DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245182

October 23, 2020

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 October 13, 2020 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.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare and Medicaid Program.

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
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

October 23, 2020

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

RE: CCN: 245182
Cycle Start Date: September 3, 2020

Dear Administrator

On October 22, 2020 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 October 13, 2020.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 5, 2020 did not go into effect. (42 CFR 488.417 (b))

In our letter of September 21, 2020, 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), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 5, 2020 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 13, 2020, 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.

Your request for a continuing waiver involving the deficiency(ies) cited under K521 at the time of the September 3, 2020 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

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 AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3TV9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00278

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245182**

2.STATE VENDOR OR MEDICAID NO.
(L2) **242478000**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE VILLA AT ST LOUIS PARK**
(L4) **7500 WEST 22ND STREET**
(L5) **SAINT LOUIS PARK, MN** (L6) **55426**

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **08/01/2013**

6. DATE OF SURVEY **09/03/2020** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **100** (L18)
13.Total Certified Beds **100** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	100			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Magdalene Jares, HFE NE II 10/09/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 10/22/2020 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/31/1973
(L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Electronically delivered
September 21, 2020

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

RE: CCN: 245182
Cycle Start Date: September 3, 2020

Dear Administrator:

On September 3, 2020, a survey was completed at your facility by the Minnesota Department(s) 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 5, 2020.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 5, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 5, 2020.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only

if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by November 5, 2020, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Villa At St Louis Park will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 5, 2020. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Metro C Survey Team
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: susanne.reuss@state.mn.us
Phone: (651) 201-3793

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 3, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals

Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DIRECTED PLAN OF CORRECTION

A Directed Plan of Correction (DPOC) is imposed in accordance with 42 CFR § 488.424. Your facility must include the following in their POC for the deficient practice cited at F880:

PERSONAL PROTECTIVE EQUIPMENT (PPE)

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

POLICIES/PROCEDURES/SYSTEM CHANGES:

- The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing, shall complete the following:

- Review policies and procedures for donning/doffing PPE during COVID-19 with current guidelines to include crisis standard of care, contingency standard of care and standard care.
- Develop and implement a policy and procedure for source control masks.
- Review policies regarding standard and transmission based precautions and revise as needed.

TRAINING/EDUCATION:

As a part of corrective action plan, the facility must provide training for the Infection Preventionist, the Director of Nursing, all staff providing direct care to residents, and all staff entering resident's rooms, whether it be for residents' dietary needs or cleaning and maintenance services. The training must cover standard infection control practices, including but not limited to, transmission-based precautions, appropriate PPE use, and donning and doffing of PPE.

- The training may be provided by the Director of Nursing, Infection Preventionist, or Medical Director with an attestation statement of completion.
- The training must include competency testing of staff and this must be documented.
- Residents and their representatives should receive education on the facility's Infection Prevention Control Program as it related to them and to the degree possible/consistent with resident's capacity.
- Online infection prevention training courses may be utilized. The CDC and MDH websites have several infection control training modules and materials.

CDC RESOURCES:

Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html
CDC: Isolation Precautions Guideline:

https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/
Healthcare Infection Prevention and Control FAQs for COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:

Personal Protective Equipment (PPE) for Infection Control: https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html
MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf
Interim Guidance on Facemasks as a Source Control Measure (PDF): https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf
Interim Guidance on Alternative Facemasks (PDF): https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf
Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF): https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf
Droplet Precautions: https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html
Airborne Precautions: https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist, and other facility leadership will conduct audits of donning/doffing PPE with Transmission Based Precautions i.e. Droplet precautions.
- The Director of Nursing, Infection Preventionist, and other facility leadership will conduct routine audits on all shifts four times a week for one week, then twice weekly for one week once compliance is met. Audits should continue until 100% compliance is met on source control masking for staff, visitors and residents.
- The Director of Nursing, Infection Preventionist, and other facility leadership will conduct real time audits on all aerosolized generating procedures to ensure PPE is in us.
- The Director of Nursing, Infection Preventionist, or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

EQUIPMENT/ENVIRONMENT

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

POLICIES/PROCEDURES/SYSTEM CHANGES:

- The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.
- The director of housekeeping, director of maintenance, and director of nursing must review policies and procedures regarding disinfecting multiuse/shared equipment/items and/or environmental disinfection to ensure they meet the CDC guidance for disinfection in health care facilities and follow disinfectant product manufacturer directions for use including contact time.

TRAINING/EDUCATION :

- The Director of Housekeeping/Maintenance, and/or Director of Nursing, or Infection Preventionist must train all staff responsible for resident care equipment and environment on the facility policies/practices for proper disinfection, including following manufacturer direction for use. Each staff person must demonstrate competency at the conclusion of the training.

Training and competency testing must be documented. The Minnesota Department of Health (MDH), Center for Disease Control (CDC), and Environmental Protection Agency have education materials that may be used for training.

- CDC: Infection Control Guidelines and Guidance Library. https://www.cdc.gov/infectioncontrol/guidelines/index.html/eic_in_HCF_03.pdf
- MDH COVID-19 Toolkit. https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf
- EPA: List N: Disinfectants for Use Against SARS-CoV-2 (COVID-19) https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2-covid-19

CDC RESOURCES:

Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html
CDC: Isolation Precautions Guideline:
https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/
Healthcare Infection Prevention and Control FAQs for COVID-19:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:

Personal Protective Equipment (PPE) for Infection Control:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html
MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf
Interim Guidance on Facemasks as a Source Control Measure (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf
Interim Guidance on Alternative Facemasks (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf

Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf
Droplet Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html
Airborne Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist, and/or other facility leadership will conduct audits for proper cleaning and disinfection of resident use equipment/environmental cleaning, on all shifts every day for one week, then may decrease frequency as determined by compliance.

HAND HYGIENE

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

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

POLICIES/PROCEDURES/SYSTEM CHANGES:

- The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing, shall complete the following:

- Review hand hygiene policies and procedures to ensure they meet CDC guidance, and revise as needed.

TRAINING/EDUCATION:

- As a part of corrective action plan, the facility must provide training for the Infection Preventionist, the Director of Nursing, all staff providing direct care to residents, and all staff entering resident's rooms, whether it be for residents' dietary needs or cleaning and maintenance services. The training must cover standard infection control practices, including but not limited to, transmission-based precautions and adequately caring for and disinfecting shared medical equipment. Findings of the RCA should also be incorporated into staff training.
- The Infection Preventionist, Director of Nursing and Clinical Education Coordinator must implement competency assessments for staff on proper hand hygiene and develop a system to ensure all staff have received the training and are competency
- Online infection prevention training courses may be utilized. The CDC and MDH websites have several infection control training modules and materials.

  https://www.health.state.mn.us/people/handhygiene/ (MDH)
  Hand Hygiene (MDH) https://www.health.state.mn.us/people/handhygiene/index.html
  Hand Hygiene for Health Professionals (MDH)
  https://www.health.state.mn.us/people/handhygiene/index.html

Cleaning Hands with Hand Sanitizer (MDH)
https://www.health.state.mn.us/people/handhygiene/clean/index.html
CDC: Guideline for Hand Hygiene in Health-Care Settings (CDC)
https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm
WHO Guidelines on Hand Hygiene in Health Care (WHO)
https://apps.who.int/iris/bitstream/handle/10665/44102/9789241597906_eng.pdf;jsessionid=A770590E49844880F6F3E1D8F22F0841?sequence=1
Hand Hygiene in Outpatient and Home-based Care and Long-term Care Facilities (WHO)
https://www.who.int/gpsc/5may/hh_guide.pdf

CDC RESOURCES:
Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html
CDC: Isolation Precautions Guideline: https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/
Healthcare Infection Prevention and Control FAQs for COVID-19:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:
Personal Protective Equipment (PPE) for Infection Control:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html
MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf
Interim Guidance on Facemasks as a Source Control Measure (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf
Interim Guidance on Alternative Facemasks (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf
Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf
Droplet Precautions: https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html
Airborne Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist and other facility leadership will conduct audits on all shifts, every day for one week, then may decrease the frequency based upon compliance. Audits should continue until 100% compliance is met.

The Director of Nursing, Infection Preventionist or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

In accordance with 42 CFR § 488.402(f), this remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed on or after that date. The effective date is not a deadline for completion of the DPOC. However, a revisit will not be approved prior to receipt of documentation confirming the DPOC was completed. To demonstrate that the facility successfully completed the DPOC, the facility must provide all of the following documentation. Documentation should be uploaded as attachments through ePOC.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies (including F880) within 10 days after receipt of the Form CMS 2567.

Item	Checklist: Documents Required for Successful Completion of the Directed Plan
1	Documentation of the RCA and intervention or corrective action plan based on the results with signatures of the QAPI Committee members.
2	Documentation that the interventions or corrective action plan that resulted from the RCA was fully implemented
3	Content of the training provided to staff, including a syllabus, outline, or agenda, as well as any other materials used or provided to staff for the training
4	Names and positions of all staff that attended and took the trainings
5	Staff training sign-in sheets
6	Summary of staff training post-test results, to include facility actions in response to any failed post-tests
7	Documentation of efforts to monitor and track progress of the interventions or corrective action plan

In order to speed up our review, identify all submitted documents with the number in the "Item" column.

Attach all items into ePOC.

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 09/03/2020

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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E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 8/31/2020 - 9/3/2020, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On August 31, 2020, through September 3, 2020, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5182084C, H5182085C and H5182086C The following complaint was found to be SUBSTANTIATED: H5182083C, however, no deficiencies were issued because the facility had implemented interventions before the survey was conducted. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the	F 000		

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

Electronically Signed | 09/30/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 regulations has been attained in accordance with your verification.	F 000		
F 559 SS=D	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide proper notification of room change for 1 of 3 residents (R21) reviewed for beneficiary notice. Findings include: R21's admission Minimum Data Set (MDS) dated, 6/24/20, identified R21 had intact cognition with diagnoses of morbid obesity, difficulty walking, post-laminectomy syndrome, and muscle weakness. During interview on 8/31/20 at 8:54 a.m., R21 verbalized being upset because she was moved from first floor to second floor. R21 became teary and repeatedly said, "it's depressing up here."	F 559	All residents have the potential to be impacted by this practice. Administrative interdisciplinary team education completed on the regulations of room transfers, 7-day notice, roommate notifications, timelines and allowable exceptions. Social Worker/Designee will audit all room transfers for proper notification, timelines, and documentation weekly x 90 days. Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance.	10/13/20

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F 559	Continued From page 2	F 559		

When asked what was depressing, R21 responded, "it's just bad up here." R21 acknowledged she received a 7 day notice of the move but she was moved after only 4 days. R21 denied being offered an opportunity to see the new room or meet her new roommate. R21 was unsure of reason for room change but thought it had something to do with insurance. R21 verbalized she was so upset she did not let staff help her pack her belongings at the time of the move.

During a follow-up interview on 9/3/20, at 12:17 p.m., R21 again verbalized being very upset at having to leave the first floor and expressed how depressing it was on second floor.

R21's admission record, dated 6/17/20, indicated she was admitted to Station 1 [on first floor] for quarantine during first 14 days of admission.

R21's progress note, dated 7/7/20, indicated she was notified of a move to Station 2 [still on first floor] after completion of quarantine and she had no concerns.

R21's progress note, dated 7/8/20, indicated she was moved from Room 114 to Room 132.

R21's progress note, dated 8/20/20, indicated she was notified she would be moved that day to second floor and she was very upset because she had previously been told she would move on 8/24/20. The progress note also indicated R21 was to move to room 245-1.

R21's progress note, dated 8/21/20, indicated R21 was moved from room 131 to room 213-2 because the room was not available the previous

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F 559	Continued From page 3	F 559		

day.

During interview on 9/2/20, at 2:33 p.m., social worker (SW)-A acknowledged R21 should have been given a 7 day notice for a room change. SW-A stated the room change was moved from 8/24/20 to 8/20/20 to accommodate the new admission of a male resident who was COVID-19 negative. SW-A acknowledged R21 had a right to be shown a new room and given the opportunity for refusal and accommodation. The assistant administrator (AA)-A stated this did not happen because someone was already in the room. AA-A further stated they needed to change the new room from 245-1 to 213-2 to accommodate R21's bariatric equipment. SW-A acknowledged R21 was not offered to see either room 245-1 or 213-2 prior to the move.

In follow-up interview on 9/3/20, at 9:21 a.m., AA-A stated the initial plan was to move R21 to second floor because her discharge plan was changed from going home to going to long-term care. AA-A suggested a new Notice of Room Change should have been completed when her room change was moved up to accommodate an admission.

R21's care plan, dated 6/19/20, noted R21 would be discharged home with home health services. Care plan had not been updated since 6/19/20.

A Notice of Room Change document, signed by R21 and social worker (SW)-A on 8/18/20 stipulated R21 would be moved on 8/24/20. The document also indicated a resident was required to have 7 day notice for a room change. Several exceptions were listed for when a 7 day notice could be shortened. The exception for R21's

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	245182	A. BUILDING _____ B. WING _____	C 09/03/2020

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F 559	Continued From page 4 shortened notice for room change was marked as a change in resident's medical or treatment program. A Room Change Guideline, dated 11/28/17, indicated the facility would make every effort to minimize resident's stress during a room change, assess well-being, and resolve negative impact for a resident.	F 559		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584		10/13/20

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F 584	Continued From page 5 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure a homelike environment that protected 1 of 5 resident's (R3) property from loss or theft. Findings Include: R3's diagnoses obtained from the admission record printed on 9/3/2020, included anxiety and dementia. R3's quarterly Minimum Data Set (MDS) indicated that R3 had intact cognition. On 8/31/20, at 1:29 p.m. R3 indicated she was missing a blouse and a dress. R3 further indicated that she had told staff about the missing items. On 9/2/20, at 3:17 p.m. the administrator indicated R3 had not reported she had any missing items and any items that were reported missing would be on the concern log.	F 584	A grievance was completed for R3's missing clothing item. All residents have the potential to be impacted by this practice. All staff were educated on the procedure for missing items, including the completion of a grievance form, and follow-up resolution within 5 days. Social Worker/designee will audit grievances for proper completion, resident follow-up, and adequate timeliness weekly x 90 days. Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance.	

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F 584	Continued From page 6 During a follow up interview with R3 on 9/3/20, at 8:51 a.m., R3 indicated she had told "a lady with red hair that worked in laundry." On 9/3/20, at 9:23 a.m. during an interview with the laundry aide about R3's missing items, the laundry aide indicated R3 had told her about a green striped blouse missing about a month ago. When the laundry aide was asked what she did with the information from R3, the laundry aide indicated she came to the laundry room to look for them but did not find them. When surveyor asked if the laundry aide reported the missing items, she stated "no, I didn't report it." On 9/3/20, at 9:31 a.m. the housekeeping manager stated the expectation of staff when items were reported missing by residents was "staff are to search and report back to me if they were found or not, then I would report back to the resident and social services." On 9/3/20, at 9:41 a.m. the administrator stated the laundry aide should have reported the missing items so that a resident concern form or grievance could be filled out and a follow up would have been done with R3 about the missing items. A Grievance Guideline policy with a revision date of 4/23/18, indicated the facility would make prompt efforts (within 5 days) to resolve grievances a resident may have. The intent of the grievance process was to support resident rights about lost clothing and to assure that after receiving a complaint/grievance, the facility actively seeks a resolution.	F 584		
F 600 SS=D	Free from Abuse and Neglect	F 600		10/13/20

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F 600	Continued From page 7 CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation review, the facility failed to ensure 1 of 5 residents (R3) who were reviewed for abuse, was free from verbal abuse from another resident (R31). Findings Include: On 8/31/20, at 1:13 p.m. during an interview, R3 reported to the surveyor that when she was going to the day room/living room area to sit, "a tall gentleman cussed me out, he called me an F'in B." R3 explained that she reported the incident to a nurse the previous day and that the altercation had happened the week before. R3stated that she likes to sit in the living room/day room area and stated, "I won't go down there if he's down there in that living room." R3 further stated "I use to like to sit down there" and explained that there used to be others, about five or six people at a	F 600	Interventions to maintain safety, and comfort discussed and implemented with R3 to prevent resident to resident abuse. All residents have the potential to be impacted by this practice. LPN-A, who received initial allegation of abuse was educated immediately by Administrator upon interview regarding failure to report potential abuse/neglect. All staff educated on Vulnerable Adult Reporting, policy and procedures, and immediacy of reporting standards; including the need for immediate intervention. IDT will audit progress notes daily for reporting flags x 30 days. 5 residents/week will be audited/interviewed regarding routine care and treatment x 90	

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F 600	Continued From page 8 time, sitting in the living room area but indicated not seeing anyone any more. R3's diagnoses of anxiety and dementia was obtained from the admission record dated 9/3/20. R3's quarterly Minimum Data Set (MDS) dated 6/4/20, indicated R3 had intact cognition and R3 did not exhibit any behaviors during the assessment period. R3's care plan dated 9/18/19, identified R3 had an actual or potential vulnerability due to nursing home placement and directed staff if they observed or suspected abuse, were to remove R3 from the aggressor and relocate R3 to a safe area and staff were to immediately notify the supervisor of observed or suspected abuse per the facility and State guidelines. A nurse's note dated 8/30/20, by licensed practical nurse (LPN)-A identified [R3] had reported that when she started to walk into the day room where resident [R31] was present, R31 yelled at her to get out of "his room" and got up to approach her. Resident reported she turned around and returned to her room. On 9/1/20, at 8:46 a.m. LPN-A stated R3 did tell her of the incident on 8/30/20 and indicated the resident who had yelled at R3 was identified as R31. LPN-A explained that staff will need to work with R31 to prevent further incidences of R31 yelling at R3 from occurring, however, a specific plan had not been implemented. R31's quarterly MDS, dated 7/10/20 identified a cognitive status of 15/15 with no behaviors noted. R31 admitted to the facility 4/20/20 with diagnosis of hypertension, Schizophrenia, anxiety disorder	F 600	days. Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance.	

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F 600	Continued From page 9	F 600		

and Diabetes.

Observations were made on 9/2/20, from 9:49 a.m. to 10:10 a.m. R3 was up and dressed for the day, up and about in her room. R31 was observed sitting in the day room/living room area, using his cell phone. No altercations were observed between R31 and R3.

On 9/3/20, at 9:57 a.m. R31 was again observed in the day room/ living room area, using his cell phone. R3 remained in her room. No altercations were observed between R31 and R3.

Interview on 9/3/20, at 10:20 a.m. the administrator stated the verbal abuse did not get reported to her because she and the director of nursing (DON) came in late on Monday 8/31/20. The administrator identified that the incident needed to be reported to the State Agency and that the facility will need to begin their investigation to determine appropriate interventions.

The Villa Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of resident property policy dated 11/28/2017, defined abuse as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Abuse includes verbal abuse, sexual abuse, physical abuse and mental abuse. Section G of the policy directed the facility to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involved abuse or result

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F 600	Continued From page 10 in serious bodily injury, or not later than 24 hours if the event that cause the allegation do not involve abuse and do not result in serious bodily injury.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and	F 609	An OHFC report was filed regarding R3's	10/13/20

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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 609	Continued From page 11 documentation, the facility failed to report timely an allegation of verbal abuse to the administrator and the State Agency (SA) for 1 of 5 residents (R3) reviewed for abuse allegations. Findings Include: The Villa Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of resident property policy dated 11/28/2017, defined abuse as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Abuse includes verbal abuse, sexual abuse, physical abuse and mental abuse. Section G of the policy directed the facility to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involved abuse or result in serious bodily injury, or not later than 24 hours if the event that cause the allegation do not involve abuse and do not result in serious bodily injury. R3's diagnoses anxiety and dementia obtained from the admission record dated 9/3/20. R3's quarterly Minimum Data Set (MDS) dated 6/4/20, indicated R3 had intact cognition and R3 did not exhibit any behaviors during the assessment period. R3's care plan dated 9/18/19, identified R3 had an actual or potential vulnerability due to nursing home placement and directed staff if they observed or suspected abuse, they were to remove R3 from the aggressor and relocate R3 to	F 609	complaint. All residents have the potential to be impacted by this practice. LPN-A, who received initial allegation of abuse was educated immediately by Administrator upon interview regarding failure to report potential abuse/neglect. All staff educated on Vulnerable Adult Reporting, policy and procedures, and immediacy of reporting standards. NHA/Designee will audit progress notes daily for reporting flags x 30 days. 5 residents/week will be audited/interviewed regarding routine care and treatment x 90 days. Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance.	

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F 609	Continued From page 12	F 609		

a safe area and staff was to immediately notify the supervisor of observed or suspected abuse per the facility and State guidelines.

On 8/31/20, at 1:13 p.m. during an interview, R3 reported to the surveyor that, when she was going to the day room/living room area to sit, "a tall gentleman cussed me out, he called me an F'in B." R3 explained that she reported the incident to a nurse the previous day and that the altercation had happened the week before. R 3 stated that she likes to sit in the living room/day room area and stated, "I won't go down there if he's down there in that living room." R3 further stated "I use to like to sit down there" and explained that there used to be others, about five or six people at a time, sitting in the living room area but indicated not seeing anyone any more.

R3's diagnoses of anxiety and dementia was obtained from the admission record dated 9/3/20. R3's quarterly Minimum Data Set (MDS) dated 6/4/20, indicated R3 had intact cognition and R3 did not exhibit any behaviors during the assessment period.

R3's care plan dated 9/18/19, identified R3 had an actual or potential vulnerability due to nursing home placement and directed staff if they observed or suspected abuse, were to remove R3 from the aggressor and relocate R3 to a safe area and staff were to immediately notify the supervisor of observed or suspected abuse per the facility and State guidelines.

A nurse's note dated 8/30/20, by licensed practical nurse (LPN)-A identified [R3] had reported that when she started to walk into the day room where another resident was present,

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F 609	Continued From page 13 the resident yelled at her [R3] to get out of "his room" and got up to approach her. Resident [R3] reported she turned around and returned to her room. On 9/1/20, at 8:46 a.m., during interview, LPN-A acknowledged that R3 told her of the incident on 8/30/20. On 9/3/20, at 10:20 a.m. the administrator stated the verbal abuse did not get reported to her because she and the director of nursing (DON) came in late on Monday, 8/31/20. The administrator then indicated they will have to report it to the State Agency (SA) and begin their investigation to determine appropriate interventions. The administrator acknowledged the allegation was reported late to the SA and that the facility planned on doing further education with staff about preventing and reporting abuse, despite that it had been conducted the previous month. On 9/3/20, at 11:05 a.m. the administrator stated reporting abuse to the State Agency is completed by either herself, the DON, social services or the charge nurse. The administrator also indicated that there is always a charge nurse on duty who can call the administrator to determine responsibilities about reporting abuse.	F 609		
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	F 676		10/13/20

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F 676	Continued From page 14 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, (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 provide assistance and encouragement with meals for 1 of 3 residents (R84) reviewed for nutrition. Findings include:	F 676	All residents who require assistance with feeding have the potential to be impacted by this practice. Dietary slips were updated to reflect the residents need for assistance with feeding. Dietary department reorganized the tray line setup	

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F 676	Continued From page 15 R84's quarterly Minimum Data Set (MDS) dated 8/21/20, indicated R84 had severe cognitive impairment and required limited assistance of one person with eating. R84's care plan dated 8/11/20, identified R84 had actual activities of daily living (ADL) self-care performance deficit related to cognitive loss and schizophrenia. The care plan directed staff to set up R84 with meals to eat, provide one assist to eat meals and strong encouragement for intake. On 8/31/20, at 4:55 p.m. R84's meal tray was delivered to her room and left on bedside table by nursing assistant (NA)-B. On 8/31/20, at 5:16 p.m. R84 was observed laying in bed with eyes closed. The bed was in a low position with the head of the bed elevated at 30 degrees. The meal tray remained on the bedside table untouched. On 8/31/20, at 5:20 p.m. NA-B was observed to pick up R84's uneaten meal tray from bedside table and placed the meal tray on the metal cart in the hallway where the finished trays were being collected after being taken out of the residents rooms. During an interview on 8/31/20, at 5:21 p.m. NA-B indicated R84 did not want to eat and she had removed the tray from the room. NA-B verified she had not offered R84 an alternate meal item from the menu and also she had not encouraged and/or offered assitance to R84 with eating prior to taking the food tray out of room, as directed by the care plan.	F 676	to keep food hot for those needing feeding assistance. Social distance communal dining will be performed for those needing feeding assistance and identified as appropriate by the Interdisciplinary Team. All residents that need assistance or cueing for eating will be re-evaluated for appropriate level of dining assistance. Nursing staff were re-educated on providing proper feeding assistance to those identified as needing assistance to include appropriate setup and notification to residents when meals arrive, and encouragement for residents to eat when noted to not be initiating eating their meals. Dietitian will perform weekly audits to identify residents eating less than 25% for 90 days and report results to the interdisciplinary team. IDT will audit 5 residents/week for adequate feeding assistance x 90 days Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance.	

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F 676	Continued From page 16 On 8/31/20, at 5:28 p.m. registered nurse (RN)-A, also the unit nurse manager, stated R84 preferred minimal interaction however, indicated NA-B should have encouraged R84 to eat the meal or make an attempt to assist R84 prior to removing the tray. RN-A also stated staff were supposed to report to the nurse if R84 did not eat. RN-A verified NA-B did not report to the nurse that R84 had not eaten. On 9/3/20, at 2:00 p.m. the meal assistance policy was requested, but was not provided.	F 676		
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 interview and record review, the facility failed to accommodate preferences for assistance with toileting, in accordance with the care plan, for 1 of 8 residents (R21) reviewed for activities of daily living (ADL). Findings include: R21's admission Minimum Data Set (MDS) dated 6/24/20, identified R21 had intact cognition, required extensive physical assistance of two staff with toilet assistance and was was occasionally incontinent of both bowel and bladder. R21's diagnoses included morbid obesity, difficulty walking, post-laminectomy syndrome, and muscle weakness obtained from the MDS.	F 677	R21 was reassessed for toileting needs, transfer status, and diuretic medications to optimize R21's plan of care and preferences related to toileting. All resident's dependent on staff for toileting were reviewed for accuracy of assessment, effectiveness of interventions, and satisfaction with their current plan of care. Nursing staff re-educated on following the ADL plan of care for each resident. DON/Designee will audit 5 residents/week for prompt toileting assistance and adherence to their ADL plan of care x 90 days.	10/13/20

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F 677	Continued From page 17 R21's care plan, dated 6/17/20, identified R21 had inability to do cares because of lower extremity difficulty. The care plan revised 9/2/20, indicated R21's preference to use the EZ Stand (a mechanical lift) to transfer to the commode for toileting. Also the care plan directed nurses to use the EZ Stand for all transfers when R21 used the commode. In addition, the care plan indicated R21 was "Okay with a bedpan at night but still preferred to use the commode." During interview on 8/31/20, at 3:29 p.m. R21 expressed a preference to use the commode for toileting and with two staff needed to use the EZ Stand to transfer her to the commode. R21 stated when one person answered her call light, they had to leave to go get another person. R21 further stated "I can't wait because I take Lasix, so I just use the bedpan." During observation on 9/1/20, at 2:47 p.m. nursing assistant (NA)-A and registered nurse (RN)-A nurse manager were observed use the EZ Stand to transfer R21 from the wheelchair to a commode. During the observation, it took both staff to put sling around R21 and to transfer R21 onto the commode. During interview on 9/2/20, at 9:46 a.m. NA-A stated R21 needed the EZ Stand for transferring from bed to toilet and it took two people to use the EZ Stand. NA-A then stated "At night, there was only one NA on the unit and one nurse covered the 3 units on the floor. The nurse could sometimes help but if they were busy, a nursing assistant had to leave another unit to come assist." NA-A also stated R21 cannot hold her urine and if it took a long time to get a second	F 677	Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance.	

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F 677	Continued From page 18 person to assist, R21 would use a bedpan. NA-A also stated R21's preference was to use the EZ Stand to get on the commode and when R21 used the bedpan, it was difficult to get R21 off the bedpan without spilling urine. and they would have to clean R21 and change the bed linens because of the spilled urine. NA-A estimated she could get assistance to transfer R21 to the commode two out of five times during a shift. During interview on 9/2/20, at 11:38 a.m., RN-A stated R21 preferred to use the commode. RN-A explained being able to assist when available but otherwise two nursing assistants were needed to use the EZ stand to assist R21 on the commode. During interview on 9/2/20, at 2:02 p.m., RN-A acknowledged R21 preferred to use the commode versus a bedpan for her toileting needs.	F 677		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI 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	F 690		10/13/20

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F 690	Continued From page 19 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 review, the facility failed to comprehensively assess and develop interventions to reduce urinary incontinence or associated complications for 1 of 3 residents (R21) reviewed for bowel and bladder and who had repeated episodes of incontinence. Findings include: R21's admission Minimum Data Set (MDS), dated 6/24/20, identified R21 had intact cognition and required extensive assistance with toileting. Further, R21 was recorded as having occasional urinary incontinence (less than 7 episodes during the review period), however, had not been trailed on a toileting plan.	F 690	R21 Had a new Comprehensive Bowel & Bladder Assessment completed and Toileting Schedule/Plan was updated based on results of the assessment. Nursing met with R21 to discuss updated toileting plan and acceptance of plan. All residents who are coded as mixed continence/incontinence on the MDS assessment for bowel/bladder were reviewed for completion of a bowel & bladder assessment, accuracy of assessment, implementation of interventions, and revisions of care as needed to maintain continence as appropriate. Nursing staff educated on individualized	

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F 690	Continued From page 20 R21's Nursing Evaluation - V4 assessment, dated 6/17/20, identified a section labeled, "Section I: Bladder/Bowel/Dialysis," which identified R21 as being continent of bladder. Further, R21's care plan, revised 9/2/20, identified R21 had functional and stress incontinence. The care plan lacked evidence of R21's urinary incontinence, or subsequent interventions to reduce it, prior to 9/2/20. When interviewed on 9/2/20, at 9:46 a.m. nursing assistant (NA)-A stated R21 used a mechanical stand for toileting, however, if staff were not able to respond timely R21 would then be incontinent of urine. R21 was not on any scheduled toileting program to her knowledge, and NA-A verified R21 had sensation to feel the urge to void and could alert staff to it. On 9/2/20, at 10:15 a.m. R21 was seated in her wheelchair by the elevator, and had a noticeable urine odor on her. R21's POC (Point of Care) Response History, dated 8/20/20 to 9/2/20, identified R21 had a total of 14 episodes of urinary incontinence recorded. Further, R21's progress note(s), dated 8/30/20, identified R21 had been incontinent of urine and required a "total bed change this shift X 2" on the overnight shift. R21's medical record was reviewed and lacked evidence R21 had been comprehensively assessed for her urinary incontinence despite multiple recorded episodes of incontinence which, at times, required total linen changes. Further, there was no evidence the facility had attempted or trialed a toileting program to reduce R21's incontinence.	F 690	toileting plans. MDS staff re-educated on reporting to IDT when residents are triggering for a decline in incontinence. DON/Designee will conduct weekly audits on 5 residents with incontinence x 90 days. MDS staff will notify Interdisciplinary Team (IDT) when residents trigger for a decline in incontinence-IDT will complete a comprehensive review, care plan and revision of interventions as appropriate. Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance.	

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F 690	Continued From page 21 During interview on 9/2/20, at 11:38 a.m., registered nurse (RN)-A stated she was unaware if R21 had the sensation to void or not, and felt any incontinence could be a sign of urge incontinence. RN-A voiced urinary incontinence should be assessed upon admission and then quarterly thereafter. RN-A reviewed R21's medical record and verified her admission assessment (Nursing Evaluation - V4) identified R21 to be continent and added she was unaware R21 was having repeated episodes of urinary incontinence despite them being recorded in the medical record. RN-A reviewed R21's medical record and verified a comprehensive bladder assessment had never been completed for R21 and should have been adding the NA should have been reporting the incontinence to the nurses so it could be addressed. During interview on 9/2/20, at 2:02 p.m. assistant director of nursing/nurse manager (ADON) verified residents should be assessed for bladder incontinence upon admission through a three-day observation period. ADON also stated the care plan would then be updated to reflect the incontinence and subsequent interventions to reduce it. ADON reviewed R21's medical record and verified a comprehensive bladder assessment had not been completed for R21 since she was identified to have urinary incontinence and should have been. A policy on bladder assessment was requested, however, was not received on 9/3/20.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		10/13/20

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F 695	Continued From page 22 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident's (R69) Bilevel Positive Airway Pressure (BiPAP) mask was properly cleaned related to respiratory care. Findings include: R69's diagnoses obtained from the admission record printed on 9/3/20 included respiratory failure, shortness of breath, chronic obstructive pulmonary disease (COPD), sleep apnea, and heart failure. R69's quarterly Minimum Data Set (MDS) dated 8/13/20, indicated R69 had intact cognition, and needed extensive assist of one to two staff with activities of daily living (ADL's). On 8/31/20, at 2:36 p.m. during an interview R69 stated she wore a BiPAP at night and that staff did not clean the BiPAP mask. R69 then stated since being re-admitted to the facility on 8/6/20, staff had not cleaned her BiPAP. During interview the BiPAP mask was observed having dried white crusted particles on the inside of the mask. On 9/2/20, at 10:24 a.m. R69's BiPAP mask was	F 695	R69's Bipap was cleaned immediately and Bipap use was added to R69's care plan. Residents that utilize C-PAPs, Bipaps, or Nebulizers have the potential to be impacted by this practice. Nurses educated on the proper cleaning technique, frequency, and care of C-paps, Bipaps, and nebulizers. DON/Designee will audit 10 residents who utilize respiratory equipment for proper cleaning weekly x 30 days, then audit 5 residents/weekly x 60 days. Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance	

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	245182	A. BUILDING _____ B. WING _____	C 09/03/2020

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 695	Continued From page 23 observed again to have spotty cloudy thick white particle build-up on the inside of the mask. On 9/2/20, at 12:25 p.m. during an interview with the director of nursing (DON) indicated that the BiPAP is supposed to be cleaned every day. After observation of the BiPAP mask, the DON indicated that the face area on BiPAP needs to be cleaned and that it needs to be cleaned every day. The August 2020 Medication Administration Record (MAR) was reviewed and revealed as of 8/6/20, R69 had an an order for staff to wipe the BiPAP mask daily with a damp cloth. The MAR also revealed staff were signing off completing the task daily despite the mask being observed to not be clean. In addition, R69's care plan did not indicate R69 used a BiPAP. A procedure manual for Resmed Airfit/Airtouch full face mask directed daily after each use the mask was to be disassembled, the frame, elbow and cushion was to be ran under water and cleaned with a soft brush until dirt is removed. In addition, the procedure directed staff to soak the components in warm water with a mild liquid detergent for up to 10 minutes, brushing the moving parts of the elbow and around the vent holes. Then leave the components to air dry.	F 695		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by:	F 760		10/13/20

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	245182	A. BUILDING _____ B. WING _____	C 09/03/2020

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F 760	Continued From page 24 Based on observation, interview, and documentation the facility failed to ensure that a significant medication error did not occur for 1 of 2 resident (R592) observed to receive insulin from a flexpen. Findings Include: R592's diagnoses included type two diabetes and a fracture of the ulna (bone in the forearm) obtained from the admission record printed on 9/3/20. R592's admission Minimum Data Set (MDS) dated 8/19/20, indicated R592 had severely impaired cognition. R592's care plan dated of 8/12/20, identified R592 had a nutritional problem or potential for nutritional problem due to diabetes and the care plan directed staff to administer medications as ordered. On 8/31/20, at 4:20 p.m. the surveyor intervened prior to registered nurse (RN)-A administering Novolog insulin via Flexpen to R592. When asked if she had primed the insulin pen, RN-A stated "I was taught that when the pen is new, you do it." RN-A also stated "no, we prime the pen when it's first new." When surveyor explained to RN-A when and why the Flexpen was primed, RN-A responded with "oh ok" but still proceeded to give insulin to R592 without priming it despite surveyor explanation. August Medication Administration Record (MAR) indicated R592 received Novolog Flexpen three times a day before meals and eight units was to be injected subcutaneously (just under the skin).	F 760	Medication error was completed on R592's insulin administration on 8/31/20. RN-A was re-educated on on the proper priming/administration of insulin pen. All diabetic residents receiving insulin administration have the potential to be affected by this practice. All nurses educated on the proper technique of insulin pen priming, administration, storage, and expiration. DON/Designee will audit 10 residents receiving insulin administration weekly x 30 days, then 5 residents receiving insulin administration weekly x 60 days. Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance.	

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F 760	Continued From page 25	F 760		

From the dates of 8/18/20, through 8/31/20, of August's MAR, R592's blood sugars ranged from 101 to 360.

On 9/2/20, at 8:41 a.m. RN-B stated during an insulin administration she primed every time a new needle is added to the Flexpen. RN-B further stated "I heard I don't have too, but I do each time."

During an interview on 9/3/20, at 11:01 a.m. the consultant pharmacist stated "I always refer back to facility policy, but the standard is to prime with two units prior to administration, this ensures that the dose that is dialed is the dose that is administered."

During an interview on 9/3/20, at 11:08 a.m. the director of nursing (DON) stated the expectation for Flexpens was all insulin pens would be primed with two units prior to administration to ensure that there is no air in the system.

The Insulin Administration policy/procedure revised 10/2010, was reviewed but lacked documentation on instructions on priming an insulin Flexpen.

Instructions for use of Novolog Flexpen with a revision date of 11/2019, indicated step by step instructions on giving the airshot before each injection. The instructions indicated before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing the following steps were to be taken: E. Turn the dose selector to select two units. F. Hold the Novolog Flexpen with the needle point up, tap the cartridge gently with your finger a few times to make any air bubbles

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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 760	Continued From page 26 collect at the top of the cartridge. G. Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to zero. A drop of insulin should appear at the needle tip.	F 760		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		10/13/20

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F 880	Continued From page 27 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure appropriate hand hygiene/gloving, donning of personal protective equipment (PPE), and cleaning equipment in a manner to prevent the potential	F 880	All residents have the potential to be affected by this practice. Staff re-educated on the appropriate guidelines for hand washing and glove	

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	245182	A. BUILDING _____ B. WING _____	C 09/03/2020

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F 880	Continued From page 28 spread of infection for 4 of 5 residents (R36, R35, R14, R58) reviewed for infection control. Findings include: R36 who resided on a unit for COVID exposure observation, was observed on 9/2/20, at 7:33 a.m. during morning cares. Nursing assistant (NA)-C was observed to enter R36's room, after applying a gown and gloves outside the room in the hallway. -At 7:38 a.m. as NA-C applied socks on R36's feet, R36 reported she was experiencing pain. NA then stated to R36 "I can get the nurse for you." NA-C finished to apply the socks and as she stood by the bed registered nurse (RN)-D came into the room carrying a medication in a small cup with water as she approached R36. -At 7:40 a.m. as RN-D approached R36 who stated to RN-D she was experiencing pain to both her legs. RN-D gave the medication at hand and told R36 she was going to get the cream for her legs and would be right back. Before leaving the room the pain cream was noted to be on top of the counter by the sink.RN-D squeezed cream out of the bottle, approached R36's bed and applied the cream to both knees on the top and under the knees, per R36's request. RN-D's scrubs were observed to touch R36's legs and bedding. RN-D was not wearing a gown despite R36 being on droplet precautions due to Covid exposure. RN-D then removed her gloves, washed hands before she left R36's room and continued with the medication pass for other residents. -At 7:46 a.m. NA-C assisted R36 to sit on the edge of the bed and put her shoes on. As NA-C applied the shirt, R36 stated to NA-C she wanted Asper cream to be applied to her left arm. RN-D	F 880	usage practices during resident care techniques, and proper protocol for use of slings. All staff re-educated on the infection prevention via proper Donning/Doffing practices of Personal Protective Equipment, and CDC guidance for droplet precautions. See also POC for F695 DON/Infection Preventionist/Designee will conduct routine audits on all shifts 4x/week x 1 week, then 2x/week x 1 week, then weekly on random shifts thereafter for a total of 12 weeks. Audit results will be reviewed at QAPI to determine the need to continued monitoring and compliance.	

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	245182	A. BUILDING _____ B. WING _____	C 09/03/2020

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F 880	Continued From page 29	F 880		

returned to the room, did not apply a gown, and again RN-D's scrubs were observed to touch R36 and the bedding as she applied the Asper cream to both of R36's arms. RN-D then removed gloves and washed hands before leaving the room.
-At 7:50 a.m. NA-C cued R36 she was going to assist her to the commode using a mechanical machine. NA-C looked at the lift sheet for the machine and stated the one in the room was too big. NA-C then removed the PPE, washed hands, and left the room.
-At 7:53 a.m. NA-C came back into R36's room and stated another staff was getting her the right size lift sheet to use to transfer R36.
-At 7:57 a.m. NA-C applied the correct lift sheet to R36's torso then hooked it to the mechanical lift and then was observed to get R36 off the bed into a standing position using the mechanical lift and then sat R36 on the commode which was next to the bed.
-At 8:04 a.m. NA-C cued R36 she was going to get her to a standing position as she brought her up. NA-C then was observed to provide front pericare then proceeded to do the pericare in the back. NA-C then with the same gloves adjusted R36's adult dignity pad and pants then went over and grabbed the wheelchair still with the same gloves and put it behind R36. NA-C then removed the right glove, lowered R36 into the wheelchair then removed the left glove. NA-C still without washing hands applied another pair of gloves and proceeded to clean the mechanical lift. When questioned, NA-C acknowledged she was supposed to remove gloves and wash hands before continuing with tasks.
-At 8:12 a.m. NA-B entered R36's room and was observed to wheel the mechanical lift and lift sheet used for R36 to the hallway. NA-B

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	245182	A. BUILDING _____ B. WING _____	C 09/03/2020

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F 880	Continued From page 30	F 880		

proceeded to take the lift and the lift sheet out of Station 3 which was a quarantine unit, due to Covid exposure, and went down the Station 4 hallway.
-R35, at 8:18 a.m., NA-B entered R35's room as NA-D pushed the mechanical lift with the lift sheet into the room and shut the door.
-At 8:20 a.m. surveyor entered R35's room and did not see any other lift sheet except the one on top of the mechanical lift from R36's room.
-At 8:27 surveyor re-entered R35's room to observe the transfer. When NA's were asked if residents were supposed to share lift sheets NA-B stated "yes we do. we do clean it between residents which we did" as she pointed to the garbage to show the wipes used. NA's then applied the lift sheet used for R36 around R35's torso and hooked R35 into the mechanical lift and and both NA's were observed to transfer R35 into the wheelchair. After transferring R35 to the wheelchair NA-B was observed to clean the mechanical lift and wiped down the cloth material lift sheet before taking it out of R35's room.

On 9/2/20, at 9:09 a.m. registered nurse (RN)-A nurse manager stated "each person should have their own sling sheet." Regarding hand hygiene RN-A stated staff was supposed to remove gloves, wash hands and put clean gloves on before they continued with cares when staff went from dirty to clean and after pericare. Also RN-A stated "If staff was doing direct care they are to apply gloves and gown and remove when leaving room in Station 3, which was quarantine unit."

On 9/3/20, at 1:27 p.m. the director of nursing (DON) stated staff was supposed to perform hand hygiene before and after providing cares. Also staff was to wash hands prior and after they

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	245182	A. BUILDING _____ B. WING _____	C 09/03/2020

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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 880	Continued From page 31	F 880		

removed gloves. The DON further stated staff was supposed to wear a gown and gloves when they provided direct care for a resident in the quarantine unit Station 3.

R14, on 9/2/20, at 7:08 a.m. nursing assistant (NA)-A was observed to apply a gown in the hallway with the opening towards the front as she stood outside R14's room who was on quarantine due to a recent COVID exposure. As NA-A entered R14's room the gown was observed to be partially open in the front as she approached R14 to transfer her from bed to the wheelchair. During the observation, NA-A scrubs were touching R14's clothing.

During an interview on 9/2/20, at 7:12 a.m. NA-A stated she had been provided education on donning and doffing protective personal equipment months prior and indicated the gown was applied properly.

R58, on 9/2/20, at 7:46 a.m. NA-A again was observed apply a gown in the hallway with the opening towards the front and gown was partially opened as NA-A entered R58's room who was on quarantine due to a recent Covid exposure. NA-A then was observed to approach R58 to assist with getting dressed for the day. During the observation, NA-A scrubs were observed to touch R58's body and then clothing after R58 was dressed.

During an interview on 9/2/20, at 8:03 a.m. NA-A indicated the PPE gown was put on backwards with the opening toward the front since there was not any available staff to help tie the gown and she did not want to remove gown to find another staff member to help to tie it. NA-A acknowledged

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	245182	A. BUILDING _____ B. WING _____	C 09/03/2020

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 880	Continued From page 32	F 880		

her scrubs were exposed as she assisted R58 and R14's while providing direct contact care. NA-A verified the proper donning of the PPE gown was to don the gown with the opening to the back and tied it to prevent her scrubs being exposed.

During an interview on 9/2/20, at 8:35 a.m. registered nurse (RN)-A indicated R58, R14 and the entire Station 3 was on droplet precautions due to an exposure from a positive Covid staff. RN-A stated the proper way to don a PPE gown was to have the opening to the back and was supposed to be tied to ensure clothing was fully covered. RN-A also stated the staff had been educated several months ago regarding donning and doffing of PPE and there were signs posted by every room on how to don and doff PPE for reminders.

During interview on 9/3/20, at 9:09 a.m. the DON indicated the proper way to don a PPE gown was with the opening toward the back and was to be tied to not expose clothing. The DON also stated staff was supposed to properly apply PPE to prevent the spread of infection. The DON further stated the facility used the Centers for Disease Control (CDC) guidelines for donning and doffing of PPE.

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 _____	**09/08/2020**

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 000	INITIAL COMMENTS FIRE SAFETY 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. An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on September 08, 2020. 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, the Health Care Facilities Code. 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 | 10/01/2020

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.

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 _____	**09/08/2020**

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 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 description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. 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 notification. The facility has a capacity of 114 beds and had a census of 83 at the time of the survey.	K 000		

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 _____	**09/08/2020**

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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K 000	Continued From page 2 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, 19.5.2.1 and NFPA 90A (2012), Standard for the Installation of Air-Conditioning and Ventilating Systems. This deficient practice could affect all 83 residents. Findings include: On a facility tour between the hours of 10:00 AM and 2:00 PM on September 08, 2020, it was revealed that the ventilation system has supply ducts serving the resident corridors without return ducts in the corridors. It appears that the only return is through the continuous operation of the resident room bathroom fans. Date of building construction is 1971. This deficient practice was verified by the Director	K 521	Please find our waiver request for K521 attached.	10/13/20

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 _____	**09/08/2020**

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 of Facilities Maintenance at the time of discovery.	K 521		

Name of Facility Villa at St. Louis Park

2012 LIFE SAFETY CODE

PART III – RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety Code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K521	INSTRUCTIONS FOR COMPLETING AN ANNUAL/CONTINUING WAIVER REQUEST An annual/continuing waiver is being requested for K-521 A. Compliance with this provision will cause an unreasonable hardship in accordance with CMS SOM 2480C because of the following: 1. The most recent cost estimate for complying HVAC dated 6/24/19 is $5243,000 and will include the upgrade of the following systems; install 3 new rooftop units and reconfigure one existing unit. Duct work to run on roof and penetrate above resident rooms. Plus an additional $27,000 to install sheet rock enclosures and 23 vertical ducts in resident rooms. 2. Installing a complying HVAC system will force disruption to the facility residents by displacing during the period of installation in specific room and add to noise and dust levels for an extended period of time. In 23 resident rooms, spaces available to residents will be negatively reduced. 3. Under current CMS reimbursement rates, it is estimated to take 20 or more years to recoup the cost. 4. Given the facilities financial condition, it would be difficult to acquire a loan in the amount of the estimate. However, a bank loan at 5% over 20 years would add $300,000 in interest to the cost of the project. The annual cash burden for the loan would be $35,479. 5. The building is 49 years old and is not slated for replacement. B. There will be no adverse effect on the building occupant's safety in accordance with SOM 2480B. 1. The building is Type II(2222) construction with an interior finish ration Class A. 2. The walls, floors, ceiling and vertical openings resist the passage of smoke. 3. The following life safety features are installed: Notifier fire alarms throughout; Reliable and Tyco brand sprinkler system throughout

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date
Thomas Lindell 12424	FIRE SAFETY SUPERVISOR	MN STATE FIRE MARSHAL	10-2-20

GILBERT

Gilbert Mechanical Contractors, Inc
Gilbert Electrical Technologies
4451 West 76th Street
Minneapolis, MN 55435
Phone: (952) 835-3810
Fax: (952) 835-4765

HVAC • Plumbing • Electrical • Controls • Fire Protection • Service

Company:	The Villa at Saint Louis Park	**Date:**	06/24/19 (revised from 08/06/18)
Street:	7500 West 22nd Street	**Project:**	Westwood Health Care – Ducted
City/State:	Saint Louis Park, MN 55426		Fresh Air to Resident Rooms
ATTN:	Kent Netzer	**Pages**	2

Proposal

Gilbert Mechanical Contractors will provide the necessary labor and materials to complete the following at 7500 West 22nd Street in Saint Louis Park:

Installation of (3) new Aaon heat/cool roof top units and reconfigure/reuse (1) existing Aaon heat/cool unit to directly serve fresh air to resident rooms. Installation of double wall insulated distribution ductwork across roof to each of the resident rooms. One new 15 ton 100% outside air unit will replace existing Reznor make-up-air unit and serve the east wing 1st and 2nd floors. One existing 15 ton 100% outside air unit will be reconfigured and used to serve the west wing 1st and 2nd floors. One new 6 ton 100% outside air unit will be installed to serve the south wing 2nd floor. One new 10 ton 50% outside air unit will replace existing Reznor make-up-air unit and serve the center common area on first and second floor. We are delivering air to a total of 87 resident rooms. Ductwork will be run on the roof and penetrate above resident rooms. Ductwork will run through roof to a registers in the second floor resident rooms and continue through a fire damper at the floor to registers in the first floor resident rooms. The installation of these systems will achieve 2 air changes of fresh air per hour in the resident rooms. Work specifically includes: (2) new Aaon double wall construction 100% outside air heat/cool roof top units, (1) new Aaon double wall construction 50% outside air heat/cool roof top unit, reconfiguration of one existing Aaon roof top unit, roof top unit curbs, duct penetration curbs, duct support bucks, roofing for all duct roof curbs/supports/roof top units, core drilling and saw cutting of holes through roof and floors, double wall insulated ductwork on roof, single wall externally insulated ductwork inside space, supply air registers & return air grill, fire dampers at penetrations through first floor ceiling, gas piping to new units, power wiring, discharge air temp control with space temperature override, control wiring, smoke detector inside unit, remove & dispose of existing units, crane, professional mechanical engineering, drawing, labor, material, taxes, check/test/start, air balance and one year warranty

Amount: $543,000.00 (budget price)

Add: $730.00 to $1,920.00 for structural engineering. This should not be necessary but the city may require it.

Add: $28,000.00 (rough approximate price) to have a general contractor install sheet rock enclosures around each of approximately 23 vertical ducts in the resident rooms as a result of this project. You may also want to have a contingency fund for patching and painting at penetrations (approximately $8,000.00?)

Exclusions:

Work to be performed during normal working hours.
We have not included any asbestos abatement.
Pricing is based on 2019 installation costs.

Payment Terms: Project will be invoiced monthly as work progresses. Invoice terms are net 30 days.

Proposed By:
Gilbert Mechanical Contractors, Inc.

_____ Date: 4/24/19
Ed Dahlgren
Vice President, PE

Accepted By:

_____ Date: _____
Print Name: _____

Name of Facility Villa at St. Louis Park

2012 LIFE SAFETY CODE

PART III – RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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Surveyor *(Signature)*	Title	Office	Date
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Thomas Lindell 12424	FIRE SAFETY SUPERVISOR	MN STATE FIRE MARSHAL	10-2-20

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HVAC • Plumbing • Electrical • Controls • Fire Protection • Service

Company:	The Villa at Saint Louis Park	**Date:**	06/24/19 (revised from 08/06/18)
Street:	7500 West 22nd Street	**Project:**	Westwood Health Care – Ducted
City/State:	Saint Louis Park, MN 55426		Fresh Air to Resident Rooms
ATTN:	Kent Netzer	**Pages**	2

Proposal

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Amount: $543,000.00 (budget price)

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We have not included any asbestos abatement.
Pricing is based on 2019 installation costs.

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Proposed By:
Gilbert Mechanical Contractors, Inc.

_____ Date: 4/24/19
Ed Dahlgren
Vice President, PE

Accepted By:

_____ Date: _____
Print Name: _____

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 21, 2020

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

Re: State Nursing Home Licensing Orders
Event ID: 3TV911

Dear Administrator:

The above facility was surveyed on August 31, 2020 through September 3, 2020 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:

Susanne Reuss, Unit Supervisor
Metro C Survey Team
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: susanne.reuss@state.mn.us
Phone: (651) 201-3793

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.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@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 09/03/2020

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) COMPLETE DATE
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 August 31, 2020, through September 3, 2020, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Additionally, complaints were investigated and the following complaints were found to be	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 UNSUBSTANTIATED: H5182084C, H5182085C and H5182086C The following complaint was found to be SUBSTANTIATED: H5182083C however, no deficiencies were issued because the facility had implemented interventions before the survey was conducted. 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 surveyors findings are the Suggested Method of Correction and Time period for Correction.	2 000		
2 435	MN Rule 4658.0210 Subp. 2 A.B. Room Assignments Room assignment complaints. A nursing home must develop and implement written policies and procedures for addressing resident complaints, including complaints regarding room assignments and roommates. At a minimum, the policies and procedures must include the following: A. a mechanism for informal dispute resolution of room assignment and roommate complaints; and B. a procedure for documenting the complaint and its resolution.	2 435		10/13/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 435	Continued From page 2 This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to provide proper notification of room change for 1 of 3 residents (R21) reviewed for beneficiary notice. Findings include: R21's admission Minimum Data Set (MDS) dated, 6/24/20, identified R21 had a Brief Interview of Mental Status (BIMS) score of 15 relevant diagnoses of morbid obesity, difficulty walking, post-laminectomy syndrome, and muscle weakness. During interview on 8/31/20 at 8:54 a.m., R21 verbalized being upset because she was moved from first floor to second floor. R21 became teary and repeatedly said, "it's depressing up here." When asked what was depressing, R21 responded, "it's just bad up here." R21 acknowledged she received a 7 day notice of the move but she was moved after only 4 days. R21 denied being offered an opportunity to see the new room or meet her new roommate. R21 was unsure of reason for room change but thought it had something to do with insurance. R21 verbalized she was so upset she did not let staff help her pack her belongings. During a follow-up interview on 9/3/2020, at 12:17 p.m., R 21 again verbalized being very upset at having to leave the first floor and expressed how depressing it was on second floor. R21's admission record, dated 6/17/20, indicated	2 435	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 435	Continued From page 3 she was admitted to Station 1 [on first floor] for quarantine during first 14 days of admission. R21's progress note, dated 7/7/20, indicated she was notified of a move to Station 2 [still on first floor] after completion of quarantine and she had no concerns. R21's progress note, dated 7/8/20, indicated she was moved from Room 114 to Room 132. R21's progress note, dated 8/20/20, indicated she was notified she would be moved that day to second floor and she was very upset because she had previously been told she would move on 8/24/20. The progress note also indicated R21 was to move to room 245-1. R21's progress note, dated 8/21/20, indicated R21 was moved from room 131 to room 213-2 because the room was not available the previous day. During interview on 9/2/20, at 2:33 p.m., social worker (SW)-A acknowledged R21 should have been given a 7 day notice for a room change. SW-A stated the room change was moved from 8/24/20 to 8/20/20 to accommodate the new admission of a male resident who was COVID-19 negative. SW-A acknowledged a resident had a right to be shown a new room and given the opportunity for refusal and accommodation. The assistant administrator (AA)-A stated this did not happen because someone was already in the room. AA-A further stated they needed to change the new room from 245-1 to 213-2 to accommodate R21's bariatric equipment. SW-A acknowledged R21 was not offered to see either room 245-1 or 213-2 prior to the move.	2 435		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 435	Continued From page 4 In follow-up interview on 09/03/20, at 9:21 a.m., AA-A stated the initial plan was to move R21 to second floor because her discharge plan was changed from going home to going to long-term care. AA-A suggested a new Notice of Room Change should have been completed when her room change was moved up to accommodate an admission. R21's care plan, dated 6/19/20, noted R21 would be discharged home with home health services. Care plan had not been updated since 6/19/20. A Notice of Room Change document, signed by R21 and social worker (SW)-A on 8/18/20 stipulated R21 would be moved on 8/24/20. The document also indicated a resident was required to have 7 day notice for a room change. Several exceptions were listed for when a 7 day notice could be shortened. The exception for R21's shortened notice for room change was marked as a change in resident's medical or treatment program. A Room Change Guideline, with an effective date of 11/28/17, indicated the facility would make every effort to minimize resident's stress during a room change, assess well-being, and resolve negative impact for a resident. SUGGESTED METHOD OF CORRECTION: The licensed social workers (LSWs) could revise policies and procedures to ensure residents received required notice of room changes and documentation to that effect could be maintained in the resident records on the room changes. The LSW or designee could complete audits and report the findings to the quality assurance committee.	2 435		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 435	Continued From page 5 TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 435		
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 interview and record review, the facility failed to accommodate preferences for assistance with toileting, in accordance with the care plan, for 1 of 8 residents (R21) reviewed for assistance with activities of daily living (ADL). Findings include: R21's admission Minimum Data Set (MDS) dated, 6/24/20, identified R21 had a Brief Interview of Mental Status (BIMS) score of 15, preferences for her customary routine, and substantial assistance with toileting. The MDS further noted relevant diagnoses of morbid obesity, difficulty walking, post-laminectomy syndrome, and muscle weakness. R21's care plan, initiated on 6/17/20, noted an inability to do cares because of lower extremity difficulty. Interventions, dated 9/2/20, included R21's preference to use the EZ Stand to transfer to the commode for toileting. -Okay with a bedpan	2 835	Corrected	10/13/20

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 09/03/2020

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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2 835	Continued From page 6 at night but still preferred to use the commode. R21's care plan, dated 6/17/20, instructed nurses to use the EZ Stand for all transfers and when R21 used the commode. During interview on 8/31/20, at 3:29 p.m., R21 expressed a preference to use the commode for toileting and two staff needed to use the EZ Stand to transfer her to the commode. If one person answered her call light and they had to leave to go get another person, R21 stated "I can't wait because I take Lasix, so I just use the bedpan." During observation on 9/1/20, at 2:47 p.m., nursing assistant (NA)-A and director of nursing/nurse manager (ADON)-G used the EZ Stand to transfer R21 from the wheelchair to a commode. It took both staff to put sling around R21. During standing and pivoting, the ADON-G controlled the EZ Lift while NA-A assisted with positioning and movement of R21. During interview on 9/2/20, at 9:46 a.m., nursing assistant (NA)-A stated R21 needed the EZ Stand for transferring from bed to toilet and it took two people to use the EZ Stand. At night, there was only one NA on the unit and one nurse covered the floor [3 units]. The nurse could sometimes help but if they were busy, a nursing assistant had to leave another unit to come assist. NA-A stated R21 cannot hold her urine and if it took a long time to get a second person to assist, R21 would use a bedpan. NA-A stated R21's preference was to use the EZ Stand to get on the commode. NA-A stated when R21 used the bedpan, it was difficult to get R21 off the bedpan without spilling urine. The NA-A would have to clean R21 and change the bed linens because of the spilled urine. NA-A estimated she could get	2 835		

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2 835	Continued From page 7 assistance to transfer R21 to the commode in only two out of five times during a shift. During interview on 9/2/20, at 11:38 a.m., registered nurse (RN)-A stated R21 preferred to use the commode and RN-A assisted when she could. Otherwise, two nursing assistants needed to use the EZ stand to get R21 on the commode. During interview on 9/2/20, at 2:02 p.m., ADON-G acknowledged R21 preferred to use the commode versus a bedpan for her toileting needs. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service all direct care staff on the need to follow the residents comprehensive care plan regarding treatments and services that are needed to meet the residents needs. The DON or designee could conduct audits and report the results to the quality assurance assurance to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 835		
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every	2 840		10/13/20

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2 840	Continued From page 8 other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to comprehensively assess and develop interventions to reduce urinary incontinence or associated complications	2 840	Corrected	

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2 840	Continued From page 9 for 1 of 3 residents (R21) reviewed for urinary elimination. Findings include: R21's admission Minimum Data Set (MDS), dated 6/24/20, identified R21 having occasional urinary incontinence. R21's admission assessment, dated 6/17/20, noted R21 had urinary continence. R21's Nursing Evaluation - V4 assessment, dated 6/17/20, identified a section labeled, "Section I: Bladder/Bowel/Dialysis," which identified R21 as being continent of bladder. R21's care plan, revised 9/2/20, identified R21 had functional and stress incontinence. The care plan lacked evidence of R21's urinary incontinence prior to 9/2/20. When interviewed on 9/2/20, at 9:46 a.m. nursing assistant (NA)-A stated R21 used a mechanical stand for toileting, however, if staff were not able to respond timely R21 would be incontinent of urine. R21 was not on any scheduled toileting program to her knowledge, and NA-A verified R21 had sensation to feel the urge to void and could alert staff to it. On 9/2/20, at 10:15 a.m. R21 was seated in her wheelchair by the elevator, and had a noticeable urine odor about her. R21's POC (Point of Care) Response History, dated 8/20/20 to 9/2/20, identified R21 had a total of 14 episodes of urinary incontinence recorded. Further, R21's progress note(s), dated 8/30/20, identified R21 had been incontinent of urine and required a "total bed change this shift X2" on the overnight shift.	2 840		

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2 840	Continued From page 10 R21's medical record was reviewed and lacked evidence R21 had been comprehensively assessed for her urinary incontinence despite multiple recorded episodes of incontinence which, at times, required total linen changes. During interview on 9/2/20, at 11:38 a.m., registered nurse (RN)-A stated she did not know if R21 was aware she had to go or if she just could not hold her urine. RN-A thought R21's incontinence might be more of a form of urgency. RN-A stated incontinence should be assessed for a resident upon admission and then quarterly [on the MDS]. In between MDS assessments, RN-A stated if a resident was continent 90% of the time, they did not need a urinary assessment; if less than 90% of the time, then the RN would do a urinary assessment. RN-A was unaware of R21's frequency of incontinence documented in the medical record. RN-A stated the expectation was nursing assistants report to the nurse any episode of incontinence and the nurse would then do an assessment. RN-A verified there was no assessment of R21's urinary incontinence since admission. During interview on 9/2/20, at 2:02 p.m., assistant director of nursing/nurse manager (ADON)-G stated the expectation was a resident was assessed for urinary incontinence on admission and then again during a 3 day observation period. After that time, if the resident had an episode of incontinence, then the expectation was the resident had another 3 day observation period and adjustment of care plan. The ADON-G stated it was the expectation that a nursing assistant informed the nurse about episodes of incontinence. The ADON-G verified a urinary assessment was not completed on R21 since her	2 840		

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2 840	Continued From page 11 admission. A policy on bladder assessment was requested, however, was not received. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review policies and procedures, train staff, and implement measures to assure residents are receiving the necessary services to prevent incontinence. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to better ensure implementation of treatment. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 840		
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 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	2 915		10/13/20

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2 915	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide assistance and encouragement with meals for 1 of 3 residents (R84) reviewed for nutrition. Findings include: R84's quarterly Minimum Data Set (MDS) dated 8/21/20, indicated R84 had severe cognitive impairment and required limited assistance of one person with eating. R84's care plan dated 8/11/20, identified R84 had actual activities of daily living (ADL) self-care performance deficit related to cognitive loss and schizophrenia. The care plan directed staff to set up R84 with meals to eat, provide one assist to eat meals and strong encouragement for intake. On 8/31/20, at 4:55 p.m. R84's meal tray was delivered to her room and left on bedside table by nursing assistant (NA)-B. On 8/31/20, at 5:16 p.m. R84 was observed laying in bed with eyes closed. The bed was in a low position with the head of the bed elevated at 30 degrees. The meal tray remained on the bedside table untouched. On 8/31/20, at 5:20 p.m. NA-B was observed to pick up R84's uneaten meal tray from bedside table and placed the meal tray on the metal cart in the hallway where the finished trays were being collected after being taken out of the residents	2 915	corrected	

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2 915	Continued From page 13 rooms. During an interview on 8/31/20, at 5:21 p.m. NA-B indicated R84 did not want to eat and she had removed the tray from the room. NA-B verified she had not offered R84 an alternate meal item from the menu and also she had not encouraged and/or offered assitance to R84 with eating prior to taking the food tray out of room, as directed by the care plan. On 8/31/20, at 5:28 p.m. registered nurse (RN)-A, also the unit nurse manager, stated R84 preferred minimal interaction however, indicated NA-B should have encouraged R84 to eat the meal or make an attempt to assist R84 prior to removing the tray. RN-A also stated staff were supposed to report to the nurse if R84 did not eat. RN-A verified NA-B did not report to the nurse that R84 had not eaten. On 9/3/20, at 2:00 p.m. the meal assistance policy was requested, but was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent residents to ensure they are provided assistance and encouragement with meals. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		

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2 915	Continued From page 14	2 915		

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2 915	Continued From page 15 F676	2 915		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure appropriate hand hygiene/gloving, donning of personal protective equipment (PPE), and cleaning equipment in a manner to prevent the potential spread of infection for 4 of 5 residents (R36, R35, R14, R58) observed for infection control. Findings include: R36 who resided on a unit for COVID exposure observation, was observed on 9/2/20, at 7:33 a.m. during morning cares. Nursing assistant (NA)-C was observed to enter R36's room, after applying a gown and gloves outside the room in the hallway. -At 7:38 a.m. as NA-C applied socks on R36's feet, R36 reported she was experiencing pain. NA then stated to R36 "I can get the nurse for you." NA-C finished to apply the socks and as she stood by the bed registered nurse (RN)-D came into the room carrying a medication in a small cup with water as she approached R36. -At 7:40 a.m. as RN-D approached R36 who stated to RN-D she was experiencing pain to both	21375	corrected	10/13/20

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21375	Continued From page 16 her legs. RN-D gave the medication at hand and told R36 she was going to get the cream for her legs and would be right back. Before leaving the room the pain cream was noted to be on top of the counter by the sink.RN-D squeezed cream out of the bottle, approached R36's bed and applied the cream to both knees on the top and under the knees, per R36's request. RN-D's scrubs were observed to touch R36's legs and bedding. RN-D was not wearing a gown despite R36 being on droplet precautions due to Covid exposure. RN-D then removed her gloves, washed hands before she left R36's room and continued with the medication pass for other residents. -At 7:46 a.m. NA-C assisted R36 to sit on the edge of the bed and put her shoes on. As NA-C applied the shirt, R36 stated to NA-C she wanted Asper cream to be applied to her left arm. RN-D returned to the room, did not apply a gown, and again RN-D's scrubs were observed to touch R36 and the bedding as she applied the Asper cream to both of R36's arms. RN-D then removed gloves and washed hands before leaving the room. -At 7:50 a.m. NA-C cued R36 she was going to assist her to the commode using a mechanical machine. NA-C looked at the lift sheet for the machine and stated the one in the room was too big. NA-C then removed the PPE, washed hands, and left the room. -At 7:53 a.m. NA-C came back into R36's room and stated another staff was getting her the right size lift sheet to use to transfer R36. -At 7:57 a.m. NA-C applied the correct lift sheet to R36's torso then hooked it to the mechanical lift and then was observed to get R36 off the bed into a standing position using the mechanical lift and then sat R36 on the commode which was next to the bed.	21375		

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21375	Continued From page 17 -At 8:04 a.m. NA-C cued R36 she was going to get her to a standing position as she brought her up. NA-C then was observed to provide front pericare then proceeded to do the pericare in the back. NA-C then with the same gloves adjusted R36's adult dignity pad and pants then went over and grabbed the wheelchair still with the same gloves and put it behind R36. NA-C then removed the right glove, lowered R36 into the wheelchair then removed the left glove. NA-C still without washing hands applied another pair of gloves and proceeded to clean the mechanical lift. When questioned, NA-C acknowledged she was supposed to remove gloves and wash hands before continuing with tasks. -At 8:12 a.m. NA-B entered R36's room and was observed to wheel the mechanical lift and lift sheet used for R36 to the hallway. NA-B proceeded to take the lift and the lift sheet out of Station 3 which was a quarantine unit, due to Covid exposure, and went down the Station 4 hallway. -R35, at 8:18 a.m., NA-B entered R35's room as NA-D pushed the mechanical lift with the lift sheet into the room and shut the door. -At 8:20 a.m. surveyor entered R35's room and did not see any other lift sheet except the one on top of the mechanical lift from R36's room. -At 8:27 surveyor re-entered R35's room to observe the transfer. When NA's were asked if residents were supposed to share lift sheets NA-B stated "yes we do. we do clean it between residents which we did" as she pointed to the garbage to show the wipes used. NA's then applied the lift sheet used for R36 around R35's torso and hooked R35 into the mechanical lift and and both NA's were observed to transfer R35 into the wheelchair. After transferring R35 to the wheelchair NA-B was observed to clean the mechanical lift and wiped down the cloth material	21375		

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21375	Continued From page 18 lift sheet before taking it out of R35's room. On 9/2/20, at 9:09 a.m. registered nurse (RN)-A nurse manager stated "each person should have their own sling sheet." Regarding hand hygiene RN-A stated staff was supposed to remove gloves, wash hands and put clean gloves on before they continued with cares when staff went from dirty to clean and after pericare. Also RN-A stated "If staff was doing direct care they are to apply gloves and gown and remove when leaving room in Station 3, which was quarantine unit." On 9/3/20, at 1:27 p.m. the director of nursing (DON) stated staff was supposed to perform hand hygiene before and after providing cares. Also staff was to wash hands prior and after they removed gloves. The DON further stated staff was supposed to wear a gown and gloves when they provided direct care for a resident in the quarantine unit Station 3. R14, on 9/2/20, at 7:08 a.m. nursing assistant (NA)-A was observed to apply a gown in the hallway with the opening towards the front as she stood outside R14's room who was on quarantine due to a recent COVID exposure. As NA-A entered R14's room the gown was observed to be partially open in the front as she approached R14 to transfer her from bed to the wheelchair. During the observation, NA-A scrubs were touching R14's clothing. During an interview on 9/2/20, at 7:12 a.m. NA-A stated she had been provided education on donning and doffing protective personal equipment months prior and indicated the gown was applied properly.	21375		

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

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21375	Continued From page 19 R58, on 9/2/20, at 7:46 a.m. NA-A again was observed apply a gown in the hallway with the opening towards the front and gown was partially opened as NA-A entered R58's room who was on quarantine due to a recent Covid exposure. NA-A then was observed to approach R58 to assist with getting dressed for the day. During the observation, NA-A scrubs were observed to touch R58's body and then clothing after R58 was dressed. During an interview on 9/2/20, at 8:03 a.m. NA-A indicated the PPE gown was put on backwards with the opening toward the front since there was not any available staff to help tie the gown and she did not want to remove gown to find another staff member to help to tie it. NA-A acknowledged her scrubs were exposed as she assisted R58 and R14's while providing direct contact care. NA-A verified the proper donning of the PPE gown was to don the gown with the opening to the back and tied it to prevent her scrubs being exposed. During an interview on 9/2/20, at 8:35 a.m. registered nurse (RN)-A indicated R58, R14 and the entire Station 3 was on droplet precautions due to an exposure from a positive Covid staff. RN-A stated the proper way to don a PPE gown was to have the opening to the back and was supposed to be tied to ensure clothing was fully covered. RN-A also stated the staff had been educated several months ago regarding donning and doffing of PPE and there were signs posted by every room on how to don and doff PPE for reminders. During interview on 9/3/20, at 9:09 a.m. the DON indicated the proper way to don a PPE gown was with the opening toward the back and was to be	21375		

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21375	Continued From page 20 tied to not expose clothing. The DON also stated staff was supposed to properly apply PPE to prevent the spread of infection. The DON further stated the facility used the Centers for Disease Control (CDC) guidelines for donning and doffing of PPE. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee could monitor to assure proper PPE is worn to prevent the potential spread of infections. The DON or designee could monitor to ensure staff was using gloves properly and hand hygiene was performed during care appropriately. The DON or designee could educate staff and perform audits to ensure the policies are being followed. Time Period for Correction: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis 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	21426		10/13/20

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21426	Continued From page 21 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 ensure 3 of 5 employees were appropriately screened for Tuberculosis symptom upon hire before working directly with residents according to the State Tuberculosis screening guidelines during the Covid-19 pandemic. Findings include: A list of new hires in the last six months was provided by the facility and were identified as staff who worked with residents in different departments at the facility. During the review of the personnel TB information, it was revealed: A Dietary aide (DA)-A with a hire date of 4/15/20, file lacked evidence of a symptom screen upon hire at the facility per State guidelines. A receptionist staff with a hire date of 5/12/20, file lacked evidence of a symptom screen upon hire at the facility per State guidelines. The director of activities with a hire date of 7/7/20, file lacked evidence of a symptom screen upon hire at the facility per State guidelines. On 9/1/20, at 2:14 p.m. the facility administrator approached the surveyor and provided TB screening for two of the five randomly selected new hires. The administrator went over the list	21426	corrected	

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21426	Continued From page 22 and stated the facility did not have documentation this staff had tuberculosis symptom screen completed before working with residents. Minnesota Department of Health Temporary Changes to Tuberculosis Requirements dated 6/22/2020, directed the following "Extension of timeframe for the baseline tuberculin skin test (TST) or TB blood test. -Health care personnel (HCP) may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease). The baseline TB blood test or first step of the baseline TST blood test can be deferred until after the date of hire to reduce interaction with additional healthcare settings and non-urgent use of PPE required during these visits. This change was effective starting April 1, and will remain in effect until December 31, 2020. At that time, all facilities will have 60 days to complete baseline testing on those personnel who had been deferred. MDH will notify health care facilities by December 15, 2020 if the timeline will be extended. If facilities are currently able to maintain internal new hire screening, please continue to do so. -All health care facilities must document the date they began modifying their baseline TB screening protocol. -All health care facilities must continue to screen all newly hired HCP for symptoms of TB..." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review policies and procedures related to the components of the infection control and TB monitoring program. Facility staff could be educated on the TB regulations and procedures. The director of nursing and/or designee could develop a monitoring system to ensure ongoing	21426		

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21426	Continued From page 23 compliance. TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21426		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation	21545		10/13/20

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21545	Continued From page 24 must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview, and documentation the facility failed to ensure that a significant medication error did not occur for 1 of 2 residents (R592) observed to receive insulin from a flexpen. Findings Include: R592's diagnoses included type two diabetes and a fracture of the ulna (bone in the forearm) obtained from the admission record printed on 9/3/20. R592's admission Minimum Data Set (MDS) dated 8/19/20, indicated R592 had severely impaired cognition. R592's care plan dated of 8/12/20, identified R592 had a nutritional problem or potential for nutritional problem due to diabetes and the care plan directed staff to administer medications as ordered. On 8/31/20, at 4:20 p.m. the surveyor intervened prior to registered nurse (RN)-A administering	21545	corrected	

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21545	Continued From page 25 Novolog insulin via Flexpen to R592. When asked if she had primed the insulin pen, RN-A stated "I was taught that when the pen is new, you do it." RN-A also stated "no, we prime the pen when it's first new." When surveyor explained to RN-A when and why the Flexpen was primed, RN-A responded with "oh ok" but still proceeded to give insulin to R592 without priming it despite surveyor explanation. August Medication Administration Record (MAR) indicated R592 received Novolog Flexpen three times a day before meals and eight units was to be injected subcutaneously (just under the skin). From the dates of 8/18/20, through 8/31/20, of August's MAR, R592's blood sugars ranged from 101 to 360. On 9/2/20, at 8:41 a.m. RN-B stated during an insulin administration she primed every time a new needle is added to the Flexpen. RN-B further stated "I heard I don't have too, but I do each time." During an interview on 9/3/20, at 11:01 a.m. the consultant pharmacist stated "I always refer back to facility policy, but the standard is to prime with two units prior to administration, this ensures that the dose that is dialed is the dose that is administered." During an interview on 9/3/20, at 11:08 a.m. the director of nursing (DON) stated the expectation for Flexpens was all insulin pens would be primed with two units prior to administration to ensure that there is no air in the system. The Insulin Administration policy/procedure revised 10/2010, was reviewed but lacked documentation on instructions on priming an	21545		

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21545	Continued From page 26 insulin Flexpen. Instructions for use of Novolog Flexpen with a revision date of 11/2019, indicated step by step instructions on giving the airshot before each injection. The instructions indicated before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing the following steps were to be taken: E. Turn the dose selector to select two units. F. Hold the Novolog Flexpen with the needle point up, tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. G. Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to zero. A drop of insulin should appear at the needle tip. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and educated nurses on proper procedures for preparation of insulin pens per the manufacturers instructions prior to insulin administration. The director of nursing or designee could educate staff and develop a monitoring system to ensure medication were correctly administered. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545		