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	02/26/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure care plans were revised for 6 of 14 residents (R5, R8, R10, R40, R47 and R7) whose care plans were reviewed for accuracy.Findings include: R5 R5's admission Minimum Data Set (MDS) dated [DATE], identified R5 had severe cognitive impairment and required assistance with all activities of daily living (ADLs). R5's diagnoses included non-traumatic brain dysfunction, Alzheimer's disease, hypertension (high blood pressure), diabetes mellitus (high blood sugar due to impaired insulin regulation), arthritis (joint inflammation causing pain and stiffness), other fractures (history of bone fractures), anxiety disorder (excessive worry or fear), depression (persistent feelings of sadness), metabolic encephalopathy (altered brain function due to metabolic imbalance) and paroxysmal atrial fibrillation (intermittent irregular heart rhythm). The MDS indicated R5 had experienced one fall with a major injury and was dependent will all transfers. R5's quarterly MDS dated [DATE], identified R5 had severe cognitive impairment and required assistance with all ADLs. R5's diagnoses included non-traumatic brain dysfunction, Alzheimer's disease, hypertension, diabetes mellitus, arthritis, other fractures, anxiety disorder, depression, metabolic encephalopathy and paroxysmal atrial fibrillation. The MDS indicated R5 had experienced one fall with a major injury was needed partial to moderate assistance with all transfers. Review of R5's comprehensive care plan, printed 2/24/26, identified R5 was at risk for falls with the following interventions in place: TRANSFERS: R5 requires Stand lift with 2assist for transfers. Date Initiated: 08/05/2025 Additionally, R5's care plan identified R5 needing assistance with ADLs with the following interventions in place: TOILETING: Resident requires LA 1 staff assistance for toileting transfers with awalker, gait belt.Date Initiated: 01/23/2026 TRANSFERS: Resident requires Stand lift with 2 assist for transfers. Date Initiated: 08/05/2025 During interview on 2/25/26 at 12:32 p.m., registered nurse (RN)-G stated R5 required assistance of one staff member with transfers, although R5 sometimes attempted to transfer independently. (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
	245619	A. Building B. Wing	02/26/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 2/26/26 at 10:19 a.m., nursing assistant (NA)-E stated R5 required assistance of one staff member with transfers and reported therapy sometimes walked with R5. During interview on 2/26/26 at 10:48 a.m., NA-A stated R5 required assistance of one staff member with transfers and stated staff notified the nurse when a resident fell. NA-A stated R5 self-transfers herself often and stated that if staff see her self-transferring, they supervise as they don't want to scare R5. R8 R8's quarterly Minimum Data Set (MDS) dated [DATE], identified R8 had severe cognitive impairment and required assistance with activities of daily living (ADLs). R8's diagnoses included non-traumatic brain dysfunction (impaired brain function affecting cognition or behavior not caused by physical injury); vascular dementia – severe – without behavioral, psychological, mood, or anxiety disturbances (advanced cognitive decline caused by impaired blood flow to the brain); hypertension (chronically elevated blood pressure); arthritis (joint inflammation causing pain and reduced mobility); chronic obstructive pulmonary disease (COPD) (chronic lung disease causing airflow limitation and breathing difficulty); paroxysmal atrial fibrillation (intermittent irregular heart rhythm that increases the risk of stroke); gastroesophageal reflux disease (GERD) (stomach acid flowing back into the esophagus); insomnia (difficulty falling or staying asleep); chronic idiopathic constipation (long-term constipation without a known cause); pain in the right ankle and joints of the right foot (musculoskeletal pain affecting mobility); and rheumatic tricuspid insufficiency (incomplete closure of the tricuspid valve causing backward blood flow in the heart). R8's order summary report, printed on 2/25/26, included an order for Haloperidol 0.5 milligrams (mg) to be administered sublingually (under the tongue) two times per day for agitation, hallucinations, and delusions. Furthermore, Lorazepam was not included on the order summary report. R8's comprehensive care plan, with print date of 2/24/26, indicated the following: Wandering behaviors. Interventions included monitoring the resident for wandering behaviors and redirecting the resident when wandering occurred. Use of antianxiety medication, Lorazepam (a medication commonly used to treat anxiety or agitation) with associated monitoring and interventions. However, review of physician orders revealed the resident was no longer prescribed or receiving Lorazepam, and the care plan continued to include interventions related to the medication. R8's comprehensive care plan failed to include Antipsychotic medication had been initiated on 12/31/25. However, R8's care plan failed to include interventions, monitoring, or care plan revisions related to the newly initiated antipsychotic medication. During an interview on 2/26/26 at 10:19 a.m., NA-E stated R8 did not wander any longer and had not for quite a while, as the resident required total assistance. During an interview on 2/26/26 at 10:24 a.m., RN-G confirmed R8 did not wander and had not for quite some time. (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	02/26/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/26/26 at 10:48 a.m., NA-A stated R8 had not wandered for a while because the resident was not able to move around independently. During an interview on 2/26/26 at 12:49 p.m., the registered nurse clinical coordinator (CC)-F stated care plans could be updated and revised by herself, nursing staff, or the social worker. CC-F stated the care plan should be updated whenever there was a change in the resident's condition and reviewed at least quarterly to ensure the information was accurate. CC-F stated the care plan was important so staff were aware of how to care for the resident and to provide an overall picture of the resident's care needs. CC-F further stated R8 no longer wandered. CC-F reviewed the R8's care plan and confirmed wandering was still listed and acknowledged the care plan required revision. CC-F also stated the resident was no longer receiving Lorazepam and confirmed the medication was still listed on the care plan and should have been revised. CC-F additionally confirmed the resident was receiving an antipsychotic medication that was not addressed in the care plan. R10 R10's annual MDS dated [DATE], identified R10 had severe cognitive impairment and required extensive assistance with ADLs. R10's diagnoses included Alzheimer's disease (a progressive neurodegenerative disorder causing memory loss and impaired thinking), anxiety disorder (a mental health condition characterized by excessive worry or fear), depression (a mood disorder causing persistent feelings of sadness), hypertension (chronically elevated blood pressure), and gastroesophageal reflux disease (GERD) (stomach acid flowing back into the esophagus causing irritation). Record review of R10's EMR, on 2/25/26, revealed R10 utilized a motorized wheelchair for mobility within the resident's room and throughout the facility. However, review of R10's comprehensive care plan revealed the use of a motorized wheelchair, including associated safety considerations or staff interventions, was not addressed in R10's care plan. R10's comprehensive care plan, reviewed on 2/25/26, failed to include R10's use of a motorized wheelchair as well as safety considerations and staff interventions. During an interview on 2/26/26 at 11:28 a.m., the clinical coordinator (CC)-B stated R10 utilized a motorized wheelchair in her room and throughout the facility. CC-B expected R10's use of the motorized wheelchair was included in R10's care plan as part of R10's care needs. CC-B reviewed R10's care plan and confirmed the use of the motorized wheelchair was not included. CC-B further stated the care plan contained information staff needed to appropriately care for the resident and was an ongoing process, as residents' conditions could change. CC-B stated baseline care plans were developed within 24 to 48 hours of admission and could be updated by nursing staff or the clinical coordinator as changes occurred. CC-B stated significant changes, such as skin issues or other care needs, should be added to the care plan when identified by staff aware of the situation. CC-B stated the comprehensive care plan was reviewed in its entirety at least quarterly. During an interview on 2/26/26 at 1:32 p.m., the director of nursing (DON) stated the care plan was intended to reflect each resident's overall status and care needs. The DON expected each resident's care plan was updated whenever there was a change in the resident's condition and reviewed at least quarterly to ensure it accurately reflected the resident's current care needs. Review of the facility policy titled Care Plan Revisions Upon Status Change, revised 10/2024, (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	02/26/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated the facility was to provide a consistent process for reviewing and revising the care plan for residents experiencing a status change. The comprehensive care plan would be reviewed and revised as necessary when a resident experienced a change in status. R40 R40's care plan with revision date 12/5/25, indicated R40 required the following: Activities of Daily Living (ADLs): Bathing- one staff assist Hygiene/grooming- one staff assist Skin: Repositioning- resident will be repositioned every two hours R40's care plan indicated R40 was receiving antiplatelet medication and included interventions to monitor for side effects. R40's quarterly Minimum Data Set (MDS) dated [DATE], indicated R40 was cognitively intact and was independent with transfers, shower/bathing, hygiene and bed mobility. R40 required supervision or touch assist for ambulation. R40 was not taking an anticoagulant. R40's physician orders last signed 1/6/26, did not include an antiplatelet medication. R40's face sheet printed 2/26/26, indicated R40's diagnoses included ataxia (neurological condition characterized by poor muscle control), heart failure and narcolepsy. During interview on 2/25/26 at 1:50 p.m., nursing assistant (NA)-B stated R40 was independent with toileting, bathing, personal hygiene, transfers in his room and repositioning. R47 R47's annual MDS dated [DATE], indicated R47 was dependent on staff for eating, oral hygiene and all other ADLs. R47's physician orders last signed 1/6/26, did not include an order for trazadone. R47's care plan with revision date 1/29/26, indicated R47 required the following: ADLs: Eating assistance- staff set up assistance. Use of adaptive equipment, built up handled silverware, cup with lid Oral care- staff set up assistance (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	02/26/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R47's care plan indicated R47 was receiving trazadone for insomnia. R47's face sheet printed 2/26/26 indicated R47's diagnoses included dementia, insomnia, and weakness. During observation on 2/25/26 at 12:09 p.m., R47 was seated at the table in the dining room. NA-B brought R47 his food and beverage. NA-B assisted R47 to eat the noon meal and to drink beverages. R47 made no attempt to assist himself with eating or drinking. No adaptive silverware or cups were observed. During interview on 2/25/26 at 1:50 p.m., NA-B stated R47 always required assistance to eat and for all ADLs. R47 made no attempts to use silverware, was not able to eat finger foods on his own and was not able to drink from any type of glass on his own. R47 had not used adaptive equipment, for a long while. R7 R7's quarterly MDS dated [DATE], indicated R7 had moderate cognitive impairment and required staff assistance with ADLs included partial/moderate assistance with eating, dependent on staff for transfer to/from toilet, dependent on staff for toileting hygiene, and dependent on staff for lower body dressing. R7's care plan with revision date 2/16/26, indicated R7 required the following: Nutrition- Eating: Independent after set-up. Resident prefers to eat meals in room. ADLs- Toileting: two staff assist with standing lift Eating Assistance: limited assistance of one staff with eating assistance, set-up meal, cut up food, place utensils on right side Eating: Bring resident to dining room for all meals Transfers: I require ceiling lift for transfers. Elimination- Extensive assist of two and Hoyer (brand of full body mechanical lift) with toileting transfers and extensive assist with hygiene cares and clothing management Skin- lambs wool applied to sling to protect bilateral arms during transfer Wheelchair mobility- (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	02/26/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff to put foot pedals on my wheelchair R7's face sheet printed 2/26/26, indicated R7's diagnoses included dementia, multi-system degermation of the autonomic nervous system (causes loss of coordination and balance, also to become slow and stiff) and chronic venous hypertension (high blood pressure within the veins). During observation on 2/24/26 at 4:11 p.m., R7 received assistance to transfer from w/c to toilet with two staff and ceiling lift. No padding was observed on the lift sling straps. Following completion of toilet use, NA-C provided full assistance to R7 for toileting hygiene and to adjust clothing. R7 did not physically participate in these tasks. During observation on 2/25/26 at 11:31 a.m., R7 was assisted in her wheelchair from her room to the dining room. No foot pedals were on R7's wheelchair. R7's feet were sliding on the floor. During observation on 2/25/26 at 11:53 a.m. NA-B was seated next to R7 while assisting another resident to eat. NA-B included R7 in conversation but made no attempt to assist R7 with eating. R7 was eating and drinking independently after set-up. During interview on 2/25/26 at 3:30 p.m., NA-C stated R7 used the standing lift for transfers a long time ago. R7 was not able to support her upper body, so she was changed to a ceiling lift. NA-C was not aware lamb's wool padding to the transfer sling straps was on R7's care plan. NA-C stated R7 required physical assistance with eating at every meal, R7 may be able to eat finger foods on her own but required assistance when using silverware. R7 refused to use her foot pedals, NA-C stated, staff were supposed to offer the foot pedals, but R7 always refused so NA-C was not sure all staff offered. During interview on 2/26/26 at 8:37 a.m. registered nurse (RN)-B stated resident care plans are usually updated by the clinical coordinator (CC). The NAs usually let the nurses know if a change needed to be made, the nurse would update the CC. RN-B stated she reviews all resident care plans weekly and will make changes herself if the need is urgent. During interview on 2/26/26 at 9:21 a.m., CC-B stated care plans were reviewed quarterly and with any changes in the resident's needs. She updates the care plan as soon as she is notified a change is needed. The nurses on the floor were also able to update the care plans. CC-B would be notified if changes were made by the nurses on the floor and would review the care plan herself to determine if, it needs further tweaking or additional work. CC-B did not consider aspirin to be an anticoagulant and stated it should not be on the care plan as such. CC-B verified R40's care plan did not accurately depict R40's physical needs accurately and should have been changed when R40's needs changed. CC-B stated aspirin should not be considered an anticoagulant and should not be on R40's care plan as such. CC-B verified R47's care plan was not up-to-date and stated she did not know why it did not get updated when R47's needs changed. CC-B stated two different transfer methods could be found on the care plan if a resident had increased weakness at different times of day, so required more support to transfer. Upon review of R7's care plan, CC-B verified the inconsistencies and inaccurate information in R7's care plan but was not able to give specific reasons for the inconsistencies and inaccurate information. CC-B stated R7's foot pedals should be noted as, frequently refused, on the care plan. During interview on 2/26/26 at 10:10 a.m., director of nursing (DON) stated she expected the care plans to be up-to-date with each resident's specific needs. Changes should be completed quarterly and as needed. When interventions were no longer appropriate, DON expected them to be removed (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	02/26/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	from the care plan. DON stated it was important for residents to have updated care plans to ensure each resident received the level of assistance needed to meet their needs and so there was not confusion on what the resident needed.

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	02/26/2026

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure residents received an ongoing program of activities designed to meet their assessed needs, interests, and abilities in accordance with their comprehensive care plans for 4 of 5 residents reviewed for activities (R6, R10, R13, and R42).Findings include:R6R6's quarterly Minimum Data Set (MDS), dated [DATE], identified R6 had intact cognition. R6's diagnoses included arthritis (joint inflammation causing pain and stiffness), macular degeneration (loss of central vision), overactive bladder (frequent or urgent need to urinate), cervicalgia (neck pain) and sensorineural hearing loss - bilateral (permanent hearing loss in both ears). Observations of R6 were conducted on multiple occasions during the survey:On 2/23/26 at 11:14 a.m., R6 was observed sitting in her recliner with her legs elevated, eyes closed, and mouth open. No activity materials or staff interaction were present.On 2/24/26 at 11:39 a.m., R6 was observed sitting in her recliner looking around the room. No activity materials or staff interaction were present.On 2/24/26 at 3:00 p.m., R6 was observed sitting in her recliner with her legs elevated. No activity materials or staff interaction were present.On 2/24/26 at 6:21 p.m., R6 was observed sitting in her recliner in her room. During the observation, R6 asked the surveyor if they would be present the following day and stated, Could you please come and visit with me? It really breaks up my day. No activity materials or staff interaction were present.On 2/25/26 at 8:35 a.m., R6 was observed sitting up in her recliner while staff delivered breakfast to her room.On 2/25/26 at 8:42 a.m., the Administrator entered the resident's room and greeted R6 by saying good morning.On 2/25/26 at 12:41 p.m., R6 was observed sitting in her recliner with her eyes closed. No activity materials or staff interaction were present.On 2/25/26 at 2:28 p.m., R6 was observed sitting in her recliner with her legs extended. R6 asked the surveyor how many residents still had COVID and stated she was going crazy just sitting in my room all day and reported she liked to talk to people. R6 asked the surveyor if they would be present the following day and stated, Oh yes please, now I have something to look forward to. It means so much to me having you stop and talk to me. No activity materials or staff interaction were present.On 2/26/26 at 7:21 a.m., R6 was observed lying in bed with her eyes closed and the lights off. Review of R6's activity interests assessment, undated, indicated R6 preferred one-to-one visits, being invited and/or escorted to activities, pastoral care visits, pet visits, Protestant worship services, and watching television or movies. Review of R6's activity documentation, from 2/12/2026 through 2/25/26, failed to include documented participation in any type of activity despite the resident's identified preferences. There was no documented evidence R6 was offered individualized or in-room activities during this period. R10R10's annual MDS dated [DATE], identified R10 had severe cognitive impairment R10's diagnoses included stroke (brain injury caused by interrupted blood flow), aphasia (difficulty speaking or understanding language), hemiplegia (paralysis on one side of the body), depression (persistent feelings of sadness or loss of interest), Observations of R10 were conducted on multiple occasions during the survey:On 2/24/26 at 11:37 a.m., R10 was observed sitting in her room in her motorized wheelchair watching television. No activity materials or staff interaction were present.On 2/24/26 at 2:59 p.m., R10 was again observed sitting in her room in her motorized wheelchair watching television. No activity materials or staff interaction were present.On 2/24/26 at 6:20 p.m., R10 was observed sitting in her motorized wheelchair near the window looking outside. No activity materials or staff interaction were present.On 2/25/26 at 8:37 a.m., R10 was observed sitting at the table in her room eating breakfast. No activity materials or staff interaction were present.On 2/25/26 at 12:40 p.m., R10 was observed sitting in her wheelchair in her room while a nurse obtained the resident's vital signs.On 2/25/26 at 2:25 p.m., R10 was observed sitting in her motorized wheelchair in her room watching television. No activity materials or staff interaction were present.On 2/26/26 at 7:21 a.m., R10 was observed lying in bed with her eyes closed and the door shut. No activity materials or staff interaction were present.On (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	02/26/2026

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/26/26 at 8:12 a.m., R10 was observed sitting in her room in her motorized wheelchair watching television. No activity materials or staff interaction were present. Review of R10's activity interests assessment, undated, indicated R10 preferred adult coloring, baking, balloon volleyball, bean bag toss/cornhole, being outdoors, Bible study, bingo, cardio drumming, Catholic communion, community drum circle, crafts, devotions, dice games, Eucharistic ministry visits, exercise, happy hour, being invited to activities, Mass, music and entertainment, music therapy, painting and drawing, parties and socials, pet visits, resident council, singing, table games, trivia, walking, watching television or movies, and Wii bowling. Review of R10's activity documentation, from 2/12/2026 through 2/25/26, failed to include documented participation in any type of activity despite the resident's identified preferences. There was no documented evidence R10 was offered individualized or in-room activities during this period. R13R13's annual MDS dated [DATE] identified R13 had moderate cognitive impairment R13's diagnoses included non-traumatic brain dysfunction (impaired brain function not caused by injury), unspecified dementia without behavioral, psychological, mood, or anxiety disturbances (decline in memory and thinking without significant behavioral symptoms), anemia (low red blood cell count), and non-Alzheimer's dementia (cognitive decline not caused by Alzheimer's disease). Observations of R13 were conducted on multiple occasions during the survey:On 2/24/26 at 11:39 a.m., R13 was observed sitting in her chair in her room with her eyes closed. No activity materials or staff interaction were present.On 2/24/26 at 3:00 p.m., R13 was observed sitting in her recliner with her legs elevated and her eyes closed. No activity materials or staff interaction were present.On 2/24/26 at 6:28 p.m., R13 was observed sitting in her recliner in her room. No activity materials or staff interaction were present.On 2/25/26 at 8:35 a.m., R13 was observed sitting up in her recliner while staff delivered breakfast to her room. No activity materials or staff interaction were present.On 2/25/26 at 12:42 p.m., R13 was observed sitting in her recliner in her room. No activity materials or staff interaction were present.On 2/25/26 at 2:30 p.m., R13 was again observed sitting in her recliner in her room. No activity materials or staff interaction were present.On 2/26/26 at 7:22 a.m., R13 was observed sitting in her recliner in her room. No activity materials or staff interaction were present.On 2/26/26 at 7:31 a.m., R13 activated her call light and then came to the doorway of her room, looked into the hallway, and asked staff for a cup of coffee.On 2/26/26 at 7:38 a.m., R13 stated she had a good night but reported she was going stir crazy because she was not able to leave her room. No activity materials or staff interaction were present Review of R13's activity interests assessment, undated, indicated R13 preferred baking, being outdoors, Bible study, bingo, card bingo, card games, Catholic communion, devotions, being invited and/or escorted to activities, Eucharistic ministry visits, happy hour, Mass, music and entertainment, music livestream, music therapy, parties and socials, reading, reminiscing, resident council, singing, table games, tenant/resident meetings, and watching television or movies. Review of R13's activity documentation, from 2/12/2026 through 2/25/26, failed to include documented participation in any type of activity despite the resident's identified preferences. There was no documented evidence R13 was offered individualized or in-room activities during this period. R42R42's quarterly MDS dated [DATE] identified R42 had severe cognitive impairment. R42's diagnoses included non-traumatic brain dysfunction (impaired brain function not caused by injury), unspecified dementia (decline in memory and thinking abilities), arthritis (joint inflammation causing pain and stiffness), non-Alzheimer's dementia (cognitive decline not caused by Alzheimer's disease), depression (persistent sadness or loss of interest), and chronic pain (persistent long-term pain). Observations of R42 were conducted on multiple occasions during the survey:On 2/23/26 at 11:16 a.m., R42 was observed sitting in her wheelchair in her room with her eyes closed. The resident was leaning to the left in the wheelchair with her left arm draped over the side.On 2/24/26 at 11:40 a.m., R42 was observed sitting in her wheelchair in her room with her eyes closed.On 2/24/26 at 3:00 p.m., R42 was observed lying in bed with her eyes closed.On 2/24/26 at 6:28 p.m., R42 was observed sitting in her wheelchair in her room with her eyes closed.On 2/25/26 at 8:36 a.m., R42 was observed sitting in her wheelchair with her eyes closed while staff delivered (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	02/26/2026

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	breakfast to her room. Staff remained in the room and sat next to the resident while assisting her with eating.On 2/25/26 at 12:42 p.m., R42 was observed sitting in her wheelchair in her room with her eyes closed. The television was on and the resident was holding a newspaper in her hand.On 2/26/26 at 7:21 a.m., R42 was observed lying in bed with her eyes closed and the lights off. Review of R42's activity interests assessment, undated, indicated the resident preferred one-to-one visits, being outdoors, being invited and/or escorted to activities, Methodist services, newspapers, reading, and watching television or movies. Review of R42's activity documentation, from 2/12/2026 through 2/25/26, revealed no documented participation in any type of activity despite the resident's identified preferences. There was no documented evidence R42 was offered individualized or in-room activities during this period. During interview on 2/26/26 at 9:53 a.m., nursing assistant (NA)-D stated R42 required one-to-one activities and R6, R10, and R13 typically attended activities. NA-D stated activities had not been occurring for the previous several weeks due to COVID. During interview on 2/26/26 at 10:00 a.m., community life director (CLD)-A stated the activity department used a website to document activity participation and complete activity assessments. CLD-A stated they were new to the position. CLD-A reported the facility printed a list of residents interested in attending Mass and utilized volunteers for those services who did not document attendance. CLD-A stated if residents did not have COVID, activity staff utilized a mobile activity cart to provide one-to-one activities. CLD-A stated activity staff had not been entering participation into each resident's record, but expected activity staff should enter notes and document when activities are offered. During interview on 2/26/26 at 10:17 a.m., activity aide (AA)-A stated activity participation was documented in Toolkit (computer software program). Documentation included if the resident participated, declined, or received one-to-one activities, and stated all activities should be documented. During interview on 2/26/26 at 11:28 a.m., registered nurse clinical coordinator (CC)-B stated activities were expected to continue on a smaller scale for residents who did not have COVID. CC-B stated residents who did not have an active COVID diagnosis could attend activities in the living room if they wore a mask and reported activity staff should enter each resident's room individually to check on residents and offer activities. During interview on 2/26/26 at 1:32 p.m., director of nursing (DON) stated the Roadhouse unit had minimal activities occurring due to COVID precautions. DON expected activities were still be occurring with residents independently in their rooms. Review of the facility policy titled Activities, dated 6/2024, indicated the facility was to provide an ongoing program of activities to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Facility-sponsored group, individual, and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental, and psychosocial well-being. Activities will encourage both independence and interaction within the community. Activities may be conducted in different ways:One-to-One programsPerson Appropriate - activities relevant to the specific needs, interests, culture, background, etc. for the resident they are developed for.Program of Activities - to include a combination of large and small groups, one-to-one, and self-directed as the resident desires to attend.

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	02/26/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure a resident was treated with dignity and respect by maintaining privacy of a urinary catheter drainage bag, resulting in the visible exposure of urine to others passing by for 1 of 1 resident observed (R10).Findings include: R10's annual Minimum Data Set (MDS), dated [DATE], identified R10 had severe cognitive impairment and required assistance with activities of daily living (ADLs). R10's diagnoses included stroke (a condition in which blood flow to the brain is interrupted or reduced causing brain cell damage), atrial fibrillation (an irregular and often rapid heart rhythm that can increase the risk of stroke and heart-related complications), heart failure (a chronic condition in which the heart is unable to pump blood effectively), hypertension (chronically elevated blood pressure), peripheral vascular disease (a circulatory disorder that causes narrowing or blockage of blood vessels outside of the heart and brain), gastroesophageal reflux disease (GERD) (a condition in which stomach acid frequently flows back into the esophagus causing irritation), diabetes mellitus (a metabolic disorder characterized by elevated blood glucose levels due to the body's inability to produce or effectively use insulin), aphasia (a disorder affecting the ability to communicate, including speaking or understanding language), hemiplegia (paralysis affecting one side of the body), depression (a mood disorder causing persistent feelings of sadness and loss of interest), chronic obstructive pulmonary disease (COPD) (a progressive lung disease that causes airflow limitation and difficulty breathing), aphasia following cerebral infarction (difficulty with language caused by damage to the brain following a stroke), dysphasia (difficulty swallowing), edema (swelling caused by excess fluid trapped in body tissues), acquired absence of the right leg above the knee (surgical removal or loss of the right leg above the knee), and presence of a cardiac pacemaker (a device implanted in the chest that helps regulate abnormal heart rhythms). Review of R10's physician orders, dated 2/24/26, indicated a Foley catheter was present and the collection bag was to be kept below the level of the bladder at all times. The order further indicated the collection bag should not rest on the floor and staff were to ensure a dignity bag was in use at all times. Observations included the following: 2/24/26 at 11:37 a.m. - R10's catheter drainage bag was hanging from the side of the wheelchair and was not covered. The bag contained straw-colored liquid and was visible from the hallway. 2/24/26 at 2:59 p.m. - R10's catheter drainage bag remained in the same location on the wheelchair and continued to be visible from the hallway. 2/25/26 at 9:05 a.m., 12:40 p.m., and 2:25 p.m. - R10 was observed sitting in a wheelchair with the drainage bag hanging from the side of the wheelchair without a dignity cover. The straw color, liquid, filled bag was visible to individuals walking past the room. 2/26/26 at 8:12 a.m. - R10's catheter drainage bag continued to hang from the side of the wheelchair without a dignity cover and remained visible from the hallway. During an interview on 2/26/26 at 9:53 a.m., nursing assistant (NA)-D confirmed the urinary catheter drainage bag was visible and stated the bag should typically be placed in a privacy or dignity cover when the resident was in areas visible to others to maintain dignity. NA-D stated R10 did not have a dignity bag available. During an interview on 2/26/26 at 11:28 a.m., registered nurse clinical coordinator (CC)-B confirmed residents with urinary catheter drainage bags should have the bag covered or positioned in a manner that maintained the resident's dignity and prevented unnecessary exposure. During an interview on 2/26/26 at 1:32 p.m., the director of nursing (DON) stated she expected catheter drainage bags to be covered at all times to maintain resident privacy and dignity. The facility Promoting/Maintaining Resident Dignity policy, dated 10/22, indicated the facility would protect and promote resident rights and treat each resident with respect and dignity, as well as provide care in a manner and environment that maintained or enhanced each resident's quality of life. The policy further indicated all staff were responsible for promoting and maintaining resident dignity and respecting resident rights.

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	02/26/2026

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents were provided the opportunity to participate in the planning of their care through timely care conferences for 2 of 7 residents reviewed for care planning (R8 and R19).Findings include:R8R8's quarterly Minimum Data Set (MDS) dated [DATE] identified R8 had severe cognitive impairment and required assistance with activities of daily living (ADLs). R8's diagnoses included non-traumatic brain dysfunction (impaired brain function affecting cognition or behavior not caused by physical injury); vascular dementia - severe - without behavioral, psychological, mood, or anxiety disturbances (advanced cognitive decline caused by impaired blood flow to the brain); hypertension (chronically elevated blood pressure); arthritis (joint inflammation causing pain and reduced mobility); chronic obstructive pulmonary disease (COPD) (chronic lung disease causing airflow limitation and breathing difficulty); paroxysmal atrial fibrillation (intermittent irregular heart rhythm that increases risk of stroke); gastroesophageal reflux disease (GERD) (stomach acid flowing back into the esophagus); insomnia (difficulty falling or staying asleep); chronic idiopathic constipation (long-term constipation without a known cause); pain in the right ankle and joints of the right foot (musculoskeletal pain affecting mobility); and rheumatic tricuspid insufficiency (incomplete closure of the tricuspid valve causing backward blood flow in the heart). Review of R8's electronic medical record (EMR) revealed the most recent care conference had been conducted on 4/10/25. Further record review indicated subsequent care conferences had been due in July 2025, September 2025, and December 2025 in accordance with facility practice. However, there was no documented evidence that the facility scheduled, conducted, or attempted to schedule the care conferences or provided R8 and/or the resident representative with the opportunity to participate in the review and development of the care plan at the time of survey. R19R19's quarterly Minimum Data Set (MDS) dated [DATE] identified R19 had moderate cognitive impairment and required assistance with activities of daily living (ADLs). R19's diagnoses included non-traumatic brain dysfunction (impaired brain function affecting cognition or behavior not caused by physical injury), Alzheimer's disease (a progressive neurodegenerative disorder that causes memory loss, impaired thinking, and decline in functional abilities), heart failure (a chronic condition in which the heart is unable to pump blood effectively to meet the body's needs), hypertension (chronically elevated blood pressure), obstructive uropathy (blockage of urine flow that can impair kidney and bladder function), diabetes mellitus (a metabolic disorder characterized by elevated blood glucose levels due to impaired insulin production or use), anxiety disorder (a mental health condition characterized by excessive worry or fear), depression (a mood disorder causing persistent feelings of sadness and loss of interest), insomnia (difficulty falling or staying asleep), constipation (infrequent or difficult bowel movements), other reduced mobility (limited ability to move independently due to physical or medical conditions), long-term use of anticoagulants (ongoing use of medications that reduce blood clotting and increase bleeding risk), alcohol abuse (harmful or excessive use of alcohol that may impact physical and mental health), obstructive sleep apnea (a sleep disorder in which breathing repeatedly stops and starts due to airway obstruction during sleep), and atrial fibrillation (an irregular heart rhythm that increases the risk of blood clots and stroke). Review of R19's EMR revealed the most recent care conference had been conducted on 7/29/25. Further record review indicated subsequent care conferences had been due in November 2025 and February 2026 in accordance with facility practice. However, there was no documented evidence that the facility scheduled, conducted, or attempted to schedule the care conferences or provided R19 and/or the resident representative with the opportunity to participate in the review and development of the care plan at the time of survey. During interview on 2/26/26 at 12:02 p.m., Social Services (SS)-B confirmed care conferences had not been completed for R8 and R19 within the expected timeframe (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	02/26/2026

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and acknowledged the residents and/or their representatives had not been provided the opportunity to participate in a timely review of the residents' care plans. SS-B stated she would document in the resident's record if attempts were made to contact the family to schedule a care conference and confirmed there was no documentation indicating attempts had been made to schedule care conferences for R8 or R19. During interview on 2/26/26 at 1:32 p.m., the Director of Nursing (DON) stated care conferences were expected to be completed quarterly or with a significant change in condition. The DON stated attempts by the social worker to contact the resident's family or representative to schedule a care conference should be documented in the progress notes. Review of the facility policy titled Care Planning - Resident Participation, dated 10/23, indicated the facility would discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences and allow them to review the care plan initially, at routine intervals, and after significant changes. The policy further indicated the facility would make an effort to schedule the conference at the best time of day for the resident or resident's representative and would obtain a signature from the resident and/or resident representative following discussion or review of the care plan.

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	02/26/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure discharge against medical advice (AMA) was documented for 1 of 1 residents (R76) reviewed for discharge. R76's entry minimum data set (MDS) dated [DATE], indicated R76 admitted to the facility on [DATE]. R76 admitted from a hospital stay. R76's discharge MDS dated [DATE], indicated R76 had an unplanned discharge. R76 had diagnoses that included lumbar vertebra compression fracture, depression, hallucinations, and peripheral vascular disease. Progress note dated 12/18/25, at 2:10 p.m. indicated R76 admitted to facility following hospitalization. Progress note dated 12/18/25, at 7:06 p.m. indicated R76 had gotten agitated and physically aggressive towards staff. Staff attempted to redirect but unsuccessful. Resident was noted attempting unsafe self-transfers. An electronic medical record (EMR) Medication administration note dated 12/18/25, at 8:44 p.m. indicated R76 left AMA. Review of R76's progress noted and documents in the EMR on 2/25/26, failed to indicate R76 discharged from the facility. R76's EMR also failed to indicate the medical provider and/or family were notified R76 discharged AMA. R76's EMR failed to indicate R76 had received education and/or was not presented with AMA form for signature. Review of notes related to medication administration indicated R76 was not administered evening medications because R76 had discharged AMA. When interviewed on 2/25/26 at 4:32 p.m., registered nurse (RN)-C stated When a resident wanted to discharge AMA there was an AMA form that needed to be signed, the provider and family/resident representative need to be updated and this was to be documented in the residents EMR. When interviewed on 2/26/26 at 9:42 a.m., RN-D stated when a resident discharged AMA the nurses were expected to educate the resident/family regarding inability to provide medications, the resident/family was to sign the AMA form, update that provider, director of nursing (DON) or nurse manager then document everything in the residents progress notes in the EMR. When interviewed on 2/26/26, at 10:35 a.m. clinical coordinator (CC)-F stated when a resident discharged from the facility for any reason there should be documentation in the progress notes regarding any paperwork/information that had been discussed with the resident/family, the progress note was also expected to include the time and how the resident had discharged . CC-F reviewed R76's progress notes, CC-F stated there was no note located in the EMR regarding the discharge from the facility. When interviewed on 2/26/26, at 1:49 p.m. DON stated when a resident discharged there should be a note located in the progress notes that the resident/family had been educated on the discharge, if the resident had discharged AMA family and/or resident needed to sign AMA paperwork which would have been scanned into resident documents in the EMR. DON stated documentation of discharge and update to provider was important to ensure resident safety, and continuity of care. Facility Transfer and Discharge (including AMA) policy dated 3/2025, indicated resident and family/legal representative should be informed of risks involved, benefits of staying the facility and the alternatives to both. The Physician should be notified of the intended AMA discharge. Documentation of the notification should be entered into the nurses notes.

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	02/26/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to send a copy of the notice of transfer or discharge to the representative of the Office of the State Long-Term Care (LTC) Ombudsman for 1 of 2 residents (R76) reviewed for discharge. R76's entry minimum data set (MDS) dated [DATE], indicated R76 admitted to the facility on [DATE], R76 admitted from a hospital stay. R76's discharge MDS dated [DATE], indicated R76 had an unplanned discharge. R76 had diagnoses that included lumbar vertebra compression fracture, depression, hallucinations, and peripheral vascular disease. Review of the December 2025 and January 2026 Ombudsman notifications sent by the facility failed to indicate Ombudsman office was notified R76 had discharged from the facility. Review of R76's electronic medical record (EMR), indicated R76 was not administered evening medications on 12/18/25, due to having discharged against medical advice (AMA). When interviewed on 2/26/26 at 1:00 p.m., social worker (SW)-B stated Ombudsman notifications were sent for all residents who discharged or were hospitalized , SW-B further stated notification was not sent for residents that had discharged AMA. When interviewed on 2/26/26 at 1:35 p.m., nursing home administrator stated she was informed R76 discharged AMA but was not aware Ombudsman office needed to be informed of a resident who discharged AMA. When interviewed on 2/26/26 at 1:49 p.m., director of nursing (DON) stated the Ombudsman was to be notified of any resident that was hospitalized or discharged that included residents who had discharged AMA for resident safety. Facility Transfer and Discharge (including AMA) policy dated 2/2025, indicated the facility would provide transfer/discharge notice to the ombudsman.

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	02/26/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident's comprehensive care plan was individualized and resident-specific for 1 of 1 resident (R19) reviewed for behavioral care planning.Findings include:R19R19's quarterly Minimum Data Set (MDS), dated [DATE], identified R19 had moderate cognitive impairment and required assistance with activities of daily living (ADLs). R19's diagnoses included non-traumatic brain dysfunction (impaired brain function affecting cognition or behavior not caused by physical injury), Alzheimer's disease (a progressive neurodegenerative disorder that causes memory loss, impaired thinking, and decline in functional abilities), heart failure (a chronic condition in which the heart is unable to pump blood effectively to meet the body's needs), hypertension (chronically elevated blood pressure), obstructive uropathy (blockage of urine flow that can impair kidney and bladder function), diabetes mellitus (a metabolic disorder characterized by elevated blood glucose levels due to impaired insulin production or use), anxiety disorder (a mental health condition characterized by excessive worry or fear), depression (a mood disorder causing persistent feelings of sadness and loss of interest), insomnia (difficulty falling or staying asleep), constipation (infrequent or difficult bowel movements), other reduced mobility (limited ability to move independently due to physical or medical conditions), long-term use of anticoagulants (ongoing use of medications that reduce blood clotting and increase bleeding risk), alcohol abuse (harmful or excessive use of alcohol that may impact physical and mental health), obstructive sleep apnea (a sleep disorder in which breathing repeatedly stops and starts due to airway obstruction during sleep), and atrial fibrillation (an irregular heart rhythm that increases the risk of blood clots and stroke). Review of R19's comprehensive care plan, print date of 2/25/26, included a focus area titled Substance Use, which indicated: I have a history of substance use disorder. As evidenced by: (specify) Use of/addiction to {prescription/illegal/alcohol} drugs (specify). My drug(s) of choice is/was: _____. The care plan failed to identify the residents' specific substance use history, triggers, risks, or individualized interventions for staff to follow. Further review of the care plan revealed a focus area titled Trauma, which indicated: I have a history of trauma that affects me negatively. (Describe trauma): _____. The care plan failed to describe the resident's trauma history, identify potential triggers, or include individualized trauma-informed care approaches for staff. During interview on 2/26/26 at 12:49 p.m., registered nurse clinical coordinator (CC)-F stated care plans could be updated and revised by nursing staff, including herself, other nurses on the unit, and the social worker. CC-F stated care plans should be developed and updated when there was a change in the resident's condition and reviewed at least quarterly to ensure the information was accurate. CC-F stated the care plan was important so staff were aware of how to care for the resident and so it reflected the overall picture of the resident's care needs. CC-F confirmed the resident's care plan contained several generic areas that were not person-centered and acknowledged the care plan should have been updated. During interview on 2/26/26 at 1:32 p.m., director of nursing (DON) acknowledged the care plan contained templated focus areas and stated the care plan should have been individualized to reflect the resident's specific needs and history. Review of the facility policy titled Comprehensive Care Plans, dated 9/24, indicated comprehensive care plans were to be individualized and developed based on the residents' assessed needs, preferences, strengths, and goals. The policy further indicated care plans were to include resident-specific problems, measurable goals, and individualized interventions to guide staff in providing person-centered care.

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	02/26/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to ensure residents who were dependent on others for activities of daily living (ADLs) received the services needed. This affected 1 of 3 residents (R65) observed for partial bathing and nail care and 1 of 3 residents (R47) observed for facial shaving.Findings include: R65 R65's annual MDS dated [DATE], indicated R65 was dependent on staff for personal hygiene, oral cares, bathing and all other ADLs. R65 had severe cognitive impairment. R65's care plan with revision date 2/16/26, indicated R65 required total assistance of one staff for bathing and oral cares, extensive assistance of one staff for dressing and hygiene/grooming tasks. R65's face sheet printed 2/26/26, indicated R65's diagnoses included dementia, anxiety, hypertension, chronic pain insomnia and major depression. During observation on 2/23/26 at 1:52 p.m., R65 had long fingernails with an unknown, dark brown/black substance under the nails. During observation on 2/24/26 at 2:56 p.m., R65 had long fingernails with an unknown dark brown/black substance underneath the nails. During observation on 2/25/26 at 3:42 p.m., R65 was sitting at a table in the common area using her hands to eat a snack, R65 had long fingernails with an unknown, dark brown/black substance underneath the nails. During observation on 2/26/26 at 7:55 a.m., NA-A entered R65's room, announced she was there to help R65 to get ready for breakfast. R65 was laying in bed. NA-A applied R65's socks and pants. NA-A assisted R65 to sit on edge of the bed. NA-A removed R65's gown, applied deodorant, assisted R65 with applying shirt. NA-A assisted R65 with standing up with use of standing lift, NA-A used a disposable wipe to clean R65's peri-area with one swipe from front to back, applied clean incontinent brief, pulled up pants then place R65 in wheelchair. R65 was assisted to bathroom for oral cares, NA-A provided resident with toothbrush prepared with toothpaste. R65 then brushed hair with toothpaste covered toothbrush. NA-A then rinsed toothbrush, applied fresh toothpaste, handed R65 the prepared toothbrush, R65 again brushed hair with prepared toothbrush. NA-A noticed R65 brushing hair with toothbrush, took toothbrush and stated to R65, If you don't want to brush your teeth that's fine Hair was cleaned of toothpaste and brushed. R65 had long fingernails with an unknown, dark brown/black substance underneath the nails. NA-A stated R65 kind of refused to wash her face, frequently refused to brush her teeth. NA-A stated in the mornings she dressed R65 for the day, changed incontinent brief, washed face and brushed teeth. NA-stated they did not usually wash residents underarms, under breasts or clean peri-area with soap and water so that R65 would not fuss, nail care included cutting and cleaning of nails only happened on bath day. During observation on 2/26/26 at 11:27 a.m., R65 was in common are playing trivia, R65 had long nails with an unknown, dark brown/black substance under the nails. (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	02/26/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 2/26026 at 11:29 a.m., RN-G stated trimming of nails was expected to be completed during bath day, nails were expected to be cleaned when hands were washed during morning and evening partial bathing. Partial bathing included washing hands, face, underarms, under breasts and peri-area with soap and water. RN-G stated R65 could be, spicy, at times but nursing assistants should attempt to provide partial bathing. RN-G observed R65's nails, stated they should have been trimmed and definitely should have been cleaned for comfort and infection control. When interviewed on 2/26/26 at 11:53 a.m., CC-F stated when providing morning cares the expectation was oral cares, washing residents face, underarms, hands including nails if needed, under breast using soap and water, when incontinence care was provided expectation was clean with wipes if soiled then follow with soap and water. CC-F stated when a toothbrush was used by a resident for something other than brushing teeth, she would expect that NA to replace it with a new one due to infection control. When interviewed on 2/26/26 at 12:20 p.m., director of nursing (DON) stated the expectation for morning ADLs the nursing assistants should encourage residents to complete what they are able to do, assist with partial bath that included washed face, hands that included under nails, under arms, under breasts and peri care/bottom with soap and water, and oral cares. Partial bath, nail care and oral cares were important for resident comfort, cleanliness and infection control. Facility Activities of Daily Living (ADLs) policy stated 10/2022, indicated care and services will be provided for the following ADLs bathing, dressing, grooming and oral care; A resident who is unable to carry out ADLs will receive necessary services to maintain good nutrition, grooming and personal and oral hygiene. Facility Nail Care policy dated 10/2022, indicated routine cleaning and inspection of nails would be provided during ADL care on an ongoing basis. R47 R47's annual MDS dated [DATE], indicated R47 was dependent on staff for eating, oral hygiene and all other ADLs. R47 had moderate cognitive impairment. R47's care plan with revision date 1/29/26, indicated R47 required total assistance from two staff for hygiene and grooming tasks. Care plan failed to include R47's preference for frequency of grooming. R47's face sheet printed 2/26/26 indicated R47's diagnoses included dementia, insomnia, and weakness. During observation on 2/23/26 at 11:17 a.m., R47 had coarse, white hair approximately 1/4 inch long covering his cheeks, chin, above upper lip, and under chin. During observation on 2/24/26 at 2:01 p.m., R47 had coarse, white hair slightly longer than was observed on 2/23/26, covering his cheeks, chin, above upper lip, and under chin. During interview on 2/24/26 at 4:39 p.m., family member (FM)-A stated there are several times R47's spouse will assist to shave R47 during visits, but R47's spouse did not visit every day. R47's facial hair is not shaved as frequently as it would be if he was living at home and family would prefer for facility staff to assist R47 with shaving more frequently. FM-A stated they felt facility staff expected (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	02/26/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	family to assist R47 with shaving so staff did not offer or attempt as often as they should. During observation and interview on 2/24/26 at 6:49 p.m., R47's facial hair remained unchanged. Nursing assistant (NA)-C stated they assisted residents with shaving facial hair if there was time, but R47's family provided assist with shaving facial hair. During interview on 2/25/26 at 1:50 p.m., NA-B stated R47 required total assistance from staff, this included shaving facial hair. NA-B was not sure the last time she assisted R47 to shave facial hair. During interview on 2/25/26 at 3:30 p.m., NA-C stated assistance with grooming residents can happen on any shift. NA-C stated she assisted R47 with shaving, a few days ago. During interview on 2/26/26 at 9:21 a.m., clinical coordinator (CC)-B stated she expected residents, male or female, were assisted to shave facial hair as frequently as they desired. Assistance should be provided by facility staff unless resident or family have requested otherwise. CC-B stated R47's family has not requested to assist R47 with shaving and should not be expected to. During interview on 2/26/26 at 10:10 a.m., director of nursing (DON) stated she expected residents were assisted with shaving daily or according to their personal preference. This was important for each resident's happiness, self-image and dignity. Facility policy, Activities of Daily Living (ADLs) dated January 2023, section: Policy Explanation and Compliance Guidance: number three indicated, A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming and personal oral hygiene.

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	02/26/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to identify, assess and monitor a new skin concern for 1 of 1 resident (R47) observed for quality of care. Additionally the facility failed to ensure care and services were provided in accordance with professional standards of practice to prevent avoidable harm when assisting a resident with mobility for 1 of 1 resident (R19) observed for wheelchair mobility. Findings include: R47 R47's annual MDS dated [DATE], indicated R47 was dependent on staff for eating, oral hygiene and all other ADLs. R47 had moderate cognitive impairment. R47's physician orders last signed 1/6/26, included, Nurse to complete the Skin Assessment. This order was scheduled weekly on R47's bath day. R47's care plan revision date 1/29/26, failed to instruct staff to observe skin as well as who to report concerns to. No interventions were noted regarding R47's right thumb. R47's face sheet printed 2/26/26 indicated R47's diagnoses included dementia, insomnia, type 2 diabetes mellitus, and weakness. Review of R47's Skin assessment dated [DATE], indicated, No new skin alterations. Assessment did not include dark, round, raised area next to the nail on R47's right thumb as a previously noted skin alteration. Review of R47's 2/2026 treatment record (TAR) reviewed 2/1/26 through 2/25/26, did not indicate nurses or other staff were monitoring the dark, round, raised area next to the nail on R47's right thumb. Review of nurse notes in R47's electronic health record (EHR) 1/1/26 through 2/25/26 did not indicate assessment or monitoring of the dark, round, raised area next to the nail on R47's right thumb was completed or ordered. Nurse notes also did not indicate R47's physician or nurse practitioner were made aware of the area. During observation on 2/23/26 at 11:19 a.m., noted a dark, round, raised area next to the nail on R47's right thumb. R47 denied pain. During interview on 2/24/26 at 4:39 p.m., family member (FM)-A stated family was aware of the blood blister, on R47's right thumb but were not aware of how or when it happened. FM-A stated they noticed it, last week sometime, FM-A did not alert the facility when the area was noticed. During observation on 2/25/26 at 12:07 p.m., dark, round, raised area next to the nail on R47's right thumb was unchanged. R47 denied pain. During interview on 2/25/26 at 1:50 p.m., nursing assistant (NA)-B stated any changes in resident's (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	02/26/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	skin were immediately reported to the nurse. NA-B was not aware of skin changes for R47. During interview on 2/25/26 at 3:30 p.m., NA-C stated new skin concerns are immediately reported to the nurse. NA-C noticed the area on R47's right thumb, over the weekend. I told the nurse about it and showed it to her. During interview and observation on 2/26/26 at 8:37 a.m., registered nurse (RN)-A stated skin checks are completed weekly on each resident's bath/shower day. If the resident refuses their bath/shower, the skin check is completed while the resident is in bed. When new concerns are noted either when the skin check is completed or when it is reported by staff or family, the clinical coordinator (CC)-B would be made aware. CC-B would put a nursing order in the resident's TAR for the area to be monitored. The resident's provider and family should be updated. RN-A was not aware of the area on R47's right thumb. When observed, RN-A described the area as, a reabsorbing blood blister. During interview on 2/26/26 at 9:21 a.m., CC-B stated she expected to be alerted to all skin concerns noted. The nurse identifying the new skin concern is expected to complete a, Risk Management, form in the facilities EHR, the area needed to be assessed, resident's provider and family were expected to be updated, and care plan should be updated with instructions to monitor and interventions to prevent. CC-B expected the resident's TAR was also updated with a nursing order to monitor and how to treat if treatment is needed. During interview on 2/26/26 at 1010 a.m., director of nurse (DON) stated she expected all skin concerns to be reported to the nurse working that day and for that nurse to report the concern to the CC. DON expected the nurse to assess the area, complete a risk management form, update the family and the provider, get orders put in place if needed and update the resident's care plan. Depending on the type of skin concern, the resident may need to be placed on would rounds for closer observation and monitoring. DON stated skin concerns need to be properly communicated so they can be assessed and observed properly. This is important to prevent worsening skin breakdown and possible infection. R19 R19's quarterly Minimum Data Set (MDS) dated [DATE], identified R19 had moderate cognitive impairment and required assistance with activities of daily living (ADLs). R19's diagnoses included non-traumatic brain dysfunction (impaired brain function affecting cognition or behavior), Alzheimer's disease (progressive disorder causing memory loss and cognitive decline), heart failure (heart unable to pump blood effectively), hypertension (high blood pressure), obstructive uropathy (blockage of urine flow), diabetes mellitus (high blood sugar due to insulin problems), anxiety disorder (excessive worry or fear), depression (persistent sadness or loss of interest), insomnia (difficulty sleeping), constipation (difficulty passing stools), reduced mobility (limited ability to move independently), long-term use of anticoagulants (blood-thinning medications), alcohol abuse (harmful alcohol use), obstructive sleep apnea (breathing repeatedly stops during sleep), and atrial fibrillation (irregular heart rhythm increasing the risk of stroke). During observation on 2/24/26 at 12:18 p.m., nursing assistant (NA)-E assisted R19 to the dining room in a wheelchair without foot pedals in place. R19's feet were observed sliding on the floor while the wheelchair was in motion. During observation on 2/25/26 at 9:13 a.m., NA-A assisted R19 to the dining room for breakfast in a wheelchair without foot pedals in place. R19's feet were observed bouncing on the floor during (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	02/26/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transport. Review of R19's care plan, print date of 2/25/26, lacked documentation for the use of wheelchair foot pedals when staff assisted the resident with mobility. During an interview on 2/26/26 at 10:19 a.m., NA-E stated residents should have foot pedals in place if staff were pushing them in a wheelchair. During an interview on 2/26/26 at 10:48 a.m., NA-A stated residents should have foot pedals in place when staff assisted them by pushing the wheelchair. During an interview on 2/26/2026 at 12:49 p.m., registered nurse clinical coordinator (CC)-F stated if a resident required foot pedals, it should be reflected in the care plan. CC-F further stated foot pedals were expected to be used anytime staff assisted a resident with wheelchair mobility to prevent injury. During an interview on 2/26/2026 at 1:32 p.m., the Director of Nursing (DON) stated residents should have foot pedals in place when staff assisted them with wheelchair mobility to ensure proper positioning and prevent injury. Review of facility policy related to wheelchair use and resident transport was requested; however, the facility did not provide the requested policy during the survey.

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	02/26/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure interventions identified in the comprehensive care plan were implemented to prevent the recurrence of pressure ulcers for 1 of 3 residents reviewed for pressure ulcer prevention (R6).Findings include:R6's quarterly Minimum Data Set (MDS) dated [DATE], identified R6 had intact cognition and required assistance with all activities of daily living (ADLs). R6's diagnoses included type 2 diabetes mellitus with diabetic neuropathy (high blood sugar causing nerve damage) and arthritis (joint inflammation causing pain and stiffness), Review of R6's electronic medical record (EMR) indicated R6 previously had a stage three pressure ulcer (full-thickness skin loss where fat tissue may be visible) on the left heel which was documented as healed as of 1/23/26. The EMR identified R6 remained at risk for skin breakdown and recurrence of a pressure ulcer. Review of R6's comprehensive care plan printed 2/25/26, included interventions to prevent recurrence of pressure ulcers. Interventions included: Elevate resident's heels on heel manager when in bed, initiation date of 10/10/25 Float heels on two pillows when in recliner, initiation date of 10/10/25 During observation on 2/24/26 at 11:39 a.m., R6 was reclined back in a recliner in her room with her legs elevated and eyes closed. No pillows were noted under R6's legs. R6's heels were resting directly on the foot rest of the recliner. During observation on 2/24/26 at 3:00 p.m., R6 was observed reclined back in her recliner with her legs elevated and eyes closed. No pillows were present under R6's legs. R6's heels were resting directly on the foot rest of the recliner. During observation on 2/24/26 at 6:21 p.m., R6 was observed reclined back in a recliner with no pillows under her legs. R6's heels were resting directly on the foot rest of the recliner. A sign posted on the wall near the recliner instructed, Make sure resident feet are floating on 2 pillows when in recliner. During observation on 2/25/26 at 8:35 a.m., R6 was observed reclined back in a recliner with no pillows under her legs. R6's heels were resting directly on the foot rest of the recliner while staff delivered breakfast. During observation on 2/25/26 at 2:28 p.m., R6 was observed reclined back in her recliner with her legs extended. One pillow was present under her legs; however, R6's heels continued to rest on the foot rest of the recliner despite the placement of the pillow. During interview on 2/26/26 at 9:53 a.m., nursing assistant (NA)-D stated R6 previously had sores on her heels that had healed. NA-D stated when R6 was in the recliner, staff were supposed to place a pillow under her legs to prevent swelling. During interview on 2/26/26 at 11:28 a.m., registered nurse clinical coordinator (CC)-B stated R6 previously had pressure ulcers on her heels that had since resolved. When R6 was in the recliner, her legs were to be elevated on two pillows to ensure her heels were not resting on the foot rest. CC-B stated R6 received weekly skin checks and staff were expected to ensure the resident's heels were floating and not touching the recliner to prevent the pressure ulcers from returning. During interview on 2/26/26 at 1:32 p.m., the director of nursing (DON) stated she expected staff to follow interventions put in place to prevent recurring pressure ulcers. The DON stated the interventions were important because they were intended to prevent skin breakdown. Review of the facility policy titled Pressure Injury Prevention and Management, dated 10/22, indicated the facility was committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal pressure ulcers/injuries, prevent infection, and prevent the development of additional pressure ulcers/injuries. The policy indicated evidence-based interventions for prevention would be implemented for all residents assessed as at risk or who had a pressure injury present.

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	02/26/2026

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to following therapy recommended ambulation program for 1 of 1 resident (R40) reviewed with scheduled ambulation assistance. Findings include: R40's quarterly Minimum Data Set (MDS) dated [DATE], indicated R40's cognition was intact and required supervision or touch assist for ambulation. R40 did not participate in a restorative nursing program. R40's care plan with edit date of 9/2/25, included ambulation recommendation for R40 to ambulate to meals with staff assistance with front wheeled walker. Additional instruction included, supervision- nursing ambulation program with support of front wheeled walker to and from all meals with supervision assistance daily. Can also provide walking assistant with restroom use. R40's nursing progress notes reviewed 1/28/25 through 2/25/26, no notes found to indicate R40 refused when staff offered assistance. R40's face sheet printed 2/26/26, indicated diagnoses included ataxia (poor muscle control), nontraumatic intracerebral hemorrhage (spontaneous bleeding within the brain tissue), and heart failure. During observation on 2/24/26 at 11:33 a.m., R40 propelled self, in wheelchair, from bedroom to the dining room. No attempts were made to ask R40 to ambulate to the dining room, by staff who walked past him. During observation on 2/24/26 at 4:57 p.m., R40 propelled self, in wheelchair, from bedroom to the dining room.During observation and interview on 2/25/26 at 8:46 a.m., R40 propelled self, in wheelchair, from bedroom to the dining room. R40 stated he used to walk to meals, but is not doing it now. R40 did not know why stating, I'm able to walk but its been a while since I walked to a meal. Staff do still offer, not like they used to. R40 stated he used ask the staff to walk with him to meals, . they always have a reason not to. Sometimes they're too busy, or they have other residents to take care of. So I quit asking. R40 voiced a desire to walk more, I would like to walk more. So, if you talk with them and they start walking me again, I'm okay with that.During interview on 2/25/26 at 1:50 p.m., nursing assistant (NA)-B stated assisting residents to ambulate was easily done in the morning. R40 is supposed to get staff assistance to ambulate to and from meals. R40 would only do it if offered. R40 was typically offered to ambulate in the morning, If I come before he leaves his room. NA-B thought the last time R40 ambulated was sometime the week prior, but NA-B was not certain. During interview on 2/26/26 at 8:37 a.m., registered nurse, clinical coordinator (CC)-B stated if a resident's care plan included ambulation, she expected assistance was offered. If a resident refused, she expected staff to reapproach and alert the nurse if resident continued to refuse. CC-B reviewed R40's nurse progress notes 1/28/26 through 2/25/26. CC-B was not able to locate progress notes to indicate R40 had refused ambulation assistance. CC-B was not sure if resident ambulation notes were being reviewed, CC-B did not review ambulation notes unless something occurred and was brought to her attention. CC-B stated it was important to encourage and offer assistance to residents for ambulation to ensure they do not decline physically.During interview on 2/26/26 at 10:10 a.m., director of nursing (DON) stated residents who receive assistance with ambulation have a sneaker sticker outside their room. DON expected, when therapy gave recommendations for an ambulation program, the resident would be assisted to ambulate according to the instructions in their care plan. If a resident refused ambulation assistance, DON expected the nurse to write a progress note, alert family and therapy of the refusal.Facility policy for ambulation was requested but was not received.

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	02/26/2026

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	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** Based on document review, interview and observation, the facility failed to ensure a root cause analysis was completed after a fall to determine interventions to prevent falls, and failed to continue to assess for changes after a head injury per policy, for 1 of 3 (R5) residents reviewed for falls.Findings include:R5's admission Minimum Data Set (MDS) dated [DATE], identified R5 had severe cognitive impairment was dependent on staff for all activities of daily living (ADLs) including transfers and bed mobility. R5's diagnoses included non-traumatic brain dysfunction, Alzheimer's disease, hypertension (high blood pressure), diabetes mellitus (high blood sugar due to impaired insulin regulation), arthritis (joint inflammation causing pain and stiffness), other fractures (history of bone fractures), anxiety disorder (excessive worry or fear), depression (persistent feelings of sadness), metabolic encephalopathy (altered brain function due to metabolic imbalance) and paroxysmal atrial fibrillation (intermittent irregular heart rhythm). The MDS indicated R5 had experienced one fall since admission with a injury (except major). Progress note dated 8/5/25 at 2:56 p.m., indicated R5 was attending a musical activity when R5 fell asleep, was startled, and slid from a chair onto the carpet, landing on her right side. The note indicated R5 did not hit her head. Documentation indicated the nurse assessed R5 for injuries, cause of the fall, and pain. Range of motion (ROM) was noted to be unchanged for R5. No signs of pain were documented. R5 was assisted off the floor with a Hoyer lift and assistance of two staff and was assisted to bed. The note further indicated therapy was notified and a tilt-in-space wheelchair was delivered. R5's care plan was updated to include anticipating needs, wear gripper socks when up without shoes, staff will remind and reinforce safety awareness by telling Rt5 to lock breaks on bed anc chair, therapy provided new tilt-in-space wheelchair (a wheelchair that tilts back to assist in preventing slipping out of chair). Progress note dated 8/8/25 at 6:12 p.m., indicated staff had assisted R5 out of bed and brought R5 to the common area for dinner. The nurse documented staff left briefly to assist another resident with a bathroom transfer. While staff were assisting the other resident, a third staff member present in the common area observed R5 lying on the floor. The note indicated staff exited the other resident's room and found R5 on the floor at approximately 4:25 p.m. Staff reported they did not witness the fall but observed R5 hit her head on the floor. R5 was lying on her right side approximately three feet away from her wheelchair, which had the leg rest extended. R5 was noted to be wearing gripper socks. R5 was bleeding from the nose and had a laceration on the forehead. Review of the North Memorial Health After Visit Summary, dated 8/8/2025, indicated the reason for the visit was a head injury. Diagnoses included fall, head injury, contusion of the face, neck, or scalp, facial laceration, facial bone fracture, and right hip injury (initial encounter). Discharge instructions included follow-up in five days for suture removal and follow-up with the primary care provider or facility physician within one week. Progress note dated 8/8/25 at 10:32 p.m., indicated R5 returned from the emergency department via North Memorial EMS at approximately 10:00 p.m. Computed tomography (CT) scans of the head, face, pelvis, and spine were completed and reported as normal. An X-ray of the pelvis and hip was also completed. Vital signs were documented as blood pressure 166/81, temperature 97.3 F, pulse 84, oxygen saturation 92% on room air, and respirations 18. R5 received seven stitches to the forehead and top of the nose. R5 received bedtime medications and was documented as stable. Information was reported to the oncoming shift. Progress note dated 8/11/25, indicated interdisciplinary team (IDT) met to review R5's unwitnessed fall on 8/8/2025. R5's diagnoses included cerebrovascular accident (CVA), metabolic encephalopathy, and anxiety disorder. Predisposing physiological factors included confusion, gait imbalance, weakness, and poor safety awareness. Predisposing situational factors included ambulating without assistance and self-transferring. R5 was sent to the emergency department. R5's post-fall assessment dated [DATE] at 4:25 p.m. indicated on 8/8/25 staff had (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	02/26/2026

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	assisted R5 out of bed and brought R5 to the common area for dinner. Staff left the area to assist another resident with a bathroom transfer. A third staff member who remained in the common area observed R5 lying on the floor. Staff exited the other resident's room and found R5 on the floor at approximately 4:25 p.m. Staff did not witness the fall but reported observing R5 strike her head on the floor. R5 was observed lying on her right side approximately three feet away from her wheelchair, which had the footrests in a raised position. R5 was bleeding from the nose and had a laceration to the forehead. R5 was noted to be wearing gripper socks and was unable to describe what had occurred. R5 was oriented to person. Immediate interventions included placing a pillow under R5's head, not moving the resident, and calling 911 at 4:27 p.m. Staff applied pressure to R5's nose to control bleeding. The Director of Nursing (DON), Administrator, and Admissions Specialist responded to assist following the fall. Vital signs at the time of the fall were blood pressure 174/79, pulse 79, temperature 97.2 F, respirations 20, and oxygen saturation 91% on room air. Family member (FM)-B was notified at 4:43 p.m. and provided verbal consent to send R5 to North Memorial and to hold the resident's bed. Emergency medical services (EMS) arrived, and R5 was transported via stretcher to North Memorial at approximately 4:43 p.m. The on-call provider was notified at 6:05 p.m. R5's EHR indicated R5 experienced a fall on 8/8/25. Documentation failed to include root cause analysis of the fall as well as changes to R5's care plan to prevent future falls. Progress note dated 10/20/2025 at 3:09 p.m., indicated R5 was placed on one-to-one (1:1) supervision due to multiple attempts to self-transfer. Staff redirected R5 with activities such as reading the newspaper and caring for a baby doll; however, the interventions were short-lived. R5 remained near the nurse's station when no activities were occurring. Progress note dated 10/23/2025 at 8:02 a.m., indicated R5 was found on the floor during rounds at approximately 7:10 a.m. R5 sustained a skin tear to the right outer eyebrow with ongoing bleeding, and a bandage was applied. R5 was noted to have left-sided weakness and complained of pain in the left hand. The provider was notified and orders were received to send R5 to the emergency department for further evaluation. Review of R5's post-fall assessment, dated 10/23/2025, indicated R5 was found on the floor beside her bed in a prone position with her right hand underneath her body, positioned laterally to the bed. R5's head was facing the window and her legs were toward the door. Blood was noted on the floor, and R5 was calling out for her husband. R5 was assisted to a sitting position and cleaned. An initial neurological assessment was completed. A skin tear was noted to the right outer eyebrow with continued bleeding, a bandage was applied. R5's left hand was noted to be weaker than the right. R5 followed commands and complained of pain in the left hand. A hematoma was noted at the base of the left, fifth finger. R5 was unable to describe what had occurred. Immediate interventions included assisting R5 to bed using a Hoyer lift with assistance of two staff. Vital signs at the time of the fall included blood pressure 145/69, pulse 75, oxygen saturation 95% on room air, respirations 20, and temperature 97.5 F. R5 denied headache or blurred vision. R5 was dressed and brought to the common area. The bed was noted to be in the lowest position. R5 was sent to the emergency department for further evaluation. Physical therapy (PT) and occupational therapy (OT) to assess R5 upon return. The care plan updated to indicate R5 should be first to get up in the morning. R5 was oriented to person. Predisposing physiological factors included confusion, gait imbalance, and poor safety awareness. Predisposing situational factors included self-transfer. Review of a progress note dated 10/23/2025 at 3:47 p.m., indicated R5 returned from the hospital at approximately 2:15 p.m. R5 was restless, confused, and fidgety, and removed the splint from her left hand and refused staff attempts to reapply. Staff attempts at redirection were unsuccessful. R5 was observed sitting at the nurse's station receiving one-to-one supervision. R5 was able to move the affected arm and denied pain at that time. R5 also removed the dressing from the right eye. Family member (FM)-B was notified and was attempting to arrange for a family member to visit. Continued efforts to redirect and maintain R5's safety. Review of the North Memorial Health After Visit Summary, dated 10/23/2025, indicated the reason for the visit was a closed displace fracture of shaft of fifth metacarpal bone of left hand and head injury. Discharge instructions included (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	02/26/2026

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	follow-up with the primary care provider or facility physician within one week and to schedule an appointment with Twin Cities Orthopedics as soon as possible. Facility IDT notes dated 10/24/25, indicated 10/23/25 fall was discussed. Documentation indicated R5 resided on the memory care unit with a diagnosis of Alzheimer's disease and was described as impulsive. R5 was reported to have attempted to self-transfer out of bed, resulting in injury to the right outer eyebrow and a hematoma at the base of the left fifth finger. R5 was sent to the emergency department and returned to the facility the same day at approximately 2:15 p.m. Updated interventions included ensuring R5 was first to get up in the morning and initiating therapy services through OT and PT. The care plan was updated accordingly. R5's quarterly MDS dated [DATE], identified R5 had severe cognitive impairment and required partial/moderate staff assistance with transfers and bed mobility. The MDS indicated R5 had experienced one fall after admission with a major injury. During observation on 2/24/26 at 11:34 a.m., R5 was lying sideways in bed with her wheelchair positioned next to the bed. R5 was wearing gripper socks. During observation on 2/24/26 at 2:39 p.m., R5 self-propelled her wheelchair from the dining room toward her room. R5's gripper socks had slid down on both feet, with approximately three inches of the socks hanging off the ends of her toes but heels were still partially covered. Activity aide (AA)-A asked R5 if she wanted to join activities; however, R5 continued propelling toward her room. During observation on 2/25/26 at 8:25 a.m., R5 was in the living room propelling herself in her wheelchair toward her room. Registered nurse (RN)-G asked R5 where she was going, and R5 stated she was going to lie down for a while before breakfast. RN-G stated she would come get R5 when breakfast was ready. R5 then entered her room and transferred herself into bed. During observation on 2/25/26 at 2:09 p.m., R5 was lying in bed in her room with the door closed. During interview on 2/25/26 at 12:32 p.m., RN-G stated R5 required assistance of one staff member with transfers, although R5 sometimes attempted to transfer independently. RN-G stated that if staff observed R5 attempting to self-transfer, they would typically watch to ensure she was safe and would assist if able. Staff sometimes avoided immediately intervening because they did not want to startle R5. RN-G confirmed, earlier this morning R5 told RN-G she intended to go to room and lay down. RN-G stated she did not attempt to intervene but should have assisted R5. RN-G stated assisting R5 was important to prevent falls. During interview on 2/26/26 at 9:53 a.m., nursing assistant (NA)-D stated that when a resident fell, staff notified the nurse and remained with the resident to ensure the resident was safe while the nurse completed an assessment. During interview on 2/26/26 at 10:19 a.m., NA-E stated when a resident fell, staff notified the nurse. NA-E stated the nurse completed an assessment and updated the care plan as needed. NA-E stated R5 required assistance of one staff member with transfers and reported therapy sometimes walked with R5. During interview on 2/26/26 at 10:24 a.m., RN-G stated when a resident fell, the nurse completed a fall assessment and communicated the event to other staff. RN-G stated neurological assessments might be completed for unwitnessed falls depending on the circumstances and were followed by vital sign monitoring. RN-G stated multiple staff could update the care plan following a fall. RN-G further stated the focus of care planning was often ensuring tasks for nursing assistants were clearly identified so staff knew how to care for R5. RN-G stated R5 used a tilt-in-space wheelchair when first admitted then transitioned to a regular wheelchair. At the time of the falls she was in the tilt-in-space wheelchair. During interview on 2/26/26 at 10:48 a.m., NA-A stated R5 required assistance of one staff member with transfers and stated staff notified the nurse when a resident fell. NA-A stated R5 self-transfers herself often and stated that if staff see her self-transferring, they supervise as they don't want to scare R5. During interview on 2/26/26 at 12:49 p.m., Clinical Coordinator (CC)-F stated that when a resident fell, the nurse entered the fall into the facility's incident reporting system, and the fall was reviewed by the interdisciplinary team to ensure interventions were implemented to prevent additional falls. CC-F stated R5 experienced a fall on 8/8/25, was sent to the emergency department, and returned the same day. CC-F confirmed an intervention was not implemented following that fall. CC-F stated neurological assessments were expected when a resident hit their head or when a fall was (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	02/26/2026

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	unwitnessed and that neurological monitoring was documented in a neurological assessment. CC-F confirmed neurological assessments were not initiated or completed following R5's falls on 8/8/25 and 10/23/25 and stated neurological monitoring would have been expected following each fall. CC-F stated neurological monitoring was important to detect changes in condition, particularly for memory care residents who might not be able to report symptoms. CC-F stated R5 required assistance of one staff member to stand-by assistance with transfers and stated R5 tended to self-transfer but required staff assistance due to being very unsteady. CC-F stated staff were expected to assist R5 with transfers when aware R5 was attempting to transfer due to R5's fall history and unsteadiness. During interview on 2/26/26 at 1:32 p.m., the Director of Nursing (DON) stated after every fall, whether witnessed or unwitnessed, interventions were expected to be implemented to prevent additional falls and reduce the risk of serious injury. The DON stated fall interventions should be added to the resident's care plan. The DON further stated neurological assessments should be completed when a fall was unwitnessed or when a resident hit their head. The DON stated staff were expected to assist residents who required assistance with transfers and should not allow residents to self-transfer due to the risk of falls. Review of the facility policy titled Fall Mitigation Program, dated 1/26, indicated each resident would be assessed for fall risk and would receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls.

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	02/26/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review and interview the facility failed to ensure appropriate infection control practices were followed for 1 of 1 resident (R25) reviewed who was diagnosed with COVID and received an aerosol breathing treatment. Findings include:R25's face sheet printed 2/26/26 included diagnosis COVID-19 (2/18/26)During observation and interview on 2/25/26 at 8:30 a.m., licensed practical nurse (LPN)-A explained she needed to assist R25 with a nebulizer treatment. LPN-A entered R25's room after donning appropriate personal protective equipment (PPE), LPN-A left R25's room door fully open. LPN-A set up the nebulizer, applied the face mask to R25 and turned the machine on. At 8:41 a.m., LPN-A turned off the nebulizer machine, cleaned the face mask and medication container with water, then placed on a towel on the counter in R25's room. LPN-A left R25's room and appropriately removed PPE. During interview on 2/25/26 at 9:36 a.m., LPN-A stated not being aware of special instructions when administering aerosol breathing treatments (i.e. nebulizer) to a resident diagnosed with COVID. During interview on 2/26/26 at 9:21 a.m., clinical coordinator (CC)-B stated not being the, . best person to answer . regarding infection control practices when administering an aerosol breathing treatment to a resident diagnosed with COVID. CC-B stated based on previous directions, the resident should be screened to determine if able to self administer the medication. R25 was not assessed, therefore could not self administer the nebulizer. R25 was not residing in an airborne infection isolation room (AIIR), facility did not have those type of rooms. CC-B expected the bedroom door of the COVID positive resident's room was kept closed during the nebulizer treatment. CC-B expected the nurse to also close the door after the nebulizer was finished, for at least 15 minutes. This was important so the virus was not spread to other residents, staff and/or visitors.During interview on 2/26/26 at 10:10 a.m., director of nursing (DON) stated for residents who are COVID positive, she expected the resident's room door was closed prior to starting the nebulizer treatment and remained closed for at least 15 minutes after the nebulizer treatment was finished. This was important because COVID is spread through the respiratory system and use of the nebulizer treatment could carry the virus to other residents and/or staff. DON stated the facility did not have rooms designated as AIIR. Facility policy, COVID-19 Prevention, Response and Reporting dated 1/2025, failed to direct staff how to manage use of a nebulizer during administration. The policy provided the following instructions:18. Aerosol-generating procedures should be performed cautiously and avoided if appropriate alternatives exist.19. Aerosol-generating procedures should take place in an airborne infection isolation room (AIIR), if possible, and the number of HCP (health care providers) present during the procedure should be limited to those essential for resident care and support. Visitors should not be present for the procedure.

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	02/26/2026

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure 1 of the 5 residents (R5) reviewed for immunizations was offered and/or provided the pneumococcal vaccination series as recommended by the Centers for Disease Control (CDC) to help reduce the risk of associated infection(s). A CDC Pneumococcal Vaccine Timing for Adults feature, dated 3/2025, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over [AGE] years old had received no prior pneumococcal vaccine should receive PCV20 or PCV21, those who had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after [AGE] years old. R5's face sheet dated 2/25/26, indicated R5 was [AGE] years old. The immunization record, undated, failed to indicate R5 had received any doses of pneumococcal vaccine. R5's electronic medical record (EMR) identified a signed consent dated 8/6/25 which indicated R5's family had consented to R5 receiving the pneumococcal vaccine, however, review of R5's EMR failed to indicate R5 was offered or received pneumococcal vaccine. R5's EMR failed to indicate their Minnesota Immunization Information Connection (MIIC) was reviewed for vaccinations R5 had received prior to admission to the facility. When interviewed on 2/26/26 at 12:28 p.m., director of nursing (DON) stated when a resident was admitted their MIIC was reviewed for received vaccinations If there were vaccinations due, consent for the vaccination(s) was received from the resident or the resident representative after education regarding the vaccinations. The dose(s) would be obtained from the pharmacy and administered once there were received from the pharmacy. DON reviewed R5's EMR, was unable to locate R5's MIIC report or indication that resident had received any doses of pneumococcal vaccines. DON did locate signed consent dated 8/6/25. DON stated pneumococcal vaccine was important for infection control, to help reduce the risk of associated infections. Facility Pneumococcal Vaccine (Series) policy dated 1/2026, indicated each resident would be assessed for pneumococcal immunizations upon admission, each resident would be offered a pneumococcal immunization unless medically contraindicated or the resident had already bee immunized.

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	02/26/2026

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 0572 Level of Harm - Potential for minimal harm Residents Affected - Many	Give residents a notice of rights, rules, services and charges. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure the most up to date Nursing Home Resident [NAME] of Rights (RBOR) was provided to each resident residing in the facility and displayed for residents, visitors and staff to review. This had the potential to affect all 53 residents currently residing in the facility as well as all staff and visitors.Findings include:During observation on 2/25/26 at 3:45 p.m., displayed by the memory care entrance was the RBOR, year revised 2009.During interview on 2/25/26 at 3:50 p.m. the campus executive director (E stated she was aware of the changes to the [NAME] for assisted living but was not aware of the changes made 12/22/25 to the RBOR.

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	02/26/2026

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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation and interview, the facility failed to ensure facility survey results were posted in an accessible location for residents, staff and visitors. This had the potential to affect all 53 residents residing in the facility as well as staff and visitors. Findings include:During observation on 2/25/26 at 3:40 p.m., a three-ring binder was noted to the left of the front desk, in a clear, plastic holder, screwed to the wall approximately five feet from the floor. The front cover of the binder noted, Survey Results.During interview on 2/25/26 at 3:51 p.m., the administrator stated a resident in a wheelchair or shorter than height at which the binder is currently stored, would not have access to the binder without assistance. Administrator stated, It needs to come down a bit.