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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 31TQ

Facility ID: 00129

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245083**

2.STATE VENDOR OR MEDICAID NO.
(L2) **046342600**

3. NAME AND ADDRESS OF FACILITY
(L3) **PARK HEALTH AND REHABILITATION CENTER**
(L4) **4415 WEST 36 1/2 STREET**
(L5) **SAINT LOUIS PARK, MN** (L6) **55416**

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY 03/29/2014 (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **81** (L18)

13.Total Certified Beds **81** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	81			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Supervisor 03/12/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 05/02/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
__ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
02/01/1979
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00450
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/24/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN# 24-5083

The facility was not in substantial compliance with Federal participation requirements at the time of the standard survey completed on 02/13/14. On 03/29/14, the Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction. Based on the PCR, it has been determined that the facility achieved substantial compliance pursuant to the standard survey completed on 02/13/14, effective 03/25/14. Refer to the CMS-2567B for both health and life safety code.

Effective 03/25/14, the facility is certified for 81 skilled nursing facility beds.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5083

May 2, 2014

Ms. Kristie Johnsrud, Administrator
Park Health and Rehabilitation Center
4415 West 36 1/2 Street
Saint Louis Park, Minnesota 55416

Dear Ms. Johnsrud:

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

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

Effective March 25, 2014, the above facility is certified for:

81 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 81 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination. Please contact me if you have any questions.

Sincerely,

Anne Kleppe

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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 9, 2014

Ms. Kristie Johnsrud, Administrator
Park Health and Rehabilitation Center
4415 West 36 1/2 Street
Saint Louis Park, Minnesota 55416

RE: Project Number S5083024

Dear Ms. Johnsrud:

On February 28, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 13, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 29, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 13, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 25, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 13, 2014, effective March 25, 2014 and therefore remedies outlined in our letter to you dated February 28, 2014, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions about this letter.

Sincerely,

Anne Kleppe

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

Enclosure

cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245083	A. Building B. Wing	3/29/2014

Name of Facility	Street Address, City, State, Zip Code
PARK HEALTH AND REHABILITATION CENTER	4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **03/25/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **03/25/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **03/25/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **03/25/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/AK	04/09/2014	18623	03/29/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/13/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 31TQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00129

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245083**
2.STATE VENDOR OR MEDICAID NO.
(L2) **046342600**

3. NAME AND ADDRESS OF FACILITY
(L3) **PARK HEALTH AND REHABILITATION CENTER**
(L4) **4415 WEST 36 1/2 STREET**
(L5) **SAINT LOUIS PARK, MN** (L6) **55416**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/13/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **81** (L18)

13.Total Certified Beds **81** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	81			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Sandra Nelson, HFE NE II 03/17/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 03/18/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
02/01/1979
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00450
(L31)

30. REMARKS
Posted 03/24/2014 CO.
31TQ

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN# 24-5083

At the time of the standard survey completed February 13, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 4509

February 28, 2014

Ms. Kristie Johnsrud, Administrator
Park Health and Rehabilitation Center
4415 West 36 1/2 Street
Saint Louis Park, Minnesota 55416

RE: Project Number S5083024 and Complaint Number H5083054

Dear Ms. Johnsrud:

On February 13, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the February 13, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5083054.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the February 13, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5083054 that was found to be unsubstantiated.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3792
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 25, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 25, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 13, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 13, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

Park
HEALTH AND REHABILITATION CENTER

3/10/14

MN Dept. of Health

P.O. Box 64900

St. Paul, MN 55164

Dear Gloria Derfus,

Enclosed is Park Health and Rehabilitation Center's plan of correction for our most recent survey. Corrections are included for ;F253, F329, F431 and F441. Our alleged compliance date is March 25th, 2014.

If you have any questions, you can contact me at 952-927-9717 or by email at kjohnsrud@extendicare.com.

Respectfully,

Kristie Johnsrud, Administrator

4415 West 36 1/2 Street • St. Louis Park, Minnesota 55416 • Phone (952) 927-9717 • Fax (952) 927-7687
An Extendicare® Facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245083	A. BUILDING _____ B. WING _____	02/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK HEALTH AND REHABILITATION CENTER	4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A standard recertification survey was conducted and complaint investigation was also completed at the time of the standard survey. An investigation of complaint H5083049 was completed. The complaint was not substantiated.	F 000	RECEIVED MAR 12 2014 DISCARDED	3/25/14
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident room walls, door frames, toilet, bathroom floor and wheelchair were not kept in good repair, clean and in a sanitary manner for resident's . This had the potential to affect 11 of 62 residents. Findings include: On 2/12/14, at 2:00 p.m. and 2/13/14, at 11:32	F 253	POC accepted KHanto 3/17/14 F253 1. All areas identified on 2567 have been corrected. 2. Maintenance Director has repaired and re-painted all door frames as needed. All wheelchairs have been cleaned as needed. 3. Education has been completed for all staff regarding identifying dirty wheelchairs or any other housekeeping/ maintenance issues. 4. All rooms will be audited weekly by caring partners for any maintenance or housekeeping concerns. 5. Results will be reviewed at QPI by the NHA or designee.	

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

See cover letter

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	245083	A. BUILDING _____ B. WING _____	02/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK HEALTH AND REHABILITATION CENTER	4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416

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F 253	Continued From page 1 a.m. environmental tours were conducted with the administrator, maintenance director and housekeeping director and the following were identified: Garden Floor: R49's and R74's bathroom was noted to be in ill repair. On 2/10/14, at 5:15 p.m. edges of the door to the bathroom observed to be heavily scuffed scraped and gouged at the level of shin and ankle for residents in wheelchair. On 2/10/14, at 5:16 p.m. observed missing tiles at the base of the toilet, dark brown colored stained flooring observed under which rendered the area an uncleanable surface. On 2/10/14, at 5:17 p.m. during the interview R49's and R74's shared toilet was observed to be running continuously in the shared bathroom. R49 stated it had been running for a "long time", she had told several staff before and the maintenance staff had "messed" with a plunger and "giggled" things, but had not repaired it. She further stated staff coming in and out of the room and thought they were be able to hear the toilet running and be aware to fix it. In addition, R49 stated "Do I have to tell staff about everything?" R49's facial expression appeared to be exasperated and her tone of voice sounded irritated. R49's annual Minimum Data Set (MDS) dated 2/6/14, indicated R49 had no cognition impairment and needed assist of one for toileting. R74's quarterly MDS dated 11/18/13, indicated	F 253		

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F 253	Continued From page 2 R74 had moderate impaired cognition and needed one person assist for toileting. R74 was unavailable for an interview at the time of the tour. On 2/11/14, at 2:00 p.m. both administrator and maintenance director verified the edges of the door to the bathroom observed to be heavily scuffed and gouged at the level of shin, ankle for residents. The administrator verified the tile was missing and was not a cleanable surface stated the tile may have been removed maybe when toilet was removed or repaired. In addition the maintenance director stated the toilet flapper was worn out and would fix it as soon as possible R31's bathroom wall was noted to be in ill repair. On 2/11/14, at 8:42 a.m. surveyor observed the walls in bathroom and observed one of the walls had a medium apple sized spot which had been patched and was not re-painted. R31's quarterly MDS dated 12/1/13, indicated R31 had no cognition impairment and needed assist of two for toileting. R31 was unavailable for an interview at the time of the tour. On 2/11/14, at 2:00 p.m. the administration and maintenance director verified stated the area had been patched but was not painted. The administrator further stated usually the area was patched then somebody went back and painted the areas later. The maintenance director denied patching the area and thought the former staff may have done it.	F 253		

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F 253	Continued From page 3 R24's wheelchair was not clean. On 2/10/14, at 3:31 p.m. R24's wheelchair was observed to have many food spills on the edges and the front aspects of the seat. R24 was interviewed at that time and verified the spills and stated his wheelchair was provided by the facility. R24 stated wheelchairs were to be cleaned "monthly." R24's quarterly MDS dated 12/17/13, indicated R24 had moderate impaired cognition and needed assist of one for transfers and wheelchair mobility. On 2/13/14, at 12:08 p.m. the administrator, housekeeping director and maintenance director all verified R24's wheelchair was dirty and had food spills and debris. The administrator asked the housekeeping director to have the wheelchair cleaned. On 2/13/14, at 1:52 p.m. when interviewed the housekeeping director stated he had noticed a lot of wheelchairs had not been cleaned and the previous week Thursday 2/6/14, some wheelchairs including R24's had been cleaned as indicated in the log provided but further stated when a resident wheelchair is noted to be soiled the nursing staff need to let housekeeping know immediately to get the wheelchairs cleaned. 2nd Floor R11, R25 and R27 On 2/11/14, at 8:25 a.m. during observation the foam around both hand holders on toilet riser in the bathroom for R11, R25 and R27 were observed to have smeared brown substance and	F 253		

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F 253	Continued From page 4 had yellow to brown stained areas on both sides. On 2/11/14, at 8:26 a.m. the wall next to R11 was observed to several white scrapes and splattered spots. In addition, the wall behind the recliner had a patched area which was not painted and the doorway into bathroom from either side to shared bathroom had several deep scratched on door frame. R11's quarterly MDS dated 12/11/13, indicated R11 had severe impaired cognition and needed assist of one for toileting and mobility. R11 was unavailable for an interview at the time of the tour. R25's significant change MDS dated 1/13/14, indicated R25 had moderate impaired cognition and needed assist of one for toileting and wheelchair mobility. R25 was unavailable for an interview at the time of the tour. R27's quarterly MDS dated 12/3/13, indicated R27 had severe impaired cognition and needed assist of one for toileting and wheelchair mobility. R27 was unavailable for an interview at the time of the tour. On 2/13/14, at 12:06 p.m. the administrator and maintenance director verified the scrapes on the bathroom frame stated that was an on-going problem as the residents and staff would jam the wheelchairs into the walls. The maintenance director stated the area needed re- painting. On 2/13/14, at 12:09 p.m. the administrator stated usually the area was patched then somebody went back and painted the areas later. The maintenance director stated he had not	F 253		

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F 253	Continued From page 5 patched the area as far as he knew and thought the former staff may have done it. On 2/11/14, at 2:00 p.m. housekeeping director verified the foam on the arms of the toilet riser had still brown/black matter/stains. Stated the toilet risers are cleaned daily. Immediately after issue was brought to their attention, the director of housekeeping was overheard calling one of the housekeeping staff to clean the foam handles of the toilet risers. -At 2:32 p.m. the housekeeping director reported to surveyor the area had been cleaned. R158 On 2/10/14, at 8:31 a.m. the door going into the bathroom was observed to have several scrapes in the frame. R158's admission MDS dated 1/10/14, indicated R158 had severe impaired cognition and needed assist of two for toileting and assist of one for wheelchair mobility. R158 was unavailable for an interview at the time of the tour. On 2/11/14, at 2:00 p.m. administrator and maintenance director verified the scrapes on the bathroom frame stated that was an on-going problem as the residents' and staff would jam the wheelchairs into the walls. The maintenance director stated the area needed painting and sanding. Maintenance director stated some of the walls had been painted that last year either October or November 2013 but was not sure. He further stated he would provide the information but was not sure as that had been done by the offer maintenance staff who had resigned.	F 253		

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F 253	Continued From page 6 R39 and R110 On 2/10/14, at 4:28 p.m. the doorway to the bathroom was observed with chipped paint going into bathroom, approximately nine (9) inches long and down to floor on right and left sides had some chips and gouges. R39's quarterly MDS dated 2/2/14, indicated R39 had severe impaired cognition and needed assist of two for toileting and one assist for wheelchair mobility. R39 was unavailable for an interview at the time of the tour. R110's quarterly MDS dated 12/3/13, indicated R110 had severe impaired cognition and needed assist of one for toileting and wheelchair mobility. R110 was unavailable for an interview at the time of the tour. R2 On 2/11/14, at 10:02 a.m. doorway and frame observed to have chipped/marked up walls of both sides going into the bathroom from bathroom door handle down to floor. R2's annual MDS dated 2/8/14, indicated R2 had moderate impaired cognition and needed assist of two for toileting and one assist for wheelchair mobility. R2 was unavailable for an interview at the time of the tour. When interviewed on 2/13/14, at 12:00 the maintenance director stated as soon as he was notified of the concern he would address it and that was one of the good things since he started to work here.	F 253		

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F 253	Continued From page 7 On 2/13/14, at 10:03 a.m. the administrator stated the facility had been challenged and there had been a struggle at the department with two staff leaving suddenly and with little notice and as a result she had to replace the positions and ensure the staff were trained which happened in October and November of 2013 last year. The administrator acknowledged safety was priority and things were prioritized and all the issues that had been identified were in working progress including some rooms had been painted. Review of the Maintenance Plan of Priority items dated 9/30/13, listed rooms and door frames that required to be painted in the Garden floor but not on the upper level of the building neither the rooms listed were identified with concerns during the tour. Review of the facility Monday Wheelchair Cleaning Checklist dated February 2014, revealed R24's wheelchair had been cleaned 2/6/14, and the Deep Clean calendar dated January 2014, revealed R24's wheelchair was scheduled to be cleaned on the 15th. The facility Physical Environment policy revised July 2013, directed weekly rounds to be conducted with housekeeping manger to include resident ' s rooms. The policy additionally directed findings to be documented, results to be tracked and trended from the tours, reviewed at the Quality Performance Improvement monthly meetings with the team to establish the root cause and subsequent plan of correction.	F 253		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		

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F 329	Continued From page 8 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 residents (R15) had parameters established for a medication that included a dose range. Findings include: Review of the February 2014, Medication Administration Record (MAR) revealed R15 had an order for Lactulose (a medication used to treat constipation) 15 to 30 milliliters (ml) daily. The	F 329	F329 1. R15's dose range for the Lactulose order was clarified to remove the range. 2. Pharmacist reviewed all other resident's orders on 2/19/14. Appropriate corrections were made immediately. 3. Education will be completed for licensed staff to ensure they get clarification on any dose rage orders. 4. Five audits will be completed weekly by DON or designee. 5. Results will be reviewed at QPI by the NHA or designee.	3/25/14

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F 329	Continued From page 9 MAR lacked direction for when to use 15 ml and when to use 30 ml and lacked documentation of how much was administered from 2/1 through 2/11/14. In addition to the Lactulose, the February 2014 MAR showed R15 also received Senokot (used for constipation) two tablets twice daily. The February 2014, Physician's Orders also lacked directions for when to give 15 or 30 ml of the Lactulose. The Bowel and Bladder Chart Detail Report for 1/1/14 through 2/12/14, revealed R15 had daily bowel movements with a total of 73 during the 43 day period. When interviewed on 2/12/14, at 2:34 p.m. licensed practical nurse (LPN)-B reported he gave R15 Lactulose for constipation. LPN-B stated he would ask R15 if she was constipated to determine how much Lactulose to give. LPN-B stated he would share how much Lactulose he had given during shift to shift report. Upon interview on 2/12/14, at 2:41 p.m. registered nurse (RN)-A verified a dose range existed for R15's Lactulose without parameters for use and the amount of Lactulose administered each day was not documented. The director of nursing (DON) was interviewed on 2/13/14, at 10:15 a.m. and stated she expected any medication with a dose range to have parameters for use. Review of the facility Physician's Orders policy dated July 2012, revealed the policy lacked direction for medications with dose ranges.	F 329		

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F 431 F 431 SS=D	Continued From page 10 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 431 F 431 F431	1. Expired bottle of Nitrostat was removed from the medication cart on 2/13/14. 2. All other medication carts have been reviewed to ensure there are no expired medications. 3. Education will be completed with licensed staff to ensure they are checking dates and taking out any expired medications from the cart. 4. All medication carts will be audited weekly to ensure there are no expired medications by DON/ designee. 5. Results will be reviewed at QPI by the NHA or designee.	3/25/14

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F 431	Continued From page 11 Based on observation, interview and document review, the facility failed to ensure medications were stored in a proper manner 1 of 6 residents (R24) who received Nitrostat (medication used to treat chest pain) on the Garden unit. Findings include: On 2/13/14, at 1:31 p.m. a medication storage tour was conducted with licensed practical nurse (LPN)-A. A bottle of Nitrostat 0.4 mg for R24 was observed in the top right drawer of the cart with open date 3/4/12. On the cap a yellow seal directed "Discard medication and reorder 6 months after opening." The Nitrostat was available and ready for resident use. R24's diagnoses included chronic systolic heart failure and hypertension was obtained from the quarterly Minimum Data Set (MDS) dated 12/17/13. Review of Physician Order signed 2/7/14, revealed R24 had an order for "Nitrostat 0.4 mg 1 tab under tongue every 5 minutes for up to 3 doses as needed for chest pain . ++CALL MD IF NO RELIEF." When interviewed on 2/13/14, at 2:05 p.m. LPN-A stated she had ordered the medication and if she were to administer medication she would have done her checks and caught the date and not given it. When interviewed on 2/13/14, at 2:11 p.m. director of nursing (DON) stated her expectation was medication was to have been removed from the cart and reordered and was going to work with the pharmacy to oversee the medication	F 431		

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F 431	Continued From page 12 storage closer. On 2/13/14, at 2:30 p.m. the DON further indicated the facility had a system for checking the medication carts and acknowledged the medication had been overlooked for twenty three months since it had been opened and had not been caught. She further stated if R24 had needed it the nurse would have caught it with the checks and gotten it from the emergency kit (E-kit) to administer. The facility Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles policy revised 05/10/10, directed "Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications..." The policy indicated it was the facility responsibility to request the pharmacy to perform a routine nursing unit inspection for each nursing station in the facility to assist with complying with the obligation relating to proper storage, labeling, security and accountability of medications and Biologicals.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441		

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F 441	Continued From page 13 in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the infection control program included tracking, trending, and analysis of employee infections/illness to determine if there was any correlation with resident infections and the facility failed ensure proper handwashing was done to prevent the spread of infection for 1 of 1 resident (R159) who was incontinent. This had the potential to affect all 62 residents who currently resided in the	F 441	F441 1. New Education and Training Director has started and is formally tracking and trending any employee call-in from illness/infection. R159 is receiving peri care with appropriate infection control technique. 2. All residents requiring assistants with peri-care are receiving peri-care utilizing appropriate infection control techniques. 3. Education has been completed with all staff on infection control policy and procedure as well as the tracking and trending requirements for illness. 4. Five care observations will be completed weekly by the DON or designee to ensure proper infection control technique is being completed. NHA or designee will audit EDT's tracking weekly to ensure proper tracking/trending of employee illnesses. 5. Results will be brought to QPI by NHA or designee.	3/25/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245083	A. BUILDING _____ B. WING _____	02/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK HEALTH AND REHABILITATION CENTER	4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416

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F 441	Continued From page 14 facility. Findings include: The director of nursing (DON) was identified as the infection control contact. During review of the facility Resident Infection Log(s) from January 2013 through January 2014. The log revealed the facility did not track or trend employee infections/illness as part of the infection control program. The DON stated that "since I was doing it, we were not specifically tracking employee infections". She further stated "I believe the two people before me were tracking employee infections and they did report it in Quality Assurance meetings, but I am not sure how they did it". No further information or documentation was provided. The facility Infection Surveillance policy with revision date of November 2009 was reviewed and lacked direction for tracking employee infection/illness. There was no indication employee infections/illness were reviewed to determine if employee and resident infections/illness were or could be related to each other. Soiled gloves were not changed during cares. During observation on 2/12/14, at 9:21 a.m. nursing assistant (NA)-A came to R159's bed explained to R159 he was going to check her incontinent pad to make sure she did not have an accident. At this time NA-A had a pair of gloves don grabbed wash towels in the room went to the bathroom to wet them came back to R159's	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245083	A. BUILDING _____ B. WING _____	02/13/2014

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PARK HEALTH AND REHABILITATION CENTER	4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416

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F 441	Continued From page 15 bedside with the wet towels set them on the bed and proceeded to give R159 pericare. During observation R159 was noted to have yellow liquid consistency bowel movement (BM). NA-A used two wash towels to complete R159's front pericare and put the soiled towels in a plastic bag at the foot of the bed. NA-A then touched a clean incontinent pad sitting on the bed and the bed foot board with the soiled gloves and moved the bed, continued to provide R159 pericare at the back still with the same soiled gloves then grabbed the clean incontinent pad tacked it under R159 then stopped went to the bathroom was observed removing his gloves and washed his hands. R159's diagnoses included urinary tract infection, septicemia, aphasia and cerebrovascular accident (CVA) obtained from admission Minimum Data Set (MDS) dated 1/24/14. In addition, the MDS identified R159 required extensive physical assist of two with toilet use. When interviewed on 2/12/14, at 9:57 a.m. NA-A acknowledged he had not changed the soiled gloves and had moved the bed and touched the clean incontinent pad with the soiled gloves. NA-A stated usually he changed the gloves between and washed hands. When interviewed on 2/12/14, at 9:59 a.m. RN-A stated her expectation was NA-A needed to change the soiled gloves and was not even paying attention during the cares on what he was doing but was focused on R159. When interviewed on 2/12/14, at 10:18 a.m. the DON stated the gloves should have been changed when the aide was done cleaning and	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245083	A. BUILDING _____ B. WING _____	02/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK HEALTH AND REHABILITATION CENTER	4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416

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F 441	Continued From page 16 removing the soiled incontinent product and washed hands before continuing with care. The Handwashing procedure revised July 2012, directed to use appropriate hand hygiene immediately between tasks and procedures on the same resident after contact with material that may contain a high concentration of microorganism. In addition, the policy directed to remove gloves promptly after use, before touching non-contaminated items and environmental surfaces.	F 441		

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

F5083024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245083	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK HEALTH AND REHABILITATION CENTEI	4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Park Health and Rehab Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid, 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101 , Life Safety Code (LSC), Chapter 19 Existing Health Care. Park Health and Rehab Center is a 2-story building with no basement. The building was constructed in 1960 and was determined to be of Type II (111) construction. In 1970 and addition was constructed and was determined to be of Type II (000) construction. In 1998 an addition was constructed and was determined to be of Type II (111) construction. It is automatic fire sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitor for fire department notification. Because the construction height and fire protection systems allow for Type II (000) construction, the facility was surveyed as 1 building. The facility has a capacity of 83 beds with a census of 63 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.