STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245619	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Therese at Oxbow Lake	9751 Regent Avenue North Brooklyn Park, MN 55443

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43080 Based on interview and document review, the facility failed to develop a person-centered baseline care plan upon admission, and failed to assess, revise and implement new fall interventions for 3 of 3 residents (R1, R2, and R3) who admitted with fall risks and sustained falls after admission. Findings include: See CMS-2567 F689 for additional details. R1: R1's face sheet identified R1 admitted on [DATE] from the hospital. R1's primary diagnosis was a left femur (upper leg bone) fracture. In addition, R1 was diagnosed with neuropathy (condition impacting nerves), atrial fibrillation (Afib - irregular heartbeat), and a history of falls. A hospital Acute Physical Therapy (PT) Evaluation, dated 7/24/24, identified R1 was oriented only to herself and was an unreliable historian. She required one-step commands, increased time to follow the commands, and required repetition of them. PT evaluation additionally indicated R1 required verbal cues for safety, displayed limited to no clearance of her right foot from the ground which produced a shuffled, unsteady gait, and had decreased balance, strength, and activity tolerance. R1 was evaluated to be a fall risk and required Standard interventions, Posey sitter on, Seated positioning system in place, In chair, Call light in hand, All needs within reach. The evaluation directed R1 would need two staff for mobility upon discharge. A hospital progress note, dated 7/24/24 at 10:29 p.m., identified R1 sundowns (increased confusion later in the day) due to baseline dementia. R1's Hospital Discharge Summary, dated 7/26/24, identified R1 presented to the emergency department (ED) for evaluation after an unwitnessed mechanical fall. She was found to have an intertrochanteric left proximal femur fracture and underwent surgical nailing. In addition, she was diagnosed with acute blood loss anemia on top of her chronic anemia. Chronic diagnoses included: chronic pain/neuropathy and low back pain related to spinal stenosis (narrowing of the spine) which required a muscle relaxant and an anticonvulsant with pain management benefits, afib which required a blood thinner, heart failure which required diuretics (reduce fluid), hypertension (HTN - high blood pressure), and memory impairment. R1 was discharged with a new opioid medication order for pain. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Admission Assessment, dated 7/26/24, identified R1 was alert and oriented to herself, location, and situation, and lacked communication concerns. Her ability to walk was severely limited or non-existent and she was unable to bear her own weight. R1 was incontinent of bowel and bladder and was prescribed an anticoagulant medication (blood thinner). She had current or recent history of pain in the past five days, and she experienced left sided weakness. She had a fall in the past month prior to admission, as well as the last two to six months; however, no fractures related to these falls. R1's initial 48-hour baseline care plan, initiated 7/26/24, identified the following information: -Elimination: R1 was incontinence of bowel and bladder; however, lacked additional details. Goal was to maintain skin integrity. Interventions lacked number of staff for toileting assist. Staff were directed to offer and encourage toileting upon rising, before and after meals, at bedtime and upon request and were also directed to toilet her more frequently, as she was incontinent and a high fall risk, without specified frequency. -Activities of Daily Living (ADL's): R1 demonstrated impaired ADLs; however, lacked additional details. Toileting and transfer interventions did not specify required care assist, nor was the use of two staff and/or a mechanical lift identified. -Cognition: impairments and sundowning were not addressed. -Diagnoses: anemia was not addressed. -Cardiovascular: the diagnoses of afib, CHF, and HTN were not addressed. -Pain: the diagnosis of femur fracture with surgical repair, neuropathy, and chronic pain with spinal stenosis, and the need for opioid and muscle relaxant medications were not addressed. -Falls: [R1] is at risk for a fall and/or fall related injury due to (specify) (a history of previous falls, there are fall risk factors present as determined by the fall risk assessment). R1's fall goal was to remain free of falls with injury and directed staff kept R1's room free of clutter, safe and appropriate footwear with mobility and when up without shoes, call light and personal belongings within reach, correct low bed positioning, seated edge of bed for a few minutes before standing up and reminding and reinforcing R1 on safety awareness during mobility. A progress note, dated 7/27/24 and entered at 3:32 a.m., identified R1 was found at 2:50 a.m. lying on the floor. The note indicated R1 attempted to get to the bathroom. Interventions put into place were Frequent checks and reminders to R1 to use her call light. A progress note, dated 7/28/24 and entered at 7:44 a.m., identified a Brief Interview for Mental Status (BIMS) was conducted with R1 and she demonstrated severe cognitive impairments, mainly related to short-term memory loss. R1's Fall Risk-Assessment, dated 7/31/24, indicated R1's fall risk was increased due to the use of opioids and muscle relaxants, along with incontinence, inability to stand/walk by self, and her diagnoses of the femur fracture, history of falling, and HTN. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prior to R1's discharge on 8/1/24 (six days after admission) , the 48-hour baseline care plan lacked individualized fall risk, and associated interventions based on her fall risks (cognitive impairments, cardiovascular diagnoses, pain conditions, femur fracture, ADLs impairments, fall history prior to admission and after, self-transfers, bowel and bladder incontinence, along with the individualized interventions of specific bed positioning, specialized toileting frequency, and frequent check designation. R2: R2's face sheet identified R2 admitted on [DATE] from the hospital. R2's primary diagnosis was a left femur neck fracture. In addition, R2 was diagnosed with a traumatic brain injury (TBI), multiple rib fractures, left shoulder scapular fracture, and a fall. An Order Summary Report identified R2 was provided a medication for BPH (benign prostatic hyperplasia - enlarged prostate gland) and anemia. R2's Admission Assessment, dated 7/20/24, identified R2 had a fall in the past month prior to admission, as well as the last two to six months in which a fracture was the result of a fall. Fall risks were identified as incontinence, short term memory deficit, and change in environment. R2's initial 48-hour baseline care plan, initiated 7/20/24, identified the following information: -Elimination: incontinence was not addressed. -Activities of Daily Living (ADL's): R2 demonstrated impaired ADLs; however, lacked additional details. Toileting and transfer interventions did not specify required care assist. -Cognition: R2's cognitive was impaired; however, lacked additional details. His goal was to make safe routine decisions with cues/supervision. Interventions directed staff to ask yes/no questions, allow time for decision making and response, and to take time to explain care before providing it. -Pain: R2 experienced pain; however, lacked additional details related to the femur fracture with surgical repair, rib, and shoulder fractures. -Falls: [R2] is at risk for a fall and/or fall related injury due to (specify) (a history of previous falls, there are fall risk factors present as determined by the fall risk assessment). R2's fall goal was to remain free of falls with injury and directed staff kept R2's room free of clutter, safe and appropriate footwear with mobility and when up without shoes, call light and personal belongings within reach, correct low bed positioning, seated edge of bed for a few minutes before standing up and reminding and reinforcing R2 on safety awareness during mobility. A progress note, dated 7/21/24 and entered at 3:18 a.m., identified R2 was found at 10:40 p.m. the previous evening lying on the floor. The note indicated R2's bed was at the lowest position and his call light was within reach, but he did not use it. He was confused. Staff were to check on him every two to three hours and as needed. A progress note dated, 7/21/24 and entered at 7:29 a.m., identified R2 informed staff he was on the floor last night as he rolled out of bed. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Fall Post Assessment, dated 7/21/24 at 7:52 a.m., identified R2's 7/20/24 fall. The note identified staff were to check on R2 every two to three hours. A progress note, dated 7/21/24 and entered at 3:17 p.m., identified R2 disliked the opioid pain medication as it made him feel too tired and that he required close supervision as R2 tends to scoot his butt down in recliner and w/c (wheelchair). He was more lucid and oriented once he woke up. A progress note, dated 7/21/24 and entered at 3:25 p.m., identified R2 was found at one point scooted down in his recliner and required two staff and the mechanical lift to sit him up safely. A progress note, dated 7/22/24 and entered at 3:26 p.m., identified an in-depth bowel and bladder review was completed on R2. He was frequently incontinence of bowel and always incontinent of bladder. An OT progress note, dated 7/22/24, indicated a SLUMS (The St. Louis University Mental Status) test was completed with R2. He scored 13 out of 30 which indicated a dementia category. R2's Fall Risk-Assessment, dated 7/23/24, identified R2's had a fall with no injury since admission. The assessment indicated R2 was oriented to self only. R1's fall risk was increased due to the use of muscle relaxant medication, along with incontinence, inability to stand/walk by self, and self-transfers, along with his diagnoses of the femur fracture and HTN. The Overall Comments section indicated R2 required extensive [physical] assist of one to two staff using a mechanical lift and that R2 was forgetful with poor judgment related to dementia. A progress note, dated 7/24/24 and entered at 4:47 p.m., identified around 3:45 p.m. R2 was found on his bathroom floor. R2 informed staff he 'was trying to go use the bathroom.' A Risk Management Unwitnessed fall incident report, dated 7/24/24, identified R2's 7/24/24 bathroom fall. The immediate Action Taken identified a check and change every two - three hours was put into place. R2's July 2024 Medication Administration Record, identified on 7/25/24 at 1:00 p.m. a nursing order which directed the nurse to remind staff to help transfer [R2] to bed/recliner after lunch to prevent falls. in the morning to prevent fall. An OT progress note, dated 7/25/24, identified OT placed a maintenance request for anti-roll back devices on R2's w/c for fall prevention due to his posture and education needed for keeping hips all the way back in the w/c. On 7/25/24 (five days after admission), R1's baseline care plan was updated with transfer designation. On 8/3/24 (14 days after admission), R1's baseline care plan was updated with pain related to chronic pain and recent surgery, toileting assist of one staff, and cognitive status for TBI. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's baseline care plan, prior to the abbreviated survey (16 days after admission), lacked information related to bowel and bladder incontinence or any adjustments related to the fall interventions for check and change and routine checks every two to three hours, the encouragement for bed/recliner placement, anti-tip device use, or monitoring/encouragement for w/c positioning, bed positioning, self-transfers. R3: R3's face sheet identified R3 admitted on [DATE] from the hospital. R2's primary diagnosis was a cystostomy catheter [urinary tract] infection. In addition, R3 was diagnosed with diabetes, Parkinson's Disease, HTN, afib, and weakness. A hospital PT note, dated 7/10/24, indicated R3 had a history of falls at home and was a fall risk during her hospital stay. R3's Admission Assessment, dated 7/12/24, identified R3 utilized a suprapubic catheter (SP) for urination. She was unable to ambulate and had a fall in the past month prior to admission, as well as the last two to six months. Additional fall risk factors included change in environment and mobility deficit with ambulation. R3's initial 48-hour baseline care plan, initiated 7/12/24, identified the following information: -Elimination: R3 utilized an assistive device; however, lacked additional details. The SP catheter was not addressed, nor the urinary tract infection. In addition, the need for enhanced precautions was not addressed. -Activities of Daily Living (ADL's): R3 demonstrated impaired ADLs; however, lacked additional details. Toileting and transfer interventions did not specify required care assist. -Cognition: impairments were not addressed. -Diagnoses: diabetes and Parkinson's were not addressed. -Cardiovascular: the diagnoses of afib and HTN were not addressed. -Falls: [R3] is at risk for a fall and/or fall related injury due to (specify) (a history of previous falls, there are fall risk factors present as determined by the fall risk assessment). R3's fall goal was to remain free of falls with injury and directed staff kept R3's room free of clutter, safe and appropriate footwear with mobility and when up without shoes, call light and personal belongings within reach, correct low bed positioning, seated edge of bed for a few minutes before standing up and reminding and reinforcing R3 on safety awareness during mobility. A progress note, dated 7/15/24, identified a BIMS was conducted with R3, and she demonstrated moderate cognitive impairments. On 7/15/24 (three days after admission), the baseline care plan was updated to reflect R3's SP and UTI status. In addition, her ADL status was updated to reflect her weakness and staff assist. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A provider note dated 7/16/24, identified R3 was diagnosed with Parkinson's Disease, recurrent UTI, neurogenic bladder with SP catheter, recent encephalopathy (damage or disease impacting the brain), afib, diabetes, and dementia in which R3 was a poor historian and required the aide of her daughter for questions during the provider visit. R3's heart rate during the visit was irregularly irregular. R3's Fall Risk-Assessment, dated 7/16/24, identified R3 was free of falls since admission and was a lower risk for falls based on the information entered into the assessment. The Overall Comments section identified R3 required assist of one staff for transfers and activities of daily living. A Fall Post Assessment, dated 7/28/24, identified R3 fell that day at 9:00 p.m. She was found on her bedroom floor after she self-transferred and lost her balance. A Risk Management Unwitnessed fall incident report, dated 7/28/24, identified R3's 7/28/24 fall. The incident report identified R3 informed staff she was rearranging cloths in her closet when she fell . An immediate action taken was the placement of a call do not fall sign and reorientation to the unit and the processes to ask for help if needed. A late entry progress note, dated 7/29/24 at 10:09 a.m., entered on 8/6/24 at 11:09 a.m., identified IDT met to review R3's fall. The note identified R3 displayed confusion and poor safety awareness. She worked with therapy to build strength related to the Parkinson's and a recent urinary tract infection (UTI). R3 reported she was rearranging some cloths in her closet at the time of the fall. R3 was aided with her cloths and a call do not fall sign was placed. R3's baseline care plan, prior to the abbreviated survey (24 days after admission), lacked any adjustments related to the fall interventions for a call do not fall sign, devices and/or processes to assist with obtaining and/or acquiring clothing, or interventions related to the clavicle fracture and any associated pain and/or treatment (diagnosed five days prior to the survey). In addition, the care plan lacked information related to R3's Parkinson's Disease. During observation and interview on 8/6/24 at 10:53 a.m., R3 sat in her w/c. R3's w/c was without adaptive devices and a soft-touched call light was near her. Her bedroom and bathroom environment lacked such devices as a Reacher to assist with picking up things from the floor which would help her obtain things from her closet. In addition, the environment lacked CALL TO NOT FALL sign(s). During observation and interview on 8/6/24 at 10:41 a.m., R2 sat in his wheelchair. R2's w/c had anti-lock and anti-tip devices. R2's environment was observed which lacked fall mitigation signs and/or devices. When interviewed via telephone on 8/6/24 at 11:55 a.m., R1, R2, and R3's medical provider (MD) stated individualized fall interventions should be implemented upon admission, if considered a fall risk, and then right after the first fall these should be reviewed and adjusted. After further discussion of R1, R2, and R3 care plan interventions, MD indicated he would have thought staff would have initiated more specific interventions, adding, That is someone's job to put those precautions in place. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview in R3's room on 8/6/24 at 1:27 p.m., with R3 and R3's family member (FM)-A, a CALL DO NOT FALL sign was located on the wall to the left of where R3 sat in her room when her husband was not there. This sign was not present during R3's interview at 10:53 a.m. FM-A stated staff brought the sign in today, while he was there, and hung it up around 12:30 p.m. He, or R3, were unaware of why it was placed other than staff stated it was a reminder for her to use the call light instead of getting up on her own. FM-A identified R3 fell many times prior to her admission. Due to this, they had a routine at home to help mitigate her falls which occurred from the time she got up in the morning to the time she went to bed. When interviewed on 8/6/24 at 1:52 p.m., nursing assistant (NA)-C stated one of the ways she was aware of residents' fall risk was based the Kardex (NA care plan). NA-C stated there could perhaps be more information on the Kardex to assist with fall risk interventions, especially as the Care Guides just indicated fall risk and not much else. When interviewed on 8/6/24 at 2:26 p.m., registered nurse (RN)-C stated she edited the baseline care plan upon admission for fall risk, via the admission assessment process. Once she was done with the admission assessment, she did not adjust the care plan further. RN-C explained she just checked the care plan associated boxes in the assessment and did not edit the information as this was the responsibility of the managers. RN-C identified fall interventions were based on the fall risk(s) and any fall circumstances; however, a lot of the time it is just to remind then to use the call light. Not necessarily would she put interventions into place after a fall, but she explained the benefit of interventions were to decrease a fall from reoccurring. During an interview on 8/7/24 at 11:15 a.m., RN-A stated on admission, when the admission assessment process was performed, fall interventions were checked, and edited, based on fall risk information that was embedded in hospital information, the hospital discharge summary, from the hospital nurse to nurse report, and then conversations with the resident and family upon admission. After this, and once therapy evaluated the resident, the care plan then again would be adjusted. RN-A was unable to provide a definitive answer related to fall interventions after a fall; however, she felt an intervention should be put into place right away to prevent further falls. When interviewed on 8/7/24 at 11:46 a.m., RN-D stated they were expected to initiate the baseline fall care plan and interventions via the admission assessment as this assessment helped build the care plan with auto-generated steps based on how they answered certain questions. After this assessment was completed, RN-D explained she did not perform any baseline care plan edits as this was then the responsibility of the nurse manager to fill in the specific details. RN-D was unconcerned the plan of care was not updated with these specifics right away, or that the care plan was edited to include individual fall interventions upon admission, as staff constantly were in resident rooms and frequently checked on everyone. She did not feel there was anything else which could be initially done other than the admission assessment process and the generalized interventions. RN-D stated the care plan was the ultimate area for information which fired to the Kardex. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/7/24 at 12:23 p.m., RN-E identified herself as the nurse manager. She explained fall risk was determined on admission and fall interventions were expected to be implemented via the admission assessment/baseline care plan process to decrease fall risk which included actions such as making sure the call light is within reach, bed in proper position, etc. After this, she then went into the care plan the day after admission and/or after the resident worked with therapy, and adjusted it as needed. She expected the nurses edited the baseline care plan options when checked and edits were indicated; however, this did not happen. RN-E explained the benefit of these initial edits would increase staff knowledge related to resident care as the care plan would be more individualized. RN-E stated she was involved in a monthly fall committee which worked on an increased fall etiology. As of this date, they were unable to determine any causes. When a fall occurred, RN-E expected an intervention to be implemented pretty much right away; however, staff typically waited for her to do this, especially if a fall occurred during the night hours. During a follow-up interview on 8/7/24 at 2:57 p.m., RN-E stated the terminology of frequent checks was vague and could range from every 15 minutes to every two to three hours depending on the resident and the associated situation. She explained she often read the intervention of frequent checks in the charting; however, it would be important to ensure this type of intervention was specific and not open to staff interpretation. RN-E stated she expected accuracy when staff completed the Fall Risk Assessment, otherwise, How are we going to take care of [the residents] if not accurate? During an interview on 8/7/24 at 3:28 p.m., the director of nursing (DON) stated an admission assessment was completed upon admission which included fall risk information and during this process, the baseline care plan options were embedded within the assessment and populated based on how the assessment questions were answered. She expected the admission nurse to edit the baseline care plan options within the assessment before the assessment was completed to provide care information from the moment they arrive. She explained this editing was a work in progress. Next, the nurse managers were expected to do a chart audit the next business day and were to update the care plan with individualized interventions, if not completed by the admission nurse. During the 72-hour care conference, she expected the care plan to be printed off, reviewed with the resident and the family, and then adjusted as needed with individualized interventions. The DON acknowledged the floor nurses do not have access to edit the care plan outside of the admission assessment process, thus the reason she expected them to adjust the baseline care plan when they completed the admission assessment. Care plan policy(s) were requested. A comprehensive Care Plans policy, dated October 2023, was provided. The policy directed staff to develop and implement a comprehensive person-centered care plan to meet a resident's medical, nursing, and mental and psychosocial needs identified in the resident's comprehensive assessment. The policy does not identify baseline care plan processes.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43080 Based on observation, interview and document review, the facility failed to comprehensively assess fall risk and implement individualized fall interventions to reduce the risk of falls for 3 of 3 residents (R1, R2, R3) reviewed for accidents. Findings include: R1: R1's face sheet identified R1 admitted on [DATE] from the hospital. R1's primary diagnosis was a left femur (upper leg bone) fracture. In addition, R1 was diagnosed with neuropathy (condition impacting nerves), atrial fibrillation (Afib - irregular heartbeat), and a history of falls. A hospital Acute Physical Therapy (PT) Evaluation, dated 7/24/24, identified R1 was oriented only to herself and was an unreliable historian. She required one-step commands, increased time to follow the commands, and required repetition of them. PT evaluation additionally indicated R1 required verbal cues for safety, displayed limited to no clearance of her right foot from the ground which produced a shuffled, unsteady gait, and had decreased balance, strength, and activity tolerance. R1 was evaluated to be a fall risk and required Standard interventions, Posey sitter on, Seated positioning system in place, In chair, Call light in hand, All needs within reach. The evaluation directed R1 would need two staff for mobility upon discharge. A hospital progress note, dated 7/24/24 at 10:29 p.m., identified R1 sundowns (increased confusion later in the day) due to baseline dementia. R1's Hospital Discharge Summary, dated 7/26/24, identified R1 presented to the emergency department (ED) for evaluation after an unwitnessed mechanical fall. She was found to have an intertrochanteric left proximal femur fracture and underwent surgical nailing. In addition, she was diagnosed with acute blood loss anemia on top of her chronic anemia. Chronic diagnoses included: chronic pain/neuropathy and low back pain related to spinal stenosis (narrowing of the spine) which required a muscle relaxant and an anticonvulsant with pain management benefits, afib which required a blood thinner, heart failure which required diuretics (reduce fluid), hypertension (HTN - high blood pressure), and memory impairment. R1 was discharged with a new opioid medication order for pain. R1's Admission Assessment, dated 7/26/24, identified R1 was alert and oriented to herself, location, and situation, and lacked communication concerns. Her ability to walk was severely limited or non-existent and she was unable to bear her own weight. R1 was incontinent of bowel and bladder and was prescribed an anticoagulant medication (blood thinner). She had current or recent history of pain in the past five days, and she experienced left sided weakness. She had a fall in the past month prior to admission, as well as the last two to six months; however, no fractures related to these falls. Her fall risk factors included incontinence, mobility deficit, and change in environment. A section for current diagnosis or diseases provided an option for afib; however, this was not checked. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's 48-hour baseline care plan, initiated 7/26/24, identified R1 was a high fall risk due to a previous fall, incontinence, and the fall risk factors present on the Fall Risk Assessment. As of 7/26/24, this assessment had yet to be completed. In addition, the baseline care plan identified R1 was incontinent of bowel and bladder and demonstrated impaired mobility that required assist with transfers and toileting management. Interventions for R1 centered around her being offered and encouraged toileting upon rising, before and after meals, at bedtime and upon request, in addition to more frequently. R1's fall goal was to remain free of falls with injury and directed the following: keep room free of clutter, safe and appropriate footwear with mobility and when up without shoes, call light and personal belongings within reach, correct low bed positioning, seated edge of bed for a few minutes before standing up and reminding and reinforcing R1 on safety awareness during mobility. The 48-hour baseline care plan lacked individualized fall risk interventions based on her fall risks. A progress note, dated 7/27/24 and entered at 3:32 a.m., identified R1 was found at 2:50 a.m. lying on the floor next to her bed, close to bathroom door. Her wheelchair was not located near the bed side and her call light was not on. No injuries were noted at that time. The note indicated R1 attempted to get to the bathroom. R1 was last toileted at 10:45 p.m. Interventions put into place were Frequent checks and reminders to R1 to use her call light. A Fall Post Assessment, dated 7/27/24 and locked at 5:51 a.m., identified R1 informed the nurse she attempted to go to the bathroom, but she collapsed and fell to the floor. The assessment identified the following question section: Was the care plan or service plan updated with new interventions to prevent fall? The question allowed for a yes or no choice. The No option was checked. A progress note, dated 7/28/24 and entered at 7:44 a.m., identified a Brief Interview for Mental Status (BIMS) was conducted with R1 and she demonstrated severe cognitive impairments, mainly related to short-term memory loss. R1's Fall Risk-Assessment, dated 7/31/24, indicated R1 was free of falls since admission and was oriented to person, place, time, and situation, despite R1's medical record indicating she fell on [DATE] and was not alert and oriented to all four. R1's fall risk was increased due to the use of opioids and muscle relaxants, along with incontinence, inability to stand/walk by self, and her diagnoses of the femur fracture, history of falling, and HTN. The assessment provided options to check the following: recent change in functional status and/or medications with the potential to affect safe mobility; anticonvulsants and bowel medications; problems with heart rate and/or arrythmias; behaviors such as sundowning; self-transfers. These six options were unchecked, and the diagnoses section lacked the afib, anemia, neuropathy, and chronic pain. The assessment allowed for Overall Comments; however, this section was blank. The assessment lacked a comprehensive review/analysis of R1's fall, her fall risks, and interventions deemed necessary to mitigate her fall risk. The Fall Risk-Assessment, in general, lacked a section and/or questions related to history of falls prior to a resident's admission. R1's medical record, 7/27/24 through 7/31/24, lacked evidence R1's fall risk was comprehensively assessed to assist with the development of individualized fall mitigation interventions or that individualized fall intervention(s) were initiated immediately after her 7/27/24 fall to mitigate further falls. R2: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's face sheet identified R2 admitted on [DATE] from the hospital. R2's primary diagnosis was a left femur neck fracture. In addition, R2 was diagnosed with a traumatic brain injury (TBI), multiple rib fractures, left shoulder scapular fracture, and a fall. An Order Summary Report identified R2 was provided a medication for BPH (benign prostatic hyperplasia - enlarged prostate gland) and anemia. R2's Admission Assessment, dated 7/20/24, identified R2 was oriented to self and situation, and lacked communication concerns. His ability to walk was severely limited or non-existent and he was unable to bear her own weight. R2 was prescribed an anticoagulant medication. He had current or recent history of pain in the past five days and experienced left sided weakness. R2 had a fall in the past month prior to admission, as well as the last two to six months in which a fracture was the result of a fall. The assessment's bowel and bladder section identified he was continent of bowel and bladder; however, the fall risk section identified a risk factor of incontinence. Additional fall risk factors included short term memory deficit and change in environment. The fall risk section provided an option for mobility deficit; however, this was not checked. R2's 48-hour baseline care plan, initiated 7/20/24, identified R2 was a fall risk due to a previous fall and the fall risk factors present on the Fall Risk Assessment. As of 7/20/24, this assessment had yet to be completed. In addition, the baseline care plan identified R2 required assist with transfers and toileting management. No baseline care plan was initiated for incontinence. R2's fall goal was to remain free of falls with injury and directed the following: keep room free of clutter, safe and appropriate footwear with mobility and when up without shoes, call light and personal belongings within reach, correct low bed positioning, seated edge of bed for a few minutes before standing up and reminding and reinforcing R2 on safety awareness during mobility. The 48-hour baseline care plan lacked individualized fall risk interventions based on his fall risks. A progress note, dated 7/21/24 and entered at 3:18 a.m., identified R2 was found at 10:40 p.m. the previous evening lying on the floor next to his bed. The note indicated R2's bed was at the lowest position and his call light was within reach, but he did not use it. He was noted to be confused. R2 was provided education to use his call light and staff were to check on him every two to three hours and as needed. A progress note dated, 7/21/24 and entered at 7:29 a.m., identified R2 was found without the covers, his brief half off, and his incision dressing off. He reported significant back itchiness. The nurse educated him on the use of the call light. He responded, 'Yah I know I was on the floor last night, I rolled out of bed.' After R2 was again situated comfortably back in bed, after an ointment was applied to his back, the nurse exited the room. A Fall Post Assessment, dated 7/21/24 at 7:52 a.m., identified R2's 7/20/24 fall. R2's call light was not activated and R2 stated, 'I didn't know what I was doing or going during the fall.' R2 was last toileted forty minutes before he was found. At the time of the fall, he was without incontinence. His w/c was not located by his bed. The note identified staff were to check on R2 every two to three hours and as needed and to educate R2 to call staff when assistance was needed. The assessment identified the following question section: Was the care plan or service plan updated with new interventions to prevent fall? The question allowed for a yes or no choice. Neither option was checked. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, dated 7/21/24 and entered at 3:17 p.m., identified R2 disliked the opioid pain medication as it made him feel too tired and that he required close supervision as R2 tends to scoot his butt down in recliner and w/c (wheelchair). He was more lucid and oriented once he woke up. A progress note, dated 7/21/24 and entered at 3:25 p.m., identified R2 was found at one point scooted down in his recliner and required two staff and the mechanical lift to sit him up safely. A progress note, dated 7/22/24 and entered at 3:26 p.m., identified an in-depth bowel and bladder review was completed on R2. He was frequently incontinence of bowel and always incontinent of bladder. The note designated a section to indicate toileting program details; however, this section was without information. An OT progress note, dated 7/22/24, indicated a SLUMS (The St. Louis University Mental Status) test was completed with R2. He scored 13 out of 30 which indicated a dementia category. R2's Fall Risk-Assessment, dated 7/23/24, identified R2's had a fall with no injury since admission. Two other questions related to falls since admission indicated R2 had two or more falls with injury and one fall with major injury. This information was incorrect based on R2's medical record since admission. The assessment indicated R2 was oriented to self only. R1's fall risk was increased due to the use of muscle relaxant medication, along with incontinence, inability to stand/walk by self, and self-transfers, along with his diagnoses of the femur fracture and HTN. The assessment provided options to check the following: recent change in functional status and/or medications with the potential to affect safe mobility; impulsiveness; antihypertensive and opioid medications. These four options were unchecked, and the diagnoses section lacked the rib and shoulder fractures, BPH, anemia, and TBI. The Overall Comments section indicated R2 required extensive [physical] assist of one to two staff using a mechanical lift and that R2 was forgetful with poor judgment related to dementia. The assessment lacked a comprehensive review/analysis of R2's fall, his fall risks, and interventions deemed necessary to mitigate his fall risk. The Fall Risk-Assessment, in general, lacked a section and/or questions related to history of falls prior to a resident's admission. A progress note, dated 7/24/24 and entered at 4:47 p.m., identified around 3:45 p.m. R2 was found on his bathroom floor by the sink with his w/c next to him. R2 informed staff he 'was trying to go use the bathroom.' The note lacked identification of an immediate fall intervention. A Risk Management Unwitnessed fall incident report, dated 7/24/24, identified R2's 7/24/24 bathroom fall. The immediate Action Taken identified a check and change every two - three hours was put into place. The report lacked an intervention to toilet, or offer R2 toileting, based on his attempt to go to the bathroom. R2's July 2024 Medication Administration Record, identified on 7/25/24 at 1:00 p.m. a nursing order which directed the nurse to remind staff to help transfer [R2] to bed/recliner after lunch to prevent falls. in the morning to prevent fall. This was scheduled at 1:00 p.m.; however, lacked a morning schedule. R2's medical record lacked any additional information related to this nursing order. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An OT progress note, dated 7/25/24, identified OT placed a maintenance request for anti-roll back devices on R2's w/c for fall prevention due to his posture and education needed for keeping hips all the way back in the w/c. A PT progress note, dated 7/31/24, identified R2 scored a 2 out of 28 which indicated he was at a high risk for falls with significant impairments in mobility tasks. He demonstrated struggles with left knee stabilization where it buckled easily even with therapist assist to block and support it. The note indicated and IDT meeting where R2 was reported to attempt self-transfers. Mechanical standing lift continued to be required for transfers. Facility nursing assistant Care Guides, undated, identified R2 was a fall risk. The Care Guide lacked fall mitigation intervention(s). R2's medical record, prior to the abbreviated survey, lacked evidence R2's fall risk was comprehensively assessed to assist with the development of individualized fall mitigation interventions or that individualized fall intervention(s) were initiated immediately after, and based upon, his 7/20/24 and 7/24/24 falls to mitigate further falls. R3: R3's face sheet identified R3 admitted on [DATE] from the hospital. R2's primary diagnosis was a cystostomy catheter [urinary tract] infection. In addition, R3 was diagnosed with diabetes, Parkinson's Disease, HTN, afib, and weakness. A hospital PT note, dated 7/10/24, indicated R3 had a history of falls at home and was a fall risk during her hospital stay. R3's Admission Assessment, dated 7/12/24, identified R3 was oriented to person, place, time, and situation, and lacked communication concerns. R3 was continent of bowel and utilized a suprapubic catheter (SP) for urination. She was unable to ambulate, was prescribed an anticoagulant medication, and she had current or recent history of pain in the past five days. R3 had a fall in the past month prior to admission, as well as the last two to six months. Additional fall risk factors included change in environment and mobility deficit with ambulation. A current conditions/diagnosis section identified R3 required enhanced precautions. This condition/diagnoses section provided options to check the following: afib, Parkinson's Disease, Diabetes. Neither of these three options were checked. R3's 48-hour baseline care plan, initiated 7/12/24, identified R3 was a fall risk due to a previous fall and the fall risk factors present on the Fall Risk Assessment. As of 7/12/24, this assessment had yet to be completed. In addition, the baseline care plan identified R3 required assist with transfers and toileting management. R2's fall goal was to remain free of falls with injury and directed the following: keep room free of clutter, safe and appropriate footwear with mobility and when up without shoes, call light and personal belongings within reach, correct low bed positioning, seated edge of bed for a few minutes before standing up and reminding and reinforcing R3 on safety awareness during mobility. The 48-hour baseline care plan lacked individualized fall risk interventions based on her fall risks. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's OT evaluation note, dated 7/14/24, identified R3 was a fall risk in which she displayed impaired safety awareness, impairments in balance, mobility, and strength, and a history of three falls in the past three months. A progress note dated 7/15/24, identified a BIMS was conducted with R3, and she demonstrated moderate cognitive impairments. A provider note dated 7/16/24, identified R3 was diagnosed with Parkinson's Disease, recurrent UTI, neurogenic bladder with SP catheter, recent encephalopathy (damage or disease impacting the brain), afib, diabetes, and dementia in which R3 was a poor historian and required the aide of her daughter for questions during the provider visit. R3's heart rate during the visit was irregularly irregular. R3's Fall Risk-Assessment, dated 7/16/24, identified R3 was free of falls since admission and was a lower risk for falls based on the information entered in the assessment. The assessment indicated R3 was oriented to person, place, time, and situation. The assessment lacked medication concerns or any additional risk factors for falls. The assessment provided options to check the following: problems with heart rate and/or arrhythmia [afib], unable to stand/walk by self and required staff assist or device, and devices present that are fall hazards [SP catheter]. These three options were unchecked. A section for diagnoses which may contribute to falls was without any entered diagnosis despite R3's Parkinson's Disease, urinary infection, weakness, diabetes, etc. The Overall Comments section identified R3 required assist of one staff for transfers and activities of daily living. The assessment lacked a comprehensive review/analysis of R3's fall history prior to admission, fall risks at the time of the assessment, and interventions deemed necessary to mitigate her fall risk. The Fall Risk-Assessment, in general, lacked a section and/or questions related to history of falls prior to a resident's admission. A Fall Post Assessment, dated 7/28/24, identified R3 fell that day at 9:00 p.m. She was found on her bedroom floor after she self-transferred and lost her balance. The assessment lacked information as to what R3 was doing at the time of the fall. Her call light was not on. A Summary section identified an area for treatment, or interventions provided immediately after the fall which lacked information. In addition, the assessment identified the following question section: Was the care plan or service plan updated with new interventions to prevent fall? The question allowed for a yes or no choice. The No option was checked. A Risk Management Unwitnessed fall incident report, dated 7/28/24, identified R3's 7/28/24 fall. The incident report identified R3 informed staff she was rearranging cloths in her closet when she fell . An immediate action taken was the placement of a call do not fall sign and reorientation to the unit and the processes to ask for help if needed. The assessment indicated R3 was confused with impaired memory and poor safety awareness, displayed weakness and gait imbalance, and was admitted within the last 72-hours. [She was admitted 16 days prior.] R3's progress notes lacked information on 7/28/24 related to her fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A late entry progress note dated 7/29/24 at 10:09 a.m., entered on 8/6/24 at 11:09 a.m., identified IDT met to review R3's fall. The note indicated R3 was alert and oriented times three; however, displayed confusion and poor safety awareness. She worked with therapy to build strength related to the Parkinson's and a recent urinary tract infection (UTI). R3 reported she was rearranging some cloths in her closet at the time of the fall. R3 was aided with her cloths and a call do not fall sign was placed. Facility nursing assistant Care Guides, undated, identified R3; however, did not identify that R3 was a fall risk, nor did the Care Guide identify any fall mitigation intervention(s). R3's medical record, prior to the abbreviated survey, lacked evidence R3's fall risk was comprehensively assessed to assist with the development of individualized fall interventions or that individualized fall intervention(s) were initiated immediately after, and based upon, her 7/28/24 fall to mitigate further falls. During observation and interview on 8/6/24 at 10:53 a.m., R3 sat in her w/c. R3's w/c was without adaptive devices and a soft-touched call light was near her. Her bedroom and bathroom environment lacked such devices as a Reacher to assist with picking up things from the floor which would help her obtain things from her closet. In addition, the environment lacked CALL TO NOT FALL sign(s). R3 was able to answer orientation questions after she reviewed a calendar; however, R3 stated she was admitted after ankle reconstructive surgery, along with surgery on her shoulder. She denied falls since admission but mentioned she had fallen many times at home and sustained many injuries due to these falls. She was unable to provide fall, or injury details and she was unaware of what the staff did for her to help her not fall while there. During observation and interview on 8/6/24 at 10:41 a.m., R2 sat in his wheelchair. R2's w/c had anti-lock and anti-tip devices. R2's environment was observed which lacked fall mitigation signs and/or devices. R2 acknowledged a history of falls; however, was unsure when they occurred or if he had fallen since his admission. He stated the last fall occurred when he transferred from the bed to a chair and got tangled up in the blankets a little bit. He stated this was the reason for his broken hip. When asked what the facility was doing to help keep him from further falls, he responded they are getting my balance back. When interviewed via telephone on 8/6/24, at 11:55 a.m., R1, R2, and R3's medical provider (MD) stated individualized fall interventions should be implemented upon admission, if considered a fall risk, and then right after the first fall these should be reviewed and adjusted. After further discussion of R1, R2, and R3 care plan interventions, MD indicated he would have thought staff would have initiated more specific interventions, adding, That is someone's job to put those precautions in place. The MD identified he, or his colleagues, are updated on falls; however, the updates basically contained general information related to the fall and if there were injury or not, not fall details or interventions put into place. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview in R3's room on 8/6/24 at 1:27 p.m., with R3 and R3's family member (FM)-A, a CALL DO NOT FALL sign was located on the wall to the left of where R3 sat in her room when her husband was not there. This sign was not present during R3's interview at 10:53 a.m. FM-A stated staff brought the sign in today, while he was there, and hung it up around 12:30 p.m. He, or R3, were unaware of why it was placed other than staff stated it was a reminder for her to use the call light instead of getting up on her own. FM-A identified R3 fell many times prior to her admission. Due to this, they had a routine at home to help mitigate her falls which occurred from the time she got up in the morning to the time she went to bed. FM-A denied staff have spoken to him related to fall interventions other than to update him on her fall. When interviewed on 8/6/24 at 1:52 p.m., nursing assistant (NA)-C stated she was aware of residents' fall risk based on the nurse's report, the Kardex (NA care plan), the Care Guides, and I just know. She explained she reviewed the Kardex maybe once a week. She denied any current resident was on a toileting plan and denied any recent toileting plans. NA-C stated, They go when they go. They can tell us here, but it may be different on the long-term care units. NA-C was aware of R1's fall but was unable to remember any individualized fall interventions for her indicating R1 had, just the normal ones we would do for everyone. NA-C denied R2 was a fall risk. She was unaware he fell twice and commented, I should have known that. When updated on the two falls, she recollected he, rolled out of bed with his blankets .maybe. NA-C explained she approached R2 every two hours to use the bathroom, morning for sure when he got up and then after meals as R2, usually has to go. NA-C indicated R3 was a fall risk as, she gets anxious sometimes and tries to attempt to do things herself or will bend over forward in her chair, especially when she dropped something on the floor. She thought she updated staff on this information; however, was unsure who or when. She explained for R3, there were no special interventions other than just keeping an eye on her. NA-C stated there could perhaps be more information on the Kardex and/or Care Guides to assist with fall risk interventions, especially as the Care Guides just indicated fall risk and not much else. During an interview on 8/6/24 at 2:07 p.m., NA-A stated fall risk was communicated during the nurse report and was more verbal versus documented. She was unsure if the Care Guides identified fall risk and/or interventions. When these were reviewed, she stated, I did not know that was on there. NA-A denied R1 was a fall risk as R1, was not the type that would just up and walk, she was not hyper or trying to get out of bed. NA-A was aware R1 fell ; however, lacked knowledge on the interventions for her after the fall especially as family was often present and updated them on R1's needs. NA-A denied R2 and R3 were fall risks stating, Not by looking at [R2], [R2] does not look like someone that will get up and get going. [R3] does not look like she would fall. NA-A indicated if a resident was agitated or self-transferred, then she was expected to increase the frequency of checks. NA-A was unaware R2 fell twice since admission, or that R3 fell on ce. In addition, she was unaware of fall interventions for R2 or R3. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 8/6/24 at 2:26 p.m., registered nurse (RN)-C stated all residents were fall risks based often on facility admission, not strong enough to go home, and cognitive impairments. She identified fall risk was passed along in report and placed on the Care Guides. A comprehensive fall risk assessment was completed when the Treatment Administration Record (TAR) triggered and typically completed by the evening shift. She denied she performed adjustments to the care plan after falls as this was the responsibility of the managers. RN-C identified fall interventions were based on the fall risk(s) and any fall circumstances; however, a lot of the time it is just to remind then to use the call light. Not necessarily would she put interventions into place after a fall, but she explained the benefit of interventions were to decrease a fall from reoccurring. RN-C stated R2 and R3 were fall risks as R2 fell and broke his hip and R3 fell and broke her clavicle. She denied knowledge R2 fell twice after admission, and she explained R2 did nothing which increased his risk. In addition, she explained R3 required the CALL DO NOT FALL sign in her room, which was put up that day, as every day that she worked with R3, she had to remind R3 to use the call light. RN-C was unaware if R2 or R3 were on toileting plans, and she only asked them if there was a need when she worked with them. She was unaware of any specific interventions after R3's fall but commented R3 should have a Reacher in her room, and she would have to ask therapy about one. For any additional interventions, she needed to review their care plans. During an interview on 8/7/24 at 11:15 a.m., RN-A stated every resident was a fall risk and fall risk was passed on via verbal report amongst the nurses and the nursing assistants. On admission, when the admission assessment process was performed, fall interventions were checked, and edited, based on fall risk information that was embedded in hospital information, the hospital discharge summary, from the hospital nurse to nurse report, and then conversations with the resident and family upon admission. After this, and once therapy evaluated the resident, the care plan then again would be adjusted. RN-A was unable to provide a definitive answer related to fall interventions after a fall; however, she felt an intervention should be put into place right away to prevent further falls. RN-A was unaware of R2 and R3's fall risk and/or fall interventions due to not working with these two; however, she stated R1 required general interventions which were utilized on any resident. RN-A lacked remembrance of any special interventions for R1 after her fall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245619	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Therese at Oxbow Lake	9751 Regent Avenue North Brooklyn Park, MN 55443

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 8/7/24 at 11:46 a.m., RN-D stated they were expected to initiate the baseline fall care plan and interventions via the admission assessment; however, she explained she did not perform any baseline care plan edits as this was then the responsibility of the nurse manager to fill in the specific details. RN-D was unconcerned the plan of care was not updated with these specifics right away, or that the care plan was edited to include individual fall interventions upon admission, as staff constantly were in resident rooms and frequently checked on everyone. She did not feel there was anything else which could be initially done other than the admission assessment process and the generalized interventions. RN-D was unaware of the fall risk assessment process expectations but explained again the nurse manager was responsible for updating the care plan with interventions when needed. RN-D stated the care plan was the ultimate area for information which fired to the Kardex. She explained, after a fall, staff were expected to initiate an intervention and identified such interventions as ensuring the call light was by the resident and making sure their needs were met before leaving the room. These such interventions were identified in the Risk Management incident report and then reported to staff via verbal shift report. RN-D stated R1 fell , and family put up about three handwritten signs in R1's room that reminded R1 where she was, to use her call light, and to not get up without assist. She was unsure of any additional care planned fall interventions. For R2, RN-D explained R2's two falls and explained interventions to make sure staff toileted him about every two hours just like everyone else, and put him in the recliner versus the bed in the afternoon. RN-D was unaware of fall interventions for R3, but stated a sign on her closet to not do things herself would be beneficial for her. During an interview on 8/7/24, at 12:23 p.m., RN-E identified herself as the nurse manager. She explained fall risk was determined on admission and fall interventions were expected to be implemented via the admission assessment/baseline care plan process to decrease fall risk which included actions such as making sure the call light is within reach, bed in proper position, etc. After this, she then went into the care plan the day after admission and/or after the resident worked with therapy, and adjusted it as needed. She expected the nurses edited the baseline care plan options when checked and edits were indicated; however, this did not happen. RN-E explained the benefit of these initial edits would increase staff knowledge related to resident care as the care plan