

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245619	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/06/2024
NAME OF PROVIDER OR SUPPLIER  Saint Therese at Oxbow Lake		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299</b></p> <p>Based on observation, interview, and document review, the facility failed to ensure a self-administration of medications assessment was completed to allow resident to safely administer their own medications for 1 of 1 resident (R9) observed with medications at bedside.</p> <p>Findings include:</p> <p>R9's quarterly Minimum Data Set (MDS) dated [DATE], indicated R9 was cognitively intact, and had diagnoses of encounter for palliative care, depression, hypertension, renal disease, and lymphedema (chronic condition characterized by swelling when the body is unable to drain extra fluid from tissues). R9 required partial/moderate to substantial/maximal assistance with most activities of daily living (ADLs).</p> <p>R9's Admission Record printed and received from the facility on 12/9/24, indicated R9 had further diagnoses of diabetes mellitus with diabetic neuropathy (diabetic neuropathy is nerve damage caused by diabetes), arthritis (group of conditions which cause inflammation of the joints), and osteoarthritis (degenerative joint disease which causes breakdown of cartilage and bone in joints).</p> <p>R9's Self Administration of Medication assessment dated [DATE], indicated R9 did not wish to self-administer medications independently.</p> <p>R9's care plan reviewed 12/2/24, lacked direction related to medication self-administration.</p> <p>R9's progress note dated 10/20/24, indicated R9 complained of chest pain and heartburn and requested Tums (antacid made of calcium carbonate and treats heartburn, indigestion, and an upset stomach caused by too much stomach acid). R9 went to their room and took the over-the-counter Tums on their nightstand. R9 reported their pain was less after taking the medication.</p> <p>R9's physician's order dated 10/21/24, indicated Tums oral tablet chewable. Give one tablet by mouth as needed for heartburn one to two tablets with heartburn. Okay to keep Tums at patient bedside for self-administration.</p> <p>R9's physician's orders did not include topical Aspercreme.</p> <p>R9's medication administration record (MAR) dated 10/1/24 to 10/31/24, did not indicate any use of Tums.</p> <p>(continued on next page)</p>

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
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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R9's MAR dated 11/1/24 to 11/30/24, indicated R9 used Tums on 11/2/24, which was effective.</p> <p>R9's MAR dated 12/1/24 to 12/6/24, did not indicate R9 used Tums.</p> <p>During observation on 12/2/24 at 2:13 p.m., there was a container of Tums and four different tubes and containers of Aspercreme (a topical pain reliever used to relieve arthritis pain) on R9's nightstand near the bed.</p> <p>During interview on 12/2/24 at 4:00 p.m., R9 stated they took the Tums when they had chest pain, it was effective, and they did not use it all the time.</p> <p>During observation on 12/3/24 at 1:49 p.m., the Tums and Aspercreme were still on R9's bedside table.</p> <p>During interview on 12/4/23 at 11:02 a.m., registered nurse (RN)-E stated residents were able to self-administer medications after nursing completed an assessment to determine if resident was able to identify their medications, dose, frequency, and reason for medication and obtained a provider's order for self-administration. RN-E stated R9 needed help with most ADLs and wheeled around independently. RN-E was not aware of any medications at R9's bedside and stated they administered all R9's medications, including Tums and Aspercreme. RN-E was not sure if the family brought the medications at R9's bedside or not. RN-E was not able to verify the medication at bedside, since R9 did not want staff in room at that time.</p> <p>During follow-up interview on 12/4/24 at 12:53 p.m., RN-E verified the Tums and Aspercreme were in R9's room.</p> <p>During interview on 12/5/24 at 1:12 p.m., RN-C stated residents were screened with the self-administration assessment to see if they were appropriate for self-administration, called the provider for an order for self-administration, care planned the self-administration, and kept medications in locked area. RN-C stated R9's self-administration of medication assessment was started 12/3/24 and finished on 12/4/24, since R9 was sleeping on 12/3/24. RN-C stated the medications were now locked in R9's nightstand and care planned for self-administration.</p> <p>During interview on 12/6/24 at 10:59 a.m., the interim director of nursing (IDON) expected residents to have a completed self-administration assessment and provider's orders to independently take medications and store at bedside. These were important steps for resident safety.</p> <p>The Resident Self-Administration of Medications policy dated 4/1/22, directed the interdisciplinary team to determine if self-administration was clinically appropriate for a resident and document on the Medication Self-Administration Assessment Form. The care plan must reflect resident self-administration and storage arrangements for such medications.</p>

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48299</p> <p>Based on observation, interview, and document review, the facility failed to ensure a resident call light was within reach for 1 of 4 residents (R115) reviewed for call lights within reach.</p> <p>Findings include:</p> <p>R115's Admission Record dated 12/6/24, indicated admitted [DATE], and diagnoses included aftercare following joint replacement surgery, unilateral primary osteoarthritis of the left knee, and chronic kidney disease.</p> <p>R115's activities of daily living (ADL) care plan dated 12/1/24, indicated R115 had an ADL deficit related to left total knee replacement and required extensive assistance of one staff for boosting, bed mobility, and dressing, and a standing lift with assistance of two staff for transfers. R115's fall risk care plan dated 12/1/24, indicated R115 was at risk for a fall related to injury due to a history of previous falls and included the intervention to keep call light within reach before exiting the room.</p> <p>During observation and interview on 12/4/24 at 8:30 a.m., R115 was laying in bed reaching toward the right side of the bed. The bed was in a low position, and the call light was on the floor. R115 was not able to reach the call light and stated they were calling out for help for half an hour.</p> <p>During observation and interview on 12/4/24 at 8:32 a.m., registered nurse (RN)-E and nursing assistant (NA)-A stated they did not go to R115's room yet that morning and thought therapy was in R115's room earlier. RN-E entered R115's room, and R115 stated they had knee pain which hurt too bad to get up. RN-E picked up R115's call light and placed the call light on R115's bed within R115's reach. NA-A entered the room and stated they thought NA-B had checked on R115 earlier. RN-E left the room and returned with an ice pack, placed the ice pack on R115's left knee, and left R115's room and prepared medications.</p> <p>During interview on 12/4/24 at 10:37 a.m., RN-E stated staff ensured residents had call lights within reach and most call lights had a clip, so the call light did not slide off the bed. RN-E verified the call light was on the floor, and stated R115 was at risk of falling if they tried to reach for it. RN-E stated R115 was asleep when staff checked on R115 earlier in the morning and they had not heard R115 yelling for help.</p> <p>During interview on 12/4/24 at 1:31 p.m., NA-A stated residents needed call lights within reach.</p> <p>During interview on 12/4/24 at 1:42 p.m., NA-B stated R115 was asleep when they glanced in R115's room earlier in the morning, but should have done more with R115 in the morning. NA-B stated their group of residents was busy.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 12/5/24 at 1:09 p.m., RN-C stated call lights were attached close to residents whether they were in bed or wheelchair or were fixed to bedside table. Residents could potentially get up and transfer when not supposed to or become distressed if call lights were not within residents' reach. RN-C stated call lights were a safety line used by residents to let staff know they needed help.</p> <p>During interview on 12/6/24 at 10:57 a.m., the interim director of nursing (IDON) stated call lights had clips to prevent call lights from falling out of bed and were expected to be within reach for the residents. It was important for residents to have accessible call lights to use when needed.</p> <p>The Call Lights: Accessibility and Timely Response policy dated January 2023, directed staff to ensure call lights were within reach of residents and secured, as needed.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49617</p> <p>Based on interview and document review, the facility failed to ensure resident-specific resuscitation wishes, based on a signed Physician Orders for Life Sustaining Treatment (POLST, a medical order indicating treatments a person would like to receive in case of serious illness and/or cardiac arrest), were accurately reflected throughout the electronic medical record (EMR) for 1 of 2 residents (R63) reviewed for advanced directives. Additionally, the facility failed to have and follow policies and procedures for implementing advance directives. This had the ability to affect all 60 residents residing in the facility.</p> <p>Findings include:</p> <p>R63's Death in facility tracking record dated [DATE], indicated R63 passed away in the facility on [DATE].</p> <p>R63's care plan, dated [DATE], indicated she had completed a POLST and her wishes would be followed and respected. The care plan directed staff to see her orders for current resuscitation orders.</p> <p>R63's record was selected for closed record review. Her EMR was reviewed on [DATE] at 4:00 p.m., and her POLST signed and dated, [DATE], indicated she wished for attempted resuscitation/cardiopulmonary resuscitation (CPR, a lifesaving procedure) if she were found with no pulse and/or active breaths.</p> <p>R63's physician's orders were reviewed on [DATE] at 9:16 a.m., and included a verbal order dated [DATE], to Refer to the advance directive document. Resident wishes are: DNR/DNI Check Living will documents, in which DNR/DNI referred to Do Not Resuscitate/Do Not Intubate, or a resident-specific wish to not be resuscitated or kept alive my means of an artificial airway in case of serious illness and/or cardiac arrest. The order indicated it was ordered by R63's Medical Doctor.</p> <p>A care conference summary dated [DATE], indicated R63 and her representative were present and her advance directives and POLST were both reviewed. The summary lacked further documentation on what R63's resuscitation wishes were.</p> <p>R63's progress notes were reviewed on [DATE] at 4:00 p.m. and lacked documentation of changes of advance directive or request to change POLST/resuscitation orders.</p> <p>A progress note dated [DATE] at 7:02 a.m., indicated R63 was observed unresponsive, chest not rising, and no pulse at 4:50 a.m. during safety checks. A second nurse was called to the resident's room and confirmed her condition, and R63's family and provider team were updated on her death. Additionally, the note indicated an investigator from the coroner's office was contacted.</p> <p>A progress note dated [DATE] at 12:31 p.m., indicated R63's family was appreciative of the support and care provided by staff, and staff had spoken with the on-call provider regarding her death certificate.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Per interview on [DATE] at 4:23 p.m., registered nurse (RN)-C, also the long-term care clinical coordinator, expected staff to follow the facility's protocol and follow a resident's POLST if a resident was found pulseless and not breathing. If a resident's POLST indicated wishes for full treatment or CPR, RN-C expected staff to call 911 and follow the protocol. If the POLST indicated wishes for DNR/DNI, RN-C expected staff to honor those wishes and notify the supervisor, the DON, manager on-call, the provider, and family of the death. RN-C could not think of a reason staff would not follow protocol.</p> <p>Per interview on [DATE] at 8:40 a.m., registered nurse (RN)-A found R63 pulseless and called out for help. RN-B arrived and verified R63 was pulseless, and the two RNs verified her code status per facility protocol. RN-A stated he verified R63's code status against her POLST and RN-B verified it against her EMR. RN-A stated both the POLST and the EMR matched DNR/DNI. RN-A stated, they all matched; it was DNR/DNI. RN-A was unable to recall conversations prior to her death about a change in code status and was also unable to recall if there was a time when R63 was a full code.</p> <p>During interview on [DATE] at 9:16 a.m. with the clinical support specialist (CSS)-B, R63's EMR was reviewed. CSS-B located and verified R63's POLST was for full treatment or CPR. CSS-B stated if a POLST changed, it would not be scanned into the EMR until was signed by the provider, but the resident's wishes for resuscitation would be reflected throughout the rest of the EMR, like the face sheet, banner, and orders.</p> <p>During subsequent interview on [DATE] at 10:00 a.m., RN-C stated staff were expected to obtain resuscitation orders from POLSTS, provider's orders, or an advance directive if a resident had one. RN-C recalled a living will R63 and family provided and indicated her living will was used as her advance directive for the DNR/DNI status. RN-C reviewed the living will and indicated the portion reading, 2. If the application of life-sustaining procedures would serve, in the opinion of these two physicians, only to artificially prolong the dying process, then; I direct that life-sustaining procedures be withheld or withdrawn and that I be permitted to die naturally according to the instructions set forth below with respect to the administration of medication, food or fluids or the performance of medical procedures deemed necessary to provide me with comfort care. RN-C stated there were conversations held with R63 and her family about her living will and her wishes if she was found pulseless, and her wishes were to let her pass. RN-C stated the family did not want to pursue a new POLST and believed the living will was sufficient to determine her code status.</p> <p>Per interview on [DATE] at 10:22 a.m., RN-D, also the transitional care clinical coordinator, and social services (SS)-A confirmed a living will was not the same as a POLST, and staff were expected to use a resident's POLST to confirm resuscitation wishes. SS-A stated if there was a discrepancy between what a resident's advance directive, living will, or POLST indicated versus what the resident verbalized, we want to get the provider involved as soon as we can to drive that conversation with the resident and the family to gain consistency on resuscitation wishes across the medical record. RN-D and SS-A reviewed R63's living will, with special attention to the portion outlined in RN-C's interview, and verified the living will did not outline the resident's specific resuscitation wishes if she was found without a pulse or in cardiac arrest. RN-D stated R63's provider should have been contacted about her wishes to change her resuscitation wishes, and those conversations should have been documented in her EMR.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Per interview on [DATE] at 10:55 a.m., SS-B explained the admission nurse discussed the POLST form with residents and families when they admitted and then put the form in the provider's folder for them to review and verify with the resident during their next rounds before signing the POLST. SS-B indicated code status was reviewed quarterly at care conferences and stated advance directives and POLSTS were essentially the same thing. SS-B recalled a care conference with R63 and her representatives in which her resuscitation wishes were discussed with RN-C. SS-B was unable to recall what R63's code status was at the time of the care conference or what RN-C discussed with her and her representatives. SS-B reviewed her EMR and verified the POLST dated [DATE] indicated R63 desired full resuscitation. SS-B reviewed R63's living will and stated it did not indicate no code, it did indicate she would not want to be kept alive if she was in a vegetative state. SS-B verified R63 would still have been a full code based on record review.</p> <p>Per interview on [DATE] at 2:02 p.m., with R63's nurse practitioner (NP)-C, staff were expected to honor a resident's POLST and if it says full code, yes, they should have performed CPR. NP-C was unable to locate documentation of updates about R63's change in resuscitation wishes. NP-C reviewed R63's EMR and identified an on-call provider took the call and the facility requested a signed POLST with updated resuscitation wishes. NP-C verified there was no updated POLST in her EMR and believed the facility was trying to change their process so we sign them [POLST] right away. NP-C was unable to find documentation regarding R63's resuscitation wishes or end of life care, but stated she had some failure to thrive, I would not be surprised if she would have been put on hospice.</p> <p>Per interview on [DATE] at 2:32 p.m., with the interim DON the deficient practice was verified. The interim DON expected staff to verify a resident's code status against the POLST and to contact their provider immediately if the POLST needed to be updated. The DON reviewed R63's EMR and was unable to find documentation of R63's updated POLST or communication of such need to the provider(s). The interim DON believed RN-C maybe had inaccurate information from previous leadership at that time but stated RN-C received education on the difference between living wills and POLSTS and the facility's procedure. The interim DON was aware of discrepancies between residents' code status in the EMR and their POLSTS and reviewed CPR Audit notes dated [DATE]. The interim DON explained an extensive facility-wide audit and education plan was developed to help facilitate improved communication of active codes in the building, decrease inconsistencies in advance directives across the EMR, and increase staff's knowledge about resuscitation policies and procedures. The interim DON reviewed PowerPoint presentation slides prepared for both nursing assistants (NAs) and nurses and stated training began prior to the survey team's entrance. This was verified through text message reminders dated [DATE], and [DATE]. In addition, the interim DON verified trainings through attendance rosters dated [DATE], [DATE], and [DATE].</p> <p>During subsequent interview on [DATE] at 2: 37 p.m., RN-A reiterated double checking R63's POLST in the folder with RN-B. RN-A stated, I'm not wrong, and stated both nurses reviewed the copy of R63's POLST in the folder to ensure she was DNR/DNI.</p> <p>Per interview on [DATE] at 5:54 p.m., with R63's medical doctor (MD)-H, staff were expected to follow her POLST, which indicated she was a full code. MD-H stated, I would have expected staff to perform CPR and call 911, if she had been found pulseless and without active breaths. MD-H was unable to locate documentation or recall discussing a change in R63's resuscitation wishes and reported the only POLST documented was for a full code.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Per interview on [DATE] at 7:59 a.m., RN-B responded to RN-A's request to confirm R63's condition. Next, RN-B confirmed her code status in the EMR as DNR/DNI and stated it was verified against her POLST to confirm with RN-A she was a DNR.</p> <p>Per interview on [DATE] at 1:38 p.m., R63's family member (FM)-A verified her specific do not resuscitate wishes were honored when she was found pulseless and not breathing. FM-A confirmed providing the facility with her living will and verbalized her wishes to not be resuscitated were in the will and they had a copy of that.</p> <p>During follow-up interview on [DATE] at 1:50 p.m., RN-C confirmed there was no discussion with R63's providers about her wishes to change her resuscitation status. RN-C explained the facility's process when a resident requested a code status change. They indicated staff were expected to either fax the POLST to the provider or leave it in their folder at the facility to sign when they round. RN-C reported discussing what DNR meant with R63 and FM-A after they brought a copy of her living will in. RN-C reviewed the living will with R63, FM-A, and SS-B. RN-C was unsure if an updated POLST that reflected R63's wishes to not be resuscitated was signed by the family but stated R63 and her representatives were firm that she did not want to be resuscitated. RN-C was able to explain appropriately the difference between a living will and a POLST and indicated the unit was in the process of updating their policy and procedures for auditing charts and reviewing orders to ensure all documents were consistent and reflected a resident's resuscitation wishes accurately across the medical record.</p> <p>Per facility policy titled Cardiopulmonary resuscitation dated [DATE], the facility would adhere to residents' rights to formulate advance directives.</p> <p>A request was made for an advance directive policy, but not received.</p> <p>A request was made for a POLST policy, but not received.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48299</p> <p>Based on observation, interview, and document review, the facility failed to cool meat at temperatures and timeframes to reduce bacterial growth, which had potential to affect all residents, staff, and visitors who consumed food from the main kitchen. In addition, the facility failed to serve food in a manner to prevent contamination and failed to ensure the second-floor ice and water dispensing machine was clean and free of excess mineral build up, which had potential to affect all residents, staff, and visitors who consumed food and ice and/or water from the second-floor kitchen area. Further, the facility failed to ensure a high temperature dish machine was reaching proper rinse temperatures and failed to ensure dietary staff followed appropriate infection control technique while washing and drying dishes, which had potential to affect all residents, staff, and visitors who consumed food on dishes from the first floor kitchen between the transitional care unit and memory care.</p> <p>Findings include:</p> <p><b>MEAT COOLING IN REFRIGERATOR</b></p> <p>During observation and interview on 12/4/24 at 11:14 a.m., the main kitchen refrigerator had a whole turkey uncovered and undated. Dietary director (DD) stated the turkey was uncovered because it was cooling after being cooked yesterday evening and should be covered after 4 to 6 hours when cooled. The turkey was for a turkey salad for 12/7/24. DD temped the turkey and the thermometer read 46 then 45.2 degrees Fahrenheit. DD stated they should have broken apart the turkey and made sure the turkey cooled to proper temperature.</p> <p>During observation and interview on 12/5/24 at 10:23 a.m., cook (C)-A stated they placed meat in an ice bath or shallow pan to get meat to 70 degrees within four hours and then 41 degrees in the next two hours. C-A stated there was potential for bacteria growth if cooling procedures were not followed and they served vulnerable adults and wanted to limit exposure so resident did not get sick.</p> <p>During interview on 12/5/24 at 11:19 a.m., DD expected staff to cool meat in shallow pans or in ice water or juice and check the temperature of the turkey to ensure correct cooling temperature parameters were followed. DD verified the turkey was cooled outside of timing parameters and should be discarded. DD stated they serve residents with weakened immune systems and did not want to expose residents to bacteria.</p> <p>During interview on 12/6/24 at 11:08 a.m., the administrator expected meat to cool at correct temperatures and timeframes to avoid infection control issues with bacteria.</p> <p>The Food Safety Requirements policy dated October 2022, indicated strategies to cool foods so the total time for cooling does not exceed six hours, such as placing foods in shallow pans, cutting roasts into smaller portions, utilizing ice water baths, and stirring periodically.</p> <p><b>MEAL SERVICE AND ICE AND WATER MACHINE</b></p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Saint Therese at Oxbow Lake		STREET ADDRESS, CITY, STATE, ZIP CODE  9751 Regent Avenue North Brooklyn Park, MN 55443	
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During observation of the second floor kitchen on 12/4/24 between 11:40 a.m., and 12:18 p.m., an ice and water dispenser machine had white streaks down the back splash, the grates, and spouts. There were brownish color particles on the inside corners of the ice spout. Dietary aide (DA)-A dispensed ice from the machine and gave to nursing staff who brought the ice to the nursing station. At 11:53 a.m., water dripped from the spout of the ice and water machine. DA-A plated a cake dessert and placed plates on top of a rolling cart. The cart had crumbs and streaks of tannish colored substance on all three levels of the cart with most substances on the bottom tier of the cart. DA-A pushed the cart out of the kitchen and served the desserts to the residents in the dining area.</p> <p>During interview on 12/4/24 at 12:21 p.m., DD stated dishes were stacked on the carts after meals, brought downstairs, and the dishes and carts were cleaned between meals. DD verified the condition of the serving cart and stated the cart would be cleaned before the next meal. DD stated the server cleans the ice and water machine every day, and maintenance had a schedule for the machine with another company. DD verified the condition of ice and water machine in the second-floor kitchen and expected staff to call maintenance any time the ice and water machine had build up or on-going issues with the machine.</p> <p>During interview on 12/4/24 at 12:28 p.m., DA-A stated the carts were cleaned a couple times a day. DA-A was not sure when the last time the cart which they used between breakfast and lunch was cleaned. DA-A stated staff scrubbed the ice and water machine every shift, and DA-A scrubbed the machine that morning and the water was hard and had mineral content.</p> <p>During interview on 12/5/24 at 1:37 p.m., maintenance director (M) stated they discussed the need for culinary to wipe down the ice and water machine every day so minerals did not accumulate. M stated the grate was replaced a year ago, and substances were hard to get off with the delimer and they may have to replace part of or all of the machine. The preventive maintenance was based on the inside of the machine and not the outside affected by water hardness. M was aware of on-going issues with the machine but had not heard any specific concerns recently about the ice and water dispensing machine.</p> <p>The facility provided Manitowoc Countertop Nugget Ice Machine Technician's Handbook dated May 2021, recommended Manitowoc ice machines to have a remedial cleaning procedure between the 6-month detailed descaling and sanitizing procedure to remove mineral build-up from the evaporator. The handbook indicated the exterior of the ice machine to be cleaned as often as necessary to maintain cleanliness and efficient operation, and weekly instructions to remove the grill and wipe splash panel, scrap ice tray and grill with sanitizer and water solution. The wipe sensor window with soft cloth and mild detergent and rinse with clear water, and dry with a clean soft cloth, and remove dust and dirt from exterior surfaces with mild household dish-washing detergent and warm water and use a clean, soft cloth to wipe dry. The handbook indicated local water conditions may require treatment of the water to inhibit scale formation, filter sediment, remove chlorine, and improve taste and clarity.</p> <p>The Food Safety Requirements policy dated October 2022, directed staff to cover all foods when traveling a distance, such as down a hallway, to prevent contamination and clean and sanitize the internal components of the ice machine according to manufacturer's guidelines.</p> <p>DISH MACHINE, DISH DRYING/STORAGE, AND HAND HYGIENE</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During observation and interview on 12/5/24 at 10:02 a.m. of the first floor kitchen between the memory care and transitional care unit dining room, DA-A ran tongs, forks, trays, food covers, and cups through the [NAME] dish machine in various cycles. DA-A verified the temperature sensor on the dish machine during a cycle indicated 154 degrees Fahrenheit ( F) at wash cycle and stated 154 F was the rinse cycle as well. DA-A pointed to another temperature sensor with Ecolab label on it and indicated the rinse temperature was above 180 F but staff were told to use the sensor on the dish machine and not the Ecolab sensor. DA-B wore gloves while running dishes through the dish machine and used the same gloves to rinse soiled dishes, put dishes through dishwasher, and place clean cups, trays, silverware, and food covers to dry and in clean bins. DA-B stacked the food covers opened side up and water particles were visible on the food covers. Metal pans stacked on a clean cart had water particles in between them. DA-B stated they stacked the food covers to dry and turned the food covers around so the food covers were opened side down and the covers remain stacked. DA-B stated they changed their gloves and washed hands between handling dishes in the kitchen and setting up for meal service in dining area. Wash temperatures on the Dish Machine Temp Log dated 12/1/24 to 12/5/24 varied between 150 F and 164 F and rinse temperatures were 180 F or above.</p> <p>During interview on 12/5/24 at 11:19 a.m., DD verified the food tray covers had water particles and were stacked. DD stated the cover needed to dry before stacked and placed the covers on their sides to dry open to air. DD stated staff were to check temperature of the dish machine using the temperature sensor on the dish machine and not the Ecolab sensor. DD put the dish machine through an empty load and the wash temperature on the machine indicated 153 F , then decreased to 150 F before showing a final temperature of 149 F . DD stated they would call maintenance. DD expected staff to change their gloves and perform hand hygiene between handling dirty and clean dishes.</p> <p>During interview on 12/5/24 at 1:37 p.m., M was not aware of any concerns with the dish machine between the transitional care unit and memory care area. M stated they were not familiar with the Ecolab temperature sensor and looked at the sensor on the dish machine. M ran an empty cycle, and the machine indicated a wash temperature of 156 F and then P2 displayed. M stated the P2 was an error code and came up when the machine should have indicated the rinse temperature of the machine. M stated the temperature sensor needed to be replaced.</p> <p>During follow-up interview on 12/5/24 at 1:47 p.m., DA-B stated they did not know what P2 meant, and the dish machine displayed P2 for about a week and a half.</p> <p>During interview on 12/6/24 at 11:08 a.m., the administrator expected the dish machine to run at correct temperature. The administrator expected staff to change gloves and perform hand hygiene after staff handled dirty dishes and before clean dishes handled to prevent cross-contamination. The administrator expected dishes to dry before stacked.</p> <p>The facility provided [NAME] AM15 Dishwasher Technical Manual, indicated a minimum wash temperature of 150 F and minimum rinse temperature of 180 F . The manual instructed staff to contact a local [NAME] service office when P2 displays.</p> <p>The Food Safety Requirements policy dated October 2022, directed staff to wash hands prior to handling clean dishes to prevent contamination and follow facility procedures for dishwashing. The policy did not specify procedure to monitor dish machine temperature. The policy indicated equipment used in the handling of food, such as dishes, utensils, and other equipment which comes in contact with food, shall be cleaned and sanitized, and handled in a manner to prevent contamination.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48299</p> <p>49617</p> <p>Based on observation, interview and document review, the facility failed to follow contact precautions and perform evidence-based hand hygiene to reduce the spread of clostridium difficile (C. diff, a highly contagious bacterium that causes diarrhea) for 1 of 1 residents (R164) reviewed for transmission-based precautions (TBP). In addition, the facility failed to ensure proper hand hygiene and glove use was utilized for 1 of 2 residents (R14) observed during personal cares. Furthermore, the facility failed to ensure infection control policies were reviewed on an annual basis. This had the potential to affect all 60 residents residing in the facility.</p> <p>Findings include:</p> <p>R164</p> <p>R164's admission Minimum Data Set (MDS) dated [DATE], indicated she had severely impaired cognition, was always continent of her bowels, and had diagnoses of right hip fracture (break), weakness, constipation, and nausea with vomiting.</p> <p>R164's Care Area Assessment (CAA) for functional abilities dated 11/21/24, indicated she had activities of daily living (ADL) deficits related to her right hip fracture after a fall and related pain.</p> <p>R164's current physician orders, printed and reviewed 12/4/24, included the following:</p> <p>- vancomycin hydrochloride (HCl) oral capsule 125 milligrams (mg); Give 125mg by mouth every 6 hours for C. diff until 12/8/24, dated 11/27/24.</p> <p>R164's medication administration record (MAR) dated 12/2024, was reviewed on 12/5/24 and confirmed the vancomycin (an antibiotic) was administered as ordered from 12/1/24 through 12/5/24 during the survey week.</p> <p>R164's treatment administration record (TAR) dated 12/2024, reflected staff's documentation of the order for Precautions: Maintain contact-based precautions with an isolation supply cart in place due to loose stool. Isolation cart to remain in place until symptoms resolved/diagnosis identified to maintain proper PPE, dated 11/26/24.</p> <p>R164's care plan dated 11/15/24, indicated she had an ADL deficit related to her right hip fracture and required one staff assistance with toileting cares. R164's care plan lacked identification of the need for contact precautions, however, identified her infection in her urine requiring contact precautions. Interventions included providing education to R164 about the importance of good hygiene techniques and directed staff to utilize appropriate PPE (personal protective equipment) as indicated.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A provider progress note dated 11/26/24, identified the nursing staff's request for a stool sample specimen to check for C. diff. The progress note indicated R164 had three loose stools the day prior to the provider's visit but had no loose stools the day of the visit. The progress note indicated a lab order was written to check for C. diff as needed if diarrhea returned.</p> <p>A provider progress note dated 11/29/24, identified a positive stool sample for C. diff infection with an order for vancomycin as treatment.</p> <p>During observation on 12/2/24 at 3:47 p.m., R164's door had signage indicating Contact and Enteric (a set of TBP that help prevent the spread of germs associated with C.diff and that indicate handwashing over the use of alcohol-based hand sanitizer (ABHS)) precautions. The signs on the door guided staff to don gown and gloves for anyone entering her room and explicitly instructed readers to perform handwashing when entering and before leaving the room.</p> <p>During a continuous observation on 12/3/24 between 9:06 a.m., and 9:42 a.m., nursing assistant (NA)-E was in R164's room and had gloves and a surgical mask on. NA-E was not wearing a gown and was holding a clear plastic bag with linens inside. NA-E exited the room with the plastic bag in hand and explained R164 was on transmission-based precautions for C. diff and required gown and gloves upon entrance. NA-E stated R164 was encouraged to wash her hands after bathroom use and staff should wash their hands and not use ABHS when they exit the room. NA-E further explained PPE should be doffed inside the room. Per interview at 9:16 a.m., with R164, staff usually wore PPE but sometimes they don't. At 9:30 a.m., an unidentified staff was at R164's doorway and without gloves or gown, collected a trash bag from inside R164's door and walked towards the soiled utility room. At 9:32 a.m., the unidentified staff placed an empty trash liner inside the garbage receptacle and used ABHS outside the door before walking away from R164's room. At 9:35 a.m., NA-E was observed donning a gown and gloves at R164's doorway to answer her call light. She did not perform hand hygiene prior to entering the room. Within two minutes, NA-E exited the room and used ABHS. NA-E was about to enter another resident's room before stopped by surveyor for interview. Per interview at 9:42 a.m., NA-E did not believe there was a difference between handwashing and using ABHS for R164. NA-E stated it was important for staff to wash their hands after assisting R164 in the bathroom and confirmed the missed opportunity for hand washing with soap and water. NA-E stated, Unless you're helping in the bathroom, the sanitizer is okay. NA-E stated staff received training and education about TBP probably about every month and felt there was open communication about infection control and prevention. NA-E denied trouble accessing a sink and soap for handwashing and denied shortages with PPE supplies.</p> <p>Per interview on 12/3/24 at 9:47 a.m., with registered nurse (RN)-G, staff were expected to perform handwashing with soap and water because handwashing is what kills the germs, not the hand sanitizer for residents on enteric precautions or for residents infected with C. diff.</p> <p>Per interview on 12/6/24 at 3:04 p.m., the infection preventionist (IP) indicated infection control program policies were verbally discussed at least once a week. The IP confirmed the following policies were outdated:</p> <ul style="list-style-type: none"> <li>- Infection Prevention and Control Program, dated 10/2022.</li> <li>- Infection Preventionist, dated 10/22.</li> <li>- Influenza Vaccination, dated 6/2023.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Antibiotic Stewardship, dated 5/2023.</p> <p>- Management of C. Difficile Infection, dated 10/2022.</p> <p>The IP stated such policies were discussed during leadership meetings every third Monday of the month but was unable to locate documentation of policy reviews.</p> <p>Per interview on 12/6/24 at 3:30 p.m., with the interim director of nursing (DON), staff were expected to don gown and gloves and perform handwashing for a resident with C. diff. The interim DON expected staff to wash their hands over using ABHS because the sanitizer is ineffective at killing the germs.</p> <p>Per facility policy titled Management of C. Difficile Infection dated 10/2022, hand hygiene shall per performed by handwashing with soap and water in accordance with facility policy for hand hygiene. Additionally, all staff should wear gloves and gown up entry into the resident's room and while providing care for the resident with C. Difficile infection.</p> <p>R14</p> <p>R14's quarterly Minimum Data Set (MDS) dated [DATE], indicated R14 had severe cognitive impairment, diagnoses of heart failure, coronary artery disease, hypertension, renal disease, dementia, epilepsy, hemiplegia and hemiparesis (neurological condition which causes paralysis or weakness to one side of the body), depression, and asthma, required substantial/maximal assistance or was dependent on staff for most activities of daily living (ADL), and had occasional incontinence of bladder and bowel.</p> <p>During observation on 12/4/24 at 7:37 a.m., nursing assistant (NA)-C and NA-D assisted R14 with morning cares. NA-C had gloves on and applied R14's stockings. NA-C and NA-D assisted R14 to sit on the side of the bed, and NA-C washed and dried R14's upper body and then put lotion and deodorant on R14. NA-C and NA-D used the ceiling lift to assist R14 to the toilet. NA-C and NA-D removed R14's incontinent brief. NA-D left the room, and NA-C placed soiled linens in a bag and then poured water out of cup which had dentures in them and grabbed a clean brief and applied around R14's thighs with the same gloves on. NA-C made R14's bed and moved other items in R14's room with the same gloves on. NA-D entered the room with gloves on, stated they assisted another resident with dressing, removed gloves, did not perform hand hygiene, and applied new gloves. R14 was raised from the toilet, and NA-D wiped R14's perineal area. NA-C and NA-D secured R14's clean incontinent product and pulled up R14's pants. NA-D left room after R14 was lowered into wheelchair. NA-C placed a towel over R14's shirt with the same gloves on, and R14 used mouth rinse and placed own dentures in. NA-C brushed R14's hair, removed gloves, and washed hands before they exited R14's room.</p> <p>During interview on 12/4/24 at 8:04 a.m., NA-C confirmed they wore the same gloves throughout R14's care and stated they would change gloves after peri-cares but did not perform R14's peri-cares.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 12/4/24 at 10:13 a.m., NA-D stated they applied another resident's pants and entered R14's room with the same gloves used to assist the other resident. NA-D confirmed they did not perform hand hygiene between glove change before they assisted R14 with peri-cares. NA-D stated actions did not follow proper protocol but was in a hurry to get back to R14. NA-D stated they should not enter into a resident's room with gloves used in another resident's room and normally would wash or sanitize their hands at the nursing station between resident rooms. NA-D stated improper glove use and hand hygiene spreads bacteria and germs.</p> <p>During interview on 12/5/24 at 9:25 a.m., registered nurse (RN)-F stated staff changed gloves and performed hand hygiene after dirty tasks and before clean tasks and needed to change gloves and perform hand hygiene between care provided to different residents. RN-F stated there was a risk of infection when glove use and hand hygiene protocols were not followed.</p> <p>During interview on 12/5/24 at 1:12 p.m., RN-C expected staff to change gloves and perform hand hygiene between providing care to different residents. RN-C stated hand hygiene and gloves changes should be completed between tasks, such as after resident shirt changed, incontinent brief touched, and before dentures touched.</p> <p>During interview on 12/6/24 at 11:00 a.m., the interim director of nursing (IDON) expected staff to perform hand hygiene after gloves removed and before new gloves applied. Staff were to change gloves and perform hand hygiene between different residents and dirty and clean tasks. IDON stated there was a risk of infection when hand hygiene and glove use procedures were not followed.</p> <p>The Hand Hygiene policy dated September 2023, directed staff to perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. The policy indicated use of gloves does not replace hand hygiene, staff were to perform hand hygiene before gloves applied and after gloves removed.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49617</p> <p>Based on interview and document review the facility failed to ensure 3 of 5 residents (R9, R20, R30) were offered and/or provided updated vaccinations for pneumococcal disease in accordance with the Centers for Disease Control (CDC) vaccination recommendations. Additionally, the facility failed to ensure 1 of 5 residents (R30) was offered and/or provided updated vaccinations for influenza disease.</p> <p>Findings include:</p> <p>R9's Admission Record printed 12/9/24, indicated he was admitted on [DATE], and was currently [AGE] years old with diagnoses that increased the risk of pneumococcal disease including chronic kidney disease and end stage kidney disease.</p> <p>R9's undated Immunizations tab in PointClickCare (PCC - the electronic medical record) reviewed 12/3/24 at 1:48 p.m., identified the PCV-13 was administered on 3/3/22.</p> <p>R9's vaccine informed consent form dated 10/10/24, reflected he previously received a pneumonia vaccine but lacked consent or declination of further doses.</p> <p>The CDC's PneumoRecs VaxAdvisor for Vaccine Providers dated 12/3/24, indicated based on R9's age, diagnoses, and vaccine history: Give one dose of PCV20 or PCV21 at least 1 year after PCV13 or give one dose of PPSV23 at least 8 weeks after PCV13. Regardless of which vaccine is used (PCV20, PCV21, or PPSV23), their pneumococcal vaccinations are complete. However, if PPSV23 is administered, use shared clinical decision-making to decide whether to administer one dose of PCV20 or PCV21 at least 5 years after the last PPSV23 dose.</p> <p>R9's medical record lacked a discussion of shared clinical decision making regarding additional pneumococcal vaccines.</p> <p>R20's Admission Record printed 12/6/24, identified he was admitted [DATE], and was currently [AGE] years old with diagnoses increasing the risk of pneumococcal disease including heart disease, alcohol abuse and obstructive sleep apnea.</p> <p>R20's vaccination informed consent dated 11/2/24, indicated he had received prior pneumococcal vaccinations but did not indicate if he consented or declined additional pneumococcal vaccine doses.</p> <p>R20's Minnesota Immunization Report dated 11/01/24, identified he received the PCV13 on 10/31/16, and two doses of the PPSV23 on 12/18/03, and 12/21/10.</p> <p>R20's undated Immunizations tab in PCC was reviewed on 12/3/24 at 2:00 p.m., and lacked documentation of pneumococcal vaccinations.</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The CDC's PneumoRecs VaxAdvisor for Vaccine Providers dated 12/3/24, identified based on R20's age and vaccine history: based on shared clinical decision-making, decide whether to administer one dose of PCV20 or PCV21 at least 5 years after the last pneumococcal vaccine dose. Regardless of whether PCV20 or PCV21 is administered, their pneumococcal vaccinations are complete.</p> <p>R20's medical record was reviewed 12/3/24, and lacked a discussion of shared clinical decision making regarding additional pneumococcal vaccines.</p> <p>R30's quarterly Minimum Data Set (MDS) dated [DATE], indicated the influenza vaccine was not received in the facility for this year's influenza season because it was offered and declined. Additionally, the MDS indicated her pneumococcal vaccination was not up to date and it was not received because it was offered and declined.</p> <p>R30's Admission Record printed 12/6/24, indicated she admitted [DATE], and was currently [AGE] years old with diagnoses increasing the risk of pneumococcal disease including diabetes, heart disease, and history of breast cancer.</p> <p>R30's vaccination informed consent dated 5/9/24, identified she declined the influenza vaccine and indicated she had previously received a pneumonia vaccine but did not identify when or which pneumonia vaccine she had received.</p> <p>R30's undated Immunizations tab in PCC was reviewed on 12/3/24, and indicated her last influenza immunization was administered 11/3/23. It lacked documentation regarding her pneumococcal vaccination status.</p> <p>R30's medical record was reviewed 12/3/24 and lacked documentation of re-attempts at vaccination consent or declination for current influenza season (Fall 2024/Winter 2025) and lacked documentation of shared clinical decision-making regarding pneumonia vaccinations.</p> <p>The CDC's PneumoRecs VaxAdvisor for Vaccine Providers dated 12/3/24, identified based on R30's age and vaccine history: give one dose of PCV15, PCV20, or PCV21. If PCV20 or PCV21 is used, their pneumococcal vaccinations are complete. If PCV15 is used, follow with one dose of PPSV23 to complete their pneumococcal vaccinations. The recommended interval between PCV15 and PPSV23 is at least 1 year.</p> <p>R30's medical record was reviewed 12/3/24, and lacked a discussion of shared clinical decision making regarding additional pneumococcal vaccines.</p> <p>During interview on 12/5/24 at 2:30 p.m., the infection preventionist (IP) verified responsibility of the facility's immunization program. The IP confirmed using the CDC's PneumoRecs VaxAdvisor, updated 2024, to review eligibility for pneumococcal vaccinations in accordance with CDC guidelines. The IP was unable to locate documentation of R9's declination of the pneumococcal vaccination. The IP confirmed R20's eligibility for additional pneumococcal vaccine but was unable to find documentation of shared clinical decision making. The IP was unable to locate documentation of R30's consent or declination for this fall [[NAME]]. The IP was unable to locate documentation of shared clinical decision making about the pneumococcal vaccine as well as if R30 was educated on the risks or benefits associated with the vaccine.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245619	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/06/2024
NAME OF PROVIDER OR SUPPLIER  Saint Therese at Oxbow Lake		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 12/6/24 at 3:30 p.m., the interim director of nursing (DON) stated the IP was responsible for overseeing immunizations of residents, but any staff person can relay a resident's wishes for vaccinations to the IP. The interim DON expected residents who may have admitted in off-seasons to be re-offered vaccinations during seasons with the potential for outbreaks.</p> <p>Per facility policy titled Infection Prevent and Control Program dated 5/2023, all staff were responsible for following all policies and procedures related to the program, but the facility designated an IP responsible for oversight of the program. The policy indicated residents would be offered influenza vaccines each year between October 1 and March 31, unless contraindicated or received the vaccine elsewhere during that time. Additionally, the policy indicated residents would be offered the pneumococcal vaccines recommended by the CDC upon admission, unless contraindicated or received the vaccines elsewhere. Furthermore, the facility directed staff to provided education to residents and/or representatives regarding the benefits and potential side effects of the immunizations and document the education provided and the details regarding whether or not the resident received the immunizations.</p>		