CROSS-REFERENCED TO THE APPROIN DEFICIENCY)	HOULD BE COMPL			
2 000	Initial Comments		2 000					
	*****ATTENTION******							
	NH LICENSING CORRECTION ORDER							
	In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon							
	result in the assess	ny item of multi-part rule will ment of a fine even if the item Iring the initial inspection was						
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.						
Minnocoto D	Department's staff, the following correct corrections are com make a copy of the original to the Minne	S: 1/10/14, surveyors of this visited the above provider and tion orders are issued. When pleted, please sign and date, se orders and return the esota Department of Health, nce Monitoring, Licensing and		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal s Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware. to			

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

TITLE

RNX611

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		27752	B. WING		01/1	0/2014
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
	HERESE AT OXBOW		NK GROVE PA LYN PARK, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLET DATE
2 000	Continued From pa	ge 1	2 000			
	2 000 Continued From page 1 Certification Programs; 85 East Seventh Place, Suite 220; P.O. Box 64900, St. Paul, Minnesota 55164-0900.			The assigned tag number appr far left column entitled "ID Pre The state statute/rule number corresponding text of the state out of compliance is listed in th "Summary Statement of Defici column and replaces the "To C portion of the correction order. column also includes the find are in violation of the state stat statement, "This Rule is not me evidenced by." Following the findings are the Suggested Me Correction and the Time Period Correction.	fix Tag." and the statute/rule encies" comply" This ings which tute after the et as surveyors thod of d For	
				THE FOURTH COLUMN WHI STATES, "PROVIDER'S PLAN CORRECTION." THIS APPLIE FEDERAL DEFICIENCIES ON WILL APPEAR ON EACH PAG THERE IS NO REQUIREMEN SUBMIT A PLAN OF CORREC VIOLATIONS OF MINNESOT STATUTES/RULES.	CH I OF IS TO ILY. THIS IE. T TO CTION FOR	
2 265	MN Rule 4658.008 Resident Health Sta	5 Notification of Chg in atus	2 265			
	policies to guide sta physicians, physicia practitioners, and if legal representative member of a reside accident, or death.	ast develop and implement aff decisions to consult an assistants, and nurse known, notify the resident's e or an interested family ent's acute illness, serious At a minimum, the director of and the medical director or an				

STATE FORM

Minneso	ota Department of He	alth				
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		27752	B. WING		01/1	0/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
SAINT T	HERESE AT OXBOW		K GROVE PAI YN PARK, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 265	Continued From pa	ige 2	2 265			
	development of the	must be involved in the se policies. The policies must address at least the tion times for:				
		involving the resident which I has the potential for requiring on;				
	physical, mental, o example, a deterior	change in the resident's r psychosocial status, for ation in health, mental, or in either life-threatening al complications;				
	example, a need to	ter treatment significantly, for discontinue an existing form adverse consequences, or to f treatment;				
	D. a decision t resident from the n	o transfer or discharge the ursing home; or				
	E. expected an	d unexpected resident deaths.				
	by: Based on interview facility failed to noti manner for 1 of 3 re	ent is not met as evidenced and document review, the fy the physician in a timely esidents (R35) who sustained g and swelling injury to the right				
	Findings include:					
Minute	history of a close fra end humerus obtain	cluded osteoporosis and acture unspecified part upper ned from the quarterly (MDS) dated 10/3/13. The				

If continuation sheet 3 of 65

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		27752	B. WING	B. WING		01/10/2014	
IAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE	• • • •		
	IERESE AT OXBOW)AK GROVE PAF KLYN PARK, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 265	Continued From pa	age 3	2 265				
	Status (BIMS-tool u	5's Brief Interview of Mental used to measure cognitive 15 (which indicated intact					
	-On 10/19/13, a sk measuring 2 centin R35 had reported s walker was noted. the note indicated s -On 10/20/13, R35 red, swollen, warm remained intact. R3 indicated staff wou -On 11/2/13, the to observed to have of skin tear and the h tender to touch. R3 exactly what happed she was constantly something. Ice was times during the sh noted. The note ind monitor R35's need -On 11/3/13, two no remained swollen/p tender to touch and Scheduled pain me administered and F -On 11/4/13, an ea R35's right hand w swollen. Later that noted to be dark re and was swollen al R35 reported pain	otes indicated R35's right har buffy, bruised, warm, and d R35 reported pain. edication and ice were R35 reported relief. rlier note indicated the top of as bruised, reddened and same day, the bruise was ed, measured 35 cm x 15 cm II the way down to the fingers with range of motion and with se practitioner (NP) was	er or. s d nd				
		ay had chacked					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		27752	B. WING		01/	10/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
SAINT TI	HERESE AT OXBOW		K GROVE PAF LYN PARK, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 265	Continued From pa	age 4	2 265			
	the right hand injur	cian (MD) or NP was notified o y until 16 days after the skin or two days after the right hand ng was noted.				
	services (DCS) was not updated when it 10/19/13, and on 1 to go back and revision stated she expecte "If injury with pain, anything out of the explained when the 11/2/13, she would	1 a.m. the director of clinical s asked why the physician was the skin tear was first noted or 1/2/13. DCS stated, "I'd have iew the incident." She further d the physician to be notified, increased swelling, tenderness the ordinary." DCS further bruising was first noted on have liked both herself and b have been notified of the righ	s			
	facility was suppos change in condition baseline immediate working, or if it was facility was to call the treatment. Addition expected the nurse issues that would in NP stated she wou working day. NP fu updated regarding 11/4/13, and stated	5 p.m. the NP stated the ed to update her of any n, new complaint, or change of ely. NP stated if she was not a during the weekend, the he on-call provider for ally, the NP stated she es to leave a voice message for not need immediate attention. Id follow up on her next rther stated she recalled being R35's bruised right hand on I she had ordered an x-ray to fracture due to the swelling	r			
	worked with R35 of 1/10/14, at 12:33 p able to re-call the b Note dated 11/2/13	cal nurse (LPN)-C who had n 11/2/13, was interviewed on .m. via telephone. LPN-C was pruising incident and Progress . LPN-C also added there was bruising at the time and had				

STATE FORM

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		27752	B. WING		01/	01/10/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
SAINT TI	HERESE AT OXBOW		GROVE PAF N PARK, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 265	LPN-C confirmed n the supervisor were the right hand. The MD/NP and/or Regarding a chang policy dated Februa were to be kept info health status so that made. SUGGESTED MET The director of nurs develop, review, an procedures to ensu The director of nurs educate all appropri procedures. The director of nurs develop monitoring compliance.	hift to continue to monitor. either the physician, NP nor e notified about the condition of Resident/Family Notification e of Resident's Condition ary 2013, indicated the MD/NP ormed of change in current at a medical decision can be THOD OF CORRECTION: sing (DON) or designee could d/or revise policies and	2 265				
2 555	MN Rule 4658.040 Plan of Care; Deve	5 Subp. 1 Comprehensive lopment	2 555				
	must develop a cor each resident within completion of the c assessment as def comprehensive pla by an interdisciplina attending physician responsibility for the	Alopment. A nursing home nprehensive plan of care for n seven days after the omprehensive resident ined in part 4658.0400. The n of care must be developed ary team that includes the , a registered nurse with e resident, and other disciplines as determined by					

STATEMEN	DIT DEPARTMENT OF HE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		27752	B. WING		01/	10/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
SAINT TI	HERESE AT OXBOW		K GROVE PAF LYN PARK, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 555	Continued From pa	age 6	2 555			
	practicable, with th	ls, and, to the extent e participation of the resident, guardian or chosen				
	by: Based on interview facility failed to dev sleep problems, sle	ent is not met as evidenced and document review, the relop a care plan to address eep monitoring and/or the use of 5 residents (R27) reviewed nedications.				
	Findings include:					
	without developme the use of the med	duled Trazodone for sleep nt of a care plan to address ication, risk factors associated and non-pharmacological as for sleep.	1			
	received Trazodon mouth (PO) twice of of sleep (HS). The diagnoses to include	dated 11/7/13, indicated R27 e HCl 25 milligrams (mg) by daily and 50 mg PO every hour orders identified R27's de unspecified psychosis, behavioral disturbance, and e.	r			
	use of Trazodone f sleep and non-pha promote sleep. In a direction for monito	d 12/13/13, did not identify the or sleep, lacked a focus for rmacological interventions to addition, the care plan lacked oring and evaluation of R27's potential side effects of the	•			
	(RN)-B verified the	p.m. the clinical coordinator care plan did not address Trazodone. At 2:31 p.m. the				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		27752	B. WING		01/	10/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
SAINT T	HERESE AT OXBOW		K GROVE PAR YN PARK, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 555	consultant pharmad	cist (CP)-F was interviewed via ied the facility should have	2 555			
	services (DCS) ver	a.m. the director of clincal and the Trazodone and R27's build have been care planned.				
	Monitoring policy and identified pertinente medications, include the policy directed and of psychotropic me monitoring and ass	otropic Medications and nd procedure dated 8/2012, nt direction for psychoactive ling antidepressants. Although appropriate indications for use dications, evaluation, essment of psychotropic blicy lacked direction for care pic medications.				
	The director of nurs develop, review, an procedures to ensu The director of nurs educate all appropri procedures. The director of nurs	THOD OF CORRECTION: sing (DON) or designee could id/or revise policies and ure compliance. sing (DON) or designee could riate staff on the policies and sing (DON) or designee could systems to ensure ongoing				
	TIME PERIOD FOI (21) Days	R CORRECTION: Twenty-one				
2 570	MN Rule 4658.040 Plan of Care; Revis	5 Subp. 4 Comprehensive sion	2 570			
	care must be review interdisciplinary tea	A comprehensive plan of wed and revised by an m that includes the attending pred nurse with responsibility				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		E SURVEY PLETED	
		07750	B. WING		_		
		27752			01/	01/10/2014	
	PROVIDER OR SUPPLIER	5200 04	DDRESS, CITY, S				
SAINT TI	HERESE AT OXBOW		LYN PARK, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 570	Continued From pa	age 8	2 570				
	disciplines as deter and, to the extent participation of the guardian or chosen quarterly and withir the comprehensive by part 4658.0400,	d other appropriate staff in rmined by the resident's needs practicable, with the resident, the resident's legal representative at least seven days of the revision of e resident assessment required subpart 3, item B.					
	by: Based on observat review, the facility f was revised regard of 5 residents (R63 medications. In ado a plan of care for 1 bruises on unknow	ent is not met as evidenced ion, interview and document failed to ensure the care plan ling bathing preferences for 1 b) reviewed for unnecessary dition the facility failed to revise of 3 residents (R75) with n origin and risk for bruising ressure skin conditions.	9				
	Findings include:						
		cord for R63 dated 12/4/13, s of dementia, aphasia, and					
	revealed R63 was every bedtime and to be given before mornings. The eve dated 8/13/13, inclu- bath/sponge bath in The bathing care p R63 had a history of very agitated and u and identified R63	ry Report dated 1/9/14, prescribed Seroquel 25mg 25mg every Friday for anxiety bath/shower on Friday ry Friday Seroquel orders uded directions of may try bed nstead. lan dated 11/6/13, indicated of refusing showers, becoming upset during the shower activity did not like water on her head. cted staff to administer a	/				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		27752	B. WING		01/10/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	HERESE AT OXBOW	5200 OA	K GROVE PAF	RKWAY		
		BROOK	LYN PARK, MN	55443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From pa	age 9	2 570			
	not to wash R63's I provide a calm app during the shower. re-approach at a la agitated or upset. T direction to offer a When interviewed of member (FM)-A rep bathing and did not FM-A stated R63 w during and after ba- used to take shower and did not know w On 1/9/14, at 9:24 a stated R63 did not kick, yell and call a NA-A reported notifi behaviors since Se R63 now needed to a shower. NA-A fur R63 a bed bath, R6 registered nurse (F very upset, verbally baths, and verified since the Seroquel stated R63 was mu On 1/9/14, at 9:57 a (RN)-B stated R63' (an anti-anxiety me to use Seroquel. R1 any notes about be "doesn't tell" her, sl reported R63 got a bath per her family' On 1/9/14, at 12:27 again and stated it got a shower every know a bed bath w	on 1/8/14, at 9:03 a.m. family ported R63 had problems with t like to take baths or showers. yould become very upset thing. FM-A further stated R63 ers regularly without problems <i>h</i> at had caused the change. a.m. nursing assistant (NA)-A like water and would scream, ngry names with showers. ng no difference in R63's eroquel was started and stated wo staff members to assist with ther stated when she gave 53 was "happy." At 9:34 a.m. RN)-A stated R63 would get <i>y</i> and physically abusive during the behavior had not improved was started on 8/13/13. RN-A uch calmer with a bed bath. a.m. the clinical coordinator 's family had requested Ativan edication), but the staff wanted N-B stated she had not seen shaviors with baths and if staff he "doesn't know." RN-B shower weekly versus a bed				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED	
		27752	B. WING		01/	01/10/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
SAINT T	HERESE AT OXBOW		K GROVE PAR YN PARK, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 570	visited the day after On 1/9/14, at 12:39 services (DCS) stat need to have a sho more comfortable f choice." The DCS s alternatives to be u antipsychotic for ba On 1/9/14, at 1:44 g stated he ordered S did not like the side MD-A further stated that was what he us MD-A stated he wo explain things to re- comfort before star behavior. R75 care plan was and the bruises on On 01/07/14, at 1:4 have several dark g at different stages of On 1/9/14, at 7:30 a on a couch in the m closed. The admini newspaper to R75 forearms and bruiss The significant chai dated 9/20/13, indic included Alzheimer degeneration of ret had severe cognitiv	r her showers. p.m. the director of clinical ted weekly residents do not wer and if a bed bath was or them, that was "their stated she would expect sed prior to using an thing. o.m. R63's physician (MD)-A Seroquel for R63 because he effects of benzodiazepines. d he used Seroquel because sually used in nursing homes. uld expect facility staff to sidents to increase their ting any medications for not revised for risk of bruising both forearms. 4 p.m. R75 was observed to purple bruises to both forearms					

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		27752	B. WING		01/	01/10/2014	
AME OF F	ROVIDER OR SUPPLIER	-	T ADDRESS, CITY, S	TATE, ZIP CODE		10/2014	
	IERESE AT OXBOW	1 AKE 5200 C	DAK GROVE PAR	RKWAY			
		BROO	KLYN PARK, MN		00000001001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 570	Continued From pa	age 11	2 570				
	integrity, "[R75 was integrity due to alw bladder and occasi risk and self-care of care plan did not ic but directed to "mo baths/showers, dur the nurse." Althoug R75 had potential f macular degenerat identified R75 wan other resident room	ted 11/20/12, identified for sl s] At risk for impaired skin ays being incontinent of ionally incontinent of bowel, the deficit related to dementia." The lentify R75's risk for bruising unitor for skin changes during ring am/pm cares and notify the vision focus identified for change in vision related to for change in vision related to tor; the behavior focus dered around the unit and in ms, neither focus included ho injury or bruising with the rist	fall The g o to				
	11/25/13, 12/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/	rogress Notes revealed on and 12/16/13, old bruising ha n of R75's forearms. Althoug ocumented occassionally in t '5's care plan did not address y the new bruising, such as erventions in place to prever	h :he s				
	registered nurse (F	a.m. the clinical coordinator RN)-D verified R75's both purple bruises at different					
		a.m. DCS stated the nurses let the clinical coordinator kn plan.					
	aware R75 had the	p.m. RN-D stated she was n bruising and stated if she w ave updated the care plan.					
		tocol dated May 2013, direct d during daily cares or during					

	NT OF DEFICIENCIES OF CORRECTION	Alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		27752	B. WING		01/10/2014	
	PROVIDER OR SUPPLIER	-	DDRESS, CITY, S			10/2014
		5200 04	K GROVE PAF			
SAINT T	HERESE AT OXBOW	LAKE BROOKL	YN PARK, MN	55443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From pa	age 12	2 570			
	nursing) will be upd the policy indicated will be provided bas and application of t resident identified a integrity. The policy to revise the care p had been assessed The Resident Asse policy dated Septer purpose was to pro- interdisciplinary tea and implement an i evaluate the effecti treatment on an on indicated this proce- resident to achieve level. The policy lad plan of care on goin identified with new the MDS's. SUGGESTED MET The director of nurs educate all appropri- procedures. The director of nurs develop monitoring compliance.	the clinical or DON (director of lated immediately. In addition, resident care interventions sed on nursing assessment he nursing process for the as being at risk for altered skin a lacked who was responsible blan when any resident's skin d and noted to have an issue. ssment and Care Planning mber 2012, indicated the ovide a means for the am to assess residents, plan individualized care plan, and veness of their care and going basis. The policy ess was used to assist each /maintain an optimal functional cked information on revising a ng when any resident was issues or risk factors between THOD OF CORRECTION: sing (DON) or designee could driate staff on the policies and sing (DON) or designee could systems to ensure ongoing R CORRECTION: Twenty-one				

	ta Department of He				0/0 5	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		27752		B. WING		10/0014
	PROVIDER OR SUPPLIER	-	r ADDRESS, CITY, S		01/	10/2014
		5200 (DAK GROVE PAF			
SAINT TI	HERESE AT OXBOW		KLYN PARK, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 13	2 830			
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830			
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must re and treatment, personal a supervision based on ad preferences as identified i e resident assessment and scribed in parts 4658.0400 a ing home resident must be o possible unless there is a the attending physician that t ain in bed or the resident n bed.	n Ind Dut			
	by: Based on observat review, the facility f root cause and pro prevent bruising for reviewed for non- p Findings include: On 1/7/14, at 1:44	ent is not met as evidenced ion, interview and record failed to identify, assess for vide preventative measures r 1 of 3 residents (R75) pressure related skin issues p.m. R75 was observed to	to			
	at different stages explain how she go - At 5:22 p.m. R75 dining room table e	was observed sitting at the eating independently. A nursi at between R75 and other	0			
anosota D	(NA)-B stated if she	p.m. the nursing assistant e noticed any resident with report to the nurse immediat	ely			

	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		27752	B. WING		01/	10/2014
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
AINT TH	HERESE AT OXBOW		K GROVE PAF _YN PARK, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE
2 830	Continued From pa	age 14	2 830			
	Although NA-B stat to the nurse immed	e assessed the bruising. ted they would report bruises diately, the clinical record 75's bruises were reported and	ł			
	couch in the middle	a.m. observed R75 sitting on b lounge eyes closed, R75's es were visible at the time.				
	history of falls, Alzh degeneration of ret significant Minimum MDS indicated R75 impairment and rec all activities of daily Assessment (CAA) was at potential ris needing extensive times. The CAA inc dementia and was needs known. The	cluded dementia, personal neimer's disease, and macular ina obtained from the n Data Set dated 9/20/13. The to had severe cognitive quire extensive assistance for diving. The Care Area dated 10/4/13, indicated R75 k for pressure ulcers related to assist with bed mobility at dicated R75 had a diagnosis of not always able to make her Pressure Ulcer CAA lacked ing due to being a wanderer.	,			
	identified R75 was integrity due to alw bladder and occasi The care plan iden had self care defici goal indicated, "Ski directed to "monito	are plan dated 11/20/12, at risk for impaired skin ays being incontinent of onally incontinent of bowel. tified R75 was a fall risk and ts related to dementia. The in will remain intact" and r for skin changes during ring am/pm cares and notify				
	11/25/13, 12/2/13, a been noted on both	rogress Notes revealed on and 12/16/13, old bruising had n of R75's forearms. A nursing ed 1/9/14 (after concern had				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED		
		27752	- B. WING		01/	01/10/2014		
JAME OF F	PROVIDER OR SUPPLIER	-	DDRESS, CITY, ST		01/10/2014			
	HERESE AT OXBOW	5200 04	K GROVE PAR					
		BROOK	LYN PARK, MN	55443				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE		
2 830	Continued From pa	age 15	2 830					
	surveyor), indicated arms. The note ind the bruises were as - right upper forear - right mid forearm - right wrist 2 cm x - below right index - at base of right th - left upper forearm - left mid forearm 5 - area to left wrist/th Although the condi documented on the record lacked evide were assessed and to prevent further b On 1/9/14, at 8:40 c clinical coordinator supposed to be not clinical services, Do immediately. For the	m 6 centimeter (cm) x 8 cm; 3 cm 1 cm; 2.5 cm; finger 4 cm x 2.5 cm; umb 3 cm x 1 cm; 5 cm x 5.5 cm; 6 cm x 3 cm; op of hand 5 cm x 3 cm. tion of bruising was above dates, the medical ence R75's current bruises d measures were put in place oruising. a.m. the registered nurse (RN)-D stated, "I am tified and my boss [director of CS], of any bruises or falls ne bruises of unknown origin, posed to measure, document	n					
	and start the invest residents skin was weekly with bath/sh supposed to docun with cares. RN-D s needed to be addre confirmed both of F	igation." She further stated all supposed to be checked nower and the nurses were nent the resident skin condition tated if anything was noted it essed immediately. The RN-D R75's forearms had dark purpled the bruises were at different	n					
	are supposed to be She further stated to the clinical coordinates	a.m. DCS stated all bruises e documented by the nurses. the nurses are supposed to let ator know to update the care he skin issue every shift until						

STATE FORM

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		27752	B. WING		01/	10/2014
AME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	TATE, ZIP CODE		
AINT TH	HERESE AT OXBOW		AK GROVE PAR (LYN PARK, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 16	2 830			
	not aware R75 had sure R75 was a wa or ran into somethi stated if she was a the care plan.	p.m. the RN-D stated she was the bruising and one thing for inderer and may have bumpe ng causing the bruising but ware she would have updated	or id			
	stated she was not soon as the bruisin	p.m. DCS was interviewed aware of R75's bruises and a g had been brought to her pruises were assessed and been put in place.	as			
	if bruises are noted weekly skin check updated immediate indicated a residen provided based on application of the n	tocol dated May 2013, directe I during daily cares or during the clinical or DON will be ely. In addition, the policy t care interventions will be nursing assessment and ursing process for the residen at risk for altered skin integrit	nt			
	The director of nursi develop, review, an procedures to ensu- necessary care and director of nursing educate all appropri- procedures. The di	THOD OF CORRECTION: sing (DON) or designee could ad/or revise policies and are compliance to ensure d services for residents. The (DON) or designee could riate staff on the policies and rector of nursing (DON) or velop monitoring systems to mpliance.	1			
	TIME PERIOD FO (21) Days	R CORRECTION: Twenty-or	ie			
2 965	MN Rule 4658.060 -Nutritional Status	0 Subp. 2 Dietary Service	2 965			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		27752	B. WING		01/	10/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
SAINT TI	HERESE AT OXBOW		K GROVE PAR LYN PARK, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 965	Continued From pa	age 17	2 965			
	must ensure that a which supplies the determined by the assessment. Subs	onal status. The nursing home resident is offered a diet caloric and nutrient needs as comprehensive resident stitutes of similar nutritive value residents who refuse food				
	by: Based on observat review, the facility f	ent is not met as evidenced ion, interview and document failed to implement a new diet idents (R99) reviewed for				
	Findings include:					
	sodium, fat and ch	as changed from a limited high olesterol diet to a regular diet observed to not be 9/14.				
	facility due to weigh index (BMI, a numbre weight and height u identify possible we R99's weight was 8 16.8 on 1/8/14. Acc Disease Control (C	to be at nutritional risk by the ht loss and a low body mass ber calculated from a person's used as a screening tool to eight problems for adults). 38 pounds and the BMI was cording to the Centers for CDC) website, date of reference below 18.5 indicates a person				
		r dated 1/7/14, directed to give upplement and,ok for regula				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		27752	B. WING		01/	10/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
SAINT TI	HERESE AT OXBOW		K GROVE PAF YN PARK, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 965	dining room at a lar socializing. R99 ha served was tomato and a cookie. R99 the tomato soup, 1 and 25% of the free On 1/9/14, at 12:30 was asked how the the correct diet, DA chart, taped to the each residents nan was listed as requir sodium/fat/choleste DA-A confirmed RS diet. On 1/9/14, at 12:44 (LPN)-A checked th medical record and limited diet with reg found the regular d stated she would h	5 p.m. R99 was observed in the rge table eating lunch and d milk and water. The meal o soup with crackers, fresh fruit was observed to eat 100% of 00% of the milk and cookie sh fruit. 0 p.m. the dietary aide (DA)-A ey ensured residents received A-A showed the surveyor a wall in the kitchen, which listed ne and prescribed diet. R99				
	been receiving a restarting on 1/7/14. (MD)-A clarified and regular starting on	egular diet with regular texture At 1:01 p.m. R99's physician d confirmed the diet order was 1/7/14.				
	R99's low BMI as a ideal body weight r assessment also n with intake and door	sment dated 1/6/14, noted a concern and identified their ange as 95-115. The oted R99 was independent cumented intakes at meals ne assessment included "will ered."				
		p.m. the director of clinical s made aware R99's diet order				

TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	27752	B. WING		01/	10/2014
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•	
SAINT THERESE AT OXBOW I		K GROVE PAF YN PARK, MN			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLET DATE
kitchen still had R99 diet. DCS stated shi order was not yet im about the process of implemented the DO the electronic medic diet orders also wer a "diet order group" director. On 1/9/14, at 1:55 p was asked about R9 changed to a regula implemented on 1/7 with you, I didn't che The facility Diet Cha 2013, indicated it wa and nursing departri keep all diet orders change. The policy must be communica department in a time responsible for trans send an email to fac policy indicated whe new diet report was kitchen and staff for SUGGESTED MET The director of nurs develop, review, and procedures to ensur The director of nurs educate all appropri procedures.	egular diet on 1/7/14, and the egular diet on 1/7/14, and the e would investigate why the pplemented. When asked of getting new orders CS stated new orders go into cal record. DCS stated new re communicated via emails to which included the dietary o.m. the dietary director (DD) 99's diet order not being ar diet and not being 7/14, DD stated, "To be honest eck the email." anges policy dated December as the facility policy the dining nents would communicate to current, whether initial or a indicated all diet changes ated to the dining services ely manner. The staff scribing the new order would cility diet order group. The en a diet order changed, a printed by dietary for the the neighborhood kitchens. HOD OF CORRECTION: ing (DON) or designee could d/or revise policies and		DEFICIENCY)		

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		27752	B. WING		01/	10/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SAINT TI	HERESE AT OXBOW		(GROVE PAI (N PARK, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 965	Continued From pa	ge 20	2 965			
	TIME PERIOD FOF (21) Days	R CORRECTION: Twenty-one				
21525	MN Rule 4658.1309 Consultation	5 A.B.C Pharmacist Service	21525			
	services of a pharm Board of Pharmacy A. provides cor provision of pharma home; B. establishes and disposition of a detail to enable an C. determines	nsultation on all aspects of the acy services in the nursing a system of records of receipt Il controlled drugs in sufficient accurate reconciliation; and that drug records are ed and that an account of all				
	by: Based on interview facility's consultant irregularities with th Haldol (both antipsy	ent is not met as evidenced and document review, the pharmacist failed to identify e use of Seroquel and PRN ychotic medications) for 1 of 5 he sample reviewed for cations.				
	Findings include:					
	received quetiapine milligrams (mg) by of sleep (HS); Hald "Agitation/restlessn sublingual (under th	dated 11/7/13, indicated R27 fumarate (Seroquel) 50 mouth (PO) daily at the hour ol 0.25 milliliters (mI) PO for ess/abusive behaviors" ne tongue) every four hours n's Orders identified R27's				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDE	R/SUPPLIER/CLIA				E SURVEY PLETED	
		27752		B. WING		01/	01/10/2014	
NAME OF F	PROVIDER OR SUPPLIER		STREET AI	ADDRESS, CITY, STATE, ZIP CODE				
ΔΙΝΤ ΤΙ	HERESE AT OXBOW	ΙΔΚΕ		K GROVE PAR				
				YN PARK, MN	55443		1	
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE	
21525	Continued From pa	age 21		21525				
	diagnoses to incluc dementia without b Alzheimer's diseas	ehavioral dis	sturbance,					
	The Psychotropic M 11/26/13, identified medications were S behaviors and occu medications were, occurrence on day evening shift, and r The indications for were, "Agitation/Re on day shift, one oc no occurrences on indicated R27 had effects when last a	R27's curre Seroquel and urrences liste "Refusal of o shift, no occ to occurrence use for both estlessness: ccurrence on night shift." no involuntat	nt psychotropic I Haldol. The ed for both cares: One urrences on es on night shift." medications No occurrences evening shift, and The assessment ry movement side	1				
	Review of the Cher dated 11/26/13, ind - The assessment reviewed was "Traz therapeutic goal of Goal is to decrease to fall asleep, stay a number of restful s - Indications for the "Sleeplessness, ag inability to redirect. - The non-pharmac address the indicat medication were "1	licated the fo identified the zadone [sic], , "Diagnosis e agitation ar asleep, and i leep hours." e use of Traz itation, verba cological inte ions for the u :1, reassura	Ilowing: e medication " with the is sleep/agitation. nd increase ability ncrease the odone were al aggression, rventions to use of the nce, validation of					
	feelings, redirection environment for sle - The efficacy secti indicated, "No nurs describes agitation - The GDR section "Will address with t - The resident inpu	eep." on of the ass ing documer or sleepless of the asses the physiciar	sessment ntation noted that ness." ssment indicated, this quarter."					

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDE	R/SUPPLIER/CLIA				E SURVEY PLETED	
		27752		B. WING		01/	01/10/2014	
NAME OF F	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	TATE, ZIP CODE	1		
SAINT TH	IERESE AT OXBOW	LAKE		(GROVE PAF YN PARK, MN				
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		FICIENCIES CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21525	Continued From pa	age 22		21525				
	"Resident offers no sleep or feeling tire The assessment in plan updates "at thi Although the asses GDR with the physic evidence the physic potential GDR. The evidence a GDR for was attempted or a contraindicated. The care plan date at risk for behaviors insomnia, and agita Alzheimer's demen I [R27] currently rea manage these behapersonal always understand information regardi and/or care." The c "Monitor/Observe for insomnia, and susp paranoia and notify doctor/nurse practiv if I resist ADL care MD/NP as needed which could lead to as needed when I a residents. Remind information about c did not identify the lacked a focus for s interventions to pro- care plan lacked di	d/not rested dicated R27 is time." sment referr cian, the clir cian was con- e clinical reco or the use of a reduction w d 12/13/13, i s of "(parano ation) r/t [rela- tia." The car ceive Seroqu aviors. I have to become ir business at that I canno- ng other resi care plan dire or restlessne biciousness/f nurse and N tioner] as ne- or I refuse to if I resist tak medical dec ask questions me that I car other residen use of Trazo sleep and no- omote sleep.	in the morning." required no care red to address the nical record lacked sulted regarding a ord lacked Seroquel or Haldol as clinically dentified R27 was ia, restlessness, ted to] e plan identified, " rel every HS to e a strong twolved in other times. I do not t receive dents health ected, ess, agitation, earfulness r/t <i>ID</i> /NP [medical eded. Notify Nurse e eat. Notify ing medications, cline. Redirect me s about other not receive ts." The care plan done for sleep, n-pharmacological In addition, the					
	evaluation of R27's	sleep patter	ns.					
nocota Dr	Review of the Medi epartment of Health	ication Admir	nistration Records					

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		27752	B. WING		01/	01/10/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE			
	HERESE AT OXBOW	5200 0	AK GROVE PAF				
	HERESE AT UXBOW	BROOK	LYN PARK, MN	55443			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21525	Continued From pa	age 23	21525				
	2013 indicated the - The September, O December 2013 M offered for the diag Dementia" and Tra "Sleep/Agitation." T medications were a PRN Haldol doses - The January 2014 Seroquel and Traze administered as or 1/1/14, at 5:00 a.m administered. Review of the Trea (TARs) from Janua 2013 indicated beg Sleep" was monito included the numb 2:45 p.m. and 10:4 R27 occasionally s rarely slept 2:45 p.1 of sleep documenter record lacked evalue such as efficacy of sleeping for eight h R27's nursing Prog from 9/4/13, at 4:55 of Sleep, Did not sl [twice] to void, and a.m.]. Offers no co states 'one of those [sic] well'" At 7:27 "Resident was eas identified R27 aske	ary 2014 through September following: Dctober, November and ARs indicated Seroquel was proses of "Alzheimer's zodone was offered for The MARs indicated both administered as ordered. No were administered. 4 MAR indicated scheduled odone medications were both dered. MAR indicated on . R27 had PRN Haldol tment Administration Records ary 2014 through September ginning on 5/28/13, "Hours of red. The documentation er of hours slept by 6:45 a.m., 5 p.m. The TARs indicated lept 0.5-1 hour 6:45 p.m., m. and usually had eight hours ed at 10:45 p.m. The clinical uation of R27s sleep patterns, Trazodone and R27 usually hours during the night. gress Notes were reviewed gh 1/8/14 and revealed the D a.m. a note indicated, "Hours leep very well tonight. Up x2 incontinent at 0430 [4:30 mplaints of pain, discomfort, e nights that cannot fall sleep p.m. a note indicated, ily agitated today" and ed for "bath soap" from the ting she "pays the bills." The	S				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		DENTITIOATION NOMBER.	A. BUILDING: _				
		27752	B. WING		01/	/10/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
SAINT T	HERESE AT OXBOW		K GROVE PAR LYN PARK, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
21525	Continued From pa	uge 24	21525				
	note indicated the o updated and the ho to" R27. R27 refuse re-approached twice said she was not he accepted her show behaviors. - On 9/5/13, at 1:46 weight taken. - On 9/18/13, at 4:5 "Resident refused shave it tomorrow. V clinical record did n received the next d - On 10/23/13, at 10 refused the shower - On 11/20/13, at 10 refused the shower - On 12/4/13, at 10 refused the shower - On 12/4/13, at 10 refused the shower - On 1/1/14, at 5:01 medication adminis Administration Note Administration was identify the PRN me the medication was effer The clinical record of clinical indication antipsychotic medic The Monthly Medic indicated from 4/23/ (Seroquel) and Tra 11/20/13, the consu PRN Haldol was ac	 clinical coordinator was buse supervisor "came to talk ed supper after being te, R27 grew "agitated and ungry." The note indicated R2" er and had no further 6 p.m. R27 refused to have he is p.m. a note indicated, shower tonight. Said she will (SS [vital signs stable]." The not indicate if the shower was ay. 0:48 p.m. a note indicated R2". :0:53 p.m. a note indicated R2". :0:6 p.m. a note indicated R2". :10:53 p.m. a note indicated R2". :2:53 p.m. a note indicated R2". :3:6 p.m. a note indicated R2". :4:8 p.m. a note indicated R2". :5:9 p.m. a note indi					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		27752	B. WING	B. WING		10/2014
NAME OF	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, ST	ATE, ZIP CODE		
SAINT T	HERESE AT OXBOW		OAK GROVE PAR OKLYN PARK, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21525	Continued From pa	age 25	21525			
		cist documentation did not s with R27's medication				
	(CP)-F was contact the indications for the Seroquel should be she had alerted the monitoring needed verified restlessness enough of a clinicat the reasons should Stated indications for monitoring and det the pharmacy, but included in the aud	p.m. the consultant pharma ted via telephone and verifie the use of PRN Haldol and e "expanded on." CP-F state e facility the Target Behavior to be "expanded on." CP-F ss and agitation was not il indication for use and state have been noted on review for use, target behavior termining GDR was audited was unclear if R27 was lit. CP-F verified the sleep have been evaluated to of Trazodone.	ed ed ed v.			
	services (DCS) ver review target behav "they've [consultan past." DCS verified member of the Qua	4 a.m. the director of clinical rified CP-F was responsible viors and identify irregulariti t pharmacists] done that in the CP-F was not an active ality Assessment and tee. "After this, she will be."	to es the e			
	Monitoring policy a identified all reside alter behavior" wer diagnosis" and "rea medication. The po a "therapeutic goal - The policy further should be administ possible only after	notropic Medications and nd procedure dated 8/2012 nts receiving a medication " te to have an "approved ason for use" of the blicy indicated there should , and symptoms monitored. r indicated, "The drug chose tered in the lowest dose non pharmaceutical ntrol/alter the behavior have	'to be "			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			E SURVEY PLETED
		27752	B. WING		01/10/2014	
NAME OF	PROVIDER OR SUPPLIER	IDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE				
SAINT T	HERESE AT OXBOW		K GROVE PAF YN PARK, MN			
(X4) ID	SUMMARY ST		ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PRÉFIX TAG	· · · · ·	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLET
21525	Continued From pa	age 26	21525			
	attempt, directed to therapeutic goal" a related to the beha - The procedure din behaviors to monito specific and approp Agitation, anxiety, a explicit behaviors is procedure directed antipsychotic media distressful or harm examples such as kicking, hurting self property, physical s non-aggression be trying to leave with agitated behaviors sexual advances, e document on the "t and identified the "u responsible to eval and the Psychotrop Review would be u psychotropic media - The policy indicat antidepressant use addressed on the C antidepressants sh RAI (Resident Asse CAAs) and docume - The policy indicat psychoactive media per "regulation;" co pharmacy review, o and/or the family. T "does not agree to	ed, "F. Symptom(s) for must be identified and	t			

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		27752	B. WING		01/10/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE. ZIP CODE		
		5200 OA	K GROVE PAR			
SAINT T	HERESE AT OXBOW	BROOK	LYN PARK, MN	55443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21525	Continued From pa	age 27	21525			
	develop, review, ar procedures to ensu The director of nurs educate all appropri procedures. The director of nurs	sing (DON) or designee could id/or revise policies and ure compliance. sing (DON) or designee could riate staff on the policies and sing (DON) or designee could systems to ensure ongoing				
	TIME PERIOD FO (21) Days	R CORRECTION: Twenty-one	9			
21535	MN Rule4658.1315 Drug Usage; Gene	5 Subp.1 ABCD Unnecessary ral	21535			
	must be free from a unnecessary drug i A. in excessive therapy; B. for excessive C. without ade D. in the prese which indicate the a discontinued. In addition to the o part 4658.1310, th with provisions in th Code of Federal Re 483.25 (1) found in Operations Manual Long-Term Care Fa Department of Hea Health Care Finand This standard is ind available through th	quate indications for its use; o ince of adverse consequences dose should be reduced or lrug regimen review required in e nursing home must comply ne Interpretive Guidelines for egulations, title 42, section Appendix P of the State I, Guidance to Surveyors for acilities, published by the lith and Human Services, cing Administration, April 1992 corporated by reference. It is ne Minitex interlibrary loan ate Law Library. It is not	r n			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		27752	B. WING		01/10/2014	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
AINT TH	HERESE AT OXBOW		K GROVE PAF LYN PARK, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21535	Continued From pa	age 28	21535			
	by: Based on observar review, the facility clinical indications Seroquel (Quetiap and as needed (PI antipsychotic), failed failed to assess for reduction (GDR) of the facility failed to use of Trazodone used to treat sleep failed to assess an scheduled Seroqu	tion, interview and document failed to ensure appropriate for the ongoing use of ine Fumarate, an antipsychotic RN) Haldol (haloperidol, an ed to monitor for efficacy and r a potential gradual dosage f the antipsychotic medications evaluate sleep for the ongoing (an antidepressant medication problems) (R27); the facility ad monitor the ongoing use of el (R63); for 2 of 5 residents sample reviewed for lications.	, ,			
	Findings include:					
	Haldol without app ongoing use, lacker monitoring and lac potential GDR for t was warranted; alt R27's sleep, the fa	eduled Seroquel and PRN ropriate clinical indications for ed appropriate target behavior ked evaluation to determine if the use of the antipsychotics hough the facility monitored ucility did not evaluate the sleep fficacy of ongoing scheduled				
	received quetiapin milligrams (mg) by of sleep (HS); Halo "Agitation/restless sublingual (under t PRN; Trazodone H	dated 11/7/13, indicated R27 e fumarate (Seroquel) 50 mouth (PO) daily at the hour dol 0.25 milliliters (ml) PO for ness/abusive behaviors" the tongue) every four hours ICI 25 mg PO twice daily and IS. The Physician's Orders				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		27752	B. WING	B. WING		01/10/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
SAINT TH	HERESE AT OXBOW		K GROVE PAR LYN PARK, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21535	Continued From pa	age 29	21535				
	identified R27's diagnoses to include unspecified psychosis, dementia without behavioral disturbance, Alzheimer's disease, and encephalopathy.						
	dated 6/6/13, identi cognitive impairme problems and indic with all activities of - The Care Area As psychotropic drug of "Resident receives for a diagnosis of p antidepressant for Dementia and psyce resident has had ag abusive behaviors, exhibited since adr medication side eff reduction [GDR] as indicated the diagn Seroquel, the CAA specific behaviors such as paranoia of diagnoses for the u include sleep/insom identified Alzheime and psychosis as the antidepressant. The which warranted a indications to warra The clinical record GDR was consider - The CAA for ADL Potential dated 6/1 had declined, she r	a diagnosis of Alzheimer's chosis. Per previous facility gitation, restlessness and which none have been nission here. Will monitor ects and look at gradual dose indicated." Although the CAA osis of psychosis was used fo did not address resident associated with the diagnosis, or hallucinations. The use of Trazodone did not nnia and inappropriately r's (not a psychiatric condition) he diagnoses for the e CAA did not identify factors potential GDR, such as lack o ant the use of the medication. lacked further evidence a	r f				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
			-			
		27752	B. WING		01/	10/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
SAINT TI	HERESE AT OXBOW)AK GROVE PAF KLYN PARK, MN			
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET DATE
21535	Continued From pa	age 30	21535			
	remained at risk fo indicated, "Resider Trazodone through contribute to falls fo for side effects." - The CAA for cogr 6/19/13, identified I indicated, "Resider dementia and cogr R27's physician's F - On 9/5/13, the nu R27 and, "Patient of complaints." The n Mood, memory, aff The note further ind [sic] PRN and Que for sleepSince lat removed from hosp - On 10/11/13, the R27 and identified, normal. Dementia: isses [sic] noted. P have haldol [sic]" A from 9/5/13, identif Hospice, the MD P on hospice no new - On 11/22/13, the new complaints, R2 sometimes that this [the facility]." The r behaviors reported any previous visits 'Have people been Although the physic	Progress Notes indicated: irse practitioner (NP) had see offers no concerns or ote indicated, "Psychiatric: fect and judgement normal." dicated, "Currently on haldol tiapine. Uses trazaDCSe [sid st visit, patient has been pice [sic]." medical doctor (MD) had see "Psychiatric: Her behavior is Stable no behavioural [sic] t [patient] does not to [sic] Nthough the Progress Note fied R27 was no longer on progress Note contradicted, "	d en en S Pt			
	psychiatric data, th of indication for the	e documentation reflected la ongoing use of antipsychoti otes lacked review of R27	ck			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	27752	B. WING		01/	01/10/2014	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
HERESE AT OXBOW						
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE	(X5) COMPLET DATE	
Continued From pa	age 31	21535				
sleep and Trazodor	ne use.					
changes in R27's c problem of "feeling had the behavior of days during the ass remained independ The Psychotropic N 11/26/13, identified medications were S behaviors and occu medications were, occurrence on day evening shift, and r The indications for were, "Agitation/Re on day shift, one oc no occurrences on indicated R27 had effects when last as the review indicated the behaviors were antipsychotic use a indications for use. review identified low behaviors, the review GDR of the antipsy	ognition, R27 had mood tired or having little energy;" f "rejecting cares" occur 1-3 sessment period; R27 lent with all ADLs. Medication Review dated R27's current psychotropic Seroquel and Haldol. The urrences listed for both "Refusal of cares: One shift, no occurrences on no occurrences on night shift." use for both medications estlessness: No occurrences ccurrence on evening shift, and night shift." The assessment no involuntary movement side ssessed on 10/22/13. Although d a review of the behaviors, not appropriate for and did not reflect appropriate In addition, although the w numbers of the target ew did not address a potential chotic medications.					
dated 11/26/13, ind - The assessment reviewed was "Traz goal of, "Diagnosis decrease agitation asleep, stay asleep	licated the following: identified the medication being zaDCSe," with the therapeutic is sleep/agitation. Goal is to and increase ability to fall b, and increase the number of	3				
	PROVIDER OR SUPPLIER HERESE AT OXBOW SUMMARY STA (EACH DEFICIENC) REGULATORY OR L Continued From particles of the quarterly MDS changes in R27's c problem of "feeling had the behavior of days during the ass remained independ The Psychotropic N 11/26/13, identified medications were S behaviors and occu medications were, occurrence on day evening shift, and r The indications for were, "Agitation/Re on day shift, one oc no occurrences on indicated R27 had effects when last at the review indicated the behaviors were antipsychotic use at indications for use. review identified low behaviors, the revie GDR of the antipsy Review of the Cher dated 11/26/13, ind - The assessment reviewed was "Traz goal of, "Diagnosis decrease agitation asleep, stay asleep restful sleep hours.	IDENTIFICATION NUMBER: 27752 PROVIDER OR SUPPLIER STREET AI HERESE AT OXBOW LAKE 5200 OA BROOKI SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 31 sleep and Trazodone use. The quarterly MDS dated 11/26/13, indicated no changes in R27's cognition, R27 had mood problem of "feeling tired or having little energy;" had the behavior of "rejecting cares" occur 1-3 days during the assessment period; R27 remained independent with all ADLs. The Psychotropic Medication Review dated 11/26/13, identified R27's current psychotropic medications were Seroquel and Haldol. The behaviors and occurrences listed for both medications were, "Refusal of cares: One occurrence on day shift, no occurrences on evening shift, and no occurrences on night shift." The indications for use for both medications were, "Agitation/Restlessness: No occurrences on day shift, one occurrence on evening shift, and no occurrences on night shift." The assessment indicated R27 had no involuntary movement side effects when last assessed on 10/22/13. Although the review indicated a review of the behaviors, the behaviors were not appropriate for antipsychotic use and did not reflect appropriate indications for use. In addition, although the review identified low numbers of the target behaviors, the review did not address a potential GDR of the antipsychotic medications. Review of the Chemical Restraint assessment dated 11/26/13, indicated the following: - The assessment identified the medication being reviewed was "TrazaDCSe," with the therapeutic goal of, "Diagnosis is sleep/agitation. Goal is to decrease agitati	IDENTIFICATION NUMBER: A. BUILDING: 27752 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST HERESE AT OXBOW LAKE 5200 OAK GROVE PAR BROOKLYN PARK, MN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 31 21535 sleep and Trazodone use. The quarterly MDS dated 11/26/13, indicated no changes in R27's cognition, R27 had mood problem of "feeling tired or having little energy;" had the behavior of "rejecting cares" occur 1-3 days during the assessment period; R27 remained independent with all ADLs. The Psychotropic Medication Review dated 11/26/13, identified R27's current psychotropic medications were Seroquel and Haldol. 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WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE HERESE AT OXBOW LAKE S200 OAK GROVE PARKWAY BROCKLYN PARK, MN 55443 SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY ON LSC IDENTIFYING INFORMATION) ID PROVIDERS PLAN OF (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY ON LSC IDENTIFYING INFORMATION) PREPK TAG Continued From page 31 sleep and Trazodone use. 21535 The quarterly MDS dated 11/26/13, indicated no changes in R27's cognition, R27 had mood problem of "teeling tired or having little energy," had the behavior of "rejecting cares" occur 1-3 days during the assessment period; R27 remained independent with all ADLS. The Psychotropic Medication Review dated 11/26/13, identified R27's current psychotropic medications were Seroquel and Haldol. 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WING 01/ PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443 SUMMARY STATEMENT OF DEFICIENCIES IREGULATORY ON LSC DEEPICIENCIES REGULATORY ON LSC DEEPICIENCIES Silep and Trazodone use. ID PREFIX Trad PROVIDERS PLAN OF COORRECTION IEXAGL CORRECTION PARENCE CONFERCICE TO THE SHOLL DE IEXAGL CORRECTION IEXAGL CORRECTION IEXAGL CORRECTION IEXAGL CORRECTION IEXAGL CORRECTION SHOLL DE IEXAGL CORRECTION ON LSC DEAPICIENCIES OF THE ADDRESS PLAN OF COORRECTION IEXAGL CORRECTION ON LSC DEAPIC REGULATION ON LSC DEAPICE PROVIDERS PLAN OF COORRECTION IEXAGL CORRECTION IEXAGL CORRECTION ON LSC DEAPICE PROVIDERS PLAN OF CORRECTION IEXAGL CORRECTION ON LSC DEAPICE OF THE ADDRESS PLAN OF CORRECTION IEXAGL CORRECTION ON LSC DEAPICE PROVIDERS PLAN OF CORRECTION IEXAGL CORRECTION ON LSC DEAPIC PROVIDERS PLAN OF CORRECTION IEXAGL CORRECTION ON LSC DEAPICE PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION IEXAGL CORRECTION DETERS PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION	

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		27752	B. WING		01/10/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET #	ADDRESS, CITY, S	TATE, ZIP CODE		
SAINT TI	HERESE AT OXBOW		AK GROVE PAF LYN PARK, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
21535	address the indicat medication were "1 feelings, redirection environment for sle - The efficacy secti indicated, "No nurs describes agitation - The GDR section "Will address with t - The resident inpu "Resident offers no sleep or feeling tire The assessment in plan updates "at the Although the asses GDR with the physi evidence the physic potential GDR for T lacked evidence the Haldol were assess restraints or if a GD antipsychotic medic clinical record lacke a GDR was clinical addition, the asses antipsychotic indica verbal aggression, of Trazodone (an a	" cological interventions to ions for the use of the :1, reassurance, validation of n, provide quiet, dark eep." on of the assessment ing documentation noted that or sleeplessness." of the assessment indicated, the physician this quarter." t/education section indicated, o c/o [complaints of] inability to ed/not rested in the morning." dicated R27 required no care is time." ssment referred to address the cian, the clinical record lacked cian was consulted regarding frazodone. The clinical record e use of Seroquel and PRN sed as potential chemical DR for the use the ctaions was attempted. The ed documented evidence why ly contraindicated for R27. In sment inappropriately included ations such as "agitation, inability to redirect" for the use ntidepressant medication).	d d a			
	at risk for behaviors insomnia, and agita Alzheimer's demen I [R27] currently red manage these beh personality and try residents personal	d 12/13/13, identified R27 was s of "(paranoia, restlessness, ation) r/t [related to] ttia." The care plan identified, ceive Seroquel every HS to aviors. I have a strong to become involved in other business at times. I do not that I cannot receive				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		27752	B. WING		01/10/2014	
NAME OF	PROVIDER OR SUPPLIER	-	ADDRESS, CITY, STA	ATE, ZIP CODE		10/2014
SAINT T	HERESE AT OXBOW		AK GROVE PARH (LYN PARK, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21535	information regardi and/or care." The of "Monitor/Observe f insomnia, and susp paranoia and notify doctor/nurse practi if I resist ADL care MD/NP as needed which could lead to as needed when I a residents. Remind information about of Chemical Restraint plan update was w care plan did not id sleep, lacked a foc non-pharmacologic sleep. In addition, t for monitoring and patterns. Although for behaviors" of pa insomnia, and agita did not identify curr use of antipsychotic specific behaviors diagnoses. During all dates of 1/10/14, R27 was of concerns, was pleat appropriately with s Review of the Med (MARs) from Janua 2013 indicated the - The September, of December 2013 M. offered for the diag Dementia" and Tra	ng other residents health care plan directed, or restlessness, agitation, piciousness/fearfulness r/t r nurse and MD/NP [medical tioner] as needed. Notify Nurs or I refuse to eat. Notify if I resist taking medications, o medical decline. Redirect me ask questions about other me that I cannot receive other residents." Although the t assessment indicated no ca arranted on 11/26/13, R27's lentify the use of Trazodone for us for sleep and cal interventions to promote he care plan lacked direction evaluation of R27's sleep the care plan identified a "risk aranoia, restlessness, ation diagnoses; the care plan rent behaviors warranting the c medication or resident to reflect the above listed the survey 1/7/14, through observed to have no behavior asant and interacted staff and other residents.	e re or k al	DEFICIEN		

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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		27752	B. WING		01/	10/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
SAINT TH	IERESE AT OXBOW		NK GROVE PAF LYN PARK, MN			
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21535	Continued From pa	ige 34	21535			
	PRN Haldol doses - The January 2014 Seroquel and Trazo administered as oro 1/1/14, at 5:00 a.m. administered. The I PRN antipsychotic Review of the Treat (TARs) from Janua 2013 indicated beg Sleep" was monitor included the numbe 2:45 p.m. and 10:44 R27 occasionally sl rarely slept by 2:45 hours of sleep docu clinical record lacked patterns, such as e usually sleeping for R27's nursing Prog from 9/4/13, throug following: - On 9/4/13, at 4:59 of Sleep, Did not sl [twice] to void, and a.m.]. Offers no con states 'one of those [sic] well''' At 7:27 "Resident was easi identified R27 aske facility and R27 sta	administered as ordered. No were administered. I MAR indicated scheduled odone medications were both dered. MAR indicated on . R27 had PRN Haldol MAR did not indicate why the was administered to R27. tment Administration Records ry 2014 through September inning on 5/28/13, "Hours of red. The documentation er of hours slept by 6:45 a.m., 5 p.m. The TARs indicated lept 0.5 -1 hour 6:45 p.m., p.m. and usually had eight umented at 10:45 p.m. The ed evaluation of R27s sleep fficacy of Trazodone and R27 reight hours during the night. ress Notes were reviewed h 1/8/14 and revealed the 0 a.m. a note indicated, "Hours eep very well tonight. Up x2 incontinent at 0430 [4:30 mplaints of pain, discomfort, e nights that cannot fall sleep p.m. a note indicated, ly agitated today" and d for "bath soap" from the ting she "pays the bills." The clinical coordinator was				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		27752	B. WING			01/10/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE			
	HERESE AT OXBOW		K GROVE PAR				
		BROOKL	YN PARK, MN	55443			
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21535	Continued From pa	ge 35	21535				
	weight taken. - On 9/18/13, at 4:5 "Resident refused as have it tomorrow. V clinical record did m received the next d - On 10/23/13, at 10 refused the shower - On 11/20/13, at 10 refused the shower - On 12/4/13, at 10 refused the shower - On 12/4/13, at 10 refused the shower - On 1/1/14, at 5:01 medication administ Administration Note Administration was identify the PRN me the medication was effer The clinical record of clinical indication antipsychotic medic On 1/9/14, at 1:13 p nurse (LPN)-B state was documented in "LH Nursing Docum of the binder includ documentation of ta R27 indicated the r target behaviors ref	2:48 p.m. a note indicated R27					
	documentation indi documented for "Ag evening shift; a "+"	cated a "+ [plus sign]" was gitation/restlessness" on the was documented for "Refusal shift of 9/5/13. Although the					

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		27752	B. WING		01/10/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
SAINT T	HERESE AT OXBOW		NK GROVE PAF LYN PARK, MN			
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21535	Continued From pa	age 36	21535			
	documentation did times the behavior documentation for the R27 had no further September. - In both October and documentation indi- target behaviors of "Agitation/Restless behaviors identified November. - In December 2013 all hash marks for the month. Although or "Agitation/Restless target behaviors be documentation indi- marks and initialed specified for R27. Second to the behaviors were bla- identified in the mo- - In January 2014, I of cares and agitati- indicated no docum 1/1/4 thru 1/3/14. A documented sporate No target behaviors January 2014. The target behaviors January 2013 through Januar four months) and d of antipsychotic me On 1/9/14, at 2:01 p	cated staff documented hash for target behaviors not Spaces for both target nk. No target behaviors were nth of December. R27 was monitored for refusa on/restlessness. The form nentation for any shift from a"-" (hash mark) was dically the rest of the month; s were identified in early r monitoring indicated R27 has al problems since September ary 2014 (for approximately id not support the ongoing use	d d d			

STATE FORM

-	NT OF DEFICIENCIES		R/SUPPLIER/CLIA				E SURVEY PLETED	
		27752		B. WING	B. WING		10/2014	
NAME OF	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE				
SAINT T	HERESE AT OXBOW	LAKE		K GROVE PAR YN PARK, MN				
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		ICIENCIES EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21535	Continued From pa	age 37		21535	22.00.2.0			
	 When LPN-B was were monitored in rantipsychotic media would "look for agit described these as antsy." LPN-B furth restlessness as "pa all sorts of things;" R27 as being "upse" non-verbal commusomething with you - When asked what administering PRN there was a note in the medication was clinical record did mwarranting the use - When asked the range of the documentation, was a "negative" ar behavior occurred at on it." RN-B verified the behavior monitoring verified the indicated were not resident s admitted to the faci had an order for Hat discontinued." RN-B verified she assessed for GDR RN-B stated GDRs "Chemical Restrain Assessments." RN did not indicate a G indicate if the physi GDR and verified the physi GDR and verified the clinical rational why contraindicated. RN-B verified R27 	s asked what f relation to the cations, LPN- tation, restless s, "If she's [R2 her gave exam- acing, rumma for agitation L et" and staff w unication" suc ur hands." t the indication Haldol was, I the clinical re- s "effective," L not include a b of the drug. meaning of th , LPN-B states not include a b of the drug. meaning of th , LPN-B states not include a b of the drug. meaning of th , LPN-B states not include a b of the drug. meaning of the signard we "put a indications fo g were not res- ons for the us pecific. RN-B ility enrolled ir aldol which was a was unclear with the use of swere addres to r Psychotro -B confirmed aDR was atter- ician was noti- he clinical rec- y a GDR was	use of the B stated staff sness," and 7's] getting nples for ging, getting into PN-B described rould observe for h as "doing n for PN-B verified ecord identifying PN-B verified the behavior e hash marks in d the hash marks n [+]" indicated a progress note r use and target sident specific, e of PRN Haldol stated R27 was n Hospice and as "not when R27 was of antipsychotics. sed either on the opic the assessments npted, did not fied of a potentia ord lacked clinically					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		27752	B. WING	B. WING		10/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	HERESE AT OXBOW		K GROVE PAF YN PARK, MN			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLET
21535	Continued From pa	ige 38	21535			
	unclear which facility staff were supposed to monitor and evaluate the sleep data to determine efficacy of the Trazodone. RN-B verified the clinical record lacked documented evidence R27's sleep or the use of Trazodone had ever been evaluated. On 1/9/14, at 2:31 p.m. the consultant pharmacist (CP)-F was contacted via telephone and verified the indications for the use of PRN Haldol and Seroquel should be "expanded on." CP-F stated she had alerted the facility Target Behavior monitoring needed to be "expanded on." CP-F verified restlessness and agitation was not enough of a clinical indication for use and stated the reasons should have been noted on review. CP-F stated indications for use, target behavior monitoring and determining GDR was audited by the pharmacy, but was unclear if R27 was included in the audit. CP-F verified the sleep monitoring should have been evaluated to determine the ongoing efficacy of Trazodone.					
	services (DCS) stat indications for use she would "look at "what she [R27] wa affected her or othe specific target behaverified restlessness resident specific into of Seroquel and PF indications for the a	a.m. the director of clinical ted when determining of a psychotropic medication, the behaviors" and determine as doing" and "how it [behavior ers" and determine resident aviors for monitoring. DCS as and agitation were not dications for the ongoing use RN Haldol. DCS confirmed administration of the PRN				
	target behavior mo the clinical coordina assessments and b periods, target beh	hould have been documented; nitoring should be reviewed by ator quarterly during the MDS between the MDS assessment avior monitoring should be rses. DCS verified R27 had no				

STATEMEN	Dita Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		27752	B. WING		01/10/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
	HERESE AT OXBOW		AK GROVE PAF LYN PARK, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21535	Continued From pa	age 39	21535			
	behaviors documented to warrant the ongoing use of the antipsychotics. DCS verified Trazodone sleep logs should be evaluated quarterly to determine efficacy of the medication and verified the clinical record lacked evaluation for R27. The facility's Psychotropic Medications and					
	Monitoring policy a identified all reside alter behavior" wer diagnosis" and "rea medication. The policy a "therapeutic goal - The policy further should be administ possible only after interventions to con been attempted." T appropriate non ph attempt, directed to therapeutic goal" a related to the beha - The procedure dii behaviors to monite specific and approp Agitation, anxiety, a explicit behaviors in procedure directed antipsychotic media distressful or harm examples such as kicking, hurting sel property, physical s non-aggression be trying to leave with	nd procedure dated 8/2012, nts receiving a medication "to e to have an "approved ason for use" of the blicy indicated there should be , and symptoms monitored." indicated, "The drug chosen the drug chosen the lowest dose non pharmaceutical ntrol/alter the behavior have The procedure identified the procedure identified to be approved the procedure identified to be approved the procedure identified to be approved the procedure identified the procedure identified the drug ordered. The drug ordered the procedure identified to the drug ordered the procedure identified the drug ordered the drug ordered the drug ordered the drug ordered the procedure identified to the drug ordered the drug ordered the procedure identified to the drug ordered the drug ordered the drug ordered the procedure identified to the drug ordered the dru				
	property, physical s non-aggression be trying to leave with agitated behaviors sexual advances, e document on the "t	sexual advances)," physical haviors "(pacing, disrobing,	ft			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		27752	B. WING		01/	10/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	I	
SAINT TH	HERESE AT OXBOW		K GROVE PAR YN PARK, MN			
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21535	Continued From pa	age 40	21535			
	and the Psychotrop Review would be up sychotropic medic - The policy indicat antidepressant use addressed on the C antidepressants sh RAI (Resident Asso CAAs) and docume - The policy indicat psychoactive medi per "regulation;" co pharmacy review, c and/or the family. T "does not agree to	ed, "F. Symptom(s) for must be identified and				
	the facility failed to for ongoing use of	quel 25 mg every Friday and identify, assess and monitor the medication. cord for R63 dated 12/4/13.				
	included diagnoses depression.	s of dementia, aphasia, and				
	revealed R63 was every bedtime and to be given before mornings. The eve dated 8/13/13, inclu- bath/sponge bath i physician ' s order	ry Report dated 1/9/14, prescribed Seroquel 25mg 25mg every Friday for anxiety bath/shower on Friday ry Friday Seroquel orders uded directions of may try bed nstead. R63 also had a for Ativan (an anti-anxiety g for anxiety 30 minutes prior e.				
		dated 11/5/13, established mpaired cognitive skills for				

Minnesc	ta Department of He	ealth				1 APPROVE
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION		E SURVEY PLETED
	or connection	IDENTIFICATION NOMBER.	A. BUILDING:	<u> </u>	001	
		27752	B. WING		01/	10/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	TATE, ZIP CODE		
SAINT T	HERESE AT OXBOW		AK GROVE PAF			
		BROOK	LYN PARK, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21535	Continued From pa	age 41	21535			
	communication onl one person for tran MDS indicated reje The Care Area Ass dated 11/5/13, indic dementia with agita with daily cares and Seroquel use. The statements of staff dead when staff att medications and no bathing. The psych 11/5/13, identified F dementia with agita any non-pharmaco used for R63. The	oted some anxiety in regards to otropic medication CAA dated R63 was receiving Seroquel for ation. The CAA did not addres logical interventions being communication CAA dated R63 was not always able to	s r o i or			
	R63 had a history of very agitated and u and identified R63 The care plan direct psychotropic medic not to wash R63's h provide a calm app during the shower. re-approach at a la	lan dated 11/6/13, indicated of refusing showers, becoming pset during the shower activit did not like water on her head eted staff to administer a cation prior to shower, directed hair with the bath, directed to roach and offer reassurance The care plan directed to ter time if R63 became The care plan did not include bed bath to R63.	y			
	following: - On 7/26/13, the to get very agitated seemed very distre - On 8/2/13, the	ogress Notes indicated the e note indicated R63 continue during the shower and ssed at the mention of showe note indicated R63 was very shower, verbally very				

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		27752	B. WING		01/10/2014	
IAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
	HERESE AT OXBOW	ΙΔΚΕ	K GROVE PAF YN PARK, MN			
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PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLE
21535	Continued From pa	age 42	21535			
	 On 8/3/13, the upset all shift, the v resident she "felt st shower "on evening nurse practitioner [Ativan would be ap reduce agitation an - On 8/9/13, the receive shower, be mention of shower, go to bed after sup getting worse each - On 8/16/13, no physically aggressi The note indicated R63 every week. On 8/23/13, the was given, resident swearing and striki - On 9/13/13, the of Seroquel was given resident swearing and striki - On 9/20/13, the given prior to R63's R63 was still physic during the shower. On 9/27/13, the given at 5:00 p.m., verbally aggressive at ment R63 refused to enter got me last time, no - On 9/27/13, the given prior to the sl R63 was still physic during the shower. On 9/27/13, the given at 5:00 p.m., verbally aggressive at ment R63 refused to the sl R63 became "very and physically aggressive at ment R63 refused to the sl R63 became "very and physically aggressive at ment R63 refused to the sl R63 became "very and physically aggressive at ment R63 refused to the sl R63 became "very and physically aggressive at ment R63 refused to the sl R63 became "very and physically aggressive at ment R63 refused to the sl R63 became "very and physically aggressive at ment R63 refused to the sl R63 became "very and physically aggressive at ment R63 refused to the sl R63 became "very and physically aggressive at ment R63 refused to the sl R63 became "very and physically aggressive at ment R63 refused to the sl R63 became "very and physically aggressive at ment R63 refused to the sl R63 became "very and physically aggressive at ment R63 refused to the sl R63 became "very and physically aggressive at ment R63 refused to the sl R63 as very upset R63 as very up	note indicated R63 did not came anxious and agitated at pleaded with writer to let her per. Noted anxiety for shower week. ted R63 to be verbally and ve with staff during shower. the shower was upsetting for e note indicated R63's shower t was very upset after shower, ng out at staff. e note indicated an extra dose ven to R63. The shower was s "very agitated and verbally ion of shower," and indicated er spa room and told staff "you ot today." e note indicated Seroquel was s shower. The note indicated cally and verbally aggressive e note indicated Seroquel was R63 was still physically and				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		27752	B. WING	B. WING		10/2014
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
SAINT TI	HERESE AT OXBOW		K GROVE PAR LYN PARK, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21535	Continued From pa	age 43	21535			
	when staff left her a - On 10/25/13, tl	te indicated R63 calmed down alone. ne note indicated R63 was d verbal aggression was still				
	a nursing concern with cares, was ge	ss Note dated 9/6/13, indicated of non-cooperative behavior tting aggressive at times and en on Seroquel with no	d			
	noted staff reported bathing and noted	r Progress Note dated 10/8/13 d behavioral issues with R63 received Seroquel 25 mg 5mg as needed for agitation weekly bath.	,			
	January 2014, indic of increased rambl	or Forms from August 2013 - cated R63 had target behavior ing speech, verbally agitated, haviors with bathing were not pring.	s			
	member (FM)-A re bathing and did nor FM-A stated R63 w during and after ba used to take showe	on 1/8/14, at 9:03 a.m. family ported R63 had problems with t like to take baths or showers yould become very upset thing. FM-A further stated R63 ers regularly without problems what had caused the change.				
	stated R63 did not kick, yell and call a NA-A reported noti behaviors since Se R63 now needed to a shower. NA-A fur	a.m. nursing assistant (NA)-A like water and would scream, ngry names with showers. ng no difference in R63's eroquel was started and stated wo staff members to assist with ther stated when she gave 63 was "happy." At 9:34 a.m.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		27752	B. WING		01/	10/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•	
SAINT T	HERESE AT OXBOW		K GROVE PAF _YN PARK, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 44	21535			
	registered nurse (F very upset, verbally baths, and verified since the Seroquel stated R63 was mu On 1/9/14, at 9:57 a (RN)-B stated R63' (an anti-anxiety me to use Seroquel. R any notes about be "doesn't tell" her, sl reported R63 got a bath per her family On 1/9/14, at 12:27 again and stated it got a shower every know a bed bath w she noted R63 was visited the day afte On 1/9/14, at 12:39 services (DCS) sta need to have a sho more comfortable f choice." The DCS s alternatives to be u antipsychotic for ba	RN)-A stated R63 would get and physically abusive during the behavior had not improved was started on 8/13/13. RN-A uch calmer with a bed bath. a.m. the clinical coordinator 's family had requested Ativan edication), but the staff wanted N-B stated she had not seen shaviors with baths and if staff he "doesn't know." RN-B shower weekly versus a bed 's request. ' p.m. FM-A was interviewed was not a family request R63 ' week and stated she did not as an option. FM-A reported as still very upset when she r her showers. D p.m. the director of clinical ted weekly residents do not over and if a bed bath was for them, that was "their stated she would expect ised prior to using an athing.	1			
	stated he ordered S did not like the side MD-A further stated that was what he u MD-A stated he wo explain things to re	p.m. R63's physician (MD)-A Seroquel for R63 because he effects of benzodiazepines. d he used Seroquel because sually used in nursing homes. ruld expect facility staff to sidents to increase their ting any medications for				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		27752	B. WING		01/10/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
SAINT T	HERESE AT OXBOW		K GROVE PAR YN PARK, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21535	The director of nurs develop, review, an	HOD OF CORRECTION: ing (DON) or designee could d/or revise policies and	21535			
	educate all appropr procedures. The director of nurs	re compliance. sing (DON) or designee could iate staff on the policies and sing (DON) or designee could systems to ensure ongoing				
	(21) Days	R CORRECTION: Twenty-one				
21630	MN Rule 4658.1350 Medications; Destru) Subp. 2 A.B. Disposition of action	21630			
	remaining in the nu discharge of a resid prescribed, or any of discontinued perma manner recommen or the consultant ph pharmacist must fu instructions and for kept on file in the nu B. Unused port	ions of controlled substances rsing home after death or lent for whom they were controlled substance anently must be destroyed in a ded by the Board of Pharmacy narmacist. The board or the rnish the necessary ms, a copy of which must be ursing home for two years. ions of other prescription				
	death or discharge were prescribed or discontinued perma according to part 6 be returned to the p 6800.2700, subpart destruction listing th medication, prescri	the nursing home after the of the resident for whom they any prescriptions anently, must be destroyed 800.6500, subpart 3, or must bharmacy according to part 2. A notation of the ne date, quantity, name of otion number, signature of the he drugs, and signature of the				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		27752	B. WING		01/	10/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
SAINT TI	HERESE AT OXBOW		K GROVE PAF YN PARK, MN			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21630	Continued From pa	ige 46	21630			
	witness to the destr the clinical record.	ruction must be recorded on				
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure Fentanyl patches were destroyed in a manner to prevent potential diversion for 1 of 1 resident (R27).					
	Findings include:					
	following was rando On 1/9/14, at 7:28 a nurse (LPN)-B state patch and offer an o was observed to re- patch from a box, to observed to remain the patches and reco patches and Percoo Record. - At 7:33 a.m. LPN- date and initials on - At 7:39 a.m. LPN- explained the medic the Percocet, a full took the medication then retrieved glove patch from R27's le applied the new pat area. LPN-B was of patch in the empty and returned to the	a.m. the licensed practical ed she had to apply a Fentanyl oral Percocet to R27. LPN-B move one sealed Fentanyl wo sealed patches were in the box. LPN-B counted corded the number of Fentanyl cet in the Individual Narcotic B opened the patch, wrote				
	spent patch and Fe Sharps container (a	entanyl patch package in a a plastic container used to azardous equipment such as				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		27752	B. WING		01/10/20		
AME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
	HERESE AT OXBOW						
(X4) ID	SUMMARY ST		LYN PARK, MN	PROVIDER'S PLAN OF	COBBECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLE DATE	
21630	Continued From pa	age 47	21630				
	container was "full" Sharps container a nursing station. LPI over to neighboring placed the spent Fe container under the be alone and did ne witness the disposa - At 8:30 a.m. LPN- dispose of the Fent container and state facility policies to di differently, "I was to putting anything oth container." LPN-B policy and stated si coordinator (RN)-B - At approximately LPN-B (with survey patch disposal. RN could dispose of th container alone. On 1/9/14, at 9:05 a the Medications: Ce and procedure data indicated, "D. Narce removed from resid sharps container of RN-B confirmed the patches in Sharps, to dispose of or dea The policy directed verify the amount of disposal of "medicated	8:35 a.m. RN-B was asked by or present) regarding Fentany I-B stated she believed LPN-B e patch in the Sharps a.m. RN-B provided a copy of ontrolled Substances policy ed 5/2005. Review of the policy otic pain patches that are dents should be disposed of in r flushed in sewer system." e policy directed to dispose the but verified the policy directed stroy "narcotics" with two staff. I to "request another nurse to of drug being wasted" and ation in the sewer system with se/TMA [trained medication					
		-					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		27752	B. WING		01/	10/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE	1	
	HERESE AT OXBOW					
(X4) ID	SUMMARY STA		ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	COMPLET
21630	Continued From pa	ge 48	21630			
	CP-F stated "it was "recommendation" "flushed" and "with surveyor explained Controlled Substan stated she was not she had not seen th not go through me, assurance], it's not she was not consul Fentanyl patches, v as any narcotic and for diversion as "the in the patch to cause On 1/9/14, at 12:42 services (DCS) ver be disposed of eith "flush them." DCS s consulted when the CP-F was not the s the policy identified patches should be the facility had not	was contacted via telephone. not regulation," but her to have the Fentanyl patches essed" when disposed of. The the facility Medications: ces policy to CP-F, CP-F familiar with the policy and ne policy. "That [policy] does I'm not part of QA [quality a requirement." CP-F verified ted regarding disposal of verified it should be the same d verified there was a high risk ere is enough medication left se harm or to give affect/relief." P.m. the director of clinical ified Fentanyl patches should er in a Sharps container or to stated a pharmacist was e policy was developed, but ame pharmacist. DCS verified "narcotics" and the Fentanyl treated the same. DCS verified required a second nurse to ction of the narcotic patches				
	the medication. SUGGESTED MET The director of nurs	Vas a high risk for diversion of THOD OF CORRECTION: sing (DON) or designee could Id/or revise policies and				
	procedures to ensu The director of nurs educate all appropr procedures. The director of nurs					

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COM	PLETED
		27752	B. WING		01/	10/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	TATE, ZIP CODE		
SAINT TH	HERESE AT OXBOW		GROVE PAR N PARK, MN			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ,	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLETE DATE
21630	Continued From pa	ge 49	21630			
	TIME PERIOD FOR (21) Days	R CORRECTION: Twenty-one				
21980	MN St. Statute 626 Maltreatment of Vu	.557 Subd. 3 Reporting - Inerable Adults	21980			
	reporter who has revulnerable adult is to or who has knowled has sustained a phy reasonably explained information to the co individual is a vulner the individual is admr reporter is not requi	of report. (a) A mandated eason to believe that a being or has been maltreated, dge that a vulnerable adult ysical injury which is not ed shall immediately report the ommon entry point. If an erable adult solely because mitted to a facility, a mandated ired to report suspected a individual that occurred prior is:				
	another facility and believe the vulneral previous facility; or (2) the reporter k that the individual is	as admitted to the facility from the reporter has reason to ble adult was maltreated in the nows or has reason to believe s a vulnerable adult as defined				
	(b) A person not provisions of this s as described above (c) Nothing in this	 e, subdivision 21, clause (4). required to report under the ection may voluntarily report s section requires a report of maltreatment, if the reporter 				
	knows or has reaso been made to the c (d) Nothing in this	on to know that a report has				
	agency. (e) A mandated r reason to believe th	eporter who knows or has nat an error under section on 17, paragraph (c), clause				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		27752	B. WING	B. WING		01/10/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
SAINT T	HERESE AT OXBOW		K GROVE PAF LYN PARK, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21980	Continued From particular continued From particular continued From particular content of the subdivision. If the subdivision of the reported error with the reported error with the criteria under subdivision of the criteria under subdivision. The lead ager information when not the report under subdivision. This MN Requirem by: Based on observation of the administration agency (SA); in additional content of the content of the subdivision of aller residents (R75, R3 prohibition. Findings include: INJURIES OF UNKR75's bruises of unwere not immediate content of the	age 50 make a report under this reporter or a facility, at any an investigation by a lead ine or should determine that vas not neglect according to ection 626.5572, subdivision clause (5), the reporter or e to the common entry point or agency information explaining ts the criteria under section ion 17, paragraph (c), clause ncy shall consider this naking an initial disposition of bdivision 9c. ent is not met as evidenced ion, interview and document ailed to immediately report origin (bruises and skin tears r and the designated State dition, the facility failed to vas protected during ged verbal abuse for 3 of 4 5, R30) reviewed for abuse	21980				
	have several dark	4 p.m. R75 was observed to burple bruises to both forearms of healing. R75 was unable to ot the bruises.	s				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		27752	B. WING	B. WING		01/10/2014	
	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST				
AINT TI	HERESE AT OXBOW	ΙΔΚΕ	YN PARK, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
21980	Continued From pa	age 51	21980				
	dining room table e assistant (NA)-B w other resident cuin observed to ackno bruises. On 1/8/14, at 2:27 any resident with b nurse immediately the bruising. Althou report bruises imm	was observed sitting at the eating independently. A nursing ras sitting between R75 and g her to eat. NA-B was not wledge or asked R75 about the p.m. NA-B stated if she noticed ruises, she would report to the to ensure the nurse assessed ugh NA-B stated she would rediately, the clinical record re observed bruises were	e				
	sitting on the coucle eyes closed. The abe reading the pap other residents. The R75; R75's forearn visible during the a administrator was clearly visible, the documented evide R75's significant cl (MDS) dated 9/20/ included Alzheimen degeneration of the R75 had severe co extensive assistan living. The Pressur (CAA) dated 10/3/ ⁻ for pressure ulcers always being able	a.m. R75 was observed to be h in the middle lounge with her administrator was observed to be outloud to R75 and four he administrator sat next to ns and the bruises were clearly activity. Although the present and the bruises were clinical record lacked nce the bruises were identified hange Minimum Data Set 13, indicated R75's diagnoses r's disease and macular e retina. The MDS indicated bognitive impairment and require ce for all activities of daily re Ulcer Care Area Assessmen 13, indicated R75 was at risk a related to dementia, not to verbalize needs. The CAA or bruising due to being a					

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		27752	B. WING	B. WING		10/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
SAINT TI	HERESE AT OXBOW		NK GROVE PAF LYN PARK, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21980	Continued From pa	age 52	21980			
	integrity due to alwa bladder and occasi risk and self-care d care plan did not id but directed to "mo baths/showers, dur the nurse." Althoug R75 had potential f macular degenerat identified R75 wand other resident room R75 was at risk for		e			
	11/25/13, 12/2/13, a been noted on both Progress Note date been brought to the surveyor), indicated arms. The note ind the bruises were as - right upper forearm - right mid forearm - right wrist 2 cm x	m 6 centimeter (cm) x 8 cm; 3 cm 1 cm; 2.5 cm;	e			
	 at base of right th left upper forearm left mid forearm 5 area to left wrist/to Although the condition documented on the record lacked evided 	5 cm x 5.5 cm; cm x 3 cm; op of hand 5 cm x 3 cm. tion of bruising was above dates, the medical ence R75's current bruises measures were put in place				
	clinical coordinator supposed to be not	a.m. the registered nurse (RN)-D stated, "I am ified and my boss [director of CS], of any bruises or falls				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		27752	B. WING		01/	01/10/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE			
SAINT T	HERESE AT OXBOW		K GROVE PAR YN PARK, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21980	immediately. For the the nurses are supported and start the investive residents skin was a weekly with bath/shises and start the investive needed to be address of the bruises and verified and stated the bruise and verified and stated the bruise healing. On 1/9/14, at 9:42 a were supposed to be address of the bruise was stated she was supposed to be and if the bruise was stated she was supposed to let the update the care plate every shift until resort On 1/9/14, at 2:10 p (RN)-D stated she was to be notific causing the bruises. RN-D stated she was to be not stated she was to be not supposed to let the update the care plate every shift until resort On 1/9/14, at 2:10 p (RN)-D stated she was to be more the bruises aware of the bruise aware of the bruise aware of the bruise aware of the bruise to the administrator to the	e bruises of unknown origin, posed to measure, document igation." She further stated all supposed to be checked ower and the nurses were hent the resident skin condition ated if anything was noted it assed immediately. The RN-D R75's forearms had dark purple after looking at both forearms ses were at different stages of a.m. DSC stated all bruises be documented by the nurses as of unknown origin, the DSC posed to be notified boon as possible. DSC stated ed even when she was on ated the nurses were clinical coordinator know to n and monitor the skin issue plved. b.m. clinical coordinator was not aware R75 had the ed R75 "was a wanderer" and or "ran into something" g. b.m. DSC stated R75's bruises her attention and she was not s. DSC stated if she had been s, she would have started an diately, reported it immediately and immediately to SA. DSC vestigation had been started					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		27752	B. WING		01/	10/2014
	PROVIDER OR SUPPLIER		ET ADDRESS, CITY, S			10/2011
	noviden on our cien		OAK GROVE PAF			
SAINT TH	HERESE AT OXBOW		OKLYN PARK, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
21980	Continued From pa	ge 54	21980			
	10/19/13, redness a on 10/20/13, and bu unknown origin on	in tear to the right wrist on and swelling to the right har ruising to the right hand of 11/2/13; none of the injuries eported to the administrato	5			
	R35's diagnoses in history of a close fra- end humerus. The Interview of Mental measure cognitive indicated intact cog addition indicated F extensive physical activities of daily liv as being unsteady	dated 10/3/13, indicated cluded osteoporosis and acture unspecified part upp MDS indicated R35's Brief Status (BIMS-tool used to status) score was 15 (whic initive status). The MDS in R35 required limited to assist of one staff with ing (ADL's), R35 was ident with balance with transition th without assist and used elchair.	h ified s,			
	following: -On 10/19/13, a ski measuring 2 centim and R35 had report over her walker. Str note indicated staff -On 10/20/13, R35's red, swollen, warm remained intact. R3 indicated staff woul -On 11/2/13, R35's observed to have o skin tear and hand tender to touch. R3	ress Notes revealed the n tear to the right wrist neter (cm) x 1.5cm was not ted she had bumped her ha eri-strips were applied and would continue to monitor. s right hand was noted to b to touch and the Steri-strip 85 denied pain and the note d continue to monitor. top of right hand was ne Steri-strip from previous was bruised, swollen and 5 was not able to explain ned when asked and state	and the s s			

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		27752	B. WING		01/10/2014	
	PROVIDER OR SUPPLIER		DDRESS, CITY, S			10/2014
		5200 OA	K GROVE PAF			
SAINT TI	HERESE AT OXBOW		YN PARK, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21980	Continued From pa	age 55	21980			
	needs. -On 11/3/13, two nor remained swollen/p tender to touch and Scheduled pain me administered and F -On 11/4/13, an ear hand was bruised, that same day the F red, measured 35 of the way down to the with range of motion nurse practitioner (was ordered. The s	d continue to monitor R35's otes indicated R35's right hand ouffy, bruised, warm, and d R35 reported pain. edication and ice were R35 reported relief. rlier note indicated top of right reddened and swollen. Later bruise was noted to be dark cm x 15 cm, was swollen all e fingers. R35 reported pain on and with pressure. The NP) was updated and an x-ray k-ray results dated 11/4/13, s no evidence of acute bony				
	have liked both her have been notified	1 a.m. DCS stated she would rself and the administrator to of the right hand injury. The dministrator should have been y.				
	nurse (LPN)-C was LPN-C confirmed h verified he recalled able to recall the nu day. LPN-C stated bruising at the time the next shift to con hand. LPN-C confir supervisor about th hand. LPN-C stated R35 regarding the and the NA both the "by the vanity." LPN she went to the toil	B3 p.m. the licensed practical interviewed via telephone. he worked with R35 on 11/2/13 the bruising incident and was ursing Progress note from that there was more swelling, than and stated he had updated ntinue to monitor the right rmed he did not update the he condition of R35's right d he asked the NA assigned to skin issue. LPN-C stated he ought the bruise was caused N-C stated R35 had told him et "back and forth" and bed herself "on something."				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		27752	B. WING		01/	01/10/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET #	ADDRESS, CITY, S	TATE, ZIP CODE			
SAINT TH	HERESE AT OXBOW		AK GROVE PAF LYN PARK, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21980	Continued From pa	age 56	21980				
	VERBAL ABUSE A R30 was not protec alleged verbal abus	cted during an investigation of					
	indicated R30 had (NA) who had work before (on 6/26/13) indicated R30 repo	(VA) report dated 6/27/13, reported a nursing assistant and with R30 the evening was abusive. The report rted the NA screamed and her (R30's) eyes were okay an ."	d				
	household coordina "reported to me just her get to bed last discribed the abusi screaming at her [F eyes are okay and Although the email reported to the DSG evidence the allega						
	R30's diagnoses in kidney disease. R3 Status (BIMS-tool u	dated 10/24/13, indicated cluded dementia and chronic 0's Brief Interview of Mental used to measure cognitive 15 (which indicated intact					
	had decreased visi degeneration and v function CAA dated	n dated 5/17/13, identified R3 on due to macular vas legally blind. The visual I 2/5/13, also identified R30 with risk factors including	0				

STATEMEN	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		27752	B. WING		01/10/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET /	ADDRESS, CITY, S	TATE, ZIP CODE		
	HERESE AT OXBOW		AK GROVE PAP			
		BROOK	LYN PARK, MN	1 55443		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21980	Continued From pa	age 57	21980			
	blindness and dem	ientia.				
	incident was called (versus online repor- have a Medicare p (and could not com After the DCS revie the administrator h on 6/27/13, at 4:50 incident and stated and review the inci- investigation, "That care of her [R30]." investigation the N her [R30] too" and the unit. When ask R30 was safe from they continued wor during the investiga R30 was protected household coordina- the complaint in the actual report, what and that he had rep immediate supervise	58 a.m. DCS stated the I in by telephone to the SA pring) as the facility did not rovider number at the time inplete online reports to SA). were the VA log, DCS stated ad been notified the same day p.m. DCS recalled the I she would need to "go back" dent. DCS stated during the t NA was asked not to take DCS further stated during the A "went back and apologized to the NA continued to work on the alleged perpetrator while ked on the same unit as R30 ation, DCS was unclear how I. DCS confirmed the ator should have documented e clinical record including the the follow up at the time was ported the incident to his sor and herself.	9			
	had been notified of indicated earlier by	on 6/27/13, at 4:50 p.m. as DSC during interview. 56 a.m. when interviewed abou				
	the procedure hand the administrator s have been interview this had been done The administrator a	dling the allegation of abuse, tated she expected R30 to wed. The administrator stated by the clinical coordinator. added she would have				
	with R30 providing	oyee in question not to work direct care until education wa inistrator verified she would	s			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		27752	B. WING		01/	01/10/2014	
AME OF F	PROVIDER OR SUPPLIER	STREET	TADDRESS, CITY, S	TATE, ZIP CODE			
	HERESE AT OXBOW	IAKE	OAK GROVE PAR				
		BROO	KLYN PARK, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
21980	Continued From pa	age 58	21980				
	investigation if the s unit unless she was further stated the fa during an investiga R30 was not protect The administrator w have been docume should have include notification, details been done. On 1/10/14, at 12:1 coordinator stated basics on the incide send an email and	ent was protected during the staff continued to work in the s "sitting right there." She acility had suspended staff tion in the past and verified cted during the investigation. verified R30's incident should ented in the clinical record an ed: the initial complaint, of the incident and what had 16 p.m. the household usually he would document to ent/report, who he spoke wit immediately report to "my	e Id I I				
	the allegation and i the DSC, was not o record. The house should have docum	household coordinator verific incident, including reporting t documented in the medical hold coordinator verified he nented the incident.					
	policy dated Augus was completed who an unusual situatio matt, (unless it is o intentionally places bruises greater tha vulnerable areas ie	rt/Falls Scene Investigation t 2012, indicated the report enever a resident is involved n, such as a fall, roll onto a on care plan that resident s self on matt), lowered to flo n a quarter, bruises in e:groin, breast, face, fingerpri ent, resident to resident counted injuries.	or,				
	The director of nurs develop, review, ar procedures to ensu The director of nurs	THOD OF CORRECTION: sing (DON) or designee coul nd/or revise policies and ure compliance. sing (DON) or designee coul riate staff on the policies and	d				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		BENTH IOAHON NOMBER.	A. BUILDING: _	A. BUILDING:		
		27752	B. WING		01/	10/2014
IAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
SAINT T	HERESE AT OXBOW	IAKF	K GROVE PAR YN PARK, MN			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
21980	Continued From pa	age 59	21980			
	develop monitoring compliance. TIME PERIOD FOR	sing (DON) or designee could systems to ensure ongoing R CORRECTION: Twenty-one				
22000		6.557 Subd. 14 (a)-(c) Itment of Vulnerable Adults	22000			
	facility, except hom personal care atten- establish and enfor prevention plan. The assessment of the environment, and it factors which may of and a statement of to minimize the risk comply with any rul promulgated by the (b) Each facility, agency and person providers, shall dev prevention plan for residing there or re The plan shall cont assessment of: (1) abuse by other indi vulnerable adults; (other vulnerable ad specific measures to risk of abuse to tha	is population identifying encourage or permit abuse, specific measures to be taken of abuse. The plan shall es governing the plan e licensing agency. including a home health care al care attendant services velop an individual abuse each vulnerable adult ceiving services from them. ain an individualized the person's susceptibility to viduals, including other 2) the person's risk of abusing lults; and (3) statements of the to be taken to minimize the t person and other vulnerable poses of this paragraph, the				
						1

Minnesc	ota Department of He	alth				
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		27752	B. WING		01/1	0/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
SAINT T	HERESE AT OXBOW		GROVE PAR (N PARK, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
22000	knows that the vuln violent crime or an toward others, the i plan must detail the minimize the risk the reasonably be expe- facility and persons unsupervised. Und of a vulnerable adu misconduct or phy- such information fre authority or through another facility, and	ge 60 attendant services providers, erable adult has committed a act of physical aggression ndividual abuse prevention e measures to be taken to the vulnerable adult might ected to pose to visitors to the outside the facility, if ler this section, a facility knows lt's history of criminal sical aggression if it receives om a law enforcement a medical record prepared by other health care provider, or g assessments of the	22000			
	by: Based on document facility failed to imp policy regarding imp skin tear injuries of administrator, imme agency (SA) and to injury to rule out po addition, the facility (R30) during invest for 3 of 4 residents abuse prohibition. Findings include: The facility Vulnera Maltreatment of pol	ent is not met as evidenced at review and interview, the lement their abuse prohibition mediately reporting bruise and unknown origin to the ediately report to the State thoroughly investigate the tential abuse (R75, R35); in failed to protect a resident igation of alleged verbal abuse (R75, R35, R30) reviewed for ble Adult, Reporting of licy dated 8/28/2013, defined igainst a vulnerable adult that				

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPI F	CONSTRUCTION	(X3) DATE SURVEY	
		IDENTIFICATION NUMBER:	A. BUILDING:		01/10/2014	
		27752				
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•	
		5200 OA	K GROVE PAR			
SAINT II	HERESE AT OXBOW	BROOK	LYN PARK, MN	55443		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMF THE APPROPRIATE DA	
22000	Continued From pa	age 61	22000			
	aiding, and abetting defined unexplaine source) as, "An inju with an explainable The policy identifie fractures as report directed to report a to the appropriate of administrator immed directed upon rece abuse/neglect the of (DCS) would review externally to the SA further directed, "e abuse/neglect is su involved supervisor department head if should be placed of based on the poter abuse/neglect and/ environment. The of notice of investigat investigation by the INJURIES OF UNK R75's bruises of ur were not investigat administrator and S On 1/7/14 and 1/9/	uspected, determine with the r and/or appropriate the named employee(s) on investigative suspension ntial of further resident /or disruption of the work employee(s) will be given a ive leave pending e supervisor." KNOWN SOURCE hknown origin to both forearms ed and reported to the SA. 14, R75 was observed to have	, f t			
	different stages of was unable to expl and a facility staff v observations. The the bruises were id immediately to the	dark purple bruises at healing to both forearms. R75 ain how she got the bruises vas present during the clinical record lacked evidence lentified and/or reported administrator and SA; the ed evidence the bruises were				
	Unitical record lack		1			1

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 27752		(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY COMPLETED	
		B. WING		01/	01/10/2014	
			DDRESS, CITY, S	TATE, ZIP CODE		
SAINT TH	IERESE AT OXBOW		K GROVE PAR			
	SUMMARY STA		YN PARK, MN	PROVIDER'S PLAN OF	CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLE DATE
22000	Continued From pa	age 62	22000			
	Review of R75's Progress Notes dated 11/25/13, 12/2/13, and 12/16/13, indicated R75 had old bruises noted on both forearms.					
	were not brought to aware of the bruise aware of the bruise investigation imme- to the administrator	p.m. DSC stated R75's bruises b her attention and she was no bs. DSC stated if she had been es, she would have started an diately, reported it immediately r and immediately to SA. DSC vestigation had been started as reported to SA.	t			
		ht wrist and bruise to right rigin were not reported to the r and SA.				
	10/19/13, 10/20/13 tear to the right wris bruising, swelling a noted. The medical evidence the skin to origin had been rep SA for 16 days sind been identified on Progress Note date right hand was brui Later that same da dark red, measured swollen all the way reported pain with r pressure. The nurs updated and an x-r	ress Notes indicated on , 11/2/13, and 11/3/13 a skin st and the right hand redness, nd warm to touch had been I record lacked documented ear and bruising of unknown ported to the administrator and to the first time the issue had 10/19/13. The nursing ed 11/4/13, indicated top of the sed, reddened and swollen. y the bruise was noted to be d 35 cm x 15 cm and was down to the fingers. R35 range of motion and with e practitioner had been ay was ordered. The x-ray 13, indicated there was no pony injury.				
		1 a.m. DCS stated she would self and the administrator to				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 27752				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING			01/10/2014		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					•		
SAINT T	HERESE AT OXBOW		OAK GROVE PAP OKLYN PARK, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
22000	Continued From pa	age 63	22000				
	have been notified of the right hand injury. The DCS verified the administrator should have been notified immediately.						
	she was supposed anything including issues. She added any VA issues such neglect, bruising, a immediately. She f have been notified have contacted he The administrator origin should have the root cause ana	41 a.m. the administrator st I to be notified "Right away" building, resident or staff I the staff are to notify her o h as any suspicion of abuse anything they report to the S further stated the DCS shou on 11/2/13, and DCS shou r which had not been done. verified skin tears of unkno been investigated to detern lysis and verified investigated ed until after reporting has b	' of f State uld ld wn mine ion				
	ALLEGATION OF R30 was not prote alleged verbal abu	cted during an investigation	n of				
	indicated R30 had assistant (NA) who before 6/26/13, wa NA was screaming eyes were okay an During further door R30 had reported to on 6/27/13, at 3:45 correspondence to	(VA) report dated on 6/27/- reported to staff a nursing b had worked with her even is abusive. R30 reported the g and yelling at her that her id that she was not blind. ument review, it was reveal to the household coordinate 5 p.m. through e-mail b the DSC. The household documented R30's complain t record.	ing e ed or				
	stated during the ir assistant was aske	58 a.m. DCS was interview nvestigation "That nursing ed not to take care of her urther stated during the	ed				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 27752		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		07750				
					01/10/2014	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST K GROVE PAR			
SAINT T	HERESE AT OXBOW		YN PARK, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From pa	lge 64	22000			
	to her (R30) too" ar on the unit. DCS was the resident was pr still working on the DCS confirmed the have documented to record including the up at the time was incident to his imme On 1/10/14, at 11:5 interviewed verified protected during the continued to work i sitting right there. S suspended pending verified the R30 was investigation. The a incident should hav clinical record, inclu- notification, details been done which was SUGGESTED MET The director of nurs educate all appropri procedures. The director of nurs develop monitoring compliance.	THOD OF CORRECTION: sing (DON) or designee could id/or revise policies and				