DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 25, 2022

Administrator
The Villa At St Louis Park
7500 West 22nd Street
Saint Louis Park, MN 55426

RE: CCN: 245182
Cycle Start Date: March 10, 2022

Dear Administrator:

On March 10, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jamie Perell, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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 June 10, 2022 (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).

In addition, if substantial compliance with the regulations is not verified by September 10, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 25, 2022

Administrator
The Villa At St Louis Park
7500 West 22nd Street
Saint Louis Park, MN 55426

Re: State Nursing Home Licensing Orders
Event ID: 3GB111

Dear Administrator:

The above facility was surveyed on March 7, 2022 through March 10, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Jamie Perell, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 23, 2022

CMS Certification Number (CCN): 245182

Administrator
The Villa At St Louis Park
7500 West 22nd Street
Saint Louis Park, MN 55426

Dear Administrator:

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 May 3, 2022 the above facility is certified for:

100 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 100 skilled nursing facility beds.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K521.

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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 23, 2022

Administrator
The Villa At St Louis Park
7500 West 22nd Street
Saint Louis Park, MN 55426

RE: CCN: 245182
Cycle Start Date: March 10, 2022

Dear Administrator:

On April 18, 2022, we notified you a remedy was imposed. On May 17, 2022 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 3, 2022.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 10, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 25, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 10, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on May 3, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Your request for a continuing waiver involving the deficiency cited under F521 at the time of the March 10, 2022 survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

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Electronically delivered

May 23, 2022

Administrator
The Villa At St Louis Park
7500 West 22nd Street
Saint Louis Park, MN 55426

Re: Reinspection Results
Event ID: 3GB112

Dear Administrator:

On May 17, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 10, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
March 25, 2022

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RE: CCN: 245182
Cycle Start Date: March 10, 2022

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Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

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Health Regulation Division
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William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245182	A. BUILDING _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA AT ST LOUIS PARK	**7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426**

(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
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 3/7/22 through 3/10/22, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 3/7/22 through 3/10/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5182154C (MN81489), with a deficiency cited at F690. The following complaints were found to be SUBSTANTIATED: H5182147C (MN80067), however, NO deficiencies were cited due to actions implemented by the facility prior to survey. The following complaints were found to be UNSUBSTANTIATED: H5182146C (MN80782, MN80783) H5182148C (MN75999) H5182149C (MN73676) H5182150C (MN58789) H5182151C (MN53601) H5182152C (MN51395) H5182153C (MN79407) H5182155C (MN51491)	F 000		

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

Electronically Signed | 03/31/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245182	A. BUILDING _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA AT ST LOUIS PARK	7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426

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F 000	Continued From page 1 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2)	F 580		5/3/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245182	A. BUILDING _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA AT ST LOUIS PARK	7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426

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F 580	Continued From page 2 is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician of a reopened Stage III pressure ulcer and the need to alter treatment for 1 of 2 residents (R4) reviewed for change of condition. Findings include: Stage III pressure ulcer: Full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of	F 580	• Action for affected resident: R4's physician was updated on new wound and treatment orders were implemented. • How facility will identify other residents: Facility has reviewed other residents with wounds to insure treatments were in place. • Measures to correct practice: Nurses will be educated on required notification to providers when new wounds are discovered to insure proper treatments are in place. • Monitor: Audits will be completed by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THE VILLA AT ST LOUIS PARK	7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426

(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 580	Continued From page 3 adjacent tissue. R4's quarterly Minimum Data Set (MDS) dated 12/9/21, indicated R4 was cognitively intact and required extensive assistance of two staff for bed mobility. R4's care plan dated 10/21/21, indicated R4 had a venous ulcer to left back of the calf and inner left ankle. R4's had a history of a left heel pressure ulcer. R4's goal was for their skin impairment to improve and have no complications. The care plan listed several interventions to help R4 meet their goal which included treatments per medical doctor (MD) orders. A Wound Evaluation dated 3/7/22, at 2:50 p.m. indicated R4 had a Stage III pressure ulcer to their left heel which measured 2.92 centimeters (cm) x 3.22 cm x 0.1 cm with 60% granulation tissue (new vascular tissue in granular form on an ulcer or the healing surface of a wound) and 30% slough (yellow devitalized tissue, that can be stringy or thick and adherent on the tissue bed.) R4's medical record was reviewed and lacked evidence the newly developed pressure ulcer was communicated to the physician despite the area being identified on 3/7/22. During interview on 3/9/22, at 10:48 a.m. the director of nursing (DON) explained the process when a new or reopened wound was discovered the nurse would assess the wound, call the physician, and give an update on the wound and obtain a treatment order. The DON verified the physician wasn't notified nor was a treatment order obtained for the reopened Stage III	F 580	staff including the IDT management team 3 times/week for 3 weeks, 2 times/week for two weeks, 1 time/week for two weeks, and monthly for 2 months. Results will be brought the QAPI committee for follow-up.	

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	245182	A. BUILDING _____ B. WING _____	C 03/10/2022

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F 580	Continued From page 4 pressure ulcer to the left heel. During interview on 3/9/22, at 11:02 a.m. the regional clinical nurse explained the process when a new or reopened wound was observed the nurse should assess the wound, update the physician, and obtain a treatment order. Further, the wound could get worse if the process wasn't followed. The Notification of Changes guideline dated 11/28/17, indicated, "it is the practice of this facility that changes in a resident's condition or treatment are immediately shared with eh resident and/or the resident representative, according to their authority, and reported to the attending physician or delegate.	F 580		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other	F 583		5/3/22

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F 583	Continued From page 5 materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure privacy for 1 of 1 residents (R384) who was observed disrobed from a public area. Findings include: R384's Admission Record dated 3/10/22, indicated R384's diagnoses included encephalopathy (altered brain function), dementia without behavior disturbance, and recent shoulder surgery. R384's admission Minimum Data Set dated 3/7/22, was incomplete, however, indicated he was severely cognitively impaired. R384's care plan dated 3/5/22, indicated R384 had limited physical mobility and used a wheelchair. Staff were directed to anticipate and meet his needs. The care plan identified R384 was incontinent of bowel and bladder and utilized	F 583	• Action for affected resident: R384 is offered clothing when not dressed and door closed during cares to provide privacy • How facility will identify other residents: All residents have the potential to be effected by deficient practice. • Measures to correct practice: Staff were educated on the need to maintain privacy when residents are receiving care. • Monitor: Audits will be completed by staff including the IDT management team 3 times/week for 3 weeks, 2 times/week for two weeks, 1 time/week for two weeks, and monthly for 2 months. Results will be brought the QAPI committee for follow-up.	

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F 583	Continued From page 6	F 583		

an incontinence brief.

On 3/7/22, at 3:37 p.m. R384's room and bathroom door were observed fully open while R384 was sitting on the toilet in full view from the hallway. Staff assisted R384 rise from the toilet. An incontinence brief was observed hanging at R384's knees while staff provided cares. Staff then pulled up R384's incontinence brief which was also within view from the hallway. Nursing assistant (NA)-L exited R384's room and stated she usually closed the doors for privacy, but another aide was in the room and left it open.

During observation on 3/9/22, at 12:24 p.m. R384 was observed on the floor next to his bed lying on his right side. His head was toward the foot of the bed and his feet toward the head. A wheelchair was approximately three feet away from R384 and the front faced toward the door and away from R384. R384 was wearing only a shirt and an incontinence brief, with no other clothing nearby. Staff were called to the room, and the door was half open while staff assessed resident and assisted him to bed. No clothing items were nearby.

On 3/9/22, at 1:23 p.m. R384's room door was fully open and R384 was observed from the hallway lying in bed on top of his sheets wearing an incontinence brief and a shirt without a sheet, blanket, or pants covering his lower half. No pants or top coverings were nearby.

During interview with the assistant administrator (AA) on 3/9/22, at 1:25 p.m. R384 was observed by AA standing next to his bed with his back to the door wearing only a shirt and an incontinence brief. AA entered the room to ensure his safety

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F 583	Continued From page 7 and additional staff were called to assist him back to bed. Two additional employees entered the room, left the door open, and helped R384 turn around to face the door to the hallway. R384's incontinence brief fell down to below his knees leaving him fully exposed to passersby in the hallway. A fourth staff person entered the room, left the door open, and staff pulled up R384's brief before helping him to bed. Upon leaving R384's room, AA apologized and stated she would definitely want him to be wearing pants or be covered up to protect his dignity and stated staff should have closed the door to provide privacy while they cared for him. During interview on 3/10/22, at 11:34 a.m. director of nursing (DON) stated privacy was a part of human dignity, and he expected everyone, whether a direct caregiver or otherwise, to respect patient privacy. He stated this included closing the door when appropriate. He stated R384 had the right to be treated with dignity, and staff should treat residents as they would want to be treated. DON stated R384 should not have been left exposed with everyone walking by, and anyone could have observed him, and it would "live in their memory." He stated staff could both ensure his safety and protect his dignity, and R384 should not have been left with his incontinence brief exposed. The facility policy Resident Rights dated 11/28/17, indicated residents had the right to be treated with respect and dignity. No other policies pertaining to resident privacy were provided.	F 583		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	F 623		5/3/22

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F 623	Continued From page 8 §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30	F 623		

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F 623	Continued From page 9 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to	F 623		

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F 623	Continued From page 10 effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide a written notice for transfer/discharge for 4 of 6 residents (R78, R234, R11, R37) who were hospitalized. Findings include: R78's quarterly Minimum Data Set (MDS) dated 2/24/22, indicated R78 had severely impaired cognition and diagnoses which included acute respiratory failure with hypoxia. R78's progress note dated 11/26/21, at 10:58 a.m. indicated R78 was transferred to the hospital for due to limited responsiveness, decreased oxygen saturation, and diagnosis of COVID-19. R78's progress note dated 12/10/21, at 10:15 a.m. indicated R78 was transferred to the hospital due to an unresponsive episode and decreased lung sounds.	F 623	• Action for affected resident: There is no way to correct issue retroactively. All affected residents have readmitted since discharge date so there was no impact. • How facility will identify other residents: Facility has reviewed other residents by audit of all potential to be affected to implement correction procedures. • Measures to correct practice: Licensed staff educated on providing transfer notices to patients and families when leaving the facility. • Monitor: Audits will be completed by staff including the IDT management team 3 times/week for 3 weeks, 2 times/week for two weeks, 1 time/week for two weeks, and monthly for 2 months. Results will be brought the QAPI committee for follow-up.	

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F 623	Continued From page 11	F 623		

R78's's medical record lacked evidence a written notice of transfer was provided to R78, or her representative, following transfer to the hospital on 11/26/21 or 12/10/21.

R234's admission MDS dated 1/19/22, indicated R234 had severely impaired cognition and diagnoses which included acute and chronic respiratory failure with hypoxia.

R234's progress note dated 2/27/22, at 9:39 a.m. indicated R234 was transferred to the hospital due to increased lethargy and decreased oxygen saturation.

R234's medical record lacked evidence a written notice of transfer was provided to R234, or her representative, following transfer to the hospital on 2/27/22.

R11's quarterly MDS dated 12/15/21, indicated R11 had intact cognition and diagnoses which included thrombocytopenia (a low blood platelet count).

R11's progress note dated 9/30/21, at 11:21 a.m. indicated R11 was transferred to the hospital due to cyanosis (nail beds turning blue due to poor circulation or decreased oxygen levels).

R11's medical record lacked evidence a written notice of transfer was provided to R11, or his representative, following transfer to the hospital on 9/30/21.

R37's significant change MDS dated 1/26/22, indicated R37 had intact cognition and diagnoses which included pulmonary embolism (blood clot in the lung).

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F 623	Continued From page 12 R37's progress note dated 2/8/22, at 12:51 p.m. indicated R37 was transferred to the hospital due to change in condition and decreased oxygen levels. R37's medical record lacked evidence a written notice of transfer was provided to R37, or his representative, following transfer to the hospital on 2/8/22. During an interview on 3/10/22, at 9:32 a.m. the administrator stated when a resident was transferred to the hospital, they should always be provided a notice of transfer at the time of the transfer. If for some reason it did not occur, at the time of the transfer, the nurse should call the resident's representative and get verbal consent. Documentation of signed or verbal consent should be documented in the resident's medical record. The facility Bed Hold and Return Guideline policy dated 4/25/19, identified the facility will provide written information to the resident, or resident representative, before the resident was transferred to a hospital or the resident goes on a therapeutic leave which specified: the transfer or discharge, and reason for the move.	F 623		
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to	F 625		5/3/22

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F 625	Continued From page 13 the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure written bed hold notices were provided to for 4 of 6 residents (R78, R234, R11, R37) who were hospitalized. Findings include: R78's quarterly Minimum Data Set (MDS) dated 2/24/22, indicated R78 had severely impaired cognition and diagnoses which included acute respiratory failure with hypoxia. R78's progress note dated 11/26/21, at 10:58 a.m. indicated R78 was transferred to the hospital for due to limited responsiveness, decreased	F 625	" Action for affected resident: There is no way to correct issue retroactively. All affected residents have readmitted since discharge date so there was no impact. " How facility will identify other residents: Facility has reviewed other residents by audit of all potential to be affected to implement correction procedures. " Measures to correct practice: Licensed staff educated on providing bed-hold notices to patients and families when leaving the facility. " Monitor: Audits will be completed by staff including the IDT management team	

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F 625	Continued From page 14 oxygen saturation and diagnosis of COVID-19. R78's progress note dated 12/10/21, at 10:15 a.m. indicated R78 was transferred to the hospital due to an unresponsive episode and decreased lung sounds. R78's's medical record lacked evidence a bed hold was provided R78, or her representative, before or following transfer to the hospital on 11/26/21 or 12/10/21. R234's admission MDS dated 1/19/22, indicated R234 had severely impaired cognition and diagnoses which included acute and chronic respiratory failure with hypoxia (low blood oxygen). R234's progress note dated 2/27/22, at 9:39 a.m. indicated R234 was transferred to the hospital due to increased lethargy and decreased oxygen saturation. R234's medical record lacked evidence a bed hold was provided to R234, or her representative, before or following transfer to the hospital on 2/27/22. R11's quarterly MDS dated 12/15/21, indicated R11 had intact cognition and diagnoses which included thrombocytopenia. R11's progress note dated 9/30/21, at 11:21 a.m. indicated R11 was transferred to the hospital due to cyanosis (nail beds turning blue due to poor circulation or decreased oxygen levels). R11's medical record lacked evidence a bed hold was provided to R11, or his representative, before	F 625	3 times/week for 3 weeks, 2 times/week for two weeks, 1 time/week for two weeks, and monthly for 2 months. Results will be brought the QAPI committee for follow-up. " Deficiency will be corrected on 5/3/22	

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F 625	Continued From page 15 or following transfer to the hospital on 9/30/21. R37's significant change MDS dated 1/26/22, indicated R37 had intact cognition and diagnoses which included pulmonary embolism. R37's progress note dated 2/8/22, at 12:51 p.m. indicated R37 was transferred to the hospital due to change in condition and decreased oxygen levels. R37's medical record lacked evidence a bed hold was provided to R37, or his representative, before or following transfer to the hospital on 2/8/22. During an interview on 3/9/22, at 7:56 a.m. licensed practical nurse (LPN)-A stated when transferring a resident to the hospital a bed hold should be reviewed with the resident at the time of transfer, if possible. If that was not possible, the nurse should call the resident's representative to review the bed hold. A copy of the bed hold would be put in the resident's medical record. During an interview on 3/9/22, at 9:32 a.m. assistant director of nursing (ADON) stated when a resident was transferred to the hospital the nurse should review the bed hold with the resident, if able. Otherwise it needed to be reviewed with the representative. The bed hold should be documented in the resident's medical record. This needed to be done with every hospitalization. The facility Bed Hold and Return Guideline policy dated 4/25/19, identified, "Residents and their representative will be provided with bed hold and return information at admission and before a	F 625		

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F 625	Continued From page 16 hospital transfer or therapeutic leave."	F 625		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech,	F 676		5/3/22

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F 676	Continued From page 17 (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a resident was provided assistance with bathing and hair washing for 1 of 1 residents (R387) who required assistance with activities of daily living (ADLs). Findings include: R387's Admission Record dated 3/10/22, indicated he had diagnoses of surgical amputation of left lower leg, bone infection, severe obesity, and diabetes. R387's admission Minimum Data Set dated 3/6/22, indicated he was cognitively intact, required assistance of one staff for transfers, and supervision with personal hygiene. The MDS further indicated he required one-person physical assistance with bathing, which was not documented as occurring. R387's care plan dated 3/1/22, indicated he had an actual or potential for an ADL self-performance deficit and limited physical mobility. Interventions included encourage the resident to use the call light for assistance. Additionally, R387's closet care plan (a hand-written information sheet used by nursing assistants to provide resident-appropriate care), undated, indicated R387 required assistance of 1 staff for bathing. R387's Order Summary Report dated 3/10/22, indicated R387 was non-weight bearing to lower left extremity until 4/12/22. The report also indicated shower/nail care/skin checks were to be	F 676	• Action for affected resident: Resident was given a bath. • How facility will identify other residents: Facility has reviewed other residents by grooming audits of all potential to be affected and those identified were given/offered appropriate ADL care. • Measures to correct practice: Education for nursing staff to bath residents as scheduled and as needed • Monitor: Audits will be completed by staff including the IDT management team 3 times/week for 3 weeks, 2 times/week for two weeks, 1 time/week for two weeks, and monthly for 2 months. Results will be brought the QAPI committee for follow-up.	

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completed weekly on Friday mornings and Monday evenings starting 3/1/22.

Review of the bath list (undated) indicated R387 was scheduled for a bath or shower on Friday mornings and Monday evenings.

R387's NA Task documentation dated 3/8/22, indicated bath type was documented as "Not Applicable" for five of the previous 8 days, and undocumented on three of the previous 8 days.

On 3/8/22, at 8:18 a.m. transmission-based precaution signs were observed on R387's closed door. A cart of gowns, gloves, masks, and eye protection was located just outside in the hallway. An unidentified staff-person stated R387 was a new admission and on quarantine related to COVID-19 vaccination status. R387 was observed lying in bed in his room with long hair which appeared oily.

During interview on 3/8/22, at 8:20 a.m. R387 stated it had been between 10 - 12 days since he took a shower and washed his hair. He stated he had been asking staff and was supposed to get a bath on Friday (3/4/22), but he had the "stomach flu," so staff said they could do it on Monday (3/7/22). He stated it was "like tumbleweeds" at the facility on 3/7/22, and nobody came to help him. He stated staff then told him he could get cleaned up on Tuesday (3/8/22) and when he asked again, he was told they could help him in the evening. R387 stated he could not do much since he recently had one leg amputated and needed someone to help him transfer. He stated the only way he could try to clean himself was with disposable wipes. He stated nobody brought him towels, washcloths, or soapy water. He

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F 676	Continued From page 19	F 676		

stated he was getting a diaper rash, but it would go away if he could just take a shower.

During interview on 3/9/22, at 7:47 a.m. nursing assistant (NA)-M stated there was a list which identified when a resident needed a bath at the nurse's station, but the only way she would know if a bath was completed was to ask the resident. She stated she knew how much assistance a resident needed by reviewing the "closet care plan" which was a hand-written sheet of paper located in the resident's closet. She stated R387 needed supervision with transfers. She stated sometimes the information was in the electronic health record (EHR), but most of the time it was wrong. NA-M stated she gave R387 a basin with water and washcloths that morning and would wash his hair in the shower or use the shower cap with soap and a little water, if needed. She stated he did not refuse, and she documented when baths were completed in the EHR.

During interview on 3/9/22, at 7:52 a.m. the director of nursing (DON) stated bath reminders and documentation were moved from paper to the EHR, and staff completed a daily audit of the bath schedule and records. He stated the EHR was updated and correct, so the NAs saw that task on the day when it was due. He stated the nurses and NAs documented if a bath was refused by the resident.

During interview on 3/9/22, at 7:58 a.m. R387 stated staff did not give him a shower or bath, however, gave him the stuff to do it himself that morning. He stated they were putting it off, and he told them to just give him the stuff to do it himself. He stated, "whatever, I don't understand." He stated he could take care of himself "pretty well,"

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but he didn't like to stink and now had diaper rash and it hurt. R387 was observed sitting on his bed with a basin of soapy water and washcloths on his side table. Towels were out of reach by the sink in the room approximately four feet from the end of his bed. R387 stated, "I'm not sure how I'm supposed to wash my hair," and stated he was getting frustrated. He stated he had to figure out how to wash his own hair without being able to stand up and make a big mess. He stated he heard staff having a lot of conversations at the desk, but when he needed something, they disappeared.

During interview on 3/9/22, at 8:19 a.m. the DON stated residents were assigned to have at least one bath per week. If a resident wished for, or appeared to need one more, often staff would offer and make it happen. He stated if baths were refused it would be documented. The DON stated R387 was in quarantine until 3/11/22, based on his COVID-19 vaccination status, and would not expect staff to bring him out to the general bathroom to get a shower during that period. The DON reviewed R387's EHR and confirmed the record was not set up to remind staff when R387 was scheduled for a bath. He stated he did not think the problem was widespread, but needed to pay closer attention to people who were on quarantine since they did not come out of their rooms. He stated he relied on staff to see the person to catch things like that.

Facility policy Activities of Daily Living (ADLs) dated 5/7/20, indicated in accordance with the comprehensive assessment, together with respect for individual resident needs and choices, the facility provides care and and services for: bathing, grooming, and oral care.

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F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to remove unwanted facial hair for 1 of 1 resident (R234) who was dependent upon staff for assistance shaving. Findings include: R234's admission Minimum Data Set (MDS) dated 1/19/22, identified R234 had severely impaired cognition, needed extensive assistance with personal hygiene, and demonstrated no behaviors. R234's diagnoses included dementia without behavioral disturbance and unspecified lack of coordination. R234's care plan dated 3/3/22, lacked indication of the amount of assistance R234 needed to complete any activities of daily living (ADLs) including management of personal hygiene. During an observation on 3/7/22, at 12:07 p.m. R234 was observed with approximately ¼ inch long hairs covering her chin. R234 stated she wanted the hair removed, but did not have access to a razor. R234 stated staff had not attempted to help her remove the unwanted facial hair. During an interview on 3/9/22, at 7:56 a.m. licensed practical nurse (LPN)-A stated nursing assistants were expected to help remove residents unwanted facial hair, as needed.	F 677	• Action for affected resident: Resident was groomed as desired. • How facility will identify other residents: Facility has reviewed other residents by grooming audits of all potential to be affected and those identified were given/offered appropriate ADL care. • Measures to correct practice: Nursing staff educated to groom as directed and as requested by patients. • Monitor: Audits will be completed by staff including the IDT management team 3 times/week for 3 weeks, 2 times/week for two weeks, 1 time/week for two weeks, and monthly for 2 months. Results will be brought the QAPI committee for follow-up. • Deficiency will be corrected on 5/3/22	5/3/22

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F 677	Continued From page 22 During an observation on 3/9/22, at 8:49 a.m. R234 facial hair was observed to be unchanged from 3/7/22. R234 continued to have ¼ inch hair covering her chin. During an interview on 3/9/22, at 8:53 a.m. nursing assistant (NA)-A stated nursing assistants were expected to provide personal hygiene care to each resident daily including shaving residents. NA-A stated if facial hair was observed on a female resident the nursing assistant needed to ask if they can help remove the hair. NA-A stated she was aware R234 would periodically request assistance with shaving her face. Most recently she overheard R234 tell staff she would like help shaving on 3/8/22, and acknowledged it was not completed as there was visible facial hair on R234's chin. NA-A approached R234 to ask if she could help her shave. R234 replied, "It didn't get done last time I asked. I would like it done now." During an interview on 3/9/22, at 9:32 a.m. the assistant director of nursing (ADON) stated nursing assistants were responsible for assisting residents with personal hygiene which would include shaving. "If [hair] is observed I would expect the nursing assistant to take care of it." Facility policy Activities of Daily Living (ADLs) dated 5/7/20, included, "In accordance with the comprehensive assessment together with respect for individual resident needs and choices our facility provides care and services for the following activities: hygiene: Bathing, dressing, grooming, and oral care."	F 677		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI	F 690		5/3/22

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F 690	Continued From page 23 CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 690	• Action for affected resident: R11 was	

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F 690	Continued From page 24 review, the facility failed to provide appropriate incontinence care or manage a suprapubic catheter to prevent urinary tract infections (UTI) for 2 of 2 residents (R11, R48) reviewed for urinary tract infections (UTI). Findings include: R11's quarterly Minimum Data Set (MDS) 12/15/21, indicated R11 was cognitively intact with diagnoses of Guillain-Barre syndrome, weakness and UTI. Further, R11 was incontinent and required extensive assistance of two persons for toileting and hygiene care. R11's Order Summary Report dated 10/31/21, R11 was ordered Bactrim DS (antibiotic) 800-160MG, give 1 tablet twice daily for UTI for 7 days on 3/4/22. R11's care plan dated 10/3/21, indicated R11 had mixed bladder incontinence, a history of acute cystitis (inflammation of bladder) with hematuria (blood in urine), and had a potential/actual UTI. Interventions included encourage fluid intake, monitor vital signs "specify frequency" and notify MD (medical doctor) of significant changes, and provide incontinent care after each incontinent episode. R11's care plan lacked frequency of checking R11 for incontinence. Additionally, the care plan lacked indication R11 refused soap, or other hygenic products, when incontinence care was performed. During an observation on 3/9/22, at 7:53 a.m. nursing assistant (NA)-B and NA-C knocked on R11's door and entered the room to provide morning cares. R11 woke up and stated "Yes, I am so wet and uncomfortable. I didn't get	F 690	cleaned for incontinence with soap and water and care plan updated on refusals. R48 had catheter changed according to physician orders. • How facility will identify other residents: Facility has reviewed other residents with urinary incontinence and urinary catheters to insure appropriate incontinence or catheter care to prevent UTI's. • Measures to correct practice: Nursing staff educated on catheter care and following physician orders for changing catheters and appropriate incontinence care. • Monitor: Audits will be completed by staff including the IDT management team 3 times/week for 3 weeks, 2 times/week for two weeks, 1 time/week for two weeks, and monthly for 2 months. Results will be brought the QAPI committee for follow-up. • Deficiency will be corrected on 5/3/22	

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changed all night." R11's legs had scabs and scratches; some blood was smeared on R11's sheets. Upon removal of the sheets, the sheet R11 was laying on was observed to be wet. There was a strong odor of urine in room. NA-B helped R11 wash their face and upper body before starting incontinence cares. NA-B filled R11's sink with warm water and did not add soap or other cleanser. NA-B and NA-C used warm water to perform R11's peri cares on frontside of body. R11 was then helped to a standing position with the EZ stand. Upon standing, R11's wet brief was removed. R11 had blanchable redness on bilateral buttocks that extended down legs. R11 had some scratches, which appeared new, on outside of right thigh. R11's buttocks and thighs were cleaned with warm water, however, no soap or cleanser was used. Licensed practical nurse (LPN)- E brought in cream to place on bottom before placing a clean brief. NA-B and NA-C then helped R11 to a chair for breakfast.

During an interview on 3/9/22, at 8:30 a.m. NA-B stated R11 was always incontinent and notified staff when they needed to be changed. NA-B stated staff checked on R11 too. NA-B verified only water was used for R11's incontinent cares. NA-B further stated sometimes disposable wipes were used, if they are in the room, but mostly R11 liked the washcloths. NA stated R11 complained about the soap as it burned and caused itching and that was why it was not used.

During an interview on 3/9/22, at 8:43 a.m. LPN-E indicated R11 stated incontinence cares should performed using more than just warm water as R11 was at risk for UTIs.

During an interview on 3/9/33, at 10:35 a.m.

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medical doctor (MD)-A stated R11 had a UTI in October 2021, January 2022, and currently was being treated for one. MD-A further stated it was his understanding R11's UTI was more of a hygiene issue as R11 did not always allow for cares to be completed. MD-A further stated the expectation was for staff to use soap, or other appropriate antibacterial, when performing R11's incontinence care.

During an interview on 3/9/22, at 1:25 p.m. the assistant director of nursing ADON stated staff would be expected to use wipes, or soap and water, for incontinent cares. Water would not clean bacteria away.

During an interview on 3/9/22, at 2:15 p.m. R11 stated soap was wanted and verbalized, "how else would I get clean?"

During an interview on 3/10/22, at 1:18 p.m. the director of nursing (DON) stated water would not be sufficient for incontinent cares, but soap and water would be okay. Improper incontinent care can put a resident at risk for infection.

R48's admission MDS dated 2/1/22, indicated R84 was cognitively intact and had diagnoses of transverse myelitis (disorder caused by inflammation of the spinal cord) causing paraplegia and UTIs. R48's MDS also indicated R48 had a suprapubic catheter.

R48's Order Summary Report dated 3/10/22, lacked indication of dressing changes, exchanges or routine cares for R48's suprapubic catheter.

R48's care plan dated 2/3/22, indicated "(SPECIFY condom, intermittent, indwelling,

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suprapubic)" catheter. R48's care plan had interventions placed on 3/4/22, to monitor for signs of infection, and ensure tubing is secure to avoid pulling. R48's care plan lacked instruction on catheter cares, dressing changes needed at insertion site or catheter exchanges.

Review of R48's progress notes revealed:
- 3/2/22, at 11:33 p.m. indicated R48's catheter had been exchanged and dressing changed with no signs of infection. The progress note lacked indication if the catheter was changed due to a complication. Review of R48's medical record lacked indication of any other dressing changes being performed.
- 3/4/22, at 4:05 p.m. indicated the facility received a call from R48's wife and R48 was admitted to the hospital for UTI and low blood pressure.

During an interview on 3/8/22, at 10:00 a.m. nursing assistant (NA)-D stated R48 catheter was often full. NA-D had seen bloody drainage and had reported it to the nurse a few days before R11 went to the hospital but wasn't sure about the date.

During an interview on 3/9/22, at 11:30 p.m. R48 stated he was currently in the hospital for a UTI. R48 stated initially, their suprapubic catheter was not getting cleaned correctly at the facility. R48 stated the gauze was supposed to be changed daily but was not getting done until he started requesting it. R48 stated the catheter tubing was not always secured to his leg and his catheter tube was moving in and out at the insertion site. R48 believed this was the cause of his UTI. R48 stated after he told staff how to do dressing changes cares were more consistent. R48 stated

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he asked for his catheter to be changed right before he was hospitalized, and the nurse changed it. R48 stated he had some bloody oozing at the site and a little area around the insertion site had re-opened.

During an interview on 3/9/22, at 12:05 p.m. licensed practical nurse (LPN)-C stated an order was needed for a catheter exchange and was not sure about suprapubic catheters. LPN-C stated the only cares which were completed for R48's catheter was irrigation. LPN-C was not aware of any dressing changes for R48's catheter.

During an interview on 3/9/22, at 12:14 p.m. NA-J stated catheter cares were done with just water, or sometimes soap and water, depending on the preference of the resident. NA-J further stated R48's catheter was emptied, and bag exchanged, but NA-J had never completed catheter cares.

During an interview on 3/10/22, at 9:54 a.m. registered nurse (RN)-B stated catheter cares were written orders and the nurses do the cares and the NAs empty the urine. RN-B stated a normal catheter change was done every 30 days and, if needed, a urology appointment would be made. RN stated R48 did not have an order to exchange his suprapubic catheter, but knew it was supposed to be completed every 30 days. RN further stated R48's catheter was possibly leaking as R48 had some bloody drainage at the insertion site, however, provider was not notified as there were no signs of infection.

During an interview on 3/10/22, at 10:15 a.m. the assistant director of nursing (ADON) explained orders were needed for catheter exchanges, but catheter cares were standard practice and was

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F 690	Continued From page 29 more of a nursing order. Further, it was not best practice to change a catheter every 30 days and standing orders were in-place for when urine was bypassing the catheter tube, however, if any other drainage was noted the medical provider should be notified. During an interview on 3/10/22, at 1:18 p.m. the director of nursing (DON) stated it was the nurse's responsibility to change catheters, but the NAs were responsible for the daily cares and emptying. The DON further stated there should be an order for dressing changes for suprapubic catheter and monthly catheter exchanges. The facility had standing orders if the catheter was leaking urine, however, if catheter was leaking was more than urine, the provider should be notified. The DON further stated catheter cares and monitoring are important as if not properly cared for could lead to an infection. A facility policy for catheter and incontinent cares was requested, but was not received.	F 690		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately assess and develop an individualized care plan to provide comfort and reduce pain for 1 of 2 residents (R8)	F 697	• Action for affected resident: R8 has been reassessed for pain and care plan was updated. • How facility will identify other	5/3/22

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F 697	Continued From page 30 reviewed for pain. Findings include: R8's quarterly Minimum Data Set (MDS) dated 12/18/21, identified R8 had intact cognition, reported frequent pain which limited his day-to-day activities, and exhibited no behaviors. R8 needed extensive assistance for bed mobility, transfers, dressing, and toileting. Additionally, the MDS identified R8's pain level was 8 on a scale of 0 - 10. R8's diagnoses included chronic pain, idiopathic peripheral autonomic neuropathy, myalgia (fatigue), and low back pain. R8's care plan dated 7/7/21, included, "The resident has (SPECIFY actual/potential) (SPECIFY acute/chronic) pain r/t [related to]." R8's care plan lacked indication of specification or cause of R8's pain. R8's care planned goals included, "Resident will not have an interruption in normal activities due to pain" and "The resident will voice a level of comfort of (SPECIFY residents states range of comfort) out of 10 through the review date." The care plan directed staff to: "Anticipate the resident's need for pain relieve and respond immediately to any complaint of pain" and "Notify physician if interventions are unsuccessful or if current complaint is a significant and change from residents past experiences of pain." R8's Active Orders printed 3/10/22, indicated the following medications were ordered for pain: - Acetaminophen tablet give 1000 milligrams (mg) by mouth three times a day for pain. - Aspercreme Lidocaine 4% patch - apply one time a day. On in the morning and off at bedtime. - Cymbalta capsule delayed release particles give	F 697	residents: Resident receiving pain medications have the potential to be affected. Facility will ensure residents are assessed properly for pain level and have an individualized care plan. • Measures to correct practice: Licensed nurses were educated on properly assessing pain levels when giving pain medication and the development of an individualized care plan regarding pain. • Monitor: Audits will be completed by staff including the IDT management team 3 times/week for 3 weeks, 2 times/week for two weeks, 1 time/week for two weeks, and monthly for 2 months. Results will be brought the QAPI committee for follow-up.	

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90 mg by mouth one time a day.
- DEPO-Medrol suspension inject 1 milliliter (mL) intramuscularly, as needed. This medication was to be administered by the physician.
- Gabapentin capsule give 1200 mg by mouth three times a day.
- Lidocaine solution 1% inject 5 mL intramuscularly, as needed. This medication was to be administered by the physician.
- Meloxicam tablet give 15 mg by mouth, as needed.
- Voltaren Gel 1% apply to bilateral knee topically two times a day.

During an interview on 3/7/22, at 2:30 p.m. R8 expressed he regularly experienced unrelieved pain. R8 rated his pain level as a 7 on a 0-10 pain scale. R8 stated his pain level had remained unchanged all day and was consistent with the pain he experienced daily. R8 stated he received pain medication, but was unsure if it was helpful.

During an interview on 3/9/22, at 7:56 a.m. licensed practical nurse (LPN)-A stated she had administered R8's morning medications, which included acetaminophen, gabapentin, and Cymbalta to treat pain. LPN-A confirmed she did not ask R8 to rate his pain, however, should had been done.

During an interview on 3/9/22, at 8:15 a.m. R8 rated his pain 8.5 on a scale of 0-10. R8 stated LPN-A had administered his scheduled pain medication that morning, but did not ask about his pain level. R8's March 2022 Medication Administration Record (MAR) was then reviewed and indicated LPN-A documented R8's pain level as "0" on 3/9/22, for the 0800 acetaminophen and gabapentin administration.

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Subsequently, LPN-A was again interviewed on 3/9/22, at 9:26 a.m. and confirmed she had documented R8's pain rating as "0." LPN-A stated it was "a mistake" and confirmed she had not assessed R8's pain level. Following the interview, review of R8's Vitals Signs dated 3/10/22, indicated LPN-A documented R8's pain level as "9" at 10:04 a.m.

Despite R8's pain level being documented as 9 out of 10 on 3/10/22, at 10:04 a.m., R8's medical record lacked indication as needed Meloxicam, or other interventions, were offered to R8 to help relieve their pain when over two hours had passed since scheduled 8:00 a.m. pain medications were administered.

During an interview on 3/9/22, at 9:32 a.m. the assistant director of nursing (ADON) stated nurses were expected to assess a residents pain level using a 0-10 scale prior to administering pain medication. Further, the nurse should also use this same scale to check if the medication was effective about an hour after administration. The ADON added accuracy when documenting pain medication was necessary to ensure a resident's pain was managed and did not negatively impact their quality of life.

During an interview on 3/9/22, at 12:16 p.m. regional registered nurse (RN)-A stated nurses should ask about a resident's pain level when administering pain medication. "You need to know the pain level to determine if the medication is effective." RN-A added, "If the resident says their pain level is 0 before getting the medication it can help determine if the pain medication is actually necessary morning forward."

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During a follow-up interview on 3/9/22, at 12:53 p.m. R8 identified his pain level as an 8. R8 expressed frustration that pain was limiting his ability to participate in physical therapy. "I can't walk and that is my goal. I want to get walking. They know my goal. That has been my goal since day 1." A subsequent physical therapy progress note dated 3/9/22, included, "Patient reports increased pain in L [left] knee an [sic] is unable to tolerate standing longer than 15 sec[onds]."

During an interview on 3/10/22, at 10:55 a.m. R8 identified his pain level at an "8-9." R8 added, "Today, my back is driving me nuts. My legs hurt, really my whole-body hurts." R8 stated the nurse who brought him his pain medication that morning did not ask his to rate his pain." R8 stated the nurse had not returned to check if the medication had been effective. "Nurses don't typically ask if the pain medication was effective."

During an interview on 3/10/22, at 11:13 a.m. LPN-B stated R8 will sometimes verbalize pain in his back, knees, and hips. LPN-B added that R8 does receive scheduled pain medication to treat his pain and saw a pain specialist to assist with chronic pain management. LPN-B stated when administering pain medication, a nurse should always ask for a pain level and get a follow-up pain level 30-60 minutes after medication administration to assess effectiveness of the medication. LPN-B stated R8 rated his pain as a 2 when provided his morning medications around 8:00 a.m. LPN-B confirmed he had not followed up with R8 to re-assess if the pain medication was effective, but it was something he should had done. Despite LPN-B verbalizing R8 reported his pain was 2 out of 10, review of R8's March 2022

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MAR revealed R8's pain was documented as "1" for the 0800 acetaminophen and gabapentin administration on 3/10/22.

During an interview on 3/10/22, at 11:25 a.m. certified occupational therapy assistant (COTA)-A stated physical therapy and occupational therapy service for R8 had been, "Tricky due to pain levels." COTA-A added, "The pain has been very limiting for him. The biggest limiting factor is pain."

During an interview on 3/10/22, at 1:11 p.m. the director of nursing (DON) stated he expected nurses to talk to residents about pain when administering pain medication and complete brief pain assessment. However, when pain medication was scheduled with other medications it "may not be practical for the nurse to talk about that. The nurse will not have time to do that. It [pain medication] is already ordered by the provider. The provider makes the judgement on the medication needed." The DON confirmed the medical provider needed an accurate pain assessments to determine whether to continue the current pain medication or if an adjustment was needed.

Facility policy, Pain Management, dated 11/28/17, included, "The facility clinicians use standardized pain scales when cares for residents that are able to assist in determining the severity of pain and effectiveness of interventions. Resident with a cognitive impairment will be evaluated for pain based on objective observations referencing the PAIN scale. The interdisciplinary team (IDT), together with the resident and/or resident representative develop a Care Plan that will address the individual goals of comfort and

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F 697	Continued From page 35 individualized interventions to meet those goals."	F 697		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure bed rails were asessed to ensure safety for 5 of 5 residents (R27, R8, R66, R11, R9) who were observed to have bed rails affixed to their beds. Findings include: R27's quarterly Minimum Data Set (MDS) dated 1/7/22, identified R27 had moderately impaired	F 700	• Action for affected resident: Grab bars were removed from residents that were not asse ssed and not requiring device. Those that require a device were assessed for appropriateness and grab bars were placed. • How facility will identify other residents: Facility has reviewed other residents with grab bars and assessed for appropriateness and grab bars were	5/3/22

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F 700	Continued From page 36 cognition and required extensive assistance with bed mobility and limited assistance with transfers. R27 diagnoses included repeated falls and personal history of traumatic brain injury. R27's care plan dated 1/6/21 identified, R27 required supervision of one staff for all transfers and was independent with bed mobility. During observation on 3/8/22, at 9:27 a.m. R27 had grab bars affixed to the right and left sides of her bed. R27's medical record contained no evidence an assessment, risk versus benefits, or informed consent was completed/obtained prior to the use of grab bars. R8's quarterly MDS dated 12/18/21, identified R8 had intact cognition and required extensive assistance with bed mobility and transfers. R8's diagnoses included generalized muscle weakness and unspecified lack of coordination. R8's care plan dated 7/7/21, identified, "The resident has limited physical mobility." During observation on 3/8/22, at 2:58 p.m. R8 had ¼ side rails affixed to the left and right sides of his bed. R8's medical record contained no evidence an assessment, risk versus benefits, or informed consent was completed/obtained prior to the use of grab bars. R66's admission MDS dated 2/20/22, identified R66 had a severe cognitive impairment and required supervision with bed mobility and	F 700	placed/removed. • Measures to correct practice: Residents will be evaluated by licensed staff prior to grab/assist bars being placed on bed. Licensed staff and maintenance educated on placing grab bars only after an assessment has been completed indicating the need for placement. • Monitor: Audits will be completed by staff including the IDT management team 3 times/week for 3 weeks, 2 times/week for two weeks, 1 time/week for two weeks, and monthly for 2 months to insure grab bars are not placed without required assessments. Results will be brought the QAPI committee for follow-up.	

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transfers. R66's diagnoses included generalized muscle weakness and encephalopathy (a disease in which the functioning of the brain is affected).

R66's care plan dated 2/13/22, identified "Resident has limited physical mobility."

During observation on 3/8/22, at 2:52 p.m. R66 had a grab bar affixed to the right and left sides of his bed.

R66's medical record contained no evidence an assessment, risk versus benefits, or informed consent was completed/obtained prior to the use of grab bars.

R11's quarterly MDS dated 12/15/21, identified R11 had intact cognition and required extensive assistance with bed mobility and transfers. R11's diagnoses included Guillain-Barre Syndrome.

R11's care plan dated 10/3/21 identified, "The resident has actual/potential for an ADL [activity of daily living] self-care performance deficits r/t [related to] history of significant immobility."

During observation on 3/8/22, at approximately 3:30 p.m. R11 had a grab bar affixed to the right and left sides of his bed.

R11's medical record contained no evidence an assessment, risk versus benefits, or informed consent was completed/obtained prior to the use of grab bars.

R9's quarterly MDS dated 12/14/21, identified R9 had intact cognition and required extensive assistance with bed mobility and was dependent on staff for transfers. R9's diagnoses included

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F 700	Continued From page 38 abnormal posture and morbid (severe) obesity. R9's care plan dated 8/10/20 identified, "Resident requires extensive assist by 1-2 staff to turn and reposition in bed every 2-3 hours and as necessary." During observation on 3/8/22, at approximately 3:30 p.m. R9 had a grab bar affixed to the right and left sides of her bed. R9's medical record contained no evidence an assessment, risk versus benefits, or informed consent was completed/obtained prior to the use of grab bars. During an interview on 3/9/22, at 7:56 a.m. licensed practical nurse (LPN)-A stated grab bars were used for anyone who could benefit with help turning in bed. The bars could be added to a resident's bed based on suggestions from management, nursing assistants, therapy staff, or nurses. LPN-A added, "There should be a device assessment completed for any resident using grab bars on the bed." During an interview on 3/9/22, at 9:32 a.m. assistant director of nursing (ADON) stated grab bars were added to a resident's bed if they needed help getting out of bed. The ADON added no additional assessment or documentation would need to be completed. During an interview on 3/9/22, at approximately 2:30 p.m. the regional nurse supervisor, registered nurse (RN)-A stated grab bars could be added to a resident's bed to assist with repositioning. When adding grab bars to a resident's bed the nurse should get an order from	F 700		

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F 700	Continued From page 39 the doctor, complete an assessment of the device, add it to the resident's care plan, and document verbal consent for the new device in the resident's medical record. The device needed to be reassessed quarterly by nursing to determine ongoing appropriate use and risk of entrapment. Facility policy, Bed Rail Device Guideline (revised 7/19/17), informed, "It is the practice of this facility to identify and reduce safety risks and hazards commonly associated with bed rail use. A duo-faceted approach will be used to achieve sustainable quality out comes, including 1) regular bed maintenance and 2) individual bed rail evaluations. In response to the requirement of providing for a "safe, clean, comfortable, and homelike environment," the facility regular maintenance program will include regular inspection of all bed systems (e.g. rails (positioning bars), frames, and mattresses and operation components) to ensure they are clean, comfortable, and safe." "The facility will also ensure individual resident bed rail evaluations are performed on a regular basis. Individual bed rail evaluations will include data collection analysis and determination of potential alternatives to bed rail use. When bed rail(s) deemed necessary and appropriate, the facility will provide education to resident and resident's repetitive pertaining to the risk and benefits of bed rail use. The facility's priority is to ensure safe and appropriate bed rail use."	F 700		
F 730 SS=C	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review	F 730		5/3/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245182	A. BUILDING _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA AT ST LOUIS PARK	7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426

(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 730	Continued From page 40 of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete annual performance reviews for 5 of 5 nursing assistants (NA-E, NA-F, NA-G, NA-H, NA-I) whose employee files were reviewed. This had the potential to affect all 89 residents who resided at the facility. Findings include: A facility provided document which was unnamed (undated) identified the following staff hire dates: -NA-E was hired on 7/30/19. -NA-F was hired on 2/5/20. -NA-G was hired on 11/26/19. -NA-H was hired on 2/11/19. -NA-I was hired on 9/25/18. The personnel files for NA-E, NA-F, NA-G, NA-H, NA-I were reviewed and all lacked performance reviews in 2021. During an interview on 3/10/22, at 3:00 p.m. the director of nursing (DON) verified the performance evaluations were not completed for NA-E, NA-F, NA-G, NA-H, and NA-I. Further, the DON stated performance evaluations were important as they were an avenue of feedback and provided an awareness of what education needs were of the employees. During an interview on 3/10/22, at 3:14 p.m. the administrator stated performance evaluations	F 730	• Action for affected resident: No residents were affected. • How facility will identify other residents: Facility has reviewed other residents by audit of all potential to be affected to implement correction procedures. • Measures to correct practice: NARS that have not received annual evaluations will have them completed. • Monitor: Audits will be completed by staff including the IDT management team 3 times/week for 3 weeks, 2 times/week for two weeks, 1 time/week for two weeks, and monthly for 2 months. Results will be brought the QAPI committee for follow-up.	

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F 730	Continued From page 41 were expected to be completed annually, but acknowledged with frequently changing leadership, could be hard to stay on top of. The administrator further stated performance evaluations were important and helped understand where staff were and what improvements or education was needed. A facility policy around performance reviews was requested but was not received.	F 730		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758		5/3/22

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F 758	Continued From page 42 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to re-evaluate the continued use of an as needed (PRN) psychotropic medication for 1 of 5 residents (R62) reviewed for unnecessary medications. Findings include: R62's significant change Minimum Data Set (MDS) dated 2/15/22, indicated R62 had a mild cognitive impairment, diagnoses of dementia, chronic pain, bipolar disorder, and was received hospice care. R62's provider order summary printed 3/10/22, indicated R62 had orders for lorazepam	F 758	• Action for affected resident: R62 was evaluated by physician to determine need for ongoing order. • How facility will identify other residents: Facility has reviewed other residents on PRN psychotropics to assess ongoing need or need for physician evaluation. • Measures to correct practice: Nursing management educated on the need to evaluate PRN psychotropic use of medications. • Monitor: Audits will be completed by staff including the IDT management team 3 times/week for 3 weeks, 2 times/week for two weeks, 1 time/week for two weeks,	

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F 758	Continued From page 43 (anti-anxiety medication) give 0.25 milligrams (mg) per mouth every 2 hours as needed (PRN) for anxiety, sleep, or severe nausea. Further, haloperidol concentrate (anti-psychotic medication) give 0.25 milliliters (mL) by mouth PRN for agitation or moderate nausea. Both orders had a start date of 2/7/22 and had no end date. R62's February and March 2022 Medication Administration Records (MAR) indicated R62 was administered haloperidol 8 times and lorazepam 6 times from 2/7/22 through 3/10/22. R62's Medication Regimen Review (MRR) dated 2/7/22, indicated the PRN haloperidol and lorazepam were limited to 14-days and if a new 14-day order was written, a provider needed to directly evaluate the resident and document a rationale. R62's subsequent MRR dated 3/4/22, indicated the pharmacist had re-issued the same recommendations listed on R62's 2/7/22 MRR. R62's medical record lacked evidence a provider acted upon the pharmacist's recommendations. During an interview on 3/10/22, at 11:58 a.m. the consulting pharmacist (CP) stated the provider had not reviewed the recommendations placed in February, so the same recommendation was re-issued in March. CP further stated these recommendations were to ensure R62 gets evaluated and did not receive unnecessary medications. During an interview on 3/10/22, at 1:30 p.m. the director of nursing (DON) stated recommendations were received from the pharmacy and usually were completed right	F 758	and monthly for 2 months. Results will be brought the QAPI committee for follow-up. • Deficiency will be corrected on 5/3/22	

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F 758	Continued From page 44 away. The DON further acknowledged hospice residents could be more challenging to get responses back and it was a work in progress.	F 758		
F 807 SS=D	Drinks Avail to Meet Needs/Prefs/Hydration CFR(s): 483.60(d)(6) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance with fluid intake for 1 of 2 residents (R10) reviewed for hydration. Findings include: R10's admission Minimum Data Set (MDS) dated 12/16/21, indicated R10 was cognitively intact and required supervision, encouragement, and/or cueing for eating. R10's care plan dated 12/20/21, indicated R10 had dehydration, or potential fluid deficit, related to a swallowing problem and the need for thickened liquids. R10 preferred regular consistency for his water and coffee. The goal indicated R10 would consume fluids as accepted, tolerated, or desired to maintain comfort at the end of life with the following interventions: educate the resident/family/caregivers on importance of fluid intake, encourage the resident to drink fluids of choice at and between meals,	F 807	• Action for affected resident: Resident was given fluids as desired/ordered. • How facility will identify other residents: Facility has reviewed other residents on thickened liquids to insure if orders for thin water, it is made available. • Measures to correct practice: Nursing staff educated on following orders for thin water and that it is made available to those residents. • Monitor: Audits will be completed by staff including the IDT management team 3 times/week for 3 weeks, 2 times/week for two weeks, 1 time/week for two weeks, and monthly for 2 months. Results will be brought the QAPI committee for follow-up.	5/3/22

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F 807	Continued From page 45	F 807		

and ensure the resident had fluids at the bedside.

A hydration evaluation dated 12/9/21, indicated R10 was assessed to be at high risk for dehydration and further assessment should be conducted to review R10's fluid status.

R10's Kardex report dated 3/10/21, indicated R10 preferred regular consistency of coffee and water as well as R10 has fresh water at bedside at all times.

A care conference note dated 3/4/22, at 6:01 p.m. indicated R10's family member (FM)-A requested his water pitcher be filled with ice water on every shift. Further, R10 was allowed to have ice water which was not thickened.

During observation on 3/9/22, at 10:14 a.m. R10 was in bed with his bedside table across the room with no water pitcher or fluids in the room.

During observation on 3/10/22, at 9:16 a.m. R10 was in the bed with his bedside table across the room with no water pitcher or fluids in the room. At 9:20 a.m. R10 was in bed and stated, "I'm thirsty all the time, but they don't give me water unless I ask for it." R10's lips were dry with skin peeling on his top and bottom lips.

During observation on 3/10/22, at 9:29 a.m. nursing assistant (NA)-B was passing out fresh ice water to the resident rooms, however, NA-B did not deliver ice water to R10's room or offer R10 any ice water.

Upon interview on 3/10/22, at 9:33 a.m. NA-B explained water was not given to R10 due to R10 being on thickened liquids.

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F 807	Continued From page 46 Upon interview on 3/10/22, at 9:37 a.m. NA-K explained R10 was on thickened liquids so he did not receive water in his room. Upon interview on 3/10/22, at 9:38 a.m. the assistant director of nursing ADON explained R10 should always have water at the bedside and verified R10 had orders for water to be regular consistency. Upon interview on 3/10/22, at 1:10 p.m. the director of nursing (DON) explained residents should receive fresh water every shift and as needed even if the resident was on thickened liquids. Further, a resident whom does not receive water at regular intervals could become dehydrated. The hydration management policy dated 9/25/17, indicated the purpose is to provide each resident with sufficient fluid to maintain proper hydration. Further, healthcare staff will ensure adequate fluid intake by keeping fluids accessible.	F 807		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 25, 2022

Administrator
The Villa At St Louis Park
7500 West 22nd Street
Saint Louis Park, MN 55426

Re: State Nursing Home Licensing Orders
Event ID: 3GB111

Dear Administrator:

The above facility was surveyed on March 7, 2022 through March 10, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Jamie Perell, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00278	A. BUILDING: _____ B. WING _____	C 03/10/2022

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THE VILLA AT ST LOUIS PARK	7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/7/22 through 3/10/22, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. The following complaints were found to be	2 000		

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2 000	Continued From page 1 SUBSTANTIATED: H5182154C (MN81489), with a deficiency cited at 0835. The following complaint was found to be SUBSTANTIATED: H5182147C (MN80067), however, NO deficiencies were cited due to actions implemented by the facility prior to survey. The following complaints were found to be UNSUBSTANTIATED: H5182146C (MN80782, MN80783) H5182148C (MN75999) H5182149C (MN73676) H5182151C (MN53601) H5182152C (MN51395) H5182153C (MN79407) H5182155C (MN51491) Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with	2 000		

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2 000	Continued From page 2 the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for:	2 265		5/3/22

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2 265	Continued From page 3 A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician of a reopened Stage III pressure ulcer and the need to alter treatment for 1 of 2 residents (R4) reviewed for change of condition. Findings include: Stage III pressure ulcer: Full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue. R4's quarterly Minimum Data Set (MDS) dated	2 265	Corrected	

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	00278	A. BUILDING: _____ B. WING _____	C 03/10/2022

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2 265	Continued From page 4 12/9/21, indicated R4 was cognitively intact and required extensive assistance of two staff for bed mobility. R4's care plan dated 10/21/21, indicated R4 had a venous ulcer to left back of the calf and inner left ankle. R4's had a history of a left heel pressure ulcer. R4's goal was for their skin impairment to improve and have no complications. The care plan listed several interventions to help R4 meet their goal which included treatments per medical doctor (MD) orders. A Wound Evaluation dated 3/7/22, at 2:50 p.m. indicated R4 had a Stage III pressure ulcer to their left heel which measured 2.92 centimeters (cm) x 3.22 cm x 0.1 cm with 60% granulation tissue (new vascular tissue in granular form on an ulcer or the healing surface of a wound) and 30% slough (yellow devitalized tissue, that can be stringy or thick and adherent on the tissue bed.) R4's medical record was reviewed and lacked evidence the newly developed pressure ulcer was communicated to the physician despite the area being identified on 3/7/22. During interview on 3/9/22, at 10:48 a.m. the director of nursing (DON) explained the process when a new or reopened wound was discovered the nurse would assess the wound, call the physician, and give an update on the wound and obtain a treatment order. The DON verified the physician wasn't notified nor was a treatment order obtained for the reopened Stage III pressure ulcer to the left heel. During interview on 3/9/22, at 11:02 a.m. the regional clinical nurse explained the process	2 265		

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2 265	Continued From page 5 when a new or reopened wound was observed the nurse should assess the wound, update the physician, and obtain a treatment order. Further, the wound could get worse if the process wasn't followed. The Notification of Changes guideline dated 11/28/17, indicated, "it is the practice of this facility that changes in a resident's condition or treatment are immediately shared with eh resident and/or the resident representative, according to their authority, and reported to the attending physician or delegate. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could develop, review, and/or revise policies and procedures to ensure residents/family representatives/physicians are notified of a change in condition or treatment; educate all appropriate staff on the policies and procedures; and, develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		
2 285	MN Rule 4658.0100 Subp. 2 Employee Orientation and In-Service Education Subp. 2. In-service education. A nursing home must provide in-service education. The in-service education must be sufficient to ensure the continuing competence of employees, must address areas identified by the quality assessment and assurance committee, and must address the special needs of residents as determined by the nursing home staff. A nursing home must provide an in-service training	2 285		5/3/22

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2 285	Continued From page 6 program in rehabilitation for all nursing personnel to promote ambulation; aid in activities of daily living; assist in activities, self-help, maintenance of range of motion, and proper chair and bed positioning; and in the prevention or reduction of incontinence. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete annual performance reviews for 5 of 5 nursing assistants (NA-E, NA-F, NA-G, NA-H, NA-I) whose employee files were reviewed. This had the potential to affect all 89 residents who resided at the facility. Findings include: A facility provided document which was unnamed (undated) identified the following staff hire dates: -NA-E was hired on 7/30/19. -NA-F was hired on 2/5/20. -NA-G was hired on 11/26/19. -NA-H was hired on 2/11/19. -NA-I was hired on 9/25/18. The personnel files for NA-E, NA-F, NA-G, NA-H, NA-I were reviewed and all lacked performance reviews in 2021. During an interview on 3/10/22, at 3:00 p.m. the director of nursing (DON) verified the performance evaluations were not completed for NA-E, NA-F, NA-G, NA-H, and NA-I. Further, the DON stated performance evaluations were important as they were an avenue of feedback and provided an awareness of what education needs were of the employees. During an interview on 3/10/22, at 3:14 p.m. the	2 285	Corrected	

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2 285	Continued From page 7 administrator stated performance evaluations were expected to be completed annually, but acknowledged with frequently changing leadership, could be hard to stay on top of. The administrator further stated performance evaluations were important and helped understand where staff were and what improvements or education was needed. A facility policy around performance reviews was requested but was not received. SUGGESTED METHOD OF CORRECTION: The administrator, or designee, could review applicable procedures and policies to ensure the timely completion of nursing assistant performance reviews; educate staff on applicable policy revision; and, audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 285		
2 835	MN Rule 4658.0520 Subp. 2 A Adequate and Proper Nursing Care; Criteria Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: Evidence of adequate care and kind and considerate treatment at all times. Privacy must be respected and safeguarded. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide appropriate incontinence care or manage a suprapubic catheter to prevent urinary tract infections (UTI)	2 835	Corrected	5/3/22

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2 835	Continued From page 8 for 2 of 2 residents (R11, R48) reviewed for urinary tract infections (UTI). Findings include: R11's quarterly Minimum Data Set (MDS) 12/15/21, indicated R11 was cognitively intact with diagnoses of Guillain-Barre syndrome, weakness and UTI. Further, R11 was incontinent and required extensive assistance of two persons for toileting and hygiene care. R11's Order Summary Report dated 10/31/21, R11 was ordered Bactrim DS (antibiotic) 800-160MG, give 1 tablet twice daily for UTI for 7 days on 3/4/22. R11's care plan dated 10/3/21, indicated R11 had mixed bladder incontinence, a history of acute cystitis (inflammation of bladder) with hematuria (blood in urine), and had a potential/actual UTI. Interventions included encourage fluid intake, monitor vital signs "specify frequency" and notify MD (medical doctor) of significant changes, and provide incontinent care after each incontinent episode. R11's care plan lacked frequency of checking R11 for incontinence. Additionally, the care plan lacked indication R11 refused soap, or other hygenic products, when incontinence care was performed. During an observation on 3/9/22, at 7:53 a.m. nursing assistant (NA)-B and NA-C knocked on R11's door and entered the room to provide morning cares. R11 woke up and stated "Yes, I am so wet and uncomfortable. I didn't get changed all night." R11's legs had scabs and scratches; some blood was smeared on R11's sheets. Upon removal of the sheets, the sheet R11 was laying on was observed to be wet. There	2 835		

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2 835	Continued From page 9	2 835		

was a strong odor of urine in room. NA-B helped R11 wash their face and upper body before starting incontinence cares. NA-B filled R11's sink with warm water and did not add soap or other cleanser. NA-B and NA-C used warm water to perform R11's peri cares on frontside of body. R11 was then helped to a standing position with the EZ stand. Upon standing, R11's wet brief was removed. R11 had blanchable redness on bilateral buttocks that extended down legs. R11 had some scratches, which appeared new, on outside of right thigh. R11's buttocks and thighs were cleaned with warm water, however, no soap or cleanser was used. Licensed practical nurse (LPN)- E brought in cream to place on bottom before placing a clean brief. NA-B and NA-C then helped R11 to a chair for breakfast.

During an interview on 3/9/22, at 8:30 a.m. NA-B stated R11 was always incontinent and notified staff when they needed to be changed. NA-B stated staff checked on R11 too. NA-B verified only water was used for R11's incontinent cares. NA-B further stated sometimes disposable wipes were used, if they are in the room, but mostly R11 liked the washcloths. NA stated R11 complained about the soap as it burned and caused itching and that was why it was not used.

During an interview on 3/9/22, at 8:43 a.m. LPN-E indicated R11 stated incontinence cares should performed using more than just warm water as R11 was at risk for UTIs.

During an interview on 3/9/33, at 10:35 a.m. medical doctor (MD)-A stated R11 had a UTI in October 2021, January 2022, and currently was being treated for one. MD-A further stated it was his understanding R11's UTI was more of a hygiene issue as R11 did not always allow for

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2 835	Continued From page 10 cares to be completed. MD-A further stated the expectation was for staff to use soap, or other appropriate antibacterial, when performing R11's incontinence care. During an interview on 3/9/22, at 1:25 p.m. the assistant director of nursing ADON stated staff would be expected to use wipes, or soap and water, for incontinent cares. Water would not clean bacteria away. During an interview on 3/9/22, at 2:15 p.m. R11 stated soap was wanted and verbalized, "how else would I get clean?" During an interview on 3/10/22, at 1:18 p.m. the director of nursing (DON) stated water would not be sufficient for incontinent cares, but soap and water would be okay. Improper incontinent care can put a resident at risk for infection. R48's admission MDS dated 2/1/22, indicated R84 was cognitively intact and had diagnoses of transverse myelitis (disorder caused by inflammation of the spinal cord) causing paraplegia and UTIs. R48's MDS also indicated R48 had a suprapubic catheter. R48's Order Summary Report dated 3/10/22, lacked indication of dressing changes, exchanges or routine cares for R48's suprapubic catheter. R48's care plan dated 2/3/22, indicated "(SPECIFY condom, intermittent, indwelling, suprapubic)" catheter. R48's care plan had interventions placed on 3/4/22, to monitor for signs of infection, and ensure tubing is secure to avoid pulling. R48's care plan lacked instruction on catheter cares, dressing changes needed at insertion site or catheter exchanges.	2 835		

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2 835	Continued From page 11 Review of R48's progress notes revealed: - 3/2/22, at 11:33 p.m. indicated R48's catheter had been exchanged and dressing changed with no signs of infection. The progress note lacked indication if the catheter was changed due to a complication. Review of R48's medical record lacked indication of any other dressing changes being performed. - 3/4/22, at 4:05 p.m. indicated the facility received a call from R48's wife and R48 was admitted to the hospital for UTI and low blood pressure. During an interview on 3/8/22, at 10:00 a.m. nursing assistant (NA)-D stated R48 catheter was often full. NA-D had seen bloody drainage and had reported it to the nurse a few days before R11 went to the hospital but wasn't sure about the date. During an interview on 3/9/22, at 11:30 p.m. R48 stated he was currently in the hospital for a UTI. R48 stated initially, their suprapubic catheter was not getting cleaned correctly at the facility. R48 stated the gauze was supposed to be changed daily but was not getting done until he started requesting it. R48 stated the catheter tubing was not always secured to his leg and his catheter tube was moving in and out at the insertion site. R48 believed this was the cause of his UTI. R48 stated after he told staff how to do dressing changes cares were more consistent. R48 stated he asked for his catheter to be changed right before he was hospitalized, and the nurse changed it. R48 stated he had some bloody oozing at the site and a little area around the insertion site had re-opened. During an interview on 3/9/22, at 12:05 p.m.	2 835		

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2 835	Continued From page 12 licensed practical nurse (LPN)-C stated an order was needed for a catheter exchange and was not sure about suprapubic catheters. LPN-C stated the only cares which were completed for R48's catheter was irrigation. LPN-C was not aware of any dressing changes for R48's catheter. During an interview on 3/9/22, at 12:14 p.m. NA-J stated catheter cares were done with just water, or sometimes soap and water, depending on the preference of the resident. NA-J further stated R48's catheter was emptied, and bag exchanged, but NA-J had never completed catheter cares. During an interview on 3/10/22, at 9:54 a.m. registered nurse (RN)-B stated catheter cares were written orders and the nurses do the cares and the NAs empty the urine. RN-B stated a normal catheter change was done every 30 days and, if needed, a urology appointment would be made. RN stated R48 did not have an order to exchange his suprapubic catheter, but knew it was supposed to be completed every 30 days. RN further stated R48's catheter was possibly leaking as R48 had some bloody drainage at the insertion site, however, provider was not notified as there were no signs of infection. During an interview on 3/10/22, at 10:15 a.m. the assistant director of nursing (ADON) explained orders were needed for catheter exchanges, but catheter cares were standard practice and was more of a nursing order. Further, it was not best practice to change a catheter every 30 days and standing orders were in-place for when urine was bypassing the catheter tube, however, if any other drainage was noted the medical provider should be notified. During an interview on 3/10/22, at 1:18 p.m. the	2 835		

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2 835	Continued From page 13 director of nursing (DON) stated it was the nurse's responsibility to change catheters, but the NAs were responsible for the daily cares and emptying. The DON further stated there should be an order for dressing changes for suprapubic catheter and monthly catheter exchanges. The facility had standing orders if the catheter was leaking urine, however, if catheter was leaking was more than urine, the provider should be notified. The DON further stated catheter cares and monitoring are important as if not properly cared for could lead to an infection. A facility policy for catheter and incontinent cares was requested, but was not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review and revise policies and procedures related to ensuring incontinence/catheter care was provided for each individual resident. The DON, or designee, could develop a system to educate staff and develop a monitoring system to ensure staff are appropriate care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 835		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the	2 915		5/3/22

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2 915	Continued From page 14 resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a resident was provided assistance with bathing and hair washing for 1 of 1 residents (R387) who required assistance with activities of daily living (ADLs). Findings include: R387's Admission Record dated 3/10/22, indicated he had diagnoses of surgical amputation of left lower leg, bone infection, severe obesity, and diabetes. R387's admission Minimum Data Set dated 3/6/22, indicated he was cognitively intact, required assistance of one staff for transfers, and supervision with personal hygiene. The MDS further indicated he required one-person physical assistance with bathing, which was not documented as occurring. R387's care plan dated 3/1/22, indicated he had an actual or potential for an ADL self-performance deficit and limited physical mobility. Interventions included encourage the resident to use the call light for assistance. Additionally, R387's closet	2 915	Corrected	

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2 915	Continued From page 15 care plan (a hand-written information sheet used by nursing assistants to provide resident-appropriate care), undated, indicated R387 required assistance of 1 staff for bathing. R387's Order Summary Report dated 3/10/22, indicated R387 was non-weight bearing to lower left extremity until 4/12/22. The report also indicated shower/nail care/skin checks were to be completed weekly on Friday mornings and Monday evenings starting 3/1/22. Review of the bath list (undated) indicated R387 was scheduled for a bath or shower on Friday mornings and Monday evenings. R387's NA Task documentation dated 3/8/22, indicated bath type was documented as "Not Applicable" for five of the previous 8 days, and undocumented on three of the previous 8 days. On 3/8/22, at 8:18 a.m. transmission-based precaution signs were observed on R387's closed door. A cart of gowns, gloves, masks, and eye protection was located just outside in the hallway. An unidentified staff-person stated R387 was a new admission and on quarantine related to COVID-19 vaccination status. R387 was observed lying in bed in his room with long hair which appeared oily. During interview on 3/8/22, at 8:20 a.m. R387 stated it had been between 10 - 12 days since he took a shower and washed his hair. He stated he had been asking staff and was supposed to get a bath on Friday (3/4/22), but he had the "stomach flu," so staff said they could do it on Monday (3/7/22). He stated it was "like tumbleweeds" at the facility on 3/7/22, and nobody came to help him. He stated staff then told him he could get	2 915		

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2 915	Continued From page 16 cleaned up on Tuesday (3/8/22) and when he asked again, he was told they could help him in the evening. R387 stated he could not do much since he recently had one leg amputated and needed someone to help him transfer. He stated the only way he could try to clean himself was with disposable wipes. He stated nobody brought him towels, washcloths, or soapy water. He stated he was getting a diaper rash, but it would go away if he could just take a shower. During interview on 3/9/22, at 7:47 a.m. nursing assistant (NA)-M stated there was a list which identified when a resident needed a bath at the nurse's station, but the only way she would know if a bath was completed was to ask the resident. She stated she knew how much assistance a resident needed by reviewing the "closet care plan" which was a hand-written sheet of paper located in the resident's closet. She stated R387 needed supervision with transfers. She stated sometimes the information was in the electronic health record (EHR), but most of the time it was wrong. NA-M stated she gave R387 a basin with water and washcloths that morning and would wash his hair in the shower or use the shower cap with soap and a little water, if needed. She stated he did not refuse, and she documented when baths were completed in the EHR. During interview on 3/9/22, at 7:52 a.m. the director of nursing (DON) stated bath reminders and documentation were moved from paper to the EHR, and staff completed a daily audit of the bath schedule and records. He stated the EHR was updated and correct, so the NAs saw that task on the day when it was due. He stated the nurses and NAs documented if a bath was refused by the resident.	2 915		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00278	A. BUILDING: _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA AT ST LOUIS PARK	7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426

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2 915	Continued From page 17 During interview on 3/9/22, at 7:58 a.m. R387 stated staff did not give him a shower or bath, however, gave him the stuff to do it himself that morning. He stated they were putting it off, and he told them to just give him the stuff to do it himself. He stated, "whatever, I don't understand." He stated he could take care of himself "pretty well," but he didn't like to stink and now had diaper rash and it hurt. R387 was observed sitting on his bed with a basin of soapy water and washcloths on his side table. Towels were out of reach by the sink in the room approximately four feet from the end of his bed. R387 stated, "I'm not sure how I'm supposed to wash my hair," and stated he was getting frustrated. He stated he had to figure out how to wash his own hair without being able to stand up and make a big mess. He stated he heard staff having a lot of conversations at the desk, but when he needed something, they disappeared. During interview on 3/9/22, at 8:19 a.m. the DON stated residents were assigned to have at least one bath per week. If a resident wished for, or appeared to need one more, often staff would offer and make it happen. He stated if baths were refused it would be documented. The DON stated R387 was in quarantine until 3/11/22, based on his COVID-19 vaccination status, and would not expect staff to bring him out to the general bathroom to get a shower during that period. The DON reviewed R387's EHR and confirmed the record was not set up to remind staff when R387 was scheduled for a bath. He stated he did not think the problem was widespread, but needed to pay closer attention to people who were on quarantine since they did not come out of their rooms. He stated he relied on staff to see the person to catch things like that.	2 915		

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2 915	Continued From page 18 Facility policy Activities of Daily Living (ADLs) dated 5/7/20, indicated in accordance with the comprehensive assessment, together with respect for individual resident needs and choices, the facility provides care and and services for: bathing, grooming, and oral care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could develop, review, and/or revise policies and procedures to ensure care and services are provided to residents. The DON, or designee, could educate all appropriate staff on the policies and procedures and develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to remove unwanted facial hair for 1 of 1 resident (R234) who was dependent upon staff for assistance shaving. Findings include:	2 920	Corrected	5/3/22

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2 920	Continued From page 19 R234's admission Minimum Data Set (MDS) dated 1/19/22, identified R234 had severely impaired cognition, needed extensive assistance with personal hygiene, and demonstrated no behaviors. R234's diagnoses included dementia without behavioral disturbance and unspecified lack of coordination. R234's care plan dated 3/3/22, lacked indication of the amount of assistance R234 needed to complete any activities of daily living (ADLs) including management of personal hygiene. During an observation on 3/7/22, at 12:07 p.m. R234 was observed with approximately ¼ inch long hairs covering her chin. R234 stated she wanted the hair removed, but did not have access to a razor. R234 stated staff had not attempted to help her remove the unwanted facial hair. During an interview on 3/9/22, at 7:56 a.m. licensed practical nurse (LPN)-A stated nursing assistants were expected to help remove residents unwanted facial hair, as needed. During an observation on 3/9/22, at 8:49 a.m. R234 facial hair was observed to be unchanged from 3/7/22. R234 continued to have ¼ inch hair covering her chin. During an interview on 3/9/22, at 8:53 a.m. nursing assistant (NA)-A stated nursing assistants were expected to provide personal hygiene care to each resident daily including shaving residents. NA-A stated if facial hair was observed on a female resident the nursing assistant needed to ask if they can help remove the hair. NA-A stated she was aware R234 would periodically request assistance with shaving her face. Most recently she overheard R234 tell staff	2 920		

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2 920	Continued From page 20 she would like help shaving on 3/8/22, and acknowledged it was not completed as there was visible facial hair on R234's chin. NA-A approached R234 to ask if she could help her shave. R234 replied, "It didn't get done last time I asked. I would like it done now." During an interview on 3/9/22, at 9:32 a.m. the assistant director of nursing (ADON) stated nursing assistants were responsible for assisting residents with personal hygiene which would include shaving. "If [hair] is observed I would expect the nursing assistant to take care of it." Facility policy Activities of Daily Living (ADLs) dated 5/7/20, included, "In accordance with the comprehensive assessment together with respect for individual resident needs and choices our facility provides care and services for the following activities: hygiene: Bathing, dressing, grooming, and oral care." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could develop policies and procedures to ensure residents receive hygiene assistance as determined necessary by their individualized plan of care; educate all appropriate staff on these policies and procedures; and, develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 920		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis	21426		5/3/22

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21426	Continued From page 21 infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to conduct a tuberculosis (TB) screening for 1 of 5 residents (R22) who was reviewed. Further, the facility failed to conduct a TB screening or testing 1 of 5 employees nursing assistant (NA)-N whose employee file was reviewed. Findings include: R22's admission Minimum Data Set dated 1/5/22, indicated R22 was admitted to the facility in December 2021. Review of R22's medical record lacked evidence of screening of symptoms, history, or risk factors for TB since admission.	21426	Corrected	

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21426	Continued From page 22 NA-N's employee record indicated a start date of 1/18/22. Review of NA-N's record lacked evidence of screening of symptoms, history, or risk factors for TB, and any evidence of TB test results. During interview on 3/10/22, at 11:34 a.m. director of nursing (DON) stated new employees attended orientation every Wednesday in another facility, and the educator on site initiated the TB testing. The employee was expected to come to the building to have it read two days later, and the facility tracked when the next step was due. The DON confirmed NA-N did not have documentation of TB symptom screening or TB test results and was unsure why R18 did not have a screening in her record. DON stated the facility "missed this." The Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by the Minnesota Department of Health (MDH) dated 6/30/21, indicated a baseline TB screening was completed at time of hire for all health care personnel, and at time of admission for all residents. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review their policies and procedures regarding TB screening/testing. The DON, or designee, could educate staff on policies and procedures and develop a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		

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21855	Continued From page 23	21855		
21855	MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure privacy for 1 of 1 residents (R384) who was observed disrobed from a public area. Findings include: R384's Admission Record dated 3/10/22, indicated R384's diagnoses included encephalopathy (altered brain function), dementia without behavior disturbance, and recent shoulder surgery. R384's admission Minimum Data Set dated 3/7/22, was incomplete, however, indicated he was severely cognitively impaired. R384's care plan dated 3/5/22, indicated R384 had limited physical mobility and used a wheelchair. Staff were directed to anticipate and meet his needs. The care plan identified R384 was incontinent of bowel and bladder and utilized an incontinence brief.	21855	Corrected	5/3/22

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21855	Continued From page 24 On 3/7/22, at 3:37 p.m. R384's room and bathroom door were observed fully open while R384 was sitting on the toilet in full view from the hallway. Staff assisted R384 rise from the toilet. An incontinence brief was observed hanging at R384's knees while staff provided cares. Staff then pulled up R384's incontinence brief which was also within view from the hallway. Nursing assistant (NA)-L exited R384's room and stated she usually closed the doors for privacy, but another aide was in the room and left it open. During observation on 3/9/22, at 12:24 p.m. R384 was observed on the floor next to his bed lying on his right side. His head was toward the foot of the bed and his feet toward the head. A wheelchair was approximately three feet away from R384 and the front faced toward the door and away from R384. R384 was wearing only a shirt and an incontinence brief, with no other clothing nearby. Staff were called to the room, and the door was half open while staff assessed resident and assisted him to bed. No clothing items were nearby. On 3/9/22, at 1:23 p.m. R384's room door was fully open and R384 was observed from the hallway lying in bed on top of his sheets wearing an incontinence brief and a shirt without a sheet, blanket, or pants covering his lower half. No pants or top coverings were nearby. During interview with the assistant administrator (AA) on 3/9/22, at 1:25 p.m. R384 was observed by AA standing next to his bed with his back to the door wearing only a shirt and an incontinence brief. AA entered the room to ensure his safety and additional staff were called to assist him back to bed. Two additional employees entered the	21855		

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21855	Continued From page 25	21855		

room, left the door open, and helped R384 turn around to face the door to the hallway. R384's incontinence brief fell down to below his knees leaving him fully exposed to passersby in the hallway. A fourth staff person entered the room, left the door open, and staff pulled up R384's brief before helping him to bed. Upon leaving R384's room, AA apologized and stated she would definitely want him to be wearing pants or be covered up to protect his dignity and stated staff should have closed the door to provide privacy while they cared for him.

During interview on 3/10/22, at 11:34 a.m. director of nursing (DON) stated privacy was a part of human dignity, and he expected everyone, whether a direct caregiver or otherwise, to respect patient privacy. He stated this included closing the door when appropriate. He stated R384 had the right to be treated with dignity, and staff should treat residents as they would want to be treated. DON stated R384 should not have been left exposed with everyone walking by, and anyone could have observed him, and it would "live in their memory." He stated staff could both ensure his safety and protect his dignity, and R384 should not have been left with his incontinence brief exposed.

The facility policy Resident Rights dated 11/28/17, indicated residents had the right to be treated with respect and dignity. No other policies pertaining to resident privacy were provided.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON), or designee, could develop, review, and/or revise policies and procedures to ensure all residents' privacy is maintained. The DON, or designee, could educate all appropriate staff on the policies and

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21855	Continued From page 26 procedures. The DON, or designee, could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21855		

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	245182	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/08/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/08/2022. At the time of this survey, The Villa at St. Louis Park was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/31/2022

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.

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Villa at St. Louis Park is a 2-story building with a partial basement. It was built in 1971 and was determined to be of Type II(222) construction. The building has a total of eight separate smoke compartments and is divided into four smoke compartments on each sleeping floor. The building is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department	K 000		

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K 000	Continued From page 2 notification. The facility has a capacity of 105 beds and had a census of 88 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility's heating, ventilation, and air conditioning is not in compliance with the NFPA 101 (2012), Life Safety Code, sections 9.2 and 19.5.2.1, and NFPA 90A (2012), Standard for the Installation of Air-Conditioning and Ventilating Systems, section 4.3.12.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/08/2022 between 9:00 AM and 1:00 PM, observation revealed that the ventilation system has supply ducts serving the resident corridors without return ducts in the corridors. The only	K 521	Please see the attached waiver request.	5/3/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245182	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/08/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA AT ST LOUIS PARK	**7500 WEST 22ND STREET** **SAINT LOUIS PARK, MN 55426**

(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
K 521	Continued From page 3 return is through the continuous operation of the resident room bathroom fans. The date of building construction is 1971. An interview with the Facility Maintenance Director verified this finding at the time of discovery.	K 521		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to use extension cords per NFPA 99	K 920	• Action to correct deficiency: extension cords removed and replaced with power	5/3/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245182	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/08/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA AT ST LOUIS PARK	**7500 WEST 22ND STREET** **SAINT LOUIS PARK, MN 55426**

(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
K 920	Continued From page 4 (2012 edition), Health Care Facilities Code, section 10.2.4, and NFPA 70 (2011 edition), National Electrical Code, sections 400.8 and 590.3. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/08/2022 at 11:30 AM, it was revealed by observation that two extension cords at the front desk are being used as permanent power. An interview with the Facility Maintenance Director verified this finding at the time of discovery.	K 920	strips meeting requirements of K920 • Action to prevent recurrence: Maintenance director educated on proper use of extension cords and power strips. • Monitor: Audits will be completed by maintenance director or designee 3 times/week for 3 weeks, 2 times/week for two weeks, 1 time/week for two weeks, and monthly for 2 months. Results will be brought the QAPI committee for follow-up.	