

#### Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 27, 2023

Administrator
The Villas At The Park
4415 West 36 1/2 Street
Saint Louis Park, MN 55416

RE: CCN: 245083

Cycle Start Date: November 9, 2023

#### Dear Administrator:

On November 9, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

#### ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

#### **DEPARTMENT CONTACT**

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

Nathan Schreier, Unit Supervisor Metro B District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite 220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900

Email: nate.schreier@state.mn.us Office: (651) 201-4348 Mobile (651) 392-2726

#### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by February 9, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by May 9, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <a href="https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm">https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm</a>

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: <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</a>

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:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
<a href="mailto:travis.ahrens@state.mn.us">travis.ahrens@state.mn.us</a>

Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: Melissa.Poepping@state.mn.us



#### Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 27, 2023

Administrator
The Villas At The Park
4415 West 36 1/2 Street
Saint Louis Park, MN 55416

Re: State Nursing Home Licensing Orders

Event ID: 6PCP11

#### Dear Administrator:

The above facility was surveyed on November 6, 2023 through November 9, 2023 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 <u>only a suggestion</u> 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 <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</a>. 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:

Nathan Schreier, Unit Supervisor Metro B District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite 220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900

Email: nate.schreier@state.mn.us

Office: (651) 201-4348 Mobile (651) 392-2726

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 feel free to call me with any questions.

Melissa Poepping, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: Melissa.Poepping@state.mn.us

PRINTED: 12/18/2023 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245083	B. WING		C 11/09/2023
	ROVIDER OR SUPPLIER  AS AT THE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE  4415 WEST 36 1/2 STREET  SAINT LOUIS PARK, MN 55416	11/03/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROP  DEFICIENCY)	O BE COMPLETION
E 000	Initial Comments		E 00	00	
	with Appendix Z, Emeror Requirements for Long \$483.73(b)(6) was conficted and survey compliance.  The facility's plan of conficted and survey and survey are compliance.	a survey for compliance ergency Preparedness of Term Care facilities, anducted during a standard The facility was NOT in sorrection (POC) will serve			
	enrolled in ePOC, you	compliance upon the ance. Because you are ur signature is not required rst page of the CMS-2567			
⊏ 0.41	onsite revisit of your for validate substantial corregulation has been a	nttained.			1 10 10 1
E 041 SS=C	§482.15(e) Condition (e) Emergency and state hospital must implem power systems based forth in paragraph (a) policies and procedur paragraphs (b)(1)(i) at §483.73(e), §485.625 (e) Emergency and state [LTC facility CAH and	for Participation: candby power systems. The ent emergency and standby d on the emergency plan set of this section and in the es plan set forth in nd (ii) of this section.  (e), §485.542(e) candby power systems. The REH] must implement	E 04	¥1	1/9/24
	the emergency plan so this section. §482.15(e)(1), §483.7	by power systems based on set forth in paragraph (a) of 3(e)(1), §485.542(e)(1),			
-AROKATORY	DIKECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE

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

Electronically Signed

12/01/2023

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G	<b>'</b> '	(X3) DATE SURVEY COMPLETED	
		245083	B. WING		1	C 1/09/2023
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E 041	§485.625(e)(1) Emergency generate must be located in a requirements found Code (NFPA 99 and Amendments TIA 12.12.5, and TIA 12.6) and Tentative Interir 12.2, TIA 12.3, and when a new structure or building 482.15(e)(2), §483.1 §485.542(e)(2) Emergency generate [hospital, CAH and the emergency pow and [maintenance] in Health Care Facilities Safety Code.  482.15(e)(3), §483.1 (3),§485.542(e)(2) Emergency generate LTC facilities] that more to power emergency for how it will keep experience by the Direction of the power emergency for how it will keep experience by the Direction are approved the standards incompletely section are approved the power efference by the Direction are approved the power effects of the power emergency for how it will keep experience by the Direction are approved the power effects of the power eff	for location. The generator accordance with the location in the Health Care Facilities of Tentative Interim 2-2, TIA 12-3, TIA 12-4, TIA, Life Safety Code (NFPA 101 on Amendments TIA 12-1, TIA TIA 12-4), and NFPA 110, re is built or when an existing is renovated.  73(e)(2), §485.625(e)(2), for inspection and testing. The LTC facility] must implement her system inspection, testing, requirements found in the less Code, NFPA 110, and Life for fuel. [Hospitals, CAHs and haintain an onsite fuel source by generators must have a plan emergency power systems the emergency, unless it	E 0	41		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		` ´	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY  COMPLETED	
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E 041	material from the so inspect a copy at the Center, 7500 Secur or at the National Ar Administration (NAF availability of this m 202-741-6030, or go http://www.archives_federal_regulations If any changes in the incorporated by refedocument in the Fedocument in the F	e CMS Information Resource ity Boulevard, Baltimore, MD rehives and Records (AA). For information on the aterial at NARA, call to to:  .gov/federal_register/code_of (s/ibr_locations.html.) is edition of the Code are erence, CMS will publish a deral Register to announce of the code are erence, CMS will publish a deral Register to announce of the code, 2012 (ast 11, 2011.)  If amendment (TIA) 12-2 to (gust 11, 2011.) If a yellow a ye	E 04			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 041	This REQUIREMENT by: Based on interview a facility failed to maint (2012 edition), Health section 6.4.4.1.1.3, a Standard for Emerge Systems, section 4.2 have a widespread in the facility.  Findings include:  Facility documentation between 11:15 a.m. a evidence of reliability fuels the emrgency good During interview on 1 a.m. and 1:30 p.m., to and two Regional Mainterview on 1	and document review, the ain generators per NFPA 99 and NFPA 110 (2010 edition), ncy and Standby Power. This deficient finding could appact on all residents within on reviewed on 11/08/2023 and 1:30 p.m., lacked for the natural gas which	E 04	<ol> <li>Letter of reliability has been obtain and secured in facility's records.</li> <li>Letter to be kept with preventative maintenance records.</li> <li>Director of Maintenance educated keeping letter of reliability in records.</li> <li>Administrator and/or designee to complete monthly audits x3 months to ensure letter of reliability is maintained preventative maintenance records. At will be brought to QAPI by Administration designee to review trends and determine if audits need to continue.</li> </ol>	on d in udits
F 000	survey was conducted investigation was also was IN NOT in composed of 42 CFR 483, Subplications Term Care Facilities.	a standard recertification of at your facility. A complaint o conducted. Your facility pliance with the requirements part B, Requirements for lities.  Sints were reviewed with NO 910)	F 00	0	
	H50836889C (MN97	7850) with a deficiency cited			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		ΞΥ	
		245083	B. WING _		11/09/20	23
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F 554 SS=D	as your allegation of of Departments acceptate enrolled in ePOC, you at the bottom of the fit form. Your electronic be used as verification.  Upon receipt of an account of your fivalidate substantial corregulations has been	correction (POC) will serve compliance upon the nce. Because you are ur signature is not required rst page of the CMS-2567 submission of the POC will n of compliance.  In ceptable electronic POC, an accility may be conducted to compliance with the		554	1/9/2	4
	§483.10(c)(7) The rig medications if the interdefined by §483.21(b) this practice is clinical This REQUIREMENT by:  Based on observation review, the facility fail (R3) were comprehent ability who were observed in the medications.  Findings include:  R3's quarterly Minimula assessment dated 9/2 cognitively intact, requesting and oral hygies difficulty or pain with states.	erdisciplinary team, as (2)(ii), has determined that appropriate. It is not met as evidenced in, interview, and document ed to ensure 1 of 1 residents asively assess for safety and erved to self-administer.  Important Set (MDS) 26/23, indicated R3 was uired set-up assistance for the, had complaints of swallowing, and had as, seizure disorder, and		1. R3 was assessed and impact due to this deficient remains unsafe to Self-act medications. Anti-fungal kept in the medication cabeing seen by speech.  2. This practice has the poother like residents. Residents reviewed to ensure other medications and creams at bedside without appropriates assessment and order.  3. Education will be compared.	Iminister power is being t. R3 is currently  Interest to affect the dents were prescription are not being left to briate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED	
			A. BUILDING	<sup>7</sup>		С	
		245083	B. WING		11	1/09/2023	
NAME OF P	ROVIDER OR SUPPLIER	<b>I</b>		STREET ADDRESS, CITY, STATE, ZIP CODE	•		
THE MILE.	A O AT THE DADY			4415 WEST 36 1/2 STREET			
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F 554	swallowing and must eating anything, no per speech therapy  R3's Upper GI (gast dated 10/25/23, indidilation procedure to narrowed areas in horeturn for a second procedure.  R3's Order Review Fincluded orders for the given at 2:00 p.m.  -Calcium Citrate + Cowith Vitamins) one the supplement puloxetine HCI Del (mg) one time per day for chronic pain oxybutynin Chlorid time per day for urin	ated she had difficulty of sit up when drinking or matter how small the amount recommendations.  rointestinal) Endoscopy note cated she had an esophageal widen two severely er esophagus, and was to procedure in one to two lacked evidence of a second  History Report dated 11/9/23, the following medications to the following medications	F 55		aluation ed by the npleted with cription nless ler has been  esignee will r four weeks weeks. by to review need to and/or		
	bipolar -Gabapentin Oral Cathree times per day -Levetiracetam Oral by mouth three time The report also inclued Ondansetron HCI O	apsule, 900 mg by mouth for neuropathy Tablet 500 mg, Give 500 mg s per day for seizures.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 554	1:09 p.m., R3 was spaghetti and a sall stated she started of because it was getted. She stated she receives sphagus but some was observed cougainterview, and stated anti-nausea medical.  During observation registered nurse (Rwhere R3 requeste RN-C left the room cart. At 1:21 p.m. Rwhere she was head buring observation 2:56 p.m., R3 was plate of spaghetti for A medication cup consisting next to the forgave the pills to head things up and unable them there until she container of anti-ful percent full sat on Fasometimes staff left could put it on hers medication without	and interview on 11/6/23 at lying in bed with a full plate of ad on her bedside table. R3 coughing and couldn't eat it ting stuck on the way down. The entity had surgery to open her netimes thing still got stuck. R3 ghing periodically during at she would ask for ation to see if it would help.  In 11/6/23 at 1:18 p.m., and went to the medication. The entity and went to the medication. The entity and then left.  In 11/6/23 at 1:18 p.m., and went to the medication. The entity and then left.  In 11/6/23 at 1:18 p.m., and went to the medication. The entity and then left.  In 11/6/23 at 1:18 p.m., and went to the medication. The entity and then left.  In 11/6/23 at 1:18 p.m., and went to the medication. The entity and then left.  In 11/6/23 at 1:18 p.m., and went to the medication. The entity are to the medication. The entity and then left.  In 11/6/23 at 1:18 p.m., and went to the medication. The entity are to the entity and the periodical periodic	F 554	4	
	stated it was not unand they gave her stored it. They stated sometimed medication with approximately	11/6/23 at 3:09 p.m., RN-C nusual for R3 to have a cough some anti-nausea medication sometimes she took her plesauce, and it could take a take her medications,			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245083	B. WING		C 11/09/2023
	ROVIDER OR SUPPLIER  AS AT THE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416	
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F 554	left at bedside. The be assessed before to make sure the rewas unsure if there assessment other trassessment. Upon RN-C was unable trassessment. Upon RN-C was unable trassed an instration. During interview on practical nurse (LP) wished to self-administration order from the provesophageal strictur identified it would not self-administer medical nursing stated if self-administer medical nursing stated if self-administer medical not self-administer	y stated a resident needed to handing the medications off sident could take them but was any specific form for that han within the initial admission review of R3's medical record, of find an order or medication assessment.  11/8/23 at 8:46 a.m., licensed N)-B stated if a resident nister medications staff asment to make sure it was dent education, and got an ider. They stated R3 had an e and difficulty swallowing and ot be appropriate for R3 to dications because she likely	F 554		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	_ ` ´		(X3) DATE SURVEY COMPLETED
		245083	B. WING		C 11/09/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE COMPLÉTION DATE
F 554	Continued From pag	e 8	F 5	54	
	dated 5/2022, indicated self-administer medical conducted by the interestident's cognitive,	ion of Medications policy ted if a resident desires to cations, and assessment is erdisciplinary team of the physical, and visual ability to sibility in the care planning			
F 677 SS=D		or Dependent Residents	F 67	77	1/9/24
	out activities of daily services to maintain personal and oral hy This REQUIREMENT by:  Based on observation	is not met as evidenced on, interview and document		1. R35 and R19 were provide	
	care to 2 of 3 resider	ed to provide hygienic nail its (R35 and R19) reviewed es of daily living (ALD's).		care. The residents care pla updated to reflect nail care to on bath days for both reside	o be offered
	severely cognitively	7/23, included R19 was mpaired, had diagnoses of a (difficulty speaking), and		2. The resident population the assistance with ADLS could by this practice. All of these nail care provided/offered, a updated to reflect nail care to on bath days.	be impacted residents had and care plans
	Assessment dated 8 assistance with ADL	ition Potential was not		3. Education will be complet nursing staff to ensure nail or provided on bath days or who soiled.	are is being
	often used his hands	dated 4/20/20, indicated he to eat and required set-up for personal hygiene, but stance needs. His		4. Director of Nursing and/or responsible for 100% complicate will be audited on resid twice a week x4 weeks. The	iance. Nail lent bath days

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		IDENTIFICATION NI IMBER:		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
			A. BUILDING	·		С	
		245083	B. WING		1	1/09/2023	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO	•		
THE VIII				4415 WEST 36 1/2 STREET			
INE VILL	AS AT THE PARK			SAINT LOUIS PARK, MN 55416			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 677	Continued From pag	e 9	F 67	7			
	behavioral focus date behaviors of putting plates/trays at mealti			Nursing and/or Designee will audits to the QAPI committe review for continued opportuguality improvements.	e monthly to		
	dated 8/23/23, instrument of the monitor for signs that [feces], and consider Ongoing monitoring digging/residue on fire	cted staff to continue to the is smearing or digging keeping fingernails short. for any signs of ngers can help manage and nt clean and maintain					
	R19's Order Review History dated 11/9/23, included weekly skin inspection by licensed nurse, and complete MHM Weekly Skin Inspection in [electronic medical record] every Thursday evening for skin care, document all refusals in a nurse's note, starting 7/20/23.  R19's MHM Weekly Skin Inspection V forms identified it was "Not Necessary" to trim his fingernails on 9/21/23, 10/9/23, 10/12/23, 10/18/23, and 11/2/23. The medical record lacked documentation for the weeks of 9/28 and 10/25.  R19's Progress Notes lacked documentation of refusal of cares, including bathing or nail care, from 9/1/23, through 11/7/23.						
	was seated on a cha nurses' station. His fi	in 11/7/23 at 10:36 a.m., R19 ir in the hallway by the ngernails were noted to be ong with brown crusted erside of all nails.					
		n 11/7/23 at 12:18 p.m., R19 r in his room with a tray table ning a plate of what					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ´	IPLE CONSTRUCTION  NG	` '	(X3) DATE SURVEY  COMPLETED	
		245083	B. WING _			C 11/09/2023
	ROVIDER OR SUPPLIER  AS AT THE PARK		<b>,</b>	STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 677	unidentified food ite his left hand to pick in his mouth through gone.  During interview on assistant (NA)-D state documented nail caresident was diabeted they charted it. They after set-up, and habehaviors, including defecating and urina smearing feces around let staff wash.  During observation 1:37 p.m. license proposed and completions and refingernails and confisciled and describerasked R19 if they can and R19 expressed staff should have at them and document unsure why it was in the chart. They staff them clean and trimpurposes and to prefintegrity concerns.	ge 10  , sweet potatoes, and another m. R19 used his fingers on up food bites and place them nout the meal until it was  11/7/23 at 1:07 p.m., nursing ated NAs completed and re on bath days unless a ic, and if a resident refused, y stated R19 ate on his own d dementia and some resisting cares and ating is his room and and, but if in a good mood his hands and trim his nails.  and interview on 11/7/12 at actical nurse (LPN)-B stated care for non-diabetic ays and charted both usals. LPN-B observed R19's irmed they were long and d them as "not great". They ould get someone to cut them willingness. LPN-B stated tempted to clean and trim at it in the record and was dentified as unnecessary in teed it was important to keep med for infection control event scratching and skin		577		
	Findings include:					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		245083	B. WING		1	C 1/09/2023
	ROVIDER OR SUPPLIER  AS AT THE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE  4415 WEST 36 1/2 STREET  SAINT LOUIS PARK, MN 55416	·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 677	R35's Face Sheet for R35 had diagnoses encephalopathy, into diabetes, and delusion R35's admission Min 6/27/23, indicated the activity preference was Additionally, R35 is showering/bathing at R35's quarterly MDS R35 was moderately not refuse care.  R35's Care Area Ass 6/27/23, indicated the assessment was not R35's care plan, date R35 required assistation and assistance of or R35's orders, dated nurses to document every day shift Saturefusals.  R35's bath and nail 11/4/23, indicated state the resident with bath R35's treatment administrated 11/7/23, indicated state and assisted the resident medical record (EM)	orm, printed 11/7/23, indicated that includes metabolic ellectual disabilities, type 2 onal disorders  nimum Data Set (MDS), dated as assessment of daily and was not conducted by staff. dependent of staff for and toileting.  6, dated 9/26/23, indicated or cognitively impaired and did sessment (CAA), dated at the ADL functional at completed or triggered.  ed 6/23/23, indicated that ance of two staff for bathing he staff for personal hygiene.  10/27/23, directed licensed R35's skin inspection weekly, rday and to document any	F 67	77		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245083	B. WING		1	C 1/09/2023	
	ROVIDER OR SUPPLIER  AS AT THE PARK			STREET ADDRESS, CITY, STATE, ZIP C 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416	•		
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F 677	During an observation 10 of R35's fingernal length with a buildup underneath the fingerne he would like them to the would like the resident and infection.  During an interview CNA-C stated that the control of the would reasted to provide in the would reasted the would reasted to the would reasted by a certification the resident is diable required to trim the nails are "pretty long trimmed.  During an interview Director of Nursing expect staff to follow residents and provide the resident's prefer trimming be performed.	on on 11/7/12 at 8:47 a.m., all ails were approximately 1/2" in of dark black residue ernail bed. R35 indicated that trimmed and cleaned.  on 11/7/23 at 12:55 p.m., R35 needed his nails d, she will call a nurse at is diabetic. CNA-A went to a, looked at the residents' ated that they were too long cleaned properly, could cause on 11/8/23 at 8:00 a.m., during bath days, she will care. If a resident was to e-approach the resident and ail care. If CNA-C was would inform the Registered on 11/7/23 at 1:37 p.m., the N-B) stated that on bath days, et their nails trimmed and and aid nursing assistant (CNA). If etic, a licensed nurse is anails. LPN-B stated that R35's grand soiled and should be on 11/8/23 at 12:38 p.m., the (DON) stated that she would with care plans for the decare in a timely manner per ences. She expected that nail are on shower/ bath days and re visibly dirty, staff should be	F 67	77			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245083	B. WING		C 11/09/2023
	ROVIDER OR SUPPLIER  AS AT THE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE  4415 WEST 36 1/2 STREET  SAINT LOUIS PARK, MN 55416	11/09/2023
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F 684 SS=D	sure to clean undern refuse nail care, staff the resident three ad nurse of any refusals. A policy titled, Activit Maintain Abilities, da resident who is unab ADLs, that staff will a maintain good nutritic and oral hygiene. Quality of Care CFR(s): 483.25  § 483.25 Quality of c Quality of care is a fu applies to all treatmet facility residents. Bas assessment of a resit that residents receive accordance with profipractice, the comprecare plan, and the retries REQUIREMENty:  Based on observation review, the facility fair gastrointestinal proceed (R3) reviewed who have a cognitively intact, received and oral hygies difficulty or pain with	eath the nailbed. If residents are expected to reapproach ditional times, inform the and document refusals.  The set of Daily Living (ADL's)/ted 3/31/23, indicates that a let to carry out their own assist them as necessary to on, grooming, and personal on, grooming, and personal of the facility must ensure the treatment and care in the facility must ensure the treatment and care in the facility must ensure the treatment and care in the facility must ensure the treatment and care in the facility must ensure the facility facility and document are for the facility services.  The set of Daily Living (ADL's)/ted 3/31/23, indicated facility fac	F 68		ent k to

PRINTED: 12/18/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245083	B. WING		11/09/2023	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
			4	415 WEST 36 1/2 STREET		
THE VILL	AS AT THE PARK			SAINT LOUIS PARK, MN 55416		
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F 684	Continued From pag	je 14	F 684			
	R3's care plan dated difficulty swallowing	l 10/10/23, indicated she had and must sit up when ything, no matter how small		3. Medical Records Director and nursing will be educated on process for post appointment paperwork review to ensurappointments are not missed.	ire	
	the upper digestive so camera on the end of dated 10/25/23, indication procedure to narrowed areas in he an order to "Repeat [monitored anesthes breathe without a marrowed in 1 [operating room] in 1 R3's record lacked excompletion of a second	dure used to visually examine system with the help of a tiny of a long, flexible tube) note cated she had an esophageal widen two severely er esophagus, and included upper endoscopy with MAC ia care - sleeping but able to achine] in Purple OR -2 weeks for retreatment".		4. Director of Nursing and/or designee complete audits of post appointment notes to be done weekly for 4 weeks a monthly thereafter to ensure that follow appointments are scheduled as needed. They will review all residents that went to an appointment during the audit week. The Director of Nursing and/or designed is responsible for 100% compliance. The Director of Nursing and/or designees who bring audit results to the QAPI committed monthly to review for continued opportunities for quality improvements.	nd /-up d. out ek. ee he vill	
	1:09 p.m., R3 was ly food on her bedside coughing and couldn' getting 'stuck' on the recently had surgery sometimes thing still coughing periodically she would ask for an if it would help.  During observation of continued to cough.	and interview on 11/6/23 at ing in bed with a full plate of table. R3 stated she started o't eat it because it was way down. She stated she to open her esophagus but got stuck. R3 was observed y during interview, and stated of interview and stated of 11/6/23 at 1:21 p.m. R3 and interview on 11/6/23 at ang in bed semi-upright, her				
	food fully eaten on th					

Facility ID: 00129

· · · · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245083	B. WING			C <b>11/09/2023</b>
	ROVIDER OR SUPPLIER  AS AT THE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416	•	170372023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	next to the food tray. the pills to her earlies up and unable to switchere until she could. During interview on registered nurse (RN for R3 to have a could anti-nausea medicate took her medication and was trying to figure to the many that the faction of the follow-up, and the faction of the	R3 stated the nurse gave r but she was throwing things allow them, so they set them get the pills down.  11/6/23 at 3:09 p.m.,  1)-C stated it was not unusual gh and they gave her some ion for it, and sometimes she with applesauce to help it go  11/8/23 at 2:12 p.m., R3 allow better some of the time ocedure, but still had trouble ure out what was going on. supposed to go back for cility had not sent her back  11/9/23 at 8:24 a.m., licensed occuments were faxed to the dithem for orders and if a not was needed, sent it to the cotor (MRD) who made the countert paperwork was see to enter orders, and then stated the nurses read all the hem to the need for future as ending the papers to MRD on the manual representation of the papers to MRD on the paperwork, and then stated R3 had a	F 68	34		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
	245083	B. WING _			C 1 <b>1/09/2023</b>
			STREET ADDRESS, CITY, STATE, ZIP CODE  4415 WEST 36 1/2 STREET  SAINT LOUIS PARK, MN 55416		
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	DULD BE	(X5) COMPLETION DATE
appointment schedul 11/30/23. MRD revie notes from R3's appropriate of a second proces alert them to the new diere die die die die die die die die die di	led with the GI clinic on ewed the post-procedure pointment on 10/25/23 and not seen the recommendation dure for R3, nor did nurses ed to schedule it.  11/9/23 at 9:02 a.m., LPN-B ment paperwork was reviewed ers and sent to the MRD who by the need for future ploaded it to the electronic iffied R3 had an esophageal by swallowing and had an procedure to help with so, and confirmed R3 should popointment scheduled one to procedure on 10/25/23, but it ged or scheduled.  11/9/23 at 10:57 a.m., director st-appointment paperwork rise, and when nursing the nurse communicated egarding the need for an RD scheduled it. DON recent esophageal dilation es second procedure ed, and it was important to rocess for scheduling ents to ensure resident ey required.  ment follow-up and scheduling not provided. zards/Supervision/Devices				1/9/24
CFK(S): 483.25(d)(1	1)(2)				
	CORRECTION  ROVIDER OR SUPPLIER  SUMMARY S  (EACH DEFICIEN REGULATORY OF  Continued From page appointment schedulation appointment they had for a second procedular them to the new  During interview on stated post-appointry by the nurse for ord reviewed it to identify appointments and un record. LPN-B ident stricture and difficulty esophageal dilation swallowing problem have had another appointments and un record. Lendent stricture and difficulty esophageal dilation swallowing problem have had another appointments and did not have the was not acknowledge  During interview on of nursing stated powas given to the nur completed orders the verbally with MRD re appointment and Mi confirmed R3 had a and did not have the scheduled as ordere have a consistent power follow-up appointment received the care the  A policy for appointry was requested but re Free of Accident Ha	AS AT THE PARK  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 16 appointment scheduled with the GI clinic on 11/30/23. MRD reviewed the post-procedure notes from R3's appointment on 10/25/23 and confirmed they had not seen the recommendation for a second procedure for R3, nor did nurses alert them to the need to schedule it.  During interview on 11/9/23 at 9:02 a.m., LPN-B stated post-appointment paperwork was reviewed by the nurse for orders and sent to the MRD who reviewed it to identify the need for future appointments and uploaded it to the electronic record. LPN-B identified R3 had an esophageal stricture and difficulty swallowing and had an esophageal dilation procedure to help with swallowing problems, and confirmed R3 should have had another appointment scheduled one to two weeks after the procedure on 10/25/23, but it was not acknowledged or scheduled.  During interview on 11/9/23 at 10:57 a.m., director of nursing stated post-appointment paperwork was given to the nurse, and when nursing completed orders the nurse communicated verbally with MRD regarding the need for an appointment and MRD scheduled it. DON confirmed R3 had a recent esophageal dilation and did not have the second procedure scheduled as ordered, and it was important to have a consistent process for scheduling follow-up appointments to ensure resident received the care they required.  A policy for appointment follow-up and scheduling was requested but not provided.	A BUILDIN 245083 B WING_  ROVIDER OR SUPPLIER  AS AT THE PARK  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 16  appointment scheduled with the GI clinic on 11/30/23. MRD reviewed the post-procedure notes from R3's appointment on 10/25/23 and confirmed they had not seen the recommendation for a second procedure for R3, nor did nurses alert them to the need to schedule it.  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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING			
		245083	B. WING		C 11/09/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 11001 20	
				4415 WEST 36 1/2 STREET		
THE VILL	AS AT THE PARK			SAINT LOUIS PARK, MN 55416		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 689	§483.25(d) Accident The facility must ens §483.25(d)(1) The reas free of accident he supervision and assist accidents. This REQUIREMENT by:  Based on observation review, the facility far fall interventions, per post-fall root cause as implement subsequent residents (R4) review. Findings include:  R4's quarterly Minimal 10/24/23, indicated Findings include:  R4's Falls Care Area indicated R4 was at problems. R4 was on assistance when more position and on and with a history of falling R4's ADL (activities of fall	sure that - esident environment remains azards as is possible; and esident receives adequate estance devices to prevent  T is not met as evidenced on, interview, and document iled implement care planned aform a comprehensive analysis, and initiate and ent fall interventions for 1 of 4 wed for falls.  The program of the present of the pressant opioid, and ations, was occasionally er and frequently incontinent a toileting program.  Assessment dated 8/2/23, risk for falls due to balance only able to stabilize with staff aving from seated to standing off toilet and was admitted ong.  Of daily living)/Functional	F 68	1. R4's 5 why's root cause analysis completed; interventions updated to declutter room and supply resident with commode. Care plan updated.  2. All residents at high risk for falls has the potential to be affected. Of current residents at high risk for falls and their care plans were reviewed with interventions in place. Root cause analysis to be completed with all falls ongoing.  3. Licensed nursing staff to be educated on implementation of fall interventions. The interdisciplinary team have been educated on completion of root cause analysis post fall.  4. The Director of Nursing and/or designee is responsible for 100% compliance. An audit of fall interventiand completion of root cause analysis be conducted weekly x4 weeks. Director of Nursing and/or designee will bring results to the QAPI committee monthly review for continued opportunities for	ted s.  ons s to ctor y to	
		Area Assessment dated required 1-2 staff for		quality improvements.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  AS AT THE PARK			STREET ADDRESS, CITY, STATE, ZIP CO 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416	•	• • • • • • • • • • • • • • • • • • •	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTION OF COROSS-REFERENCED TO THE DEFICIENCY	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 689	toileting and transfer and repair of left and falls.  R4's Urinary Inconting Catheter Care Area indicated R4 was from and required extensifor toileting and was R4's progress note of had a fall on 6/7/23, wheelchair to bed.  A progress note date provided a bedside of for toileting.  A progress note date found on the floor affound on the floor affound on the floor affound a fall while self-funterventions included commode.  R4's elimination care included R4 required offer every 2-3 hours.  R4's MHM Balance/findicated R4 was now without staff assistant seated to standing providing moving off the walking, moving off the self-funding providing moving off the walking, moving off the walking, moving off the self-funding providing moving off the walking, moving off the walking in the wal	rs due to recent spinal fusion de fracture and was at risk for mence and Indwelling Assessment dated 8/2/23 equently incontinent of urine rive assistance of 1-2 persons at risk for falls.  dated 6/7/23, indicated she while self-transferring from ded 6/8/23, indicated R4 was commode to allow more room ded 6/17/23, indicated R4 was fer coming from the desired to ankle fracture and transferring on 6/7/23, ded provision of bedside desired for a with the desir	F 68				

PRINTED: 12/18/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245083	B. WING		11/0	) 9/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  4415 WEST 36 1/2 STREET  SAINT LOUIS PARK, MN 55416		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOOD CROSS-REFERENCED TO THE APPROPRIES (PROSS-REFERENCE)	DULD BE	(X5) COMPLETION DATE
F 689	one side.  R4's progress note indicated R4 fell who using the bathroom wheelchair using a The note indicate R4 the bathroom and vipants, she felt her I note indicated R4 to could not get her with and wanted a common A progress note data indicated the interdicated the interdicated the interdicated R4's fall and lacked intervention to previous acknowledgement of bathroom.  R4's MHM Fall Reviolated R4 had fasix months, was one bladder in the previous bathroom.  R4's MHM Incident 11/6/23, indicated R4 had fasix months, was one bladder in the previous factors and interventions and interventions are well as Psych resinterventions. The find interventions are well as Psych resinterventions. The find interventions acknowledgement of bathroom.	dated 11/3/23 at 8:44 a.m., ille pulling up her pants after and was assisted into her mechanical lift and two staff. A stated she needed to use when she was pulling up her egs go weak and she fell. The old staff she fell because she heelchair into the bathroom mode.  Sed 11/3/23 at 10:04 a.m. isciplinary team met regarding indication of immediate ent further falls, nor of R4's inability to get into her liew Evaluation dated 11/6/23, llen 1-2 times in the previous casionally incontinent of ous 14 days, exhibited a loss anding and required a wide d lacked environmental	F 68			

Facility ID: 00129

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		245083	B. WING			C <b>11/09/2023</b>	
	ROVIDER OR SUPPLIER  AS AT THE PARK			STREET ADDRESS, CITY, STATE, ZIP CO 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416	•	11/00/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 689	12:47 p.m., R4 state wanted a commode had one and it was to she could walk to the able to walk because due to a broken and did not fit through the at night it was hard to the toilet and she feld did not have a commode attempt to self-proper bathroom door where NA-F verified it did not have a commode, but have a commode was a litrisk for falls and it was care plans. They stated there was a litrisk for falls and it was care plans. They stated there was a litrisk for falls and it was care plans. They stated there was a litrisk for falls and was not but hose at risk had may and needed to be chastated R4 could get safely, but sometimes a falls risk, pivot transport of the property of the could get safely, but sometimes a falls risk, pivot transport of the could get safely, but sometimes a falls risk, pivot transport of the could get safely, but sometimes a falls risk, pivot transport of the could get safely, but sometimes a falls risk, pivot transport of the could get safely, but sometimes a falls risk, pivot transport of the could get safely, but sometimes a falls risk, pivot transport of the could get safely, but sometimes a falls risk, pivot transport of the could get safely.	by her bed. She stated she aken away and staff told her be bathroom, but she wasn't be she had to drag her left leg le. She stated her wheelchair be door to the bathroom, and to transfer from the door to la couple of days prior. R4 mode in her room.  and interview on 11/8/23 at assistant (NA)-F observed R4 be her wheelchair through the le it got stuck in the doorway. For fit through the door, and the need to ambulate at to get to the toilet. R4 stated because the rails on the didn't fit, and she used to be ut the facility took it away.  11/8/23 at 10:23 a.m., NA-G ast of residents who were at as identified on the residents' ted R4 was independent with	F 68	39			

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245083	B. WING _		11/09/2023
	ROVIDER OR SUPPLIER  AS AT THE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE  4415 WEST 36 1/2 STREET  SAINT LOUIS PARK, MN 55416	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPROPRICE DEFICIENCY)	JLD BE COMPLETION
F 689	a new intervention is the fall, and manage care plan. They state independent, but so ask for assistance to think R4 was at high seen her walk.  During interview on occupational therape R4 pivot transferred her toilet in her bath R4 could ambulate.  During observation 9:02 a.m., LPN-B state implemented the specifics of the factor of the intervent of the care plan and stated R4 was non-stated R4 attempted bathroom herself. Lie where R4 attempted bathroom LPN-B conot fit through the bathroom and had a used to have a complete LPN-B stated R4 new through the bathrood decrease fall risk and and increase independent in the intervent of the issue.	ge 21 risk management form, added based upon the specifics of ers added interventions to the ted R4 was sometimes of the bathroom. They did not in risk for falling and had never and was resistant to using the an intervention based upon fall using nursing judgment. Completed a post-fall analysis, antion if needed, and added it if the NA care guide. LPN-B ambulatory but could get to elchair and usually went to the PN-B went to R4's room did to wheel herself into the confirmed R4's wheelchair did athroom door and R4 would steps to get to the toilet and she had trouble getting to the a hard time standing up, and mode but it was taken away. Beded to be able to get am door in her wheelchair to and episodes of incontinence endence and was not made LPN-B confirmed R4's care updated interventions.	F 6	89	

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	G	COMPLETED
	245083	B. WING _		11/09/2023
NAME OF PROVIDER OR SUPPLIER  THE VILLAS AT THE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416	•
(X4) ID PREFIX TAG SUMMARY STATEMENT CONTROL (EACH DEFICIENCY MUST BE REGULATORY OR LSC IDENTII	PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLÉTION
During interview on 11/9/23 at of nursing (DON) stated fall ris were completed at admission, with significant changes, and a stated if a resident fell, they excomplete a fall evaluation and immediate interventions, and the meet later to review the fall and intervention as needed. She is a new intervention after each if safety and was not aware R4's not fit through the bathroom does a new intervention and Manardated 9/2023, indicated staff with interventions related to the resirisks and causes to prevent the falling and try to minimize comfalling. If falling recurs, staff with additional or different interventionature of the fall.  F 755 SS=D CFR(s): 483.45(a)(b)(1)-(3)  §483.45 Pharmacy Services The facility must provide routing drugs and biologicals to its resistent under an agreement design system of the facility may personnel to administer drugs permits, but only under the geal licensed nurse.  §483.45(a) Procedures. A facility pharmaceutical services (inclusted that assure the accurate acquired dispensing, and administering biologicals) to meet the needs	k assessments quarterly, annually, as needed. They pected the nurse to implement he IDT team would d adjust the rated she expected all for resident s wheelchair could for.  gement policy fill identify ident's specific resident from plications from Il implement ions based on the  Pharmacist/Records  The and emergency idents, or obtain cribed in remit unlicensed if State law meral supervision of  Ility must provide ding procedures ring, receiving, of all drugs and	F 6		1/9/24

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			A. BUILDING	<u> </u>		
		245083	B. WING		11/09/2023	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE MILE.	A O AT THE DADY			4415 WEST 36 1/2 STREET		
THE VILL	AS AT THE PARK			SAINT LOUIS PARK, MN 55416		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDER) CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION	
F 755	Continued From pag	ge 23	F 75	55		
	must employ or obta pharmacist who-	Consultation. The facility ain the services of a licensed des consultation on all				
	aspects of the provise the facility.	sion of pharmacy services in				
	`	lishes a system of records of on of all controlled drugs in able an accurate				
	order and that an action is maintained and pe	mines that drug records are in count of all controlled drugs eriodically reconciled.  T is not met as evidenced				
	review, the facility farmedications (i.e., medications (i.e., medications) were tracked prevent disruption in complication for 1 of	on, interview and document illed to ensure stock edication used for multiple ed and re-ordered timely to supply and potential for the supply and potential for the sident (R38) observed to hich weren't available.		1. R38 stock medication was restorn on 11/6/23. Resident received correction after restocking. There adverse impact to R38 having to whom longer to receive the stock medicated MD updated.	ect was no ait	
	Findings include:	ary Report, dated 10/11/23,		2. 100% of current residents have potential to be affected. Inventory house stock medications complete all medications needed available.	of	
	medications and treatorder for, "Sennalax (Sennosides-Docusa	ent physician-ordered atments. This included an -S Tablet 8.6-50 MG ate Sodium) 1 tablet by lay," with a listed start date of		3. Licensed staff educated on time of medication ordering for over the counter medications, and the approsteps to take if medication is not as	opriate	
	On 11/06/23 at 7:42	p.m., licensed practical nurse 38's medications at a mobile		4. Director of Nursing and/or desig responsible for 95% or greater compliance. Audit of medication	nee is	

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7.11127 127.111 01	CONTRACTION	IDENTIFICATION NOTIFICA	A. BUILDING	<u> </u>			
		245083	B. WING			C  1/09/2023	
NAME OF PROVIDER OR SUPPLIER			<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD	•		
				4415 WEST 36 1/2 STREET			
THE VILL	AS AT THE PARK			SAINT LOUIS PARK, MN 55416			
	OLIMANA DV. OT	ATEMENT OF DEFICIENCIES			DDECTION	(34.5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 755	Continued From page	e 24	F 75	5			
F 755	cart in the hallway us Medication Administr outlined the same ord on R38's Order Summ 10/11/23). However, bottle of Senna (labe the cart, placed one locup with R38's other to administer the medication stopped by the surver acknowledged the migrovide was not the september of the sennoside Senna-S), however, with supply of the medication cart for the sennoside Senna-S), however, with supply of the medication cart for the medication cart brown-colored sennor same medication ordered an orange-colored target pharmacy, at times, of medications for the "selection on the medication on the medication on the employee to the local some.  During follow-up interest the medication and, typic scheduler" who was a medication room and needed supply from the selection of the medication room and needed supply from the selection of the medication room and needed supply from the selection and typic scheduler who was a medication room and needed supply from the selection and typic scheduler who was a medication room and needed supply from the selection and typic scheduler who was a medication room and needed supply from the selection and typic scheduler who was a medication room and needed supply from the selection and typic scheduler who was a medication room and needed supply from the selection and typic scheduler who was a medication room and the selection and typic scheduler who was a medication room and typic scheduler who was a medication r	ation Record (MAR) which der for Sennalax-S as listed mary Report (dated LPN-A removed an opened led sennosides only) from brown-colored tablet into the medications, and attempted dications before being yor (see F759). LPN-A edication they were going to same medication which had a searched the medication es-docusate sodium (i.e., was unable to locate any tion. At this time, licensed nanager (LPN)-B presented	F 75	availability to be completed w weeks to monitor compliance. Nursing and/or designee will be to the QAPI committee month for continued opportunities for improvements.	Director of oring results ly to review		
	11/06/23 (as observe	no supply the evening of ed). LPN-B explained the some "supply chain issues"					

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NAME OF PROVIDER OR SUPPLIER  THE VILLAS AT THE PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416		
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F 758	this had been happed LPN-B stated multip (i.e., HR, scheduler) and, to their knowled On 11/08/23 at 11:4 (DON) was interview was a staff member and, when needed, DON acknowledged R38's ordered stock they sent staff to the some on 11/06/23. It is supply chain issues notified of such, how until Monday when observation). Further have ensured a supply available had some of the pharmacy polymedications and relative productions and relative pharmacy, inclusioned form, however for monitoring supply medications at the relations at the relations and relations at the rel	tions supplied timely stating ening "on and off for awhile." ble people in management were aware of this issue dge, were looking into it.  3 a.m., the director of nursing wed. DON explained there assigned to monitor supply re-order stock medications. If they had run out of supply for a medication and, as a result, edrug store and purchased DON stated if there were, they typically would be evever, she "wasn't aware of it" alerted (i.e., the surveyor er, the DON stated she would exply of the medication was one told her it was gone.  On Ordering and Receiving icy, dated 1/2018, identified ated products would be spensing pharmacy on a sedure was listed for ions not automatically filled by ding use of a medication r, lacked specific instructions by or re-ordering stock nursing home; nor any this would be accomplished to supply.  Bychotropic Meds/PRN Use	F 758		1/9/24	
SS=D	CFR(s): 483.45(c)(3) §483.45(e) Psychot §483.45(c)(3) A psy					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245083	B. WING		11/09/2023	
NAME OF PROVIDER OR SUPPLIER  THE VILLAS AT THE PARK			4	STREET ADDRESS, CITY, STATE, ZIP CODE 415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416	IIII	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 758	processes and behabut are not limited to categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic  Based on a comprehesident, the facility  §483.45(e)(1) Reside psychotropic drugs and unless the medication as in the clinical record.  §483.45(e)(2) Reside drugs receive gradure behavioral intervention contraindicated, in a drugs;  §483.45(e)(3) Reside psychotropic drugs receive gradures that medication diagnosed specific of in the clinical record.  §483.45(e)(3) Reside psychotropic drugs receive gradures that medication diagnosed specific of in the clinical record.  §483.45(e)(3) Reside psychotropic drugs receive gradures that medication diagnosed specific of in the clinical record.  §483.45(e)(3) Reside psychotropic drugs receive gradures that medication diagnosed specific of in the clinical record.  §483.45(e)(3) Reside psychotropic drugs receive gradures that medication diagnosed specific of in the clinical record.  §483.45(e)(5), if the prescribing practition appropriate for the February beyond 14 days, he	es associated with mental vior. These drugs include, o, drugs in the following of the follo	F 758			

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F 758	drugs are limited to renewed unless the prescribing practition the appropriateness. This REQUIREMEN	orders for anti-psychotic 14 days and cannot be attending physician or her evaluates the resident for	F 758			
	facility failed to ensume monitoring was come the care plan and strong psychotropic (i.e., and for 2 of 5 residents (ensure as-needed (immedication use was			<ol> <li>R29 hospice provider gave order to discontinue orthostatic blood pressure monitoring. R19 and R4 orthostatic blood pressure obtained. R19's PRN anti-psychotic has been discontinued.</li> <li>All residents currently on psychotrop medications have been reviewed to ensure appropriate side effect monitoring in place. All PRN psychotropic medications reviewed to ensure stop dates are in place and discontinued whappropriate.</li> </ol>	ic	
	A National Library of of Commons Adversed Medication article, delderly were at risk of antipsychotics of antipsychotics of hypotension [which syncope, falls." It should historical and routine R29's admission Min 8/22/23, identified R required substantial actions (i.e., lying to Further, the MDS of	Medicine (NIH) Management se Effects of Antipsychotic ated 9/2018, identified the of adverse effects (i.e., falls) dication. The article outlined, arry some risk of orthostatic can] lead to dizziness, ould be evaluated by both		3. All licensed nurses are educated on importance of completing side effect monitoring and obtaining stop dates for PRN psychotropic medication.  4. Director of Nursing and/or designee responsible for 100% compliance. Nursileadership will complete audits on psychotropic side effect monitoring week x4, and audit PRN medications for stop dates weekly x4. Director of Nursing and/or designee will bring audit to the QAPI committee monthly to review for continued opportunities for quality improvements. The MD & Pharmacist a part of the psychotropic medication reviprocess for the facility monthly, and will	is sing ekly	

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			A. BUILDING	'		С	
		245083	B. WING		11	/09/2023	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•		
THE VII I	AS AT THE PARK			4415 WEST 36 1/2 STREET			
ITIE VILLA	45 AT THE PARK			SAINT LOUIS PARK, MN 55416			
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F 758	Continued From page	e 28	F 75	8			
F 758	fibrillation, and consumedication on a roution R29's Order Summari identified R29's current medications and treat order for olanzapine (medication) 2.5 milligorday for dementia with a listed start date of sorders included a sect treatment listed reading Blood Pressure while antipsychotic medication 1 month(s)," with a R29's care plan, date was at risk for falls, however the due to dementia, and with movement in an example of such medication and the summary lacked evidentified R29's collected admission (8/2023) who being recorded include (10/24/23), and 85/58 summary lacked evidentified R29's collected admission (8/2023) who being recorded include (10/24/23), and 85/58 summary lacked evidentified R29's collected admission (8/2023) who being recorded include (10/24/23), and 85/58 summary lacked evidentified R29's evidentified R29's collected admission (8/2023) who being recorded include (10/24/23), and 85/58 summary lacked evidentified R29's evidentified R29's collected admission (8/2023) who being recorded include (10/24/23), and 85/58 summary lacked evidentified R29's evidentified R29's collected admission (8/2023) who being recorded include (10/24/23), and 85/58 summary lacked evidentified R29's collected admission (8/2023) who being recorded include (10/24/23), and 85/58 summary lacked evidentified R29's collected admission (8/2023) who being recorded include (10/24/23), and 85/58 summary lacked evidentified R29's collected admission (8/2023) who being recorded include (10/24/23).	imed antipsychotic ne basis.  Ty Report, dated 10/11/23, ent physician ordered tments. This included an (an antipsychotic grams (mg) by mouth twice an behavioral disturbance with 19/14/23. Further, the signed ection labeled, "Other," with a ling, "Monitor Orthostatic eresident is receiving tions Every day shift every a listed start date 10/19/23.  The definition of the double of the doub	F 75	the facility know if any residents psychotropic medications would appropriate for dose reductions medication discontinuation, and appropriateness of the side effermonitoring and frequency.	d be s, d verifying		
	dated 10/2023, identi	ninistration Record (TAR), ified a treatment which read, Blood Pressure monthly					

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NAME OF PROVIDER OR SUPPLIER  THE VILLAS AT THE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE  4415 WEST 36 1/2 STREET  SAINT LOUIS PARK, MN 55416		11/03/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 758	start date 10/09/23. listed a discontinual and the only space (i.e., pressure) dem completed were ans subsequent TAR, distreatments or result review of R29's orthogonal with R29 several times had never complain dizzy with transfers. R29's Consultant P Regimen Review, diad still physically transfers. R29's Consultant P Regimen Review, diad admitted with orders olanzapine. The redictation had a written next to it along "Follow-Through," with transfers and lacked evidence pressure readings in the collected despite R29's meand lacked evidence pressure readings in collected despite R29's meand lacked evidence pressure readings in the collected despite R29's meand lacked evidence pressure readings in collected despite R29's meand lacked evidence pressure readings in collected despite R29's meand lacked evidence pressure readings in the collected despite R29's meand lacked evidence pressure readings in the collected despite R29's meand lacked evidence pressure readings in the collected despite R29's meand lacked evidence pressure readings in the collected despite R29's meand lacked evidence pressure readings in the collected despite R29's meand lacked evidence pressure readings in the collected despite R29's meand lacked evidence pressure readings in the collected despite R29's meand lacked evidence pressure readings in the collected despite R29's meand lacked evidence pressure readings in the collected despite R29's meand lacked evidence pressure readings in the collected despite R29's meand lacked evidence pressure readings in the collected despite R29's meand lacked evidence pressure readings in the collected despite R29's meand lacked evidence pressure readings in the collected despite R29's meand lacked evidence pressure readings in the collected despite R29's meand lacked evidence pressure readings in the collected despite R29's meand lacked evidence pressure readings in the collected despite R29's meand lacked evidence pressure readings in the collected despite R29's meand lacked evidence pressure readings in t	y 1 month(s)," with a listed However, the order also tion date which read 10/27/23, provided to record the values onstrating it had been swered, "NA." R29's ated 11/2023, lacked any s demonstrating collection or tostatic blood pressures.  on 11/7/23 at 2:58 p.m., IA)-A stated they had worked hes, and described R29 as tal assistance for most cares. ad just recently signed onto onstrated "off and on" y, if ever, ambulated; however, ansfer from her bed to the with help. NA-A stated R29 hed about being lightheaded or to their knowledge.  harmacist's Medication ated 8/21/23, identified R29	F 758			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		l` '	(X3) DATE SURVEY COMPLETED	
		245083			1	C 1/09/2023
	ROVIDER OR SUPPLIER  AS AT THE PARK			STREET ADDRESS, CITY, STATE, ZIP CO 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416	•	170372023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CONTROL (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 758	recommendations from to ensure such monity 9/21/23). In addition, order located to demand been discontinuous needed.  On 11/08/23 at 10:47 nurse unit manager of LPN-B verified they be record and were unatorthostatic blood presentation attained despite the complete such monity would typically be resummary, however attained despite the complete such monity would typically be resummary, however attained despite the complete such monity would typically be resummary, however attained despite the complete such monity would typically be resummary, however attained despite the complete such monity however attained despite the complete such monity would typically be resummary, however attained despite the complete such monity however attained despite however attained however attained however at	om the consulting pharmacist toring was in place (dated there was no physician onstrate such monitoring ed or determined as not  7 a.m., licensed practical (LPN)-B was interviewed. The provided reviewed R29's medical ble to locate evidence R29's source had been attempted or care plan directing to coring. LPN-B stated they corded in the Blood Pressure added, "I do not see those." as unlikely able to ambulate sical help, however, geto-sitting orthostatic blood e attained to help determine I symptoms were present. Important to ensure ct monitoring, including sources, was completed to c status and "[it] can alert us tion [i.e., antipsychotic] is not ""  um Data Set (MDS)  0/24/23, indicated R4 was d diagnoses of depression and identified R4 was taking tidepressant medications on ould stand and transfer	F 75	58		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION  G	` '	TE SURVEY MPLETED
		245083	B. WING		1	C 1/09/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416	•	.,
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 758	received antidepress medications to many schizophrenia and adverse reactions to included a goal to be effects.  R4's care plan date for adverse drug re psychotropic medic monitor orthostatic indicated R4 was us  R4's Order listing R -Lamotrigine Oral T bedtime and give 2 bipolar 2 disorder s -Duloxetine HCI Ca 90 mg one time per disorder starting 3/4 -Seroquel Oral Tab bipolar starting 4/17 -Trazodone HCL O 150 mg at bedtime depression starting -Orthostatic BP (blo shift starting on the every month startin -Psychotropic Monito orthostatic hypoten shift, every Monday -Psychotropic Monito orthostatic hypoten shift, every Monday -Psychotropic Monito orthostatic hypoten	dated 8/2/23, indicated she sant and antipsychotic age a diagnosis of paranoid depression and was at risk for these medications, and have no drug related side  ed 5/25/23, included potential actions related to daily use of sation, and directed staff to blood pressure. The care plan nable to stand at that time.  Report dated 11/9/23, included: ablet, 300 milligrams (mg) at 00 mg two times per day for tarting 1/20/23. apsule Delayed Release, give of day for major depressive day for major depressive day.  Ret, give 200 mg at bedtime for 7/23. aral Tablet, Give 175 mg and for insomnia associated with 8/22/23. and pressure) monthly every 15th and ending on the 15th g 8/22/23. toring- Antidepressant of the side effects including sion symptoms, weekly, every	F 78			
	orthostatic hypoten shift, every Monday	sion symptoms, weekly, every				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245083	B. WING		C 11/09/2023
	ROVIDER OR SUPPLIER  AS AT THE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 758		ge 32 complete orthostatic blood g since ordered on 8/22/23.	F 758	3	
	assessment dated a severely cognitively depression, stroke, (difficulty speaking) The MDS indicated were received only PRN (as needed).  R19's Behavioral Striggered. R19's Pstriggered. R19's Pstriggered antidepressant mediagnosis of depressions to reactions to	dications to manage a sive disorder, and he was at these medications. The ed a goal to have no			
	a mood problem relation, and instruction as order side effects. The calculation and instruction as order antipsychotic medical monitor/document sorthostatic hypotens living (ADL) focus in transfer independent	red 12/31/23, included R3 had ated to stroke, dementia and structed staff to administer red and monitor/document are plan also included R3 used cations and instructed staff to side effects, including sion. R3's activities of daily included he could stand and intly.			
	11/9/23, included:	ate Tablet 10 milligrams (mg),			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ´	ΓIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
			A. BUILDII	NG	С
		245083	B. WING _		11/09/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
	AC AT THE DADY			4415 WEST 36 1/2 STREET	
INE VILLA	AS AT THE PARK			SAINT LOUIS PARK, MN 55416	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	` '
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG		DATE
F 758	Continued From page	e 33	F 7	758	
F / 36	Give 10 mg once per starting 1/17/23Seroquel Oral Tablet times daily for major of Seroquel Oral Tablet every 24 hours as new starting 9/18/23. The datePsychotropic Monitor Medication, Monitor for orthostatic hypotensic shift, every Monday starting hypotensic hypo	day for major depression  25 mg, give one tablet two depression AND 25 mg, give one tablet eded (PRN) for agitation PRN order lacked an end  ring- Antidepressant or side effects including on symptoms, weekly, every tarting 2/27/23.  ring- Antipsychotic or side effects including on symptoms, weekly, every tarting 2/27/23.  Summary dated 11/7/23, thostatic blood pressure red on 2/27/23.  1/8/23 at 12:23 p.m., se (LPN)-B stated sure monitoring included re while lying, sitting, and dent was capable), and		758	
	psychotropic medicati medications can have				
	medication should be	on, any PRN psychotropic limited to 14 days. LPN-B			
	stop date, and it was i	quel did not have a 14 day important to use the least oic medications possible and			
	' '	liminate them if not needed.			
	During interview on 1	1/8/23 at 12:54 p.m., director			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245083	B. WING		C 11/09/2023
	ROVIDER OR SUPPLIER		4	TREET ADDRESS, CITY, STATE, ZIP CODE 415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD B  CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	DATE
F 758	used greater than 14 they can be discontinued to monitor and documents.	N psychotropic should not be days without review to see if nued, and she expected staff ment orthostatic blood at the on psychotropics and per	F 758		
F 759 SS=E	CFR(s): 483.45(f)(1) §483.45(f) Medication The facility must ensign §483.45(f)(1) Medication percent or greater;	on Errors. Sure that its- ation error rates are not 5	F 759		1/9/24
	by: Based on observation review, the facility factoristered in orders and manufactoristeristers (R25, R38, medication. A total of the second manufactorists)	on, interview and document iled to ensure medications accordance with physician turer guidelines for 3 of 6 (R45) observed to received four (4) errors out of 31 dentified resulting in a 12.9% or rate.		<ol> <li>R25, R38, and R45 were not administered the incorrect medication of to surveyor intervention prior to administration. Nurse that completed these errors received an education on Medication Administration.</li> <li>100% of current residents have the potential to be affected. All residents a receiving medications per MD orders.</li> </ol>	
	identified R25's current medications and treat order for acetaminop mouth every six hou. The order had a listed On 11/06/23 at 2:19 (RN)-A prepared R25 cart in the hallway by	ent physician-ordered atments. This included an ohen 500 milligrams (mg) by rs as needed (PRN) for pain. And start date of 9/26/23.  p.m., registered nurse 5's medications at a mobile of the nurses' station. R25 was cart and, upon being asked,		3. All licensed nurses to be educated of the medication administration process.  4. Director of Nursing and/or designee responsible for 95% or greater compliance. Three medication administration observations to be completed weekly x4. The Director of Nursing and/or designee will bring result to the QAPI committee monthly to revision continued opportunities for quality	is

STATEMENT OF DEF AND PLAN OF CORR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245083	B. WING			) 0 <b>9/2023</b>
NAME OF PROVIDE	ER OR SUPPLIER	_ <b>!</b>		STREET ADDRESS, CITY, STATE, ZIP CODE	1	
				1415 WEST 36 1/2 STREET		
THE VILLAS AT	THE PARK			SAINT LOUIS PARK, MN 55416		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 759 Con	ntinued From pag	e 35	F 759			
rate return prepared for the control outling lister 10/1 bottl two medical control order o	ed their pain an "ed trined to their room paring R25's medication Administration and the same or ed on R19's Order 11/23). However, de of acetaminop 500 mg tablets (idication cup with A then picked up to the MAR screwalk to R25's room surveyor and verwere ready for any were "pretty sur 500 mg tablets or were "pretty sur 500 mg tablets or red to the medical room as they had pat's exactly how eat's exactly	right [out of 10]." R25 then in while RN-A continued dications for administration at wed R25's electronic ration Record (MAR) which der for acetaminophen as a Summary Report (dated RN-A removed an opened then from the cart and placed e.e., 1000 mg) into the R25's other oral medications. The cup of medications, the cup of medications, the non their cart, and turned in RN-A was then stopped by diffied the medications in the dministration. RN-A stated e" the MAR directed to give if acetaminophen to R25 and cation cart to review the R25's MAR and verified it de one 500 mg tablet and prepared. RN-A added, easy it [error] can happen."	F /58	improvements.		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	` '	TE SURVEY MPLETED
			A. BUILDING	G		
		245083	B. WING		1	C 1/09/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
				4415 WEST 36 1/2 STREET		
THE VILL	AS AT THE PARK			SAINT LOUIS PARK, MN 55416		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 759	Continued From pag	ge 36	F 7	59		
	outlined the same of on R38's Order Sum 10/11/23). LPN-A re Senna (labeled sent and placed one brow with R38's other medication their cart, and tur room. LPN-A was the and verified the medication cart and orders. LPN-A verified directed to give sent (i.e., Senna-S) and inhowever, was unabled medication. At this time unit manager (LPN)-medication cart and medications which reverified the brown-content the same medications which reverified the pharmacy send the right medications of they would look for returned after severathey did not have an so they were sending drug store quick to gremoved the brownfrom R38's prepared to administer the R45's Interagency Porders/Instructions, R45 had been hospic conditions, including the same of the same returned after severathey did not have an so they were sending they were sending they did not have an so they were sending they are sending the	rder for Sennalax-S as listed mary Report (dated moved an opened bottle of nosides only) from the cart wn-colored tablet into the cup dications. LPN-A then picked cart, locked the MAR screen med to walk down to R38's en stopped by the surveyor dications in the cup were tion. LPN-A returned to the reviewed R38's current ed the medication order nosides with docusate sodium inspected the medication cart, e to locate any supply of that ime, licensed practical nurse. B presented to the reviewed LPN-A's emained in the cup. LPN-B colored sennosides tablet was action ordered because ange-colored tablet. LPN-B of at times, did not always extions for the "stock" supply, or some quick. LPN-B all minutes and expressed by of the medication on-hand, g an employee to the local get some. LPN-A then colored sennosides tablet did medications and went to his the remainder of them.				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	` <i>'</i>	) DATE SURVEY COMPLETED
		245083	B. WING			C <b>11/09/2023</b>
	ROVIDER OR SUPPLIER  AS AT THE PARK			STREET ADDRESS, CITY, STATE, ZIP CO 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 759	orders directed to more three times a day print numerous medication insulin (i.e., Humalog subcutaneous three tand Vitamin D3 50 m once daily.  On 11/8/23 at 7:47 at medications at a more then removed several	onitor R45's blood glucose or to meals, along with other n orders including Lispro	F 75	59		
	started to prepare the referencing the MAR order for Vitamin D3 (dated 10/30/23). RN bottle of Vitamin D3 2 top of the cart, however capsule (i.e., 25 mcg administration. RN-A screen, and turned to hallway. RN-A was the and verified the preparence of the preparenc	em for administration while which included the same as outlined on R45's orders I-A removed an opened 25 mcg capsules from the ver, RN-A only placed one in the cup for then locked their MAR of enter R45's room down the nen stopped by the surveyor ared medications were ready N-A returned to the reviewed R45's Vitamin D3				
	directed to administer however, they had or medication in the cup error). RN-A then add to the cup and return the medications. RN-glucose using a com resulted "301." RN-A R45's insulin and return the medication cart and reducation cart and reduca	ulin flexpen from the				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION  G	` '	ATE SURVEY OMPLETED
		245083	B. WING _			C 11/09/2023
	ROVIDER OR SUPPLIER  AS AT THE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416		11/00/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 759	301, and removed a from a box in anoth adjacent. RN-A there and walked towards insulin pen to four uprior to entering R4 questioned on the meedle prior to deliving stated the pen was to be done once where RN-A then entered medication using the flexpen. RN-A then cart and reiterated to needle should be proposed box of needles for owere no package in directions inside to a section labeled, "Indevice," which directed the user instructions directed to the user instruction device." A Lispro (insulin) Instruction device." A Lispro (insulin) Instruction labeled, "Prodirected to turn the the device upright, a drip of insulin should be proposed in the section labeled, "Prodirected to turn the the device upright, and the device upright.	nits for a blood glucose of a new Assure Duo Pro needle er medication cart parked in picked up the insulin pen is R45's room while dialing the units. RN-A was stopped just 5's room by the surveyor and need to prime the insulin very of the ordered dose. RN-A "already primed" as it only had nen the pen was first opened. R45's room and delivered the e un-primed needle and returned to the medication they were unsure if the new rimed or not adding, "Some don't." RN-A then reviewed the directions, however, there serts or manufacturer	F 7	59		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245083	B. WING		C 11/09/2023
	ROVIDER OR SUPPLIER  AS AT THE PARK		4	TREET ADDRESS, CITY, STATE, ZIP CODE 415 WEST 36 1/2 STREET 6AINT LOUIS PARK, MN 55416	1
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 759	[bolded] prime before too much or too little too much or too little On 11/8/23 at 11:43 (DON) was intervieweach of the observe errors, and the DON the situation and fol stated insulin pens stwo units" before ea "best practice" and a manufacturer guidel a.m., a subsequent DON verified they have the reported administration follow-up with educated the potential each administration follow-up with educated the medicated the medicated stopping them) them for a med error," how didn't actually received the medicated it was important to medication and dos safety."  A provided Medication of Medication and dos safety."  A provided Medication of Medication and dos safety. The policy of medications would be in accordance with gractices. The policy Right resident, right and right time, are a being administered, and right time, are a being administered.	outlined, "If you do not re each injection, you may get	F 759		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245083	B. WING		C 11/09/2023
NAME OF PE	ROVIDER OR SUPPLIER	<u> </u>	<del>_</del>	STREET ADDRESS, CITY, STATE, ZIP CODE	11/00/2020
				1415 WEST 36 1/2 STREET	
THE VILLA	AS AT THE PARK		,	SAINT LOUIS PARK, MN 55416	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD B  CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	DATE
F 759	Continued From page	e 40	F 759		
	the process of prepar	ation of a medication "			
	Residents are Free o CFR(s): 483.45(f)(2)	f Significant Med Errors	F 760		1/9/24
	The facility must ensu	ure that its-			
	•	nts are free of any significant			
	medication errors.				
		is not met as evidenced			
	by:	n interview and decument		1 D45 regident was assessed by	
		n, interview, and document ed to ensure a fast-acting		R45 resident was assessed by checking blood sugars and vital signs,	
		ewly attached needle was		Blood glucose was within normal range	غ
	•	ered in accordance with		MD was notified. No new orders given	, and the second
	•	ions to facilitate complete		continue with current orders. No advers	
	dosing of the medicat	tion for 1 of 1 resident (R45)		side effects noted. Medication error rep	oort
	observed to receive i	nsulin. This had potential to		has been completed. Nurse educated.	
	•	sulin being delivered and			
	constituted a significa	ant medication error.		2. All residents with insulin pens have t	
				potential to be affected by this practice	
	Findings include:			current residents receiving insulin via fl	lex
	R45's Interagency Ph	veician Discharge		pen had their orders reviewed and changes made as needed. Blood gluco	NS A
	•	dated 10/30/23, identified		ranges reviewed and provider updated	
	•	alized for several medical		any abnormal ranges as needed.	
	•	diabetes mellitus, and was			
	•	he nursing home. The		3. All licensed nurses to be educated of	n
		nitor R45's blood glucose		the insulin pen administration process,	
	three times a day prid	or to meals, along with other		and checking resident blood glucose to	
	numerous medication	orders including Lispro		ensure it is within range and steps to ta	ake
	insulin (i.e., Humalog	•		when not in range.	
	subcutaneous three t	imes a day per sliding scale.		4 Dinastan at Nicesia a security	
	DAF's Disad Corres C	umman, printed 11/0/00		4. Director of Nursing and/or designee	
	•	ummary, printed 11/9/23, cted blood sugars since		responsible for 100% compliance. Three insulin pen administration observations	
		sing home (11/2/23). R45's		be completed weekly x4 weeks. Direct	
		ollected three times daily and		of Nursing and/or Designee will bring	
	•	/dl (milligrams per deciliter)		results to the QAPI committee monthly	to
		er, of the total 19 blood		review for continued opportunities for	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE COMP	SURVEY
		245083	B. WING			C <b>09/2023</b>
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 117	0312023
			4	415 WEST 36 1/2 STREET		
THE VILL	AS AT THE PARK		s	AINT LOUIS PARK, MN 55416		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	Continued From page	e 41	F 760			
	sugars recorded only 200 mg/dl.	three of them were below		quality improvements.		
	medications at a mobremoved several punk R45's oral medication prepared them for ad the medications to R4 room on the bed. RN community-based glublood glucose and star RN-A returned to the hallway and removed Lispro insulin Flexper and placed it on top was RN-A stated the order units for a blood gluconew Assure Duo Proanother medication of then picked up the instowards R45's room was to four units. RN-A was entering R45's room questioned on the ne needle prior to delive stated the pen was "at to be done once whe RN-A then entered R medication using the flexpen. RN-A then recart and reiterated the needle should be pring you do, some you do box of needles for directions inside to redirections inside to redirections inside to redirections inside to redirections inside to redirections.	ministration. RN-A brought 45 who was seated in their -A then used a accometer to check R45's ated aloud it resulted, "301." medication cart in the I an opened Lilly-brand In from the medication cart while reviewing the MAR. Its were to administer four ose of 301, and removed a needle from a box in art parked adjacent. RN-A sulin pen and walked while dialing the insulin pen as stopped just prior to by the surveyor and ed to prime the insulin ry of the ordered dose. RN-A already primed" as it only had in the pen was first opened. 45's room and delivered the un-primed needle and eturned to the medication ey were unsure if the new med or not adding, "Some in't." RN-A then reviewed the ections, however, there erts or manufacturer				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	PLE CONSTRUCTION  3	(X3) DATE SURVEY  COMPLETED	
		245083	B. WING		11/	C / <b>09/2023</b>
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COI 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416		•	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPIDE DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 760	for using the needle instructions directed read the user instruction device for proper use a section labeled, "device," which directed exice according to injection device." A Lispro (insulin) Instruction device." A Lispro (insulin) Instruction labeled, "Prodirected to turn the the device upright, drip of insulin should the previous steps instructions further [bolded] prime befor too much or too little.  On 11/8/23 at 11:43 (DON) was intervied should be primed we administration. This in accordance with the A provided Medicate Guidelines policy, of medications would accordance with we however, the policy of Flexpen administration if any, manufacture followed with administration would with administration would with administration would accordance with we however, the policy of t	d written and photo instructions es with an insulin flexpen. The d, "Before injection, be sure to actions for the pen injector se and control," and outlined Priming the pen injection of the instructions for the pen injection of the instructions for the pen injection of the instructions for the pen instructions for Use, dated 2/2020, tep instructions to administer a gifth device. This included a riming your Pen," which dosing dial to two units, hold and depress the dial. A visible lid be seen and, if not, repeat until such is visible. The outlined, "If you do not one each injection, you may get be insulin."  B a.m., the director of nursing wed. DON stated insulin pensolith "the two units" before each injection was "best practice" and also the manufacturer guidelines.  Sion Administration - General dated 5/2022, identified	F 76			
F 770 SS=D	Laboratory Service	S	F 77	70		1/9/24

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING			
		245083	B. WING		11/09/2023	
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	1 111001_0	
				4415 WEST 36 1/2 STREET		
THE VILL	AS AT THE PARK			SAINT LOUIS PARK, MN 55416		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
	Continued From page CFR(s): 483.50(a) (1) §483.50(a) Laborator §483.50(a)(1) The far laboratory services to residents. The facility and timeliness of the (i) If the facility provides requirements for laboratory services, the services requirements for laboratory services, the services requirements for laboratory. This REQUIREMENT by:  Based on interview a facility failed to ensure process urinary analywere acted upon, cold the offsite laboratory manner to reduce the worsening infection) reviewed who had significantly based infection. Findings include:  R11's admission Minimum 10/17/23, identified Findings outlined R11 had more manner to request the was frequently income MDS outlined R11 had more manner to reduce the worsening infection.	e 43 (i)  Ty Services.  cility must provide or obtain or meet the needs of its is responsible for the quality services.  des its own laboratory is must meet the applicable oratories specified in part 493  T is not met as evidenced and document review, the re orders to obtain and visis' and cultures (UA/UC) lected, and transported to for processing in a timely erisk of complication (i.e., for 2 of 2 residents (R 11, R3) gas of potential		CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	ere  olved. 3 and oms ove ents ole is	
	urinary tract infection R11's care plan, date had an alteration in e care plan listed seve including, "Resident signs/symptoms of U	ed 10/18/23, identified R11 limination and mobility. The ral goals for R11's care		collection process of UA/UC urine samples timely per MD orders.  4. Director of Nursing and/or designe responsible for 100% compliance. Residents with orders for UA/UC collections to be audited weekly x4 to ensure timely collection of samples a sent to lab, and lab results reviewed	re	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
			A. BOILDING			С	
		245083	B. WING		1	1/09/2023	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE .		
THE VII I	AS AT THE PARK			4415 WEST 36 1/2 STREET			
TITE VILLA	AO AT THE FAIR			SAINT LOUIS PARK, MN 55416			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 770	Continued From pag	e 44	F 77	0			
	and incontinence prochange such product and as needed.  On 11/6/23 at 12:36 and reported, "They infection." R11 explain bladder infections are had visited the week "blood when I pee'd" result, the staff reach ordered some testing she recalled having the urine sample, howey	ng assistance with peri-cares oducts, and assisting to its every two to three hours  p.m., R11 was interviewed [family] think I have a bladder ined they had a history of ind when their family member prior, they had noticed some which caused concern. As a ned out to the physician who go be completed. R11 stated to use a bed pan to get a rer, had not heard back yet ment was to be done (i.e.,		IDT to ensure care plan, EM/provider are updated. The Di Nursing and/or designee will results to the QAPI committe review for continued opportu quality improvements.	irector of bring audit e monthly to		
	antibiotics). R11 end symptoms adding ship burning while voiding present beforehand.	orsed still having urinary					
	weekend [family] tho [R11's] urine, and the	ed. This included, "Over the ught she saw some blood in ey were concerned about a n. Explained that provider ith her symptoms."					
	R11's medical record the following:	was reviewed and identified					
	had an order for a Unit nurse, how to obtain catheterization). R11 bedpan to void, how expressed urine to concluded,	dated 11/2/23, identified R11 A/UC and was asked, by the the sample (i.e., bedpan, wanted to attempt to use the ever, did not have enough ollect an adequate sample.  "TCP [provider] updated and er for straight cath was sent."					

Facility ID: 00129

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  (		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	· '	(X3) DATE SURVEY COMPLETED	
		245083	B. WING			C <b>11/09/2023</b>	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  4415 WEST 36 1/2 STREET  SAINT LOUIS PARK, MN 55416		DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 770	Continued From pag	e 45	F 7	70			
	an electronically sign read, "OK to straight order had a handwrit symbol (i.e., staff init the page.  R11's Medication Add	rder, dated 11/3/23, identified ed physician order which cath to collect UA/UC." This ten check mark along with a ials) present on the bottom of ministration Record (MAR), ified a one-time order which					
	read, "UA/UC in the checkmark and initial completed. A subsect 11/7/23 (five days late nursing (DON) was a results would be back DON called the labor not yet have a sample working who verbalize reported R11 refused visited with R11 who a bedpan, however, an adequate sample catheterization. The evening shift for the lon 11/7/23 (morning)	ls which indicated it was quent progress note, dated er), identified the director of asked by R11 when the UA k the day prior (11/6/23). The ratory who reported they did e. DON spoke with the nurse red a previous shift nurse had to give a sample. DON then reported wanting to attempt again, was unable to provide so R11 agreed to a straight sample was collected on the aboratory service to pick up					
	(NA)-A was interview worked with R11 sev as nearly always incorporate R11 had been complesymptoms as recently yesterday [11/5/23]" collected a urine same to send to the laborate	y as "the day before and, as a result, the nurse aple "this morning [11/7/23]"					
	evidence or rationale	(i.e., refusals) why R11's					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY  COMPLETED	
		245083	B. WING		C 11/09/2023
	ROVIDER OR SUPPLIER  AS AT THE PARK		4	STREET ADDRESS, CITY, STATE, ZIP CODE 415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 770	obtained prior to 11 potential symptoms prior (i.e., blood in to care staff reporting several days later (When interviewed or registered nurse (Rusing agency and that day. RN-B stathad reported any unthat I know of [reported they received reports ample had been or still (on 11/7/23) and laboratory. RN-B stated, typically, laboratory. RN-B stated, typically, laboratory. RN-B stated, typically, laborated and sent of were unsure of the reiterated orders for "within 24 hours" and but, again, also reithere [this facility] the important to act on timely as the potentic could worsen and "On 11/7/23 at 11:39 interviewed and expobtained on 11/2/23 directed the floor statempts to collect it left the building on the statempts to collect it left the building on the statempts to collect it left the building on the statempts to collect it left the building on the statempts to collect it left the building on the statempts to collect it left the building on the statempts to collect it left the building on the statempts to collect it left the building on the statempts to collect it left the building on the statempts to collect it left the building on the statempts to collect it left the building on the statempts to collect it left the building on the statempts to collect it left the building on the statempts to collect it left the statempts the statempts the statempts the statempts to collect it left the statempts the statempts the statempts the	not been acted upon and 17/23, despite R11 having of an infection nearly a week the urine on 11/1/23) and direct those symptoms remained	F 770		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	LE CONSTRUCTION	(X3) DATE SURVEY  COMPLETED	
		245083	B. WING		11/09/2023
	ROVIDER OR SUPPLIER  AS AT THE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE  4415 WEST 36 1/2 STREET  SAINT LOUIS PARK, MN 55416	111/00/2020
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPIDEFICIENCY)	) BE COMPLETION
F 770	done." However, won 11/6/23 (three done the results where the results where (DON) to contain voiced no sample has DON acknowledge rationale or explanationale or explanationale or explanation and standard processing and standard followed through or verified orders for landard collected and acted	expressed, "Let's get this hen the DON returned to work ays later), R11 asked her vere for her test which caused at the lab, however, they had ever been sent to them. It is the medical record lacked ation for the delay in obtaining and subsequent laboratory ted, "I am asking the same I DON added, "Why wasn't this in the weekend?" Further, DON aboratory testing should be I upon timely adding such was at worsening infection	F 77	0	
	9/26/23, indicated findependent with to incontinent of urine diagnoses of diabetraumatic brain injute. R3's Urinary Incontinent of urine of one to two staff finds at risk for urinary at risk for urinary lineary for urinary lineary	inence Care Area Assessment 3, included R4 was frequently and required extensive assist or toileting, and indicated she ary infection (UTI).  ed 2/9/23, included alteration in to not wanting to get up with a see from signs and symptoms d staff to provide assistance			

1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		245083	B. WING		4	C 1/09/2023	
	ROVIDER OR SUPPLIER  AS AT THE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE  4415 WEST 36 1/2 STREET  SAINT LOUIS PARK, MN 55416			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 770	indicated R3 complated uring urination. She becoming septic.  A Provider note data last hospitalized for identified R3 was contoned burning on urination and had a history of The note included "I specified: Urinalysis A progress note data included R3 had no from signs/symptoms of idysuria (pain on urinstated "It hurts and urges". Staff encour on-call provider and UA/UC (urinalysis/u) A progress note data indicated the order for the lab by the event that morning, but stated indicated the order for the lab by the event that morning, but stated but would [10/16/23].  A progress note data indicated R3 complated but would [10/16/23].  A progress note data indicated R3 complated but would [10/16/23].  A progress note data indicated R3 complated but would [10/16/23].	ained of burning sensation e was concerned about and 10/10/23, indicated R3 was sepsis from a UTI, and oncerned she had a UTI due on, frequency, and urgency, and urgency, and urine culture".  Jrinary tract infection, site not and urine culture".  ed 10/13/23 at 9:20 p.m., antibiotics ordered, was free as of pain, resident has infection, urgency, and nation). The note includes R3 burns when I pee and I have aged fluids and notified [obtained] new order for	F 77	70			

1 ' '		IDENTIFICATION NI IMBED:		TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245083	B. WING			C <b>11/09/2023</b>	
	ROVIDER OR SUPPLIER  AS AT THE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416	•	TITOSTEGE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 770	changed in the last wher speech, confuse provider was despite indicated the provide 10/10/23 and "the reand probably weren" the change in mentaher and a urinary traconfused" and a UA/A A provider note date a confirmed UTI, convoiding with frequency confused but still forgout the st	week". She was repetitive in d and wasn't sure who the multiple visits. The note or ordered a UA/UC on sults were not forthcoming done". The note indicated status would be typical of ct infection. R3 was "clearly UC was reordered.  d 10/18/23, indicated R4 had attinued to have burning when by and urgency, and was less	F 77				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY  COMPLETED	
		245083	B. WING		C 11/09/2023
NAME OF PROVID	DER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
the the the up UT ser Du of record to I Africa SAST The SAST Out of the (i) I und (ii) SAST Africa SAS	e provider did not e same day, but se on R3's UTI conditions and a delay in posis and/or hospitality and the provider of and the provider ordingly to ensurable them safe a acility' policy on late to ensurable them. The facility must asset as a second and 24-hour and 24-	up the sample. She stated always give them their note omeone should have followed serns as she had a history of treatment could result in alization.  11/9/23 at 10:57 a.m., director as expected staff to follow up res, communicate with other are as needed, and document the residents are taken care of and healthy.  Aboratory testing and sample ested, however, none was  Dental Srvcs in NFs  )-(5)  Vices Sist residents in obtaining temergency dental care.  Facilities.  provide or obtain from an accordance with §483.70(g) wing dental services to meet esident:  rvices (to the extent covered only; and all services;  if necessary or if requested,	F 79°		1/9/24

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245083	B. WING		11/09/2023	
	ROVIDER OR SUPPLIER  AS AT THE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416	TE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	SE COMPLETION	
F 791	§483.55(b)(3) Must residents with lost of dental services. If a 3 days, the facility in what they did to ensure and drink adequate services and the excled to the delay;  §483.55(b)(4) Must circumstances where dentures is the facilic charge a resident for dentures determine policy to be the facilic charge and wish to reimbursement of dimedical expense until This REQUIREMENT by:  Based on observation review, the facility face comprehensive coordinated with a coordina	transportation to and from the ations;  promptly, within 3 days, refer or damaged dentures for referral does not occur within must provide documentation of sure the resident could still eat by while awaiting dental tenuating circumstances that  have a policy identifying those in the loss or damage of dity's responsibility and may not or the loss or damage of din accordance with facility lity's responsibility; and  assist residents who are participate to apply for ental services as an incurred inder the State plan.  It is not met as evidenced ion, interview and document failed to ensure dental needs ely assessed and, if needed, dental provider for further care of complication (i.e., cavities, residents (R29, R24) care and services.	F 79°	1. R29 oral cavity assessed and hosp provider updated with no new orders. scheduled for extraction. This is documented in R24s medical record.  2. All residents have the potential to baffected by this practice. Residents no seen by dental since admission had o assessments completed with provider updated for referral to dental as needs.	e ot ral	
	8/22/23, identified F	nimum Data Set (MDS), dated R29 had intact cognition and e., broken teeth, missing		3. Licensed nurses provided with education to ensure oral assessment completed upon admission. Social	S	

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		IDENTIFICATION NI IMBER:		X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245083	B. WING		11	C 1/09/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•	1700/2020	
				4415 WEST 36 1/2 STREET			
THE VILL	AS AT THE PARK			SAINT LOUIS PARK, MN 55416			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COMMERCE (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETION DATE	
F 791	On 11/6/23 at 4:30 playing in bed while in interviewed and explashed about her den appointments) since home several month some missing teeth which she attributed them to "fall out." R2 see a dentist as her the best shape" but addressed it with her On 11/7/23 at 1:52 p (FM)-A was interview been "kind of recluse situation and, as a retrying to help R29 wistated R29 did, at tinhaving bad bones ar had never been asked subsequent dental in appointments, provided they were agreed by a dental provider.  R29's Z-Retiring MH Management) Admissivated they were agreed by a dental provider.  R29's Z-Retiring MH Management) Admissivated they were agreed by a dental provider.  R29's Z-Retiring MH Management and provider.	.m., R29 was observed her room. R29 was ressed she had never been tal care or needs (i.e., she admitted to the nursing s' prior. R29 stated she had 'in the back" of her mouth to osteoporosis causing 9 stated she would like to teeth, in general, were not "in reiterated nobody had r since she admitted.  .m., R29's family member wed. FM-A explained R29 had e" in her previous living esult, FM-A was involved and th care decisions. FM-A nes, make comments about and "bad teeth," however, they ed about R29 or her eeds or choices (i.e., ders) to their recall. FM-A eeable to having R29 seen if she (R29) desired such.  M (Monarch Healthcare esion/Initial Data Collection dentified R29 admitted to the ne hospital. The form ions to evaluate R29's	F 79	Services educated to offer dat quarterly care conference educated on reviewing initial on all new admits for complication dental evaluation being com  4. Director of Nursing and/or responsible for 100% complication of new admissions to be audiassessments weekly x4 week conference documentation to weekly x4 weeks to ensure confered as needed. Director and/or designee will bring re QAPI committee monthly to continued opportunities for gamprovements.	s. Clinical IDT l evaluations ance with pleted. designee is ance. 100% dited for oral eks. Care to be audited dental is being of Nursing sults to the review for		

Facility ID: 00129

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245083	B. WING _		C 11/09/2023	
	ROVIDER OR SUPPLIER  AS AT THE PARK		STREET ADDRESS, CITY, STATE,  4415 WEST 36 1/2 STREET  SAINT LOUIS PARK, MN 554			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE COMPLETION THE APPROPRIATE DATE	
F 791	R29's MHM IDT (in Conference Form N R29's admission calisted several section information (i.e., metc.) This included which provided spatexamination and experimental examination was blank. The form was blank. The form was members including manager (LPN)-B.  R29's subsequent Collection V-4, data was re-admitted from again, included sexpection labeled, "D to be answered or evaluation (dated 8 checkmark placed teeth (no dentures questions of last, if subsequent summanot completed.  In addition, R29's of post-readmission in team) Care Conference was belisted a section laborated a section laborated and experimental experiment	'However, all of these sections I not completed.  Interdisciplinary team) Care V-4, dated 8/29/23, identified are conference was held and ons to record various edication use, restraint use, a section labeled, "Exams," aces to record R29's last dental ye examination, however, completed and both were left as signed by several staff plicensed practical nurse.  MHM Admission/Initial Data ed 10/17/23, identified R29 om the hospital. The form, yeral sections to evaluate the systems and included the ental," with the same questions written as the previous 8/16/23). This outlined a next to, "Resident has own or partials)," however, the any, dental examination and ary were again left blank and	F 7	791		

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245083	B. WING		C 11/09/2023
	ROVIDER OR SUPPLIER  AS AT THE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROP  DEFICIENCY)	O BE COMPLETION
F 791	was recorded.  R29's care plan, day had recently signed a mechanical soft of with personal hygie plan lacked any information or status, interventions to may maintain her teeth of the were responsible to for residents upon a Admission/Initial Day needed, refer them for appointments. In they were "not sure complained of oral pass the information could then order a runsure what, if any provided onsite. RN had complained "whowever, added the was R29 or someon completed evaluation Admission/Initial Day the spaces to recompleted evaluation and the spaces to recomplete evaluation and the spaces of	ted 9/11/23, identified R29 I onto hospice care, consumed liet, and required assistance ne cares. However, the care ormation on R29's dental nor any subsequent intain or promote oral health or condition.  on 11/8/23 at 10:40 a.m., N)-A explained the nurses o complete an oral examination admission using the MHM ata Collection tool and, if to "the social service person" However, RN-A then added" RN-A stated if a resident or dental pain, then they would in to the medical provider who referral but voiced they were dental services were I-A stated they thought R29 leeks ago" about dental pain, ley were "not 100% sure" if it the else. RN-A reviewed R29's lons (i.e., MHM lata Collection(s) and verified d information were left blank. lurses] should" be recording	F 79°		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NI IMBED:		2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		245083	B. WING		1	C 1 <b>1/09/2023</b>	
	ROVIDER OR SUPPLIER  AS AT THE PARK			STREET ADDRESS, CITY, STATE, ZIP COD 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416	•	ITOUTEUE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 791	dental pain to the floor acted upon to ensite or acted upon to ensite of they record and her dentite had not been assess should have been as dental needs were wadmission and quark LPN-B was going to for an onsite dental out here [onsite dentimportant to ensure assessed and, if need provider timely as possibility to eat, their nucause an infection.  R24's quarterly minimal 8/16/23, identified R need for extensive an hygiene and no broken the provider timely as possibility to eat, their nucause an infection.  R24's quarterly minimal 8/16/23, identified R need for extensive and hygiene and no broken to eat the provider timely as possible.  R24's diagnoses data diabetes with neuropfailure, generalized in obesity.  R24's care plan data on oral/dental health being cooperative was intervention to cooutside dental care as During an interview R24 stated that she teeth on the upper rise.	p.m. LPN-B was interviewed. had reviewed R29's medical tion and oral health needs sed. LPN-B stated R29 ssessed for what, if any, vanted or needed upon terly thereafter. As a result, work to get R29 scheduled visit "the next time they are tal]." LPN-B stated it was dental status and needs were eded, referred to a dental toor teeth can impact their utritional status and possibly mum data set (MDS) dated 24 with intact cognition, a ssistance with personal	F 79	1			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245083	B. WING		C 11/09/2023
	ROVIDER OR SUPPLIER  AS AT THE PARK		4	STREET ADDRESS, CITY, STATE, ZIP CODE 1415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416	•
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 791	need to be extracte	entist that these two teeth that ed.  valuation dated 3/1/23,	F 791		
	R24's dental exam condition of teeth widebris buildup, mode periodontal condition arrange for a referrextraction of teeth was noted in 7/202 by HealthDrive dental exam referral out for extraction of teeth arrange for a referral out for extraction of teeth arrange for a referral exam referral out for extraction of teeth arrange for a referral exam referral out for extraction of teeth arrange for a referral exam referral out for extraction of teeth arrange for a referral exam referral out for extraction of teeth arrange for a referral exam referral out for extraction of teeth arrange for a referral exam referral out for extraction of teeth arrange for a referral exam referral out for extraction of teeth arrange for a referral exam referral out for extraction of teeth arrange for a referral exam referral out for extraction of teeth arrange for a referral exam referral out for extraction of teeth arrange for a referral exam referral out for extraction of teeth arrange for a referral exam referral out for extraction of teeth arrange for a referral exam referral out for extraction of teeth arrange for a referral exam referral out for extraction of teeth arrange for a referral exam referral out for extraction of teeth arrange for a referral exam ref	dated 7/14/23, indicated for action of teeth #11/#12.  dated 7/25/23, indicated for action of teeth #11/#12,  e dated 7/19/23, indicated that end dental appointment			
	a registered nurse request to see a de appointment is place contracted dentist facility. RN-C also so needed for dental dentist can provide medical records directly.	dated 11/07/23, at 10:21 a.m., (RN)-C stated that a resident entist for a non-acute sed on list to be seen when the from HealthDrive comes to the stated that if a referral is eare beyond what the contract, the referral is sent to the ector (MRD) to arrange the at, and the nurse placed the ne resident's chart.			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	PLE CONSTRUCTION  G	(X3) DATE COM	E SURVEY PLETED
		245083	B. WING		11	C /09/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  4415 WEST 36 1/2 STREET  SAINT LOUIS PARK, MN 55416		70072020
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 791	MRD sets up appoint the referrals, but it is when the appoint mavailability and pay 9/2023 because He Center (HCMC) wo reported that R24 or chairs. MRD attempts at the University who will take reside had been no indicated MRD denied having attempts that would 7/2023 and R24 has appointments.  During an interview R24 denied ever reappointment. R24 appointment. R	dated 11/7/23, at 10:29 a.m., g sends referrals to MRD, then intments and transportation for s up to the individual clinics on ent can be set based on or. R24 could not be seen in empin Healthcare Medical uld not see her. HCMC could not fit in their dental oting to get R24 on a list to be sity of Minnesota dental school ents who cannot pay, and there tion when R24 would be seen. If any record of appointment is have been made prior to seen known for cancelling and dated 11/7/23, at 10:59 a.m., fusing to go to a dental also denied having a re to be seen.  We dated 11/7/23, at 11:17 a.m., (LPN-C) stated the MRD errals directly from rising, unless the dentist nurse before submitting a refusals by residents should DN also states there is no	F 79	91		
F 808 SS=D		g outside dental appointments. rescribed by Physician	F 80	08		1/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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		245083	B. WING		11/09/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				4415 WEST 36 1/2 STREET	
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(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X5)
PRÉFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	DATE
F 808	Continued From pag	e 58	F 80	8	
	CFR(s): 483.60(e)(1)	)(2)			
	§483.60(e) Theraper §483.60(e)(1) Thera prescribed by the att	peutic diets must be			
	delegate to a registe task of prescribing a therapeutic diet, to the law.	Ittending physician may red or licensed dietitian the resident's diet, including a ne extent allowed by State  T is not met as evidenced			
	Based on observation review, the facility facility facility of thickened liquid	on, interview, and document iled to ensure a therapeutic ids was followed and 1 resident (R21) reviewed		1. R21 did not have any adverse effection incorrect liquid being served. Resident's MD updated with no diet changes. R21 care plan reviewed and remains current. Education provided immediately to staff member.	
	Findings include:				
	diagnoses of chronic disease (COPD), no and paralysis followi	ed 8/24/21, included obstructive pulmonary n-dominant sided weakness ng a stroke, difficulty a stroke, and generalized		2. All residents on thickened liquids a have the potential to be affected. Meatickets reviewed to match MD orders resident preferences. Care plans wer reviewed and updates made as need	al and e
	muscle weakness.  R21's care plan last initiated on 5/4/23, in after a stroke, with a related to aspiration (12/27/23). The inter-	reviewed 7/26/23 and scluded a swallowing problem goal of not having injury through the review date vention initiated 7/15/2022, ament, and report as needed		3. Education provided to all staff on utilizing the meal tickets before serving any resident to ensure appropriate liquous consistencies are being served. IDT is educated to verify care plan, order, as meal ticket to all match when a new order is received.	uid s nd
	refusing to eat, or apmeals.	ns of difficulty swallowing, pearing concerned during num data set (MDS) dated		4. Administrator and/or designee is responsible for 100% compliance. Fo meal serving observations to be completed weekly x4 to verify correct liquid consistency on 20% of the	

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245083	B. WING		11/09/2023
	ROVIDER OR SUPPLIER  AS AT THE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416	1170072020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHOUL  CROSS-REFERENCED TO THE APPRO  DEFICIENCY)	LD BE COMPLETION
F 808	eating, and mechan functional status por 10/10/23, indicated resident during measured R21's Clinical Nutrity 9/26/23, indicated at textured diet with new R21's diet change for completed by the sprocess (SLP), indicated mechange that the substantial residents of the residents of	intact cognition, supervised ically altered diet. The rtion of the MDS dated there should be someone with als to assist with eating.  ion Evaluation completed on regular mechanical soft ectar thick liquids.  orm dated 10/18/23, peech language pathologist echanical soft consistency and 10/19/23, identified honey ge thickness.  ecord in which staff know ons to implement to care for 1/7/23, latest revision date of "serve diet as ordered."  on on 11/7/23, at 8:26 a.m.,	F 808	population. The Administrator and/ordesignee will bring audit results to the QAPI committee monthly to review continued opportunities for quality improvements.	he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION ILDING		(X3) DATE SURVEY COMPLETED	
		245083	B. WING		1	C <b>1/09/2023</b>	
	ROVIDER OR SUPPLIER  AS AT THE PARK			STREET ADDRESS, CITY, STATE, ZIP COI 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THIS DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 808	admitted to serving mistake.  During an interview of nurse manager (LPN beverage consistency chart, and the meal trace indicate if the beverage and NAs are the primal beverages to resider.  During an interview of culinary director (CD or department manage trays as they were all therapeutic diets.  During an interview of director of nursing (Director of nursing (Director of nursing) (Director o	on 11/7/23, at 8:53 a.m., the I-B) stated the order for y would be in the resident's icket on the tray would ge needs thickening. Nurses hary staff to deliver hts.  on 11/7/23, at 9:02 a.m. the ) stated some administration gers may, at times, pass so trained on resident  on 11/7/23, at 1:35 p.m., the OON) stated the diet, food verage thickness should all t. Nursing staff pass trays etimes others also. DON to be trained to ensure safety revent such instances, like	F 80				

$lackbox{1}{\cdot}$		DATE SURVEY COMPLETED				
		245083	B. WING			C <b>11/09/2023</b>
	ROVIDER OR SUPPLIER  AS AT THE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416	Ē	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 808	on the CDG as nectaresident's Kardex is a diet description. How meal ticket is the printfollow to assure the cresident, and the Kardenthe meal ticket was much buring an interview of LPN-B stated the Kardex information in the cardate. LPN-B also state entered to a spreadst Kardex. However, ne	r thick. NA-B stated the mother source to identify the ever, NA-B stated that the nary source that staff should correct diet is received by the dex or CDG are only used if missing.  n 11/9/23 at 9:25 a.m.,	F 80	8		
F 880 SS=E	stated expecting the changed diet orders, meal ticket in the kitch to update the care plate the Kardex and CDG Kardex, and CDG show meal plan. DON also meal plan can reduce food by the resident variation Prevention & CFR(s): 483.80(a)(1)  §483.80 Infection Con The facility must established to provide a comfortable environment.	g. Control (2)(4)(e)(f)  Introl blish and maintain an and control program a safe, sanitary and ment and to help prevent the asmission of communicable	F 88	0		1/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NITIMBER:		PLE CONSTRUCTION	l` '	(X3) DATE SURVEY COMPLETED	
			A. BUILDING	G			
		245083	B. WING		1	C 1/09/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416	•	1/00/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 880	Continued From pag	e 62	F 88	30			
	program. The facility must esta and control program a minimum, the follow \$483.80(a)(1) A systereporting, investigating and communicable of staff, volunteers, visit providing services unarrangement based of conducted according accepted national staff staff.  §483.80(a)(2) Written procedures for the procedure for the procedu	em for preventing, identifying, and controlling infections iseases for all residents, tors, and other individuals ader a contractual upon the facility assessment to §483.70(e) and following andards;  In standards, policies, and rogram, which must include, to gram, which must include, to gram, which must include, to gram, which must include, to gram spread to other to gram spread to other to gram spread to other to gram possible incidents of the gram infections should be used for a sut not limited to:					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NI IMBER:		PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED
		245083	B. WING		C 11/09/2023
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	1 11/00/2020
THE VII I	AS AT THE PARK			4415 WEST 36 1/2 STREET	
IIIL VILLA	AS AT THE PARK			SAINT LOUIS PARK, MN 55416	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHOUNDERSE ACTION SHOUNDERS)  CROSS-REFERENCED TO THE APPR  DEFICIENCY)	ULD BE COMPLETION
F 880	Continued From page	e 63	F 88	30	
	contact with residents contact will transmit to (vi)The hand hygiened by staff involved in display \$483.80(a)(4) A system identified under the factorized actions take \$483.80(e) Linens. Personnel must hand transport linens so as infection.  §483.80(f) Annual residents The facility will conducted the facility	e procedures to be followed rect resident contact.  em for recording incidents acility's IPCP and the ten by the facility.  dle, store, process, and a to prevent the spread of			
	review, the facility fail community-use glucos and disinfected between resident (R45) observing glucose checked. The 4 residents (R45, R4) diabetic on the same failed to ensure approximately with person completed with person residents (R246) who will be a sure failed to ensure approximately failed to ensure a	een patient' uses for 1 of 1 ved to have their blood is had potential to affect 4 of 1, R246, R35) who were unit. In addition, the facility opriate hand hygiene was onal cares for 1 of 2 ose cares were observed.  ANING:		1. R45 currently resides in center of adverse reactions. R246 remains it center with no adverse reactions in Nurses were educated on shared glucometer cleaning process. NAF Nurses educated on hand hygiened.  2. All residents that have blood glumonitoring or receive personal care the potential to be affected.  3. All licensed staff educated on cleaning process. Staff educated on cleaning or receive personal care the potential to be affected.	with no in the noted.  Rs and e.  ucose res have  eaning for ated on oviding
	administration was of nurse (RN)-A present			personal cares for infection prever	ntion.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION (2		(X3) DATE SURVEY COMPLETED	
			A. BUILDIN	<u> </u>			
		245083	B. WING _		1	C 1/09/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	•	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
				4415 WEST 36 1/2 STREET			
THE VILL	AS AT THE PARK			SAINT LOUIS PARK, MN 55416			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 880	black-colored, zip-medication cart and before preparing RN-A picked up the along with R45's puthem to her room. The zipped bag and glucometer from it pair of gloves from new strip into the digucose. RN-A the finger exposing a value touched the exposion which had been in reading was obtain "301." RN-A remove glucometer and distinct the placed the glucometer and distinct the placed the glucometer and distinct the placed the glucometer and the returned to the medical plack-colored bag any attempt to clear insulin, and then a another resident' in the resident' in the resident' in the was no attended they had not be a subject to the patients on the with "purple wipes there weren't any for an another resident to the patients on the with "purple wipes there weren't any for an another resident to the patients on the with "purple wipes there weren't any for an another resident to the patients on the with "purple wipes there weren't any for an another resident to the patients on the with "purple wipes there weren't any for an another resident to the patients on the with "purple wipes there weren't any for an another resident to the patients on the with "purple wipes there weren't any for an another resident to the patients on the with "purple wipes there weren't any for an another resident to the patients on the with "purple wipes there weren't any for an another resident to the patients on the with "purple wipes there weren't any for an another resident to the patients of the patients o	age 64 style (closed) bag from the d placed it on top of the cart (45's oral pills. When finished, e zipped bag from the cart repared oral pills and brought Inside the room, RN-A opened d removed an Assure Platinum. RN-A retrieved and donned a the bathroom, and inserted a device to test R45's blood in used a lancet to pierce R45's visible blood flash. RN-A ed blood droplet to the strip serted into the glucometer. A ned with RN-A stating aloud, wed the strip from the sposed of it in the trash. RN-A ucometer back into the and zipped it closed without an or sanitize the device. RN-A dication cart with the and placed it on top of the ed and administered R45's gain returned to the cart to start nedication administration. Impt to remove or clean the on 11/08/23 at 8:16 a.m., RN-A ot cleaned or sanitized the ut added, "Technically I should ated the device was used for all a unit and should be cleaned [i.e. sani-wipes]," however, so use. RN-A then looked wed a container with an (i.e., bleach wipes) and uld maybe use those instead RN-A verified blood product was an experienced blood product was a supplementation.	F 8	4. Director of Nursing and/oresponsible for 100% comp. Glucometer cleaning to be residents that have orders checks and audited weekly compliance. Hand hygiene to be completed on person x4 weeks across three shift Nursing and/or designee w to the QAPI committee mo for continued opportunities improvements.	pliance. observed on 4 for glucometer x4 weeks for competencies al cares weekly fts. Director of vill bring results onthly to review		

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  (X2) MULTIPLE ( A. BUILDING		PLE CONSTRUCTION	` ′	TE SURVEY MPLETED		
		245083	B. WING		1	C 1/09/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	and stated they wo SNSA) but had not working on the floor process on how to RN-A added, "I shot stated, in hindsight device so "we don't patients."  An Ark Care Technolidentified directions Disinfecting the Ass Monitoring System could be used for to however, cleaning should be complete transmitting blood-I meter should be clease on each patient several chemicals (sani-wipes) which of A provided electron correspondence from administrator, dated four diabetic resided resided on the unit observed to use the without cleaning or On 11/08/23 at 11:4 (DON) was intervied glucometer should between each patients stated they had not competencies for the cleaning of the glucometer should between each patients at the stated they had not competencies for the cleaning of the glucometer should between each patients at the stated they had not competencies for the cleaning of the glucometer should between each patients at the stated they had not competencies for the cleaning of the glucometer should between each patients at the stated they had not competencies for the cleaning of the glucometer should between each patients at the stated they had not competencies for the cleaning of the glucometer should be glucometer sho	via the strip) with the device, rk for a nursing agency (i.e., been trained or told prior to r with any directions or facility' clean or sanitize the device. wed up and worked." RN-A, they should have cleaned the spread germs to other  cal Brief, dated 9/2019, listed for, "Cleaning and sure Platinum Blood Glucose." This outlined the device esting on multiple patients, and disinfecting the device ed to minimize the risk of corne pathogens adding, "The eaned and disinfected after t." Further, the brief listed i.e., germicidal wipes,	F 88			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	<b>,</b> ,	(X3) DATE SURVEY COMPLETED	
		245083			11	C /09/2023	
NAME OF PROVIDER OR SUPPLIER  THE VILLAS AT THE PARK				STREET ADDRESS, CITY, STATE, ZIP CO 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416	•	10912023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CONTROL (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 880	don't know for sure.' glucometer should he "infection control" as spread."  A facility' policy on go was requested, how the standard of the spread of the standard of the spread of the	'Further, DON verified the nave been cleaned for proper dding, "That's how infections alucometer use and cleaning vever, none was received.  bservation of personal cares a.m., nursing assistant (NA)-C to R246's room. Without giene, NA-C and NA-D C assisted R246 roll to right loved hand on R246 and ff R246's brief which was diffeces, rolled it up, and trash bag. NA-D doffed nem into the trash bag and	F 88				
	for the resident to che	nts and a pair of grey pants noose from to wear. on 11/8/23, at 8:16 a.m., en helping a resident with a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245083	B. WING		C 11/09/2023	
NAME OF PROVIDER OR SUPPLIER  THE VILLAS AT THE PARK				STREET ADDRESS, CITY, STATE, ZIP CODE  4415 WEST 36 1/2 STREET  SAINT LOUIS PARK, MN 55416	1170372020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 908 SS=C	brief change, and god they are to wash han gloves on hands and in-between performing placing clean gloves performing hand hyg resident infections. Do hand sanitize when on why?  During an interview of DON stated she expeditty to clean tasks, the glove, sanitize their hand do that in-between Essential Equipment CFR(s): 483.90(d)(2)  §483.90(d)(2) Maintal and patient care equipment care equipment condition.  This REQUIREMENT by:  During observation, review, the facility fair dishwasher was main manufacturer's instructional three had the potential within the facility review, the facility review, the facility review equipment being main operating condition.  Findings include:  During observation of the had the potential within the facility review equipment being main operating condition.	Ing from dirty to clean tasks, ds prior to placing new distouching the resident, ag a dirty to clean task and on hands. NA-D stated that dene properly helps reduce aid NA-D indicate if he did completing this task and if not sompleting this task and if not an 11/9/23, at 2:18 p.m., the exts that when staff go from hely would dispose of their rands, and place new gloves an each dirty to clean task.  Safe Operating Condition  In all mechanical, electrical, apment in safe operating  It is not met as evidenced interview and document led to assure that the kitchen intained per the citions, causing buildup of a the outside of the machine. It to affect all 44 residents ewed for essential intained in a safe and	F 90	1. Dishwasher de-scaled and water softener hardness level has been low to 3dH to meet manufacturer guideline.  2. Preventative maintenance schedule has been added to TELS monthly for Ecolab to come out and service dishwashing machine monthly with Culinary Director oversight.  3. Maintenance educated on steps for Dish Machine Use and Care. Culinary Director and Dietary Staff educated on	es.	
	kitchen dishwasher, v	n 11/6/23, at 11:57 a.m., the which was a Hobart single ercial dishwasher, had 80%			n ELS	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245083	B. WING		1	C 1/09/2023	
	ROVIDER OR SUPPLIER  AS AT THE PARK			STREET ADDRESS, CITY, STATE, ZIP C 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 908	of the top covered in residue, the bottom of 100% covered in who front legs was cover raised residue.  During an interview of (CD), on 11/7/23, at not know the recommender cleaning schedule for that EcoLab comes of the dishwasher, and responsibility to call cleaning. CD stated maintain the dishwasher was last the machine dishwasher was last the machine and helmachine called Lime and CD-A state it is dishwasher needs to buring documentation p.m., kitchen staff dishwasher needs to buring an interview of the water softener is stated that the water malfunctioning since was fixed on October the water softener is stated that the wa	white and yellow peeked of the inside and sprayer was ite residue and 40% of the ed in a thick, bumpy, and with the Culinary Director 11:28 a.m., stated that he did mended maintenance or or the dishwasher. CD stated to the facility and assesses it is the facilities Hobart for maintenance and that Hobart refuses to sher because it is facility trecall the last time the cleaned or serviced.  with the Corporate Culinary CD on 11/7/23, at 3:06 p.m., to use a product that clings to ps reduce limescale on the eaway. However, both CCD not working and that the be delimed and decalcified.  on review on 11/7/23 at 3:08 d not document a limescale in the dishwasher from April of 2023.	F 9	Director educated on the machedule.  4. Culinary Director and/or responsible for 100% compound complete monthly audits to complete monthly audits to compliance with preventation maintenance schedule. Audits completed 3 shifts per wee dishwasher is in good stand Director and /or designee to to the QAPI committee more for continued opportunities improvements.	designee is bliance. signee to ensure we dit to be k to inspect ding. Culinary o bring results onthly to review		

<b>I</b> *		IDENTIFICATION NI IMBER:		PLE CONSTRUCTION	1 ' '	(X3) DATE SURVEY COMPLETED	
		0.45000				С	
NAME OF DE		245083	B. WING _	OTDEET ADDDESS OF A TABLE 71D O		11/09/2023	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE		
THE VILLA	AS AT THE PARK			4415 WEST 36 1/2 STREET			
Т				SAINT LOUIS PARK, MN 55416			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 908	Continued From page	e 69	F 9	08			
	According to the Hoba	art dishwasher					
	manufactures recomm	nendations, to protect the					
	,	r hardness should not					
		r it is recommended to use					
	a Hobart Hydroline was	ater softener/ treatment					
	According to a policy	titled, Dish Machine Use					
		12, the dish machine should					
		o. The facility is to follow the					
		1. Chemical de-limer should					
		ny buildup on the interior and					
	exterior of the dish ma						
	2. Frequency for use	on for dilution product use.					
	LivingCenter need.	is determined by					
	Livingochter need.						

Minnesota Department of Health

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		` ´	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С
		00129	B. WING		11/09/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	ΓE, ZIP CODE	
THE VILL	AS AT THE PARK		EST 36 1/2 STREE LOUIS PARK, MN		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
2 000	Initial Comments		2 000		
	****ATTEN	TION*****			
	NH LICENSING CO	DRRECTION ORDER			
	144A.10, this correction pursuant to a survey. found that the deficier herein are not correct not corrected shall be with a schedule of fine the Minnesota Depart.  Determination of where corrected requires conrected requires conrequirements of the runumber and MN Rule. When a rule contains comply with any of the lack of compliance. Line-inspection with any result in the assessments.	ther a violation has been			
	that may result from norders provided that a	earing on any assessments on-compliance with these written request is made to 15 days of receipt of a for non-compliance.			
	conducted at your factorises the Minnesota Department facility was NOT in conficency and the following issued. Please indicate	a licensing survey was ility by surveyors from the nt of Health (MDH). Your mpliance with the MN State owing correction orders are te in your electronic plan of eviewed these orders and			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

STATE FORM 6899 6PCP11 If continuation sheet 1 of 55

(X6) DATE

TITLE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:	(X3) DATE SURVEY COMPLETED
	00129	B. WING	C 11/09/2023

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ROVIDER OR SUPPLIER STRE	STREET ADDRESS, CITY, STATE, ZIP CODE						
4415	4415 WEST 36 1/2 STREET						
	NT LOUIS PARK, MN 5	5416					
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				
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 1 identify the date when they will be completed.  The following complaints were reviewed during the survey: H50836890C (MN95910) H50836889C (MN97850) and NO licensing orders were issued.  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.  You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html</a> The State licensing	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETE				
you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the							
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 1  identify the date when they will be completed.  The following complaints were reviewed during the survey: H50836890C (MN95910) H50836889C (MN97850) and NO licensing orders were issued.  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.  You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html</a> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the electronic State licensure process, under the heading completion date, the date your orders will be	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 1 identify the date when they will be completed.  The following complaints were reviewed during the survey: H50836889C (MN97850) and NO licensing orders were issued.  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.  You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin -https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the	AS AT THE PARK  SUMMARY STATEMENT OF DEFICIENCIES  (REACH CEPCIENCY MUST BE PRECEDED BY PULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 1  identify the date when they will be completed.  The following complaints were reviewed during the survey;  H5083689C (MN95910)  H50836889C (MN95950) and NO licensing orders were insued as statutes/rules for Nursing Homes. The assigned to Minnesota abea statutes/rules for Nursing Homes. The assigned to Minnesota test statutes/rules for Nursing Homes. The assigned to Minnesota test statutes/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.  You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin orlinfobulletins/bi14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date you orders will be corrected prior to electronically submitting to the				

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:	(X3) DATE SURVEY COMPLETED
	00129	B. WING	C 11/09/2023

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

#### THE VILLAS AT THE PARK

#### 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416

THE VILLAS AT THE PARK  SAINT LOUIS PARK, MN 55416					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)	(X5) COMPLETE DATE	
2 000	Continued From page 2	2 000			
	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. http://www.health.state.mn.us/divs/fpc/profinfo/inf obul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.				
	PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.				
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General	2 830		1/9/24	
	Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00129	B. WING		C 11/09/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE	
THE VILL	AS AT THE PARK		ST 36 1/2 STRE DUIS PARK, MN		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
2 830	of bed as much as power written order from the	ribed in parts 4658.0400 and g home resident must be out a ssible unless there is a attending physician that the in bed or the resident	2 830		
	by: Based on observation review, the facility fail fall interventions, performant post-fall root cause an implement subsequent residents (R4) review	n, interview, and document ed implement care planned form a comprehensive nalysis, and initiate and ht fall interventions for 1 of 4 ed for falls.		completed	
	10/24/23, indicated R lower extremity impair a wheelchair for mobilifracture, depression, antipsychotic, antidephypoglycemic medical incontinent of bladder of bowel, and not on a R4's Falls Care Area indicated R4 was at riproblems. R4 was on assistance when move position and on and of with a history of falling R4's ADL (activities of	and frequently incontinent a toileting program.  Assessment dated 8/2/23, isk for falls due to balance ly able to stabilize with staff ring from seated to standing off toilet and was admitted			

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Minnesot	a Department of Healtl	h				
STATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE S	SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			B. WING			
		00129	D. WING		11/0	9/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	ATE, ZIP CODE		
		4415 WE	ST 36 1/2 STREI	ET		
THE VILL	AS AT THE PARK	SAINT LO	DUIS PARK, MN	55416		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
2 830	Continued From page	e 4	2 830			
	8/2/23, indicated she	•				
		due to recent spinal fusion				
	•	e fracture and was at risk for				
	falls.					
	R4's Urinary Inconting	•				
		ssessment dated 8/2/23				
		quently incontinent of urine				
	•	e assistance of 1-2 persons				
	for toileting and was a	at risk for falls.				
		ated 6/7/23, indicated she				
		while self-transferring from				
	wheelchair to bed.					
		1.0/0/00 : 1: 1.54				
		d 6/8/23, indicated R4 was				
	<b>'</b>	ommode to allow more room				
	for toileting.					
	Λ	-L 0/47/00				
		d 6/17/23, indicated R4 was				
	found on the floor after	er coming from the				
	bathroom.					
	•	pdated 6/19/23, included R4				
		lated to ankle fracture and				
	had a fall while self-tr	<b>G</b>				
	_	d provision of bedside				
	commode.					
	<b>D</b> 41					
		plan focus dated 6/19/23,				
	included R4 required	assist of 2 with toileting and				

Minnesota Department of Health

offer every 2-3 hours.

R4's MHM Balance/ROM 3.0 dated 10/24/23,

without staff assistance when moving from a

transferring from surface to surface, The form

identified R4 had lower extremity impairment on

walking, moving off the toilet, and when

indicated R4 was not steady but able to stabilize

seated to standing position, walking, turning while

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
		00129	B. WING		C 11/09/2023	
NAME OF PROVIDER OR S	SI IDDI IED		ADDRESS, CITY, STATE	7 7 CODE	1170072020	
NAME OF PROVIDER OR A	DOPPLIER		EST 36 1/2 STREET			
THE VILLAS AT THE F	PARK		OUIS PARK, MN 5			
	CH DEFICIENCY MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETE THE APPROPRIATE DATE	
2 830 Continued	From page 5		2 830			
one side.						
indicated using the wheelchal The note the bathro pants, she note indicated and wants.  A progres indicated R4's fall a intervention	R4 fell while pull bathroom and war using a mechal ndicate R4 state om and when see felt her legs go ated R4 told stated a commode. In the interdisciplinate of the prevent funding a gement of R4's a digement of R4's a dige	11/3/23 at 8:44 a.m., ling up her pants after vas assisted into her anical lift and two staff. ed she needed to use he was pulling up her weak and she fell. The ff she fell because she air into the bathroom  (3/23 at 10:04 a.m. eary team met regarding ation of immediate ther falls, nor inability to get into her				
R4's MHM Fall Review Evaluation dated 11/6/23, indicated R4 had fallen 1-2 times in the previous six months, was occasionally incontinent of bladder in the previous 14 days, exhibited a loss of balance while standing and required a wide base of support, and lacked environmental factors and interventions.						
11/6/23, in ambulating occupation as well as intervention immediate acknowled bathroom.	ndicated R4 fell of gon 11/3/23. The nal, and speech Psych referral and speech ons. The form late interventions to dgement of R4's	cked identification of prevent future falls, or inability to get into her				
		terview on 11/6/23 at legs were 'bad' and she				

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STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURV	ΈΥ
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		00400	B. WING		C	
		00129	D. VVIIVO		11/09/2	023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STA	TE, ZIP CODE		
THE VII I	AS AT THE PARK	4415 WE	ST 36 1/2 STREE	T		
INE VILL	45 AT THE PARK	SAINT LO	DUIS PARK, MN	55416		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	NC	(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		OMPLETE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
2 830	Continued From page	e 6	2 830			
	wanted a commode h	by her bed. She stated she				
		aken away and staff told her				
		bathroom, but she wasn't				
		she had to drag her left leg				
		e. She stated her wheelchair				
		door to the bathroom, and transfer from the door to				
	did not have a comm	a couple of days prior. R4				
	did not nave a commi	ode in her room.				
	During observation a	nd interview on 11/8/23 at				
		ssistant (NA)-F observed R4				
	,	her wheelchair through the				
		e it got stuck in the doorway.				
		ot fit through the door, and				
	confirmed R4 would i	,				
		to get to the toilet. R4 stated				
	• •	because the rails on the				
		idn't fit, and she used to				
		t the facility took it away.				
	mave a commode, bu	t the facility took it away.				
	During interview on 1	1/8/23 at 10:23 a.m., NA-G				
		t of residents who were at				
		s identified on the residents'				
		ed R4 was independent with				
	toileting and was not	•				
	During interview on 1	1/9/23 at 8:15 a.m., NA-H				
	stated residents' care	plans identified any				
		greater risk of falling, and				
	· ·	s on the floor, lower beds,				
		ecked more often. They				
		o the bathroom by herself				
	•	s called for help. R4 was not				
	• '	sferred, and did not walk.				
	a rang non, processing					
	During interview on 1	1/9/23 at 8:24 a.m., licensed				
		-A stated for every fall the				
	•	sk management form, added				
	•	ased upon the specifics of				

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Willingson Bopartinont of Floare	11				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:	(X3) DATE SURVEY COMPLETED		
	00129	B. WING	C 11/09/2023		
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE				

	00123			11/09/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STA	ATE, ZIP CODE	
		4415 WEST 36 1/2 STRE	ET	
THE VILLA	AS AT THE PARK	SAINT LOUIS PARK, MN		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIEN (EACH DEFICIENCY MUST BE PRECEDED REGULATORY OR LSC IDENTIFYING INFO	NCIES ID PREFIX	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)	(X5) COMPLET DATE
2 830	Continued From page 7	2 830		
	the fall, and managers added intervention care plan. They stated R4 was sometime independent, but sometimes used her cask for assistance to the bathroom. The think R4 was at high risk for falling and seen her walk.	nes call light to ey did not		
	During interview on 11/9/23 at 8:30 a.m occupational therapist (OT) stated she R4 pivot transferred and was resistant therefore toilet in her bathroom. They did not R4 could ambulate.	believed to using		
	During observation and interview on 11 9:02 a.m., LPN-B stated after a resident nurse implemented an intervention base the specifics of the fall using nursing just The IDT team then completed a post-face adjusted the intervention if needed, and to the care plan and the NA care guides stated R4 was non-ambulatory but could the toilet in her wheelchair and usually bathroom herself. LPN-B went to R4's rewhere R4 attempted to wheel herself in bathroom. LPN-B confirmed R4's wheel not fit through the bathroom door and R have to walk 4 or 5 steps to get to the training. R4 told LPN-B she had trouble get bathroom and had a hard time standing used to have a commode but it was take LPN-B stated R4 needed to be able to through the bathroom door in her wheel decrease fall risk and episodes of incordand increase independence and was not aware of the issue. LPN-B confirmed R plan did not contain updated interventions.	ant fell the sed upon adgment. All analysis, ad added it . LPN-B ld get to went to the room ato the elchair did R4 would coilet and etting to the g up, and ken away. get elchair to antinence ot made R4's care		
	During interview on 11/9/23 at 10:57 a.d of nursing (DON) stated fall risk assess were completed at admission, quarterly	sments		

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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		00129	B. WING		11/09/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		4415 WES	ST 36 1/2 STREE	ET		
THE VILL	AS AT THE PARK	SAINT LC	UIS PARK, MN	55416		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
2 830	with significant changestated if a resident fer complete a fall evaluation immediate intervention meet later to review to intervention as needed a new intervention affectly and was not at not fit through the base. The Fall Prevention and the fall Prevention and the fall preventions related risks and causes to provide a falling and try to minificate and try to minificate and the fall.  SUGGESTED METHOMETHE The director of nursing review/revise policies falls, accidents and reproper assessment as implemented. They could be policies and procedure and monitoring consistence policies could be results of these audit facility's Quality Assurbase.	ges, and as needed. They II, they expected the nurse to ation and implement ons, and the IDT team would he fall and adjust the ed. She stated she expected ter each fall for resident ware R4's wheelchair could throom door.  and Management policy red staff will identify to the resident's specific orevent the resident from mize complications from s, staff will implement c interventions based on the  IOD OF CORRECTION: ag (DON) or designee, could and procedures related to resident supervision to assure and interventioins are being ould re-educate staff on the res. A system for evaluating stent implementation of the developed, with the s being brought to the rance Committee for review.	2 830			
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one				
2 860	MN Rule 4658.0520 Proper Nursing Care	Subp. 2 F. Adequate and ; Hands-Feet	2 860		1/9/24	
	Subp. 2. Criteria for proper care. The crit	determining adequate and eria for determining				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THE VII I	AS AT THE PARK	4415 WE	EST 36 1/2 STREI	ET	
THE VILL	AS AT THE PARK	SAINT L	OUIS PARK, MN	55416	
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2 860	Continued From pag	je 9	2 860		
	Fingernails and toen trimmed.  This MN Requirement by: Based on observation review the facility fails care to 2 of 3 resider for dependent activition R19's annual Minimulassessment dated 8% severely cognitively is demential and aphasing behavioral concern.  R19's Cognitive Loss Assessment dated 8% assistance with ADLs.	ention to hands and feet.  ails must be kept clean and  ant is not met as evidenced  on, interview and document led to provide hygienic nail ats (R35 and R19) reviewed ies of daily living (ALD's).  Jan Data Set (MDS) Jan D		completed	

often used his hands to eat and required set-up and encouragement for personal hygiene, but lacked nail care assistance needs. His behavioral focus dated 4/1/22, included R19 had behaviors of putting fecal matter on his plates/trays at mealtimes.

R19's ADL care plan dated 4/20/20, indicated he

assessed or triggered.

A note from the Associated Clinic of Psychology dated 8/23/23, instructed staff to continue to monitor for signs that he is smearing or digging [feces], and consider keeping fingernails short. Ongoing monitoring for any signs of digging/residue on fingers can help manage and continue to keep client clean and maintain

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		, ,	(X3) DATE SURVEY COMPLETED	
		00129	B. WING		11	C <b>/09/2023</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
THE VILL	AS AT THE PARK		EST 36 1/2 STREET	5.4.16			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	LOUIS PARK, MN 5	PROVIDER'S PLAN O	E CORRECTION	(X5)	
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2 860	Continued From page	e 10	2 860				
	hygiene.						
	included weekly skin nurse, and complete Inspection in [electron Thursday evening for refusals in a nurse's refusals in a nurse's refusals in a nurse's refusals in a nurse's refusals on 9/21/23 10/18/23, and 11/2/23 documentation for the R19's Progress Notes refusal of cares, including observation or was seated on a chain nurses' station. His find	skin care, document all note, starting 7/20/23.  Skin Inspection V forms Necessary" to trim his 3, 10/9/23, 10/12/23, 3. The medical record lacked a weeks of 9/28 and 10/25.  Is lacked documentation of ding bathing or nail care, 11/7/23.  In 11/7/23 at 10:36 a.m., R19 r in the hallway by the ngernails were noted to be ng with brown crusted					
	was seated in a chair in front of him contain appeared to be rice, sunidentified food item his left hand to pick u	n 11/7/23 at 12:18 p.m., R19 in his room with a tray table hing a plate of what sweet potatoes, and another n. R19 used his fingers on p food bites and place them but the meal until it was					
	assistant (NA)-D state documented nail care resident was diabetic	1/7/23 at 1:07 p.m., nursing ed NAs completed and on bath days unless a and if a resident refused, stated R19 ate on his own dementia and some					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
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THE VIII I		4415 WE	ST 36 1/2 STREE	<b>ET</b>		
I THE VILL	AS AT THE PARK	SAINT LO	OUIS PARK, MN	55416		
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				DEFICIENCY)		
2 860	Continued From page	e 11	2 860			
	behaviors, including r	resisting cares and				
	defecating and urinat	_				
		nd, but if in a good mood				
	would let staff wash h	is hands and trim his nails.				
		nd interview on 11/7/12 at				
		ctical nurse (LPN)-B stated				
	NAs completed nail c residents on bath day					
		sals. LPN-B observed R19's				
	' '	med they were long and				
	soiled and described	them as "not great". They				
		ıld get someone to cut them				
	•	villingness. LPN-B stated				
		empted to clean and trim				
		t in the record and was entified as unnecessary in				
		d it was important to keep				
		ned for infection control				
	purposes and to prev	ent scratching and skin				
	integrity concerns.					
	R35's Face Sheet for	m, printed 11/7/23, indicated				
		nat includes metabolic				
		lectual disabilities, type 2				
	diabetes, and delusio					
		mum Data Set (MDS), dated assessment of daily and				

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activity preference was not conducted by staff.

R35's quarterly MDS, dated 9/26/23, indicated

R35's Care Area Assessment (CAA), dated

assessment was not completed or triggered.

6/27/23, indicated that the ADL functional

R35 was moderately cognitively impaired and did

Additionally, R35 is dependent of staff for

showering/bathing and toileting.

not refuse care.

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	` '	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED	
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		00129	B. WING		1 11	/09/2023	
NAME 05 D		<b>!</b>		TE 710 000E	<u> </u>		
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA				
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2 860	Continued From page	e 12	2 860				
	R35 required assistant and assistance of one R35's orders, dated 1 nurses to document Fevery day shift Saturd refusals.  R35's bath and nail can also the resident with bath R35's treatment admit printed 11/7/23, indicated states assisted the resident medical record (EMR resident refused bath R35's treatment admit printed 11/7/23, indicated states assisted the resident medical record (EMR resident refused bath R35's treatment admit printed 11/7/23, indicated states assisted the resident medical record (EMR resident refused bath R35's treatment admit printed 11/7/23, indicated states assisted the resident medical record (EMR resident refused bath R35's treatment admit printed 11/7/23, indicated states as a sisted the resident refused bath R35's treatment admit printed 11/7/23, indicated states as a sisted the resident refused bath R35's treatment admit printed 11/7/23, indicated states as a sisted the resident refused bath R35's treatment admit printed 11/7/23, indicated states as a sisted the resident refused bath R35's treatment admit printed 11/7/23, indicated states as a sisted the resident refused bath R35's treatment admit printed 11/7/23, indicated states as a sisted the resident refused bath R35's treatment admit printed 11/7/23, indicated states as a sisted the resident refused bath R35's treatment admit printed 11/7/23, indicated states as a sisted the resident refused bath R35's treatment admit printed 11/7/23, indicated states and r35's treatment admit printed 11/7/23's treatment admit printed 11/7/23's treatment admit printed 11/	nistration record (TAR), ated that on 11/4/2023, staff with bathing. The electronic					
	10 of R35's fingernail length with a buildup underneath the finger he would like them tri  During an interview of CNA-A stated that if Fit trimmed and cleaned because the resident visit R35 in his room, fingernails and indicate the state of the state o	mail bed. R35 indicated that mmed and cleaned.  n 11/7/23 at 12:55 p.m., R35 needed his nails					
	During an interview o	n 11/8/23 at 8:00 a.m.,					

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CNA-C stated that during bath days, she will

assist R35 with nail care. If a resident was to

refuse, she would re-approach the resident and

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,		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		
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		00129	B. WING		11/09/2023	
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THE VILL	AS AT THE PARK		OUIS PARK, MN			
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2 860	Continued From page	e 13	2 860			
	attempt to provide na	il care. If CNA-C was				
	• •	ould inform the Registered				
	During an interview o	on 11/7/23 at 1:37 p.m., the				
		-B) stated that on bath days,				
	residents are to have	their nails trimmed and				
	•	d nursing assistant (CNA). If				
		ic, a licensed nurse is ails. LPN-B stated that R35's				
	•	' and soiled and should be				
	trimmed.					
	Director of Nursing (E	on 11/8/23 at 12:38 p.m., the DON) stated that she would the care plans for the				
	the resident's prefere	e care in a timely manner per ences. She expected that nail ed on shower/ bath days and				
		e visibly dirty, staff should be				
		eath the nailbed. If residents				
	· · · · · · · · · · · · · · · · · · ·	are expected to reapproach ditional times, inform the				
		, and document refusals.				
	· · · · · · · · · · · · · · · · · · ·	es of Daily Living (ADL's)/ ted 3/31/23, indicates that a				
		le to carry out their own				
	·	ssist them as necessary to on, grooming, and personal				
	and oral hygiene.	on, grooming, and personal				
		IOD OF CORRECTION:				
		ng (DON) or designee, could				
	• •	ent policies and procedures f daily living - nail care. The				
		uld provide training for all				
	,	o nail care. The quality				
	assessment and assi	urance committee could				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:	(X3) DATE SURVEY COMPLETED
	00129	B. WING	C <b>11/09/2023</b>

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

INAIVIL OI I		STREET ADDRESS, CITY, STATE, ZIP CODE				
THE VILL	AS AT THE PARK	4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)	(X5) COMPLETE DATE		
2 860	Continued From page 14  perform random audits to ensure compliance. In addition the DON or designee could develop and implement policies and procedures related to accommodating resident preferences to ensure timely nail care hygiene  TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 860				
21325	Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies.  This MN Requirement is not met as evidenced by: F791  Based on observation, interview and document review, the facility failed to ensure dental needs were comprehensively assessed and, if needed, coordinated with a dental provider for further care to reduce the risk of complication (i.e., cavities, oral pain) for 2 of 2 residents (R29, R24) reviewed for dental care and services.  Findings include:  R29's admission Minimum Data Set (MDS), dated	21325	Completed	1/9/24		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:	(X3) DATE SURVEY COMPLETED	
	00129	B. WING	C 11/09/2023	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE				

NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
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	REGULATORY OR LSC IDENTIFYING INFORMATION)	21325	CROSS-REFERENCED TO THE APPROPRIATE	DATE		
	trying to help R29 with care decisions. FM-A stated R29 did, at times, make comments about having bad bones and "bad teeth," however, they had never been asked about R29 or her subsequent dental needs or choices (i.e., appointments, providers) to their recall. FM-A stated they were agreeable to having R29 seen by a dental provider if she (R29) desired such.  R29's Z-Retiring MHM (Monarch Healthcare Management) Admission/Initial Data Collection V-3, dated 8/16/23, identified R29 admitted to the nursing home from the hospital. The form outlined several sections to evaluate R29's various health systems (i.e., allergies, immunizations) including a section labeled, "Dental." This section had spaces to record what, if any, complications R29 had with her teeth (i.e., broken teeth, inflamed gums) along with space to					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
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NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	, ZIP CODE	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIES (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIES (EACH CORRECT)	ULD BE COMPLETE
21325	record denture use a dental visit and Pysic "Dental Summary." Havere left blank and many and the R29's MHM IDT (interpretation of the R29's admission care listed several section information (i.e., medical etc.) This included a which provided space examination and eye neither section was desirable blank. The form was members including limanager (LPN)-B.	and a field labeled, "Last cians [sic] Name," and, However, all of these sections not completed.  erdisciplinary team) Care 4, dated 8/29/23, identified e conference was held and	21325		

was re-admitted from the hospital. The form, again, included several sections to evaluate R29's various health systems and included the section labeled, "Dental," with the same questions to be answered or written as the previous evaluation (dated 8/16/23). This outlined a checkmark placed next to, "Resident has own teeth (no dentures or partials)," however, the questions of last, if any, dental examination and subsequent summary were again left blank and not completed.

In addition, R29's corresponding post-readmission MHM IDT (interdisciplinary team) Care Conference Form V-4, dated 10/26/23, identified a significant change conference was being completed and, again, listed a section labeled, "Exams," with spaces to record dental and eye examination dates and any corresponding comments about each. However,

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:	(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PI	ROVIDER OR SUPPLIER STREET A	DDRESS, CITY, STATE	E, ZIP CODE	
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21325	again, these spaces were left blank and no data was recorded.  R29's care plan, dated 9/11/23, identified R29 had recently signed onto hospice care, consumed a mechanical soft diet, and required assistance with personal hygiene cares. However, the care plan lacked any information on R29's dental condition or status, nor any subsequent interventions to maintain or promote oral health or maintain her teeth condition.  When interviewed on 11/8/23 at 10:40 a.m., registered nurse (RN)-A explained the nurses were responsible to complete an oral examination for residents upon admission using the MHM Admission/Initial Data Collection tool and, if needed, refer them to "the social service person" for appointments. However, RN-A then added they were "not sure." RN-A stated if a resident complained of oral or dental pain, then they would pass the information to the medical provider who could then order a referral but voiced they were unsure what, if any, dental services were provided onsite. RN-A stated they thought R29 had complained "weeks ago" about dental pain, however, added they were "not 100% sure" if it was R29 or someone else. RN-A reviewed R29's completed evaluations (i.e., MHM Admission/Initial Data Collection(s) and verified the spaces to record information were left blank. RN-A stated "we [nurses] should" be recording such data in the tool.	21325		DATE
	R29's medical record was reviewed and lacked evidence R29's oral health or dentition had been comprehensively assessed for what, if any, dental needs or issues were present which needed to be addressed or referred to a dental provider; nor evidence R29's potential voiced complaints of			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER	IE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE			

NAME OF PI	ROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STA	TE, ZIP CODE	
THE VILL	AS AT THE PARK	4415 WEST 36 1/2 STREE SAINT LOUIS PARK, MN		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)	(X5) COMPLETE DATE
21325	Continued From page 18	21325		
	dental pain to the floor staff had been evalua or acted upon to ensure appropriate follow-u			
	On 11/8/23 at 12:52 p.m. LPN-B was intervied LPN-B verified they had reviewed R29's mediated and her dentition and oral health need had not been assessed. LPN-B stated R29 should have been assessed for what, if any, dental needs were wanted or needed upon admission and quarterly thereafter. As a result LPN-B was going to work to get R29 schedul for an onsite dental visit "the next time they a out here [onsite dental]." LPN-B stated it was important to ensure dental status and needs assessed and, if needed, referred to a dental provider timely as poor teeth can impact their ability to eat, their nutritional status and possicause an infection.	dical ds  ult, led are s were I		
	R24's quarterly minimum data set (MDS) data 8/16/23, identified R24 with intact cognition, need for extensive assistance with personal hygiene and no broken teeth.	a		
	R24's diagnoses dated 4/1/23, include type 2 diabetes with neuropathy, acute respiratory failure, generalized muscle weakness, morbi obesity.			
	R24's care plan dated 9/1/22, identified a food on oral/dental health problems, with a goal of being cooperative with dental appointments, an intervention to coordinate arrangements for outside dental care and transportation as need to be a seed of the coordinate arrangements.	f and or		
Minnesota Dei	During an interview dated 11/6/23, at 1:46 p. R24 stated that she has had chronic pain in teeth on the upper right behind the incisors (and #12) R24 also stated being advised two years ago by the dentist that these two teeth partment of Health	two #11		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:	(X3) DATE SURVEY COMPLETED
	00129	B. WING	C 11/09/2023

NAME OF PROVIDER OR SUPPLIER  THE VILLAS AT THE PARK		STREET ADDRESS, CITY, STATE, ZIP CODE  4415 WEST 36 1/2 STREET  SAINT LOUIS PARK, MN 55416				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMAT	TULL PREFIX				
21325	need to be extracted.  R24's oral/dental evaluation dated 3/1/23, indicated no oral/dental issues.  R24's oral/dental evaluation dated 8/16/23, indicated plaque or debris between teeth.  R24's dental exam dated 4/4/23, indicated plaque or debris between teeth.  R24's dental exam dated 4/4/23, indicated plaque debris buildup, moderate swollen gums, an periodontal condition. Exam also indicated arrange for a referral to an oral surgeon for extraction of teeth #11/#12 also indicating the was noted in 7/2022. Exam was done at be by HealthDrive dentist.  R24's dental exam dated 7/14/23, indicated referral out for extraction of teeth #11/#12.  R24's dental exam dated 7/25/23, indicated referral out for extraction of teeth #11/#12,  R24's progress note dated 7/19/23, indicated referral out for extraction of teeth #11/#12,  R24's progress note dated 7/19/23, indicated referral out for extraction of teeth #11/#12,  R24's progress note dated 7/19/23, indicated referral out for extraction of teeth #11/#12,  R24's progress note dated 7/19/23, indicated referral out for extraction of teeth #11/#12,  R24's progress note dated 7/19/23, indicated referral out for extraction of teeth #11/#12,  R24's progress note dated 7/19/23, indicated referral out for extraction of teeth #11/#12,  R24's progress note dated 7/19/23, indicated referral out for extraction of teeth #11/#12,  R24's progress note dated 7/19/23, indicated referral out for extraction of teeth #11/#12,  R24's progress note dated 7/19/23, indicated referral out for extraction of teeth #11/#12,  R24's progress note dated 7/19/23, indicated referral out for extraction of teeth #11/#12,  R24's progress note dated 7/19/23, indicated referral out for extraction of teeth #11/#12,  R24's progress note dated 7/19/23, indicated referral out for extraction of teeth #11/#12,  R24's progress note dated 7/19/23, indicated referral out for extraction of teeth #11/#12.	poor e/food d poor to his dside  I for  I a.m., ident en the to the ntract le the the the				
Minnesota De <sub>l</sub>	During an interview dated 11/7/23, at 10:29 partment of Health	a.III.,				

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Minnesota Department of Health

NAME OF FROMDER OR SUPPLIER  THE VILLAS AT THE PARK  415 WEST 36 12 STREET SUMMARY STATEMENT OF DEFICIENCES  PRETIX 1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		<b>■ *</b> *	E SURVEY IPLETED
NAME OF PROVIDER OR SUPPLIER  THE VILLAS AT THE PARK  **ALT SUMMARY STATEMENT OF DEPICIENCIES SAINT LOUIS PARK, MN 56418  **CAN CONTROL OF LOCAL CONTROL OF LOCAL CONTROL OF CON				A. BUILDING.			
CAS ID   SUMMARY STATEMENT OF DEFICIENCIES			00129	B. WING	_	1	
CALLIDER PARK   SAINT LOUIS PARK, MN 56416	NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE,	ZIP CODE		
PREFIX TAG  ICAOI DEFICIENCY WAST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  21325  Continued From page 20  MRD stated nursing sends referrals to MRD, then MRD sets up appointments and transportation for the referrals, but it is up to the individual clinics on when the appointment can be set based on availability and payor. R24 could not be seen in 9/2023 because Hennepin Healthcare Medical Center (HCMC) would not be seen in Horizon at the University of Minnesota dental school who will take residents who cannot pay, and there had been no indication when R24 would be seen. MRD denied having any record of appointment attempts that would have been made prior to 7/2023 and R24 has been known for cancelling appointments.  During an interview dated 11/7/23, at 11:17 a.m., the nurse manager (LPN-C) stated the MRD receives dental referrals directly from HealthDrive, not nursing, unless the dentist reports directly to a nurse before submitting a referral.  During an interview dated 11/7/23, at 14.9 p.m., the director of nursing (DON) stated a referral should be scheduled, accommodations made for	THE VILLAS AT THE PARK						
MRD stated nursing sends referrals to MRD, then MRD sets up appointments and transportation for the referrals, but it is up to the individual clinics on when the appointment can be set based on availability and payor. R24 could not be seen in 9/2023 because Hennepin Healthcare Medical Center (HCMC) would not see her. HCMC reported that R24 could not fit in their dental chairs. MRD attempting to get R24 on a list to be seen at the University of Minnesota dental school who will take residents who cannot pay, and there had been no indication when R24 would be seen. MRD denied having any record of appointment attempts that would have been made prior to 7/2023 and R24 has been known for cancelling appointments.  During an interview dated 11/7/23, at 10:59 a.m., R24 denied ever refusing to go to a dental appointment R24 also denied having a preference on where to be seen.  During and interview dated 11/7/23, at 11:17 a.m., the nurse manager (LPN-C) stated the MRD receives dental referrals directly from HealthDrive, not nursing, unless the dentist reports directly to a nurse before submitting a referral.  During an interview dated 11/7/23, at 1:49 p.m., the director of nursing (DON) stated a referral should be scheduled, accommodations made for	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE O THE APPROPRIATE	COMPLETE
be documented. DON also states there is no policy on scheduling outside dental appointments.  SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could	21325	MRD stated nursing MRD sets up appoint the referrals, but it is when the appointme availability and payo 9/2023 because Her Center (HCMC) wou reported that R24 co chairs. MRD attempt seen at the University who will take resider had been no indication MRD denied having attempts that would 7/2023 and R24 has appointments.  During an interview of R24 denied ever refer appointment. R24 all preference on where the nurse manager (receives dental refer HealthDrive, not nurse reports directly to a referral.  During an interview of the director of nursing should be scheduled residents, and any rebe documented. Do policy on scheduling SUGGESTED METHOD.	sends referrals to MRD, then thents and transportation for up to the individual clinics on a transportation for the individual clinics on the individual clinics and the individual clinics. He individual clinics who cannot pay, and there on when R24 would be seen, any record of appointment have been made prior to been known for cancelling.  Individual clinics on the individual clinics of the individual clinics who cannot pay, and there on when R24 would be seen, any record of appointment have been made prior to been known for cancelling.  Individual clinics on the individual clinics of the individual clinics of the individual clinics on the individual clinics on a list to be seen.  Individual clinics on the indi	21325			

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assessment and acting upon dental needs; then

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:	(X3) DATE SURVEY COMPLETED
	00129	B. WING	C 11/09/2023

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE VILLAS AT THE PARK SAINT LOUIS PARK, MN 55416					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENC (EACH DEFICIENCY MUST BE PRECEDED B REGULATORY OR LSC IDENTIFYING INFORI	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21325	Continued From page 21	2	21325		
	inservice staff on expectations and audit ensure ongoing compliance.	to			
	TIME PERIOD FOR CORRECTION: Tw (21) days	enty-one			
21390	MN Rule 4658.0800 Subp. 4 A-I Infection	n Control 2	21390		1/9/24
	Subp. 4. Policies and procedures. The control program must include policies and procedures which provide for the following A. surveillance based on systematic collection to identify nosocomial infection residents;  B. a system for detection, investigatic control of outbreaks of infectious diseases. C. isolation and precautions systems reduce risk of transmission of infectious and D. in-service education in infection prevention and control;  E. a resident health program including immunization program, a tuberculosis prodefined in part 4658.0810, and policies and procedures of resident care practices to a the prevention and treatment of infections. F. the development and implementate employee health policies and infection controls, including a tuberculosis progradefined in part 4658.0815;  G. a system for reviewing antibiotic of the products which affect infection control, statistically disinfectants, antiseptics, gloves, and incontinence products; and  I. methods for maintaining awareness current standards of practice in infection	d ng: data s in on, and es; s to agents; ng an ogram as and assist in s; tion of ontrol am as use; on of uch as			
	This MN Requirement is not met as evid	lenced			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:	(X3) DATE SURVEY COMPLETED
	00129	B. WING	C 11/09/2023

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NAME OF P	ROVIDER OR SUPPLIER	STREET ADDRESS, CITY, S	STATE, ZIP CODE	
		4415 WEST 36 1/2 STR	REET	
THE VILL	AS AT THE PARK	SAINT LOUIS PARK, M		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	S ID PREFIX	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 22	21390		
	by: Based on observation, interview and docur review, the facility failed to ensure a community-use glucometer was properly of and disinfected between patient' uses for a resident (R45) observed to have their blood glucose checked. This had potential to affed 4 residents (R45, R41, R246, R35) who we diabetic on the same unit. In addition, the failed to ensure appropriate hand hygiene completed with personal cares for 1 of 2 residents (R246) whose cares were observed.  Findings include:  GLUCOMETER CLEANING:  On 11/8/23 at 7:47 a.m., medication administration was observed with registere nurse (RN)-A present. RN-A removed a black-colored, zip-style (closed) bag from the medication cart and placed it on top of the before preparing R45's oral pills. When fining RN-A picked up the zipped bag from the calong with R45's prepared oral pills and brothem to her room. Inside the room, RN-A of the zipped bag and removed an Assure Plaglucometer from it. RN-A retrieved and dor pair of gloves from the bathroom, and insenew strip into the device to test R45's blood glucose. RN-A then used a lancet to pierce finger exposing a visible blood flash. RN-A touched the exposed blood droplet to the swhich had been inserted into the glucometer reading was obtained with RN-A stating ale "301." RN-A removed the strip from the glucometer and disposed of it in the trash, then placed the glucometer back into the	ment cleaned 1 of 1 od ect 4 of ere facility was ved.  ed  the cart ished, art rought opened atinum nned a erted a od e R45's A strip ter. A oud,	Completed	
	black-colored bag and zipped it closed with any attempt to clean or sanitize the device			
Minnesota De	partment of Health			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00129	B. WING		C 11/09/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STA	TE, ZIP CODE	
   THE VILL	AS AT THE PARK	4415 WE	EST 36 1/2 STREE	ĒΤ	
TITE VILLA	AS AT THE PARK	SAINT L	OUIS PARK, MN	55416	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULI  CROSS-REFERENCED TO THE APPROF  DEFICIENCY)	O BE COMPLETE
21390	Continued From page	∍ 23	21390		
	cart. RN-A prepared a insulin, and then again another resident' med another was no attempt used glucometer.  When interviewed on verified they had not device after use but a [clean it]." RN-A state the patients on the unwith "purple wipes [i.e. there weren't any to use around and observed orange-colored lid (i.e. expressed they could	and administered R45's in returned to the cart to start dication administration. It to remove or clean the added, "Technically I should ad the device was used for all hit and should be cleaned e. sani-wipes]," however, use. RN-A then looked I a container with an			

Monitoring System." This outlined the device could be used for testing on multiple patients, however, cleaning and disinfecting the device should be completed to minimize the risk of

several chemicals (i.e., germicidal wipes,

used (i.e., inserted via the strip) with the device,

and stated they work for a nursing agency (i.e.,

SNSA) but had not been trained or told prior to

process on how to clean or sanitize the device.

RN-A added, "I showed up and worked." RN-A

device so "we don't spread germs to other

An Ark Care Technical Brief, dated 9/2019,

identified directions listed for, "Cleaning and

stated, in hindsight, they should have cleaned the

working on the floor with any directions or facility'

Disinfecting the Assure Platinum Blood Glucose transmitting blood-borne pathogens adding, "The meter should be cleaned and disinfected after use on each patient." Further, the brief listed

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patients."

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
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		00129	B. WING		11/09/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	ΓE, ZIP CODE	
   TUE \/     /	AS AT THE PARK	4415 W	EST 36 1/2 STREE	:T	
I TIE VILL	45 AT THE PARK	SAINT	LOUIS PARK, MN	55416	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	SHOULD BE COMPLETE
21390	Continued From page	e 24	21390		
	sani-wipes) which co	uia be usea.			
	A provided electronic	mail (i.e., e-mail)			
	correspondence from	ո the nursing home			
	, '	11/8/23, identified a total of			
	resided on the unit w	ts (R45, R41, R246, R35)			
		community glucometer			
	without cleaning or sa	, ,			
	On 11/08/23 at 11://3	a.m., the director of nursing			
	(DON) was interview				
	,	e cleaned and disinfected			
	•	t use using sani-wipes. DON			
	,	personally completed any			
	· •	agency nurses' on the meter but expressed maybe			
		(i.e., HR) did but added, "I			
	'	Further, DON verified the			
	glucometer should ha	ave been cleaned for proper			
		ding, "That's how infections			
	spread."				

HAND HYGIENE:

During continuous observation of personal cares on 11/8/23, at 7:20 a.m., nursing assistant (NA)-C and NA-D walked into R246's room. Without performing hand hygiene, NA-C and NA-D donned gloves. NA-C assisted R246 roll to right side. NA-D placed gloved hand on R246 and proceeded to take off R246's brief which was soiled with urine and feces, rolled it up, and placed it in a plastic trash bag. NA-D doffed gloves and placed them into the trash bag and proceeded to grab new gloves. Without performing hand hygiene, NA-D donned new

A facility' policy on glucometer use and cleaning

was requested, however, none was received.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	` '	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:	COMP	COMPLETED		
						С
		00129	B. WING			09/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE	-	
TV/ (IVIL OF T	TO VIBER OR GOLT EIER		ST 36 1/2 STREET			
THE VILL	AS AT THE PARK		OUIS PARK, MN 5			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN (	OF CORRECTION	(X5)
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TAG	REGULATORT OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIE		DATE
21390	Continued From pag	o 25	21390			
21000	Continued From pag	6 25	21000			
	_	ok out a clean sanitary wipe				
		D who assisted R246 clean				
	•	ackside and placed the soiled				
		ffered his gloves into the				
		Without performing hand donned a new pair of gloves.				
	,	esident to roll to his right side				
		new brief on the resident with				
	•	A-D then went to R246's				
	•	aring gloves, and retrieved				
	,	nts and a pair of grey pants				
	for the resident to ch	oose from to wear.				
		on 11/8/23, at 8:16 a.m.,				
		en helping a resident with a				
	J , J	ing from dirty to clean tasks, ids prior to placing new				
		d touching the resident,				
		ng a dirty to clean task and				
	•	on hands. NA-D stated that				
		iene properly helps reduce				
	resident infections. D	oid NA-D indicate if he did				
	hand sanitize when d	completing this task and if not				
	why?					
	During an interview of	on 11/9/23, at 2:18 p.m., the				
		ects that when staff go from				
	•	hey would dispose of their				
	· · ·	nands, and place new gloves				
		en each dirty to clean task.				
	CHOOLOTED MET					
		HOD OF CORRECTION:  ng (DON) or designee, could				
		ent policies and procedures				
	•	ene. The DON or designee,				
	, , ,	g for all nursing staff related				
	•	e quality assessment and				
	, ,	e could perform random				
		pliance. In addition the DON				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:	(X3) DATE SURVEY COMPLETED
	00129	B. WING	C <b>11/09/2023</b>

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE VILL	AS AT THE PARK	WEST 36 1/2 STRE T LOUIS PARK, MN		
(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) COMPLET DATE
21390	Continued From page 26	21390		
	or designee could develop and implement policies and procedures related to infection control practices and hand hygiene.			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control	21426		1/9/24
	<ul> <li>(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.</li> <li>(b) Written compliance with this subdivision must be maintained by the nursing home.</li> </ul>			
	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure tuberculosis (TB) screening for history, risk factors, and symptoms was completed for 1 of 5 residents (R29) and 3 of		Completed	

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AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
	00129	B. WING		11	C <b>/09/2023</b>
NAME OF PROVIDER OR SUPPLIER  THE VILLAS AT THE PARK	4415 W	ADDRESS, CITY, STATE EST 36 1/2 STREET OUIS PARK, MN 5			
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
(DA)-A, NA-A], and far [Tuberculin skin testin blood test] was completed for Disease (Guidelines for 3 of 5 mand 4 of 5 staff (NA-ENA-A) reviewed for TIF urther, the facility fair education was completed administrator).  Findings include:  Residents  R20's quarterly Minimassessment dated 8/3 severely cognitively in of heart failure and defined for the facility of the medical record lacked evidence blood test results.  R29's admission MDS she was cognitively in pneumonia and demonstrated 8/24/23 which I findings and indicated R29's medical record history and symptom R35's quarterly MDS	ant (NA)-E, dietary aide ailed to ensure TB testing ag (TST), chest x-ray, or TB leted according to the Control & Prevention (CDC) esidents (R20, R29, R35) and administrator, DA-A, B screening and testing. Iled to ensure annual TB leted for 2 of 5 staff (DA-A, and and History Evaluation 23, instructed staff to record and result or TB blood test I record. R20's medical are of TST, chest x-ray, or TB and and had diagnoses of entia.  So dated 8/22/23, indicated at act and had diagnoses of entia.  Included an x-ray result acked identification of TB are required follow-up. Iacked evidence of TB	21426			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		1 ` ′	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
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		00129	B. WING		11/09/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE ZIP CODE	
	TO VIBER OIL OIL OOI I EIER		ST 36 1/2 STREE		
THE VILL	AS AT THE PARK		DUIS PARK, MN		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
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21426	Continued From page	e 28	21426		
	of diabetes and psyc	hotic disorder.			
	R35's MHM-TB Symptom and History Evaluation Version 3 dated 6/21/23, instructed staff to record TST administration and result or TB blood test results on the medical record. R35's medical record lacked evidence of TST, chest x-ray, or TB blood test results.				
	practical nurse (LPN) evaluated for TB histoadmission and given chest x-ray to rule ou documented in the m	either a two-step TST or t TB and the results were edical record. She was g and testing was not			
	of nursing stated TB scompleted at resident anyone with active TB treatment, and did not throughout the facility screened and tested	1/8/23 at 9:06 a.m. director screening and testing was ts' admission to ensure 3 received appropriate at spread it to other residents y. She identified staff were through the human at, and there had been recent			
	Staff				
	•	le to provide evidence of TB risk factors, and symptoms and NA-A.			
	The facility was unab results for NA-E, adm	le to provided TB testing ninistrator, and DA-A.			
	tuberculosis infection	dated 6/8/23, indicated "M. status cannot be esting recommended." No			

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AND PLAN OF CORRECTION IDENTIFICATION	J NI IMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:	
00129	B. WING		C <b>11/09/2023</b>
NAME OF PROVIDER OR SUPPLIER  THE VILLAS AT THE PARK	STREET ADDRESS, CITY, STATE 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 5	· •	
(X4) ID  PREFIX  (EACH DEFICIENCY MUST BE PRECEDED  TAG  REGULATORY OR LSC IDENTIFYING INFO	D BY FULL PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
other results were provided.  In an email dated 11/9/23, administrate TB education completion certificates for and confirmed it was "what we have for education." The attachment lacked evit TB education for administrator and DA During interview on 11/8/23 at 8:12 a.m. administrator confirmed she followed-under the was not addocumentation available for NA-E, administrator confirmed she followed-under the was not addocumentation available for NA-E, administrator available for NA-E, administrator confirmed she followed-under the was not addocumentation available for NA-E, administrator available for NA-E, administr	or 3 staff, or TB dence of -A,  n. up with Iditional TB ninistrator,  1/23, performed thin 72 a TB risk ITB  31/23, upon hire, ding a TB al TB h care  CTION: The policies and 3 nptoms, quidelines nfection		

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history, risk factors, symptoms, and TB testing on

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:	(X3) DATE SURVEY COMPLETED
	00129	B. WING	C 11/09/2023

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

#### 4415 WEST 36 1/2 STREET

THE VILLAS AT THE PARK		4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMAT	ULL PREFIX	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 30	21426		
	a regular basis to ensure compliance.			
	TIMEFRAME FOR CORRECTION: Twenty (21) days.	r-one		
21535	MN Rule4658.1315 Subp.1 ABCD Unneces Drug Usage; General	ssary 21535		1/9/24
	Subpart 1. General. A resident's drug regimust be free from unnecessary drugs. An unnecessary drug is any drug when used:			
	A. in excessive dose, including duplicate therapy;  B. for excessive duration;  C. without adequate indications for its upon the presence of adverse consequents which indicate the dose should be reduced discontinued.	ıse; or ences		
	In addition to the drug regimen review request 4658.1310, the nursing home must conwith provisions in the Interpretive Guidelines Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State	mply s for on		
	Operations Manual, Guidance to Surveyors Long-Term Care Facilities, published by the Department of Health and Human Services Health Care Financing Administration, April This standard is incorporated by reference. available through the Minitex interlibrary load	t is		
	system and the State Law Library. It is not subject to frequent change.			
	This MN Requirement is not met as eviden by:  Based on interview and document review, the second sec		Completed	
	facility failed to ensure appropriate side efferment review, the monitoring was completed, in accordance with the care plan and standard of care, related to	ect vith		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
		00129	B. WING		C 11/09/2023
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE,	, ZIP CODE	
THE VILL	AS AT THE PARK		ST 36 1/2 STREET OUIS PARK, MN 55	5416	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
21535	for 2 of 5 residents (I ensure as-needed (i.medication use was 14 days for 1 of 5 resunnecessary medical Findings include:  SIDE EFFECT MON A National Library of of Commons Advers Medication article, day elderly were at risk of antipsychotic medication [which of syncope, falls." It should historical and routine R29's admission Min 8/22/23, identified R2 required substantial actions (i.e., lying to Further, the MDS our medical diagnoses in fibrillation, and consumedication on a routine R29's Order Summa identified R29's current medications and treations and treations (i.e., lying to Further, the MDS our medical diagnoses in fibrillation, and consumedication on a routine R29's Order Summa identified R29's current medications and treations and treations and treations are distant date of the start date of the summa identified start date of the summ	ntipsychotic) medication use R29, R4); and failed to .e., PRN) antipsychotic limited or re-evaluated after sidents (R19) reviewed for ation use.  IITORING:  Medicine (NIH) Management see Effects of Antipsychotic ated 9/2018, identified the of adverse effects (i.e., falls) dication. The article outlined, arry some risk of orthostatic can] lead to dizziness, ould be evaluated by both emeasurement.  Inimum Data Set (MDS), dated 29 had intact cognition and assistance with bed mobility sitting, sitting to standing). It interest and atrial umed antipsychotic tine basis.  Interest Report, dated 10/11/23, eent physician ordered atments. This included an arrest results and a second attents. This included an arrest results are results and a second attents. This included an arrest results are results and a second attents. This included an arrest results are results and a second attents. This included an arrest results are results and a second attents. This included an arrest results are results and a second attents. This included an arrest results are results and a second attents. This included an arrest results are results and a second attents. This included an arrest results are results and a second attents. This included an arrest results are results at a second attent at a	21535		

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treatment listed reading, "Monitor Orthostatic

Blood Pressure while resident is receiving

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	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:	A. BUILDING:			
						С
		00129	B. WING			09/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE	-	
			ST 36 1/2 STREET			
THE VILL	AS AT THE PARK	SAINT LO	DUIS PARK, MN 5	5416		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH		COMPLETE
TAG	REGULATORT OR	LSC IDENTIFTING INFORMATION)	TAG	DEFICIENCY)		DATE
21535	Continued From pag	no 32	21535			
21000			21000			
		ations Every day shift every				
	1 month(s)," with a	a listed start date 10/19/23.				
	R20's care plan date	ed 9/11/23, identified R29				
	• '	nad an alteration in cognition				
		d required assistance of one				
		d out of bed. Further, the				
	care plan outlined R2	29 was at risk for				
	psychoactive medica	ation adverse effects due to				
	daily use of such me	dications and listed an				
		"Monthly orthostatis blood				
	•	ventions listed an initiation				
	date of 8/18/23.					
	R29's Blood Pressur	e Summary, printed 11/9/23,				
		cted blood pressures since				
		with several low readings				
	,	ding 105/68 (10/3/23), 87/59				
	(10/24/23), and 85/5	8 (11/7/23). However, the				
	summary lacked evid	dence a series of orthostatic				
		, lying, sitting, standing) had				
	been attempted or co	ompleted.				
	R20's Treatment Adn	ninistration Record (TAR),				
		ified a treatment which read,				
	,	Blood Pressure monthly				
		1 month(s)," with a listed				
		However, the order also				
	listed a discontinuati	on date which read 10/27/23,				
	and the only space p	provided to record the values				
	, , ,	nstrating it had been				
	completed were answ	•				
	•	ted 11/2023, lacked any				
		demonstrating collection or				
	TEVIEW OF RZ95 ORNO	ostatic blood pressures.				
	When interviewed or	n 11/7/23 at 2:58 p.m.,				
		A)-A stated they had worked				
	,	es, and described R29 as				
		al assistance for most cares.				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
	,		A. BUILDING	_		
	,	00129	B. WING		C 11/09	9/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE	•	
			T 36 1/2 STREE			
THE VILL	AS AT THE PARK	SAINT LO	UIS PARK, MN	55416		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
21535	Continued From page	∍ 33	21535			
	hospice care, demonst cognition, and rarely, did still physically transwheelchair at times wheelchair complained	if ever, ambulated; however, nsfer from her bed to the with help. NA-A stated R29 d about being lightheaded or				
	admitted with orders for olanzapine. The recording the second recording the second recording of the second recording recording the second recording reco	armacist's Medication ted 8/21/23, identified R29				
	The dictation had a blawritten next to it along "Follow-Through," who "Scanned" stamp and However, R29's mediand lacked evidence a pressure readings had collected despite R29 at times, from their becommendations from the ensure such monitor of the ensure such monitor of the ensure	lack-colored checkmark g with a column labeled, lich had a red-colored d a date written, "9/11/23." lical record was reviewed any orthostatic blood ld been attempted or g still physically transferring,				

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On 11/08/23 at 10:47 a.m., licensed practical

nurse unit manager (LPN)-B was interviewed.

attained despite the care plan directing to

complete such monitoring. LPN-B stated they

LPN-B verified they had reviewed R29's medical

record and were unable to locate evidence R29's

orthostatic blood pressure had been attempted or

would typically be recorded in the Blood Pressure

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	TOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY LETED
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		
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		00129	B. WING			09/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
THE VILL	AS AT THE PARK	4415 WE	EST 36 1/2 STREET			
		SAINT L	OUIS PARK, MN 5	5416		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21535	Continued From page	e 34	21535			
	Summary, however a LPN-B stated R29 was or stand without physicacknowledged a lying pressure could still be what, if any, potential LPN-B stated it was in appropriate side effect orthostatic blood presented to changes if medical appropriate for them.	added, "I do not see those." as unlikely able to ambulate sical help, however, g-to-sitting orthostatic blood he attained to help determine all symptoms were present. important to ensure ct monitoring, including ssures, was completed to ac status and "[it] can alert us ation [i.e., antipsychotic] is not				
	R4					
	cognitively intact, had and schizophrenia, a antipsychotic and an	um Data Set (MDS) 0/24/23, indicated R4 was d diagnoses of depression and identified R4 was taking tidepressant medications on could stand and transfer				
	received antidepress medications to mana schizophrenia and de adverse reactions to included a goal to ha effects.  R4's care plan dated for adverse drug reactions and the psychotropic medical monitor orthostatic blanches.	dated 8/2/23, indicated she sant and antipsychotic age a diagnosis of paranoid epression and was at risk for these medications, and ave no drug related side  1 5/25/23, included potential ctions related to daily use of tion, and directed staff to lood pressure. The care plan able to stand at that time.				
		port dated 11/9/23, included: blet, 300 milligrams (mg) at				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:	(X3) DATE SURVEY COMPLETED
	00129	B. WING	C 11/09/2023

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE VILLAS AT THE PARK SAINT LOUIS PARK, MN 55416								
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE				
21535	Continued From page 35	21535						
	bedtime and give 200 mg two times per day for bipolar 2 disorder starting 1/20/23.  -Duloxetine HCl Capsule Delayed Release, give 90 mg one time per day for major depressive disorder staring 3/4/23.  -Seroquel Oral Tablet, give 200 mg at bedtime for bipolar starting 4/17/23.  -Trazodone HCL Oral Tablet, Give 175 mg and 150 mg at bedtime for insomnia associated with depression starting 8/22/23.  -Orthostatic BP (blood pressure) monthly every shift starting on the 15th and ending on the 15th every month starting 8/22/23.  -Psychotropic Monitoring- Antidepressant Medication, Monitor for side effects including orthostatic hypotension symptoms, weekly, every shift, every Monday starting 7/23/23.  -Psychotropic Monitoring- Antipsychotic Medication, Monitor for side effects including orthostatic hypotension symptoms, weekly, every shift, every Monday starting 7/23/23.  R4's Blood Pressure Summary dated 11/9/23, lacked evidence of complete orthostatic blood pressure monitoring since ordered on 8/22/23.							
	R19							
	R19's annual Minimum Data Set (MDS) assessment dated 8/7/23, included R19 was severely cognitively impaired, had diagnoses of depression, stroke, dementia, and aphasia (difficulty speaking), and no behavioral concerns. The MDS indicated antipsychotic medications were received only on a routine basis and not PRN (as needed).							
	R19's Behavioral Symptoms Care Areas Assessment (CAA) dated 8/7/23, was not partment of Health							

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STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00129	B. WING		11/0	) 9/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	TE, ZIP CODE		
TUE VIII I	AC AT THE DADI/	4415 WE	ST 36 1/2 STREE	<u>:</u> T		
INE VILL	AS AT THE PARK	SAINT LC	OUIS PARK, MN	55416		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
21535	Continued From page	e 36	21535			
	indicated he used antiantidepressant medication at the assessment indicated drug-related side effects. The care antipsychotic medication as ordered antipsychotic medication and instrumentation and instrumentation and instrumentation and instrumentation are independently and included:  R19's Order Review F11/9/23, included: -Escitalopram Oxalate Give 10 mg once per starting 1/17/23.	cations to manage a live disorder, and he was at mese medications. The da goal to have no ects.  d 12/31/23, included R3 had ted to stroke, dementia and ructed staff to administer ed and monitor/document e plan also included R3 used tions and instructed staff to de effects, including on. R3's activities of daily cluded he could stand and ly.  History Report dated  te Tablet 10 milligrams (mg), and day for major depression  t 25 mg, give one tablet two				

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date.

-Seroquel Oral Tablet 25 mg, give one tablet

every 24 hours as needed (PRN) for agitation

starting 9/18/23. The PRN order lacked an end

-Psychotropic Monitoring- Antidepressant

shift, every Monday starting 2/27/23.

shift, every Monday starting 2/27/23.

-Psychotropic Monitoring- Antipsychotic

Medication, Monitor for side effects including

Medication, Monitor for side effects including

orthostatic hypotension symptoms, weekly, every

orthostatic hypotension symptoms, weekly, every

R19's Blood Pressure Summary dated 11/7/23,

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:	(X3) DATE SURVEY COMPLETED
	00129	B. WING	C 11/09/2023

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE VILLA	AS AT THE PARK	ST 36 1/2 STREE OUIS PARK, MN		
(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
21535	Continued From page 37  lacked evidence of orthostatic blood pressure monitoring since ordered on 2/27/23.  During interview on 11/8/23 at 12:23 p.m., licensed practical nurse (LPN)-B stated orthostatic blood pressure monitoring included taking a blood pressure while lying, sitting, and standing (when a resident was capable), and should be completed for any resident on psychotropic medications since these medications can have significant side effects related to cardiac function. LPN-B confirmed R4 and R19 did not have them completed	21535		
	consistently. In addition, any PRN psychotropic medication should be limited to 14 days. LPN-B confirmed R19's Seroquel did not have a 14 day stop date, and it was important to use the least number of psychotropic medications possible and re-evaluate often to eliminate them if not needed.  During interview on 11/8/23 at 12:54 p.m., director of nursing stated PRN psychotropic should not be			
	used greater than 14 days without review to see if they can be discontinued, and she expected staff to monitor and document orthostatic blood pressures for residents on psychotropics and per provider order to identify any side effect.			
	SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable procedures and policies regarding side effects monitoring and PRN use; then inservice floor staff on expectations and audit to ensure ongoing compliance.  TIME FRAME: Twenty one (21) days			
	MN Rule 4658.1320 A.B.C Medication Errors	21545		1/9/24

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
	00129	B. WING			C <b>09/2023</b>	
NAME OF PROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, STATE	E, ZIP CODE			
THE VILLAS AT THE PARK		ST 36 1/2 STREET DUIS PARK, MN 5				
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
percent as described Guidelines for Cod 42, section 483.25 the State Operation Surveyors for Long incorporated by ref purposes of this pa (1) a discrepa prescribed and what administered to rese (2) the adminimedications.  B. It is free of a error. A significant (1) an error discomfort or jeopa safety; or (2) medication error conceptive the medication error conceptive the medication error conceptive. All medications are prescribed. An incomposition or the phase in the C. All medication error must be made in the C. All medication error must be made in the C. All medications are port must be filled occurs. Any signification resident reactions are port must be filled occurs. Any signification resident reactions are port must be filled occurs. Any signification resident reactions are sident reactions.		21545				

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00129	B. WING		C 11/09/2023
	S AT THE PARK	4415 WI	ADDRESS, CITY, STA EST 36 1/2 STRE OUIS PARK, MN	ET	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETE
	designated represent	ent's legal guardian or tative and an explanation resident's clinical record.	21545		
	by: Based on observation review, the facility fail were administered in orders and manufact residents (R25, R38, medication. A total of	n, interview and document led to ensure medications accordance with physician urer guidelines for 3 of 6 R45) observed to received four (4) errors out of 31 entified resulting in a 12.9% r rate.		Completed	
	identified R25's curre medications and trea order for acetaminop mouth every six hour	ry Report, dated 10/11/23, ent physician-ordered tments. This included an hen 500 milligrams (mg) by s as needed (PRN) for pain. d start date of 9/26/23.			
	(RN)-A prepared R25 cart in the hallway by standing next to the crated their pain an "ereturned to their room preparing R25's med the cart. RN-A review Medication Administration outlined the same or listed on R19's Order 10/11/23). However,	o.m., registered nurse b's medications at a mobile the nurses' station. R25 was cart and, upon being asked, ight [out of 10]." R25 then h while RN-A continued ications for administration at yed R25's electronic ation Record (MAR) which der for acetaminophen as r Summary Report (dated RN-A removed an opened hen from the cart and placed			

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two 500 mg tablets (i.e., 1000 mg) into the

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	00129	B. WING		C 11/09/2023
	<b>I</b>		7ID CODE	1170072020
NAME OF PROVIDER OR SUPPLIER		DDRESS, CITY, STATE  ST 36 1/2 STREET		
THE VILLAS AT THE PARK		OUIS PARK, MN 5		
(VA) ID SLIMMARY S	STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN (	DE CORRECTION (Y5)
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21545 Continued From page	ge 40	21545		
RN-A then picked up locked the MAR screet to walk to R25's roomed the surveyor and veryon and veryon and returned to the med order. RN-A verified directed to only proven two as they had "That's exactly how RN-A then removed acetaminophen from and returned to R25 R38's Order Summa identified R38's current medications and tree order for, "Sennalax"	the prepared medications is room to provide them.  Ary Report, dated 10/11/23, ent physician-ordered atments. This included an ent section is a section of the section of t			
,	ate Sodium) 1 tablet by lay," with a listed start date of			
(LPN)-A prepared R cart in the hallway use Medication Administration outlined the same of on R38's Order Sum 10/11/23). LPN-A response (labeled sense and placed one brown with R38's other mesup the cup from the on their cart, and turnoom. LPN-A was the	p.m., licensed practical nurse 38's medications at a mobile sing R25's electronic ration Record (MAR). This rder for Sennalax-S as listed mary Report (dated moved an opened bottle of nosides only) from the cart wn-colored tablet into the cup dications. LPN-A then picked cart, locked the MAR screen rned to walk down to R38's len stopped by the surveyor dications in the cup were			

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ready for administration. LPN-A returned to the

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	<b>\</b> '	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:  A. BUILDING:		COMP	LETED
						С
		00129	B. WING			09/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
THF VILL	AS AT THE PARK	4415 WE	ST 36 1/2 STREET			
IIIL VILL	40 AT THE LAIM	SAINT LO	OUIS PARK, MN 55	416		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21545	Continued From pag	1e 41	21545			
21545	orders. LPN-A verified directed to give sent (i.e., Senna-S) and in however, was unable medication. At this till unit manager (LPN)-medication cart and medications which reverified the brown-conot the same medications which reverified the pharmacy send the right medication so they would look for returned after several they did not have any so they were sending drug store quick to gremoved the brown-of from R38's prepared room to administer the R45's Interagency Plant or administer the R4	reviewed R38's current ed the medication order nosides with docusate sodium inspected the medication cart, e to locate any supply of that ime, licensed practical nurse B presented to the reviewed LPN-A's emained in the cup. LPN-B clored sennosides tablet was ation ordered because inge-colored tablet. LPN-B r, at times, did not always eations for the "stock" supply, for some quick. LPN-B all minutes and expressed ry of the medication on-hand, g an employee to the local get some. LPN-A then colored sennosides tablet d medications and went to his the remainder of them. Thysician Discharge dated 10/30/23, identified talized for several medical rediabetes mellitus, and was the nursing home. The onitor R45's blood glucose for to meals, along with other an orders including Lispro	21545			
	once daily.  On 11/8/23 at 7:47 a medications at a molethen removed several	nicrograms (mcg) by mouth  i.m., RN-A prepared R45's bile cart in the hallway. RN-A al punch-pack style cards cations from the cart and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:	(X3) DATE SURVEY COMPLETED
	00129	B. WING	C <b>11/09/2023</b>

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE VILL	AS AT THE PARK	4415 WEST 3			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 42		21545		
	started to prepare them for administration referencing the MAR which included the sa order for Vitamin D3 as outlined on R45's of (dated 10/30/23). RN-A removed an opened bottle of Vitamin D3 25 mcg capsules from top of the cart, however, RN-A only placed capsule (i.e., 25 mcg) in the cup for administration. RN-A then locked their MAI screen, and turned to enter R45's room do hallway. RN-A was then stopped by the su and verified the prepared medications were for administration. RN-A returned to the medication cart and reviewed R45's Vitam orders in the MAR. RN-A verified the MAR directed to administer 50 mcg of the medication in the cup for administration (i.e. error). RN-A then added another 25 mcg of to the cup and returned to R45's room to perform the medications. RN-A checked R45's blooglucose using a community glucometer where sulted "301." RN-A stated they would reter R45's insulin and return. RN-A returned to medication cart and removed an opened Lilly-brand Lispro insulin flexpen from the medication cart and placed it on top while reviewing the MAR. RN-A stated the orders to administer four units for a blood glucose 301, and removed a new Assure Duo Proform a box in another medication cart park adjacent. RN-A then picked up the insuling and walked towards R45's room by the survey questioned on the need to prime the insuling and walked towards R45's room by the survey questioned on the need to prime the insuling needle prior to delivery of the ordered doses stated the pen was "already primed" as it to be done once when the pen was first op RN-A then entered R45's room and deliver medication using the un-primed needle and	ame orders ed in the done Rown the arveyor e ready in D3 cation, the e., capsule orders the swere end in the crieve the swere end in the cation of the catio			
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NAME OF PROVIDER OR SUPPLER  STREET ADDRESS, CITY, STATE, ZIP CODE  4416 WEST 36 12 STREET  SAINT LOUIS PARK, MN 56418  D		OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLER THE VILLAS AT THE PARK  #4415 WEST 36 12 STREET SAINT LOUIS PARK, MIN 56416    CASH   D	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLETED		
NAME OF PROVIDER OR SUPPLIER  THE VILLAS AT THE PARK   STREET ADDRESS. CITY, STATE, ZIP CODE  4416 WEST 36 12 STREET  SAINT LOUIS PARK, MN 56416  PREPTX TAG  SUMMARY STATEMENT OF DEPTICENCISS (EACH DEPTICENCY MUST BE PRECEDED 3Y PLLL TAG  PREPTX TAG  PREPTX TAG  CROSS-REFERENCE TO THE APPROPRIATE DATE  DATE  21545  Continued From page 43  flexpen. RN-A then returned to the medication cart and reiterated they were unsure if the new needle should be primed or not adding, "Some you do, some you don't." RN-A then reviewed the box of needles for directions, however, there were no package inserts or manufacturer directions inside to review.  An Assure ID Duo-Shield (needle) Training Guide, dated 3/2020, listed written and photo instructions for using the needles with an insultin flexpen. The instructions directed, "Before injection, be sure to read the user instructions for the pen injector device for proper use and control," and outlined a section labeled, "Priming the pen injection device," which directed," Prime the pen injection device, "which directed," Prime the pen injection device, "which directed," Prime the pen injection device according to the instructions for the pen injection device." A corresponding Lilly-brand Lispro (insulin) Instructions to administer a dose of insulin using the device. This included a section labeled. "Priming your Pen," which directed to turn the dosing dial to two units, hold the device upright, and depress the dial. A visible drip of insulin should be seen and, if not, repeat the previous steps until such is visible. The instructions further outlined. "If you do not [bolded] prime before each injection, you may get too much or too little insulin."  On 11/8/23 at 11:43 a.m., the director of nursing (DON) was interviewed. The surveyor reviewed						С	
CALL STATE PARK   SAINT LOUIS PARK, MN 56416   SAINT LOUIS PARK, MN 5641			00129	B. WING		11/09/2023	
SAINT LOUIS PARK, MN 56416	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES   PARTY   RECOLLATION OF DEFICIENCIES   PARTY   RECOLLATION OF U.S. IDENTIFYING INFORMATION)	THE VILL	AS AT THE PARK					
PREFEX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  21545  Continued From page 43  flexpen. RN-A then returned to the medication cart and retreated they were unsure if the new needle should be primed or not adding. "Some you do, some you don't." RN-A then reviewed the box of needles for directions, however, there were no package inserts or manufacturer directions inside to review.  An Assure ID Duo-Shield (needle) Training Guide, dated 3/2020, listed written and photo instructions for using the needles with an insulin flexpen. The instructions directed, "Before injection, be sure to read the user instructions for the pen injection device "which directed." 'Prime the pen injection device according to the instructions for the pen injection device according to the instructions for the pen injection device according to the instructions for the pen injection device according to the instructions for the pen injection device of insulin using the device. This included a section labeled, "Priming your Pen," which directed to turn the dosing dial to two units, hold the device upright, and depress the dial. A visible drip of insulin should be seen and, if not, repeat the previous steps until such is visible. The instructions further outlined, "if you do not [bolded] prime before each injection, you may get too much or too little insulin."  On 11/8/23 at 11:43 a.m., the director of nursing (DON) was interviewed. The surveyor reviewed				JIS PARK, MIN		_	
flexpen. RN-A then returned to the medication cart and reiterated they were unsure if the new needle should be primed or not adding, "Some you do, some you don't" RN-A then reviewed the box of needles for directions, however, there were no package inserts or manufacturer directions inside to review.  An Assure ID Duo-Shield (needle) Training Guide, dated 3/2020, listed written and photo instructions for using the needles with an insulin flexpen. The instructions directed, "Before injection, be sure to read the user instructions for the pen injector device for proper use and control," and outlined a section labeled, "Priming the pen injection device," which directed," Prime the pen injection device according to the instructions for the pen injection device according to the instructions for the pen injection device according to the instructions for the pen injection device," A corresponding Lilly-brand Lispro (insulin) Instructions for Use, dated 2/2020, identified step-by-step instructions to administer a dose of insulin using the device. This included a section labeled, "Priming your Pen," which directed to turn the dosing dial to two units, hold the device upright, and depress the dial. A visible drip of insulin should be seen and, if not, repeat the previous steps until such is visible. The instructions further outlined, "If you do not [bolded] prime before each injection, you may get too much or too little insulin."  On 11/8/23 at 11:43 a.m., the director of nursing (DON) was interviewed. The surveyor reviewed	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE COMPLETE	
cart and reiterated they were unsure if the new needle should be primed or not adding. "Some you do, some you do, some you do, some you don't." RN-A then reviewed the box of needles for directions, however, there were no package inserts or manufacturer directions inside to review.  An Assure ID Duo-Shield (needle) Training Guide, dated 3/2020, listed written and photo instructions for using the needles with an insulin flexpen. The instructions directed, "Before injection, be sure to read the user instructions for the pen injector device for proper use and control," and outlined a section labeled, "Priming the pen injection device," which directed, "Prime the pen injection device," which directed "Prime the pen injection device according to the instructions for the pen injection device." A corresponding Lilly-brand Lispro (insulin) Instructions for Use, dated 2/2020, identified step-by-step instructions to administer a dose of insulin using the device. This included a section labeled, "Priming your Pen," which directed to turn the dosing dial to two units, hold the device upright, and depress the dial. A visible drip of insulin should be seen and, if not, repeat the previous steps until such is visible. The instructions further outlined, "If you do not [bolded] prime before each injection, you may get too much or too little insulin."  On 11/8/23 at 11:43 a.m., the director of nursing (DON) was interviewed. The surveyor reviewed	21545	Continued From page	e 43	21545			
each of the observed medication administration errors, and the DON stated they would investigate the situation and follow-up. However, the DON stated insulin pens should be primed with "the two units" before each administration. This was	∠13 <del>4</del> 5	flexpen. RN-A then recart and reiterated the needle should be pringly ou do, some you do box of needles for directions inside to reactions directed, read the user instructions directed, read the user instructions directed, read the user instructions device," which directed device according to the injection device." A conclusion of insuling instructions further out instructions further out the device upright, and drip of insulin should the previous steps uninstructions further out [bolded] prime before too much or too little in the device upright, and (DON) was interviewed each of the observed errors, and the DON stated insulin pens should stated insulin pens should recard the user instructions further out [bolded] prime before too much or too little in the situation and follows the situation and follows the situation and follows the situation pens should be prime before the observed errors, and the DON stated insulin pens should be situation and follows the situation and follows the situation and follows the situation pens should be prime before the observed errors, and the DON stated insulin pens should be prime before the observed errors.	eturned to the medication bey were unsure if the new med or not adding, "Some in't." RN-A then reviewed the ections, however, there ectis or manufacturer view.  iield (needle) Training Guide, vritten and photo instructions with an insulin flexpen. The "Before injection, be sure to ions for the pen injector and control," and outlined iming the pen injection ed," Prime the pen injection ne instructions for the pen cresponding Lilly-brand ections for Use, dated 2/2020, or instructions to administer a the device. This included a ning your Pen," which cosing dial to two units, hold and depress the dial. A visible be seen and, if not, repeat till such is visible. The attlined, "If you do not each injection, you may get nsulin."  a.m., the director of nursing ed. The surveyor reviewed medication administration estated they would investigate w-up. However, the DON mould be primed with "the	21343			

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a.m., a subsequent interview with DON was held.

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00129	B. WING		C 11/09/2023	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT		-	
THE VILL	AS AT THE PARK		ST 36 1/2 STREE OUIS PARK, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	Ē
21545	the reported administreach involved resider stated the potential for each administration at follow-up with education members. DON states received the medications topping them) then the for a med error," howed didn't actually received doses, they reiterated stated it was important medication and doses safety."  A provided Medication Guidelines policy, data medications would be in accordance with go practices. The policy Right resident, right do and right time, are applied being administered," at these 5 Rights is received the process of preparations. SUGGESTED METHORIZED METHORIZED METHORIZED METHORIZED medications; then instandit to ensure ongoing administered on the process of preparations.	d a chance to follow-up on ration errors and review of medical record. DON or an error "was there" with and they were going to ion to the involved staff d had the residents' actually ons (instead of the surveyor hey would "follow the policy ever, since the residents' at the wrong medication or d a need for education. DON on to ensure the correct is were given to for "resident outlined, "FIVE RIGHTS - larg, right dose, right route, plied for each medication adding, "A triple check of ommended at three steps in ation of a medication"  OD OF CORRECTION: The ON), or designee, could cies and procedures on accurate delivery of ervice direct care staff and	21545			
21550	MN Rule 4658.1325 S Medications; Pharma	Subp. 1 Adminiatration of cy Serv.	21550		1/9/24	

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AND DIAN OF CORRECTION INFERIOR INFERIOR NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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		00129	B. WING		11/0	9/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	ATE, ZIP CODE			
TUE VII I		4415 WES	T 36 1/2 STREE	ET			
I TIE VILLA	AS AT THE PARK	SAINT LOI	JIS PARK, MN	55416			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE	
21550	Continued From page	÷ 45	21550				
	,	services. A nursing home provision of pharmacy					
	by: Based on observation review, the facility fail medications (i.e., medications) were tracked prevent disruption in second	dication used for multiple d and re-ordered timely to supply and potential 1 resident (R38) observed to		Completed			
	Findings include:						
	identified R38's currein medications and treat order for, "Sennalax-S (Sennosides-Docusat	tments. This included an					
	(LPN)-A prepared R36 cart in the hallway using Medication Administration outlined the same order on R38's Order Summa 10/11/23). However, Label bottle of Senna (label)	ation Record (MAR) which der for Sennalax-S as listed					

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cup with R38's other medications, and attempted

acknowledged the medication they were going to

to administer the medications before being

stopped by the surveyor (see F759). LPN-A

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE COMP	SURVEY PLETED
		A. BUILDING:				
		00129	B. WING			C / <b>09/2023</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	ZIP CODE		
			EST 36 1/2 STREET	•		
THE VILL	AS AT THE PARK		OUIS PARK, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21550	been ordered. LPN-A cart for the sennoside Senna-S), however, was supply of the medicate practical nurse unit may to the medication care brown-colored sennosame medication ordered an orange-colored tall pharmacy, at times, or medications for the "selook for some quick. I minutes and expresses the medication on-hale employee to the local some.  During follow-up interfarm., LPN-B stated the medication and, typic scheduler" who was a medication room and needed supply from the LPN-B verified they hand there had been in the sentence of the local some.	ame medication which had searched the medication es-docusate sodium (i.e., was unable to locate any tion. At this time, licensed anager (LPN)-B presented	21550	DEFICIENC	;Y)	
	with getting medication this had been happer	some "supply chain issues" ons supplied timely stating ning "on and off for awhile." e people in management				
	(i.e., HR, scheduler) \	were aware of this issue ge, were looking into it.				
	(DON) was interviewed was a staff member a and, when needed, re DON acknowledged to	a.m., the director of nursing ed. DON explained there assigned to monitor supply e-order stock medications. They had run out of supply for medication and, as a result,				

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1/9/24

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
						`
		00129	B. WING		11/0	9/2023
		00123			11/0	912023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STA	TE, ZIP CODE		
TUE VII I /	AS AT THE PARK	4415 WES	ST 36 1/2 STREE	ET		
ITIL VILLE	45 AT THE FAIN	SAINT LO	DUIS PARK, MN	55416		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	٧	(X5)
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TAG	REGULATORTORI	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	(IA) E	DATE
21550	Continued From page	e 47	21550			
	they sent staff to the	drug store and purchased				
	some on 11/06/23. D	ON stated if there were				
		they typically would be				
	,	ever, she "wasn't aware of it"				
	•	lerted (i.e., the surveyor				
	,	the DON stated she would				
	• •	ly of the medication was				
	available had someor	ne told her it was gone.				
	A provided Medicatio	n Ordering and Receiving				
	<b>'</b>	cy, dated 1/2018, identified				
		ted products would be				
		pensing pharmacy on a				
	timely basis. A proced					
	•	ons not automatically filled by				
		ing use of a medication				
	order form, however,	lacked specific instructions				
	for monitoring supply	or re-ordering stock				
	medications at the nu	ırsing home; nor any				
	information on how th	nis would be accomplished to				
	ensure no lapse in su	apply.				
	OLIOOFOTED METL					
		IOD OF CORRECTION: The				
		ON), or designee, could				
		cedures for re-ordering g stock medications, to				
		nservice applicable staff				
	members and audit to	• •				
	compliance.	Jensule origonig				
	compliance.					
	TIME PERIOD FOR	CORRECTION: Twenty-one				
	(21) days					
	(_ · , ·, ·, ·					

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21565 MN Rule 4658.1325 Subp. 4 Administration of

Subp. 4. Self-administration. A resident may

self-administer medications if the comprehensive

resident assessment and comprehensive plan of

Medications Self Admin

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21565

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THE STATE OF					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:	(X3) DATE SURVEY COMPLETED		
	00129	B. WING	C 11/09/2023		
NAME OF PROVIDER OR SUPPLIER	ME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE				

E VILL	AS AT THE PARK	ST 36 1/2 STRE OUIS PARK, MN		
X4) ID REFIX 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) COMPLET DATE
21565	Continued From page 48	21565		
	care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician.			
	This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 residents (R3) were comprehensively assess for safety and ability who were observed to self-administer medications.		Completed	
	Findings include:			
	R3's quarterly Minimum Data Set (MDS) assessment dated 9/26/23, indicated R3 was cognitively intact, required set-up assistance for eating and oral hygiene, had complaints of difficulty or pain with swallowing, and had diagnoses of diabetes, seizure disorder, and traumatic brain injury.			
	R3's care plan indicated she had difficulty swallowing and must sit up when drinking or eating anything, no matter how small the amount per speech therapy recommendations.			
	R3's Upper GI (gastrointestinal) Endoscopy note dated 10/25/23, indicated she had an esophageal dilation procedure to widen two severely narrowed areas in her esophagus, and was to return for a second procedure in one to two weeks. R3's record lacked evidence of a second procedure.			
	R3's Order Review History Report dated 11/9/23, included orders for the following medications to be given at 2:00 p.m.:			
	-Calcium Citrate + Oral Tablet (Multiple Minerals			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:	(X3) DATE SURVEY COMPLETED
	00129	B. WING	C 11/09/2023

NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
THE VILLAS AT THE PARK		4415 WEST 36 1/2 STREET					
		SAINT LOUIS PARK, MN	55416				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FI REGULATORY OR LSC IDENTIFYING INFORMAT	ULL PREFIX	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)	(X5) COMPLETE DATE			
21565	with Vitamins) one tablet one time per day for supplement -Duloxetine HCl Delayed Release, 90 millign (mg) one time per day for major depressive disorder -Meloxicam Tablet 7.5 mg, one tablet once produced for chronic pain syndrome -Oxybutynin Chloride ER 10 mg, one tablet time per day for urinary leakage -Lamotrigine tablet, 200mg two times per day bipolar -Gabapentin Oral Capsule, 900 mg by mouth three times per day for neuropathy -Levetiracetam Oral Tablet 500 mg, Give 50 by mouth three times per day for seizures.	rams  per one ay for th					
	The report also included and order for Ondansetron HCl Oral Tablet 4 mg, one table every eight hours as needed for nausea and vomiting.  During observation and interview on 11/6/23 1:09 p.m., R3 was lying in bed with a full plaspaghetti and a salad on her bedside table, stated she started coughing and couldn't eabecause it was getting stuck on the way down She stated she recently had surgery to oper esophagus but sometimes thing still got study was observed coughing periodically during interview, and stated she would ask for anti-nausea medication to see if it would held During observation on 11/6/23 at 1:18 p.m., registered nurse (RN)-C entered R3's room where R3 requested anti-nausea medication RN-C left the room and went to the medication cart. At 1:21 p.m. RN-C returned to R3's room	at at ate of R3 tit wn. her ck. R3					
Minnesota De	where she was heard coughing, and then le	ft.					

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Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  4415 WEST 36 1/2 STREET  SAINT LOUIS PARK, MN 55416  (X-1) ENCOURSERS LAN OF CORRECTION (EACH DEFOCENCY MIST BE PRECEDED BY FULL (FROULATORY OR LSC IDENTIFYING INFORMATION)  21565  Continued From page 50  21565  21565  Continued From page 50  21565  21565  21565  Deficiency (All in the food fray, RA) stated the nurse gave the pills to her earlier but she was throwing things up and unable to swallow them, so they set them there until she could get the pills down. One container of anti-fungal powder approximately 25 percent full sat on R3's nightstand R3 stated sometimes staff left the powder there so she could put it on herself. R3 proceeded to take the medication without incident.  During interview on 11/6/23 at 3:09 p.m., RN-C stated it was not unusual for R3 to have a cough and they gave her some anti-nausea medication for it. They stated a medications, however R3 had an order to allow her pills to be left at bedside. They stated a resident needed to be assessed before handing the medications off to make sure the resident could take them but	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:  (X3) DATE		
NAME OF PROVIDER OR SUPPLIER  THE VILLAS AT THE PARK  A415 WEST 36 1/2 STREET  SAINT LOUIS PARK, MN 55416    CACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   PREPIX REGULATORY OR LSC IDENTIFYING INFORMATION)   PREPIX TAG   PROVIDER'S PLAN OF CORRECTION (EACH OORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  21565   Continued From page 50   21565    2.56 p.m., R3 was lying in bed semi-upright, her plate of spaghetti fully eaten on the bedside table. A medication cup containing several pills was sitting next to the food tray. R3 stated the nurse gave the pills to her earlier but she was throwing things up and unable to swallow them, so they set them there until she could get the pills down. One container of ant-fungal powder approximately 25 percent full sat on R3's nightstand. R3 stated sometimes staff left the powder approximately 25 percent full sat on R3's nightstand. R3 stated sometimes staff left the powder approximately 25 percent full sat on R3's nightstand R3 stated sometimes staff left the powder approximately 25 percent full sat on R3's nightstand R3 stated sometimes staff left the powder approximately 25 percent full sat on R3's nightstand. R3 stated sometimes staff left the powder approximately 25 percent full sat on R3's nightstand R3 stated sometimes staff left the powder approximately 25 percent full sat on R3's nightstand R3 stated sometimes staff left the powder approximately 25 percent full sat on R3's nightstand. R3 stated sometimes staff left the powder approximately 25 percent full sat on R3's nightstand R3 stated sometimes staff left the powder approximately 25 percent full sat on R3's nightstand. R3 stated sometimes staff left the powder approximately 25 percent full sate on the state of the provider staff left the powder staff left the powder approximately 25 percent full sate of the provider staff left left left left left left left le				A. BUILDING.		
### THE VILLAS AT THE PARK  ### SAINT LOUIS PARK, MN 55416    (A4)   ID PRETIX (EACH DEPICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEPICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEPICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE DATE.    21565			00129	B. WING		
SAINT LOUIS PARK, MN 55416   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEFICIENCY WIST BE PRECEDED BY FULL TAG   PREFIX TAG   PREFX TAG   PREFIX TAG   PREFIX TAG   PREFIX TAG   PREFIX TAG   PREFX TA	NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	
SAINT LOUIS PARK, MN 55416    (X4) ID PREFIX TAG	THE VILL	Δς ΔΤ ΤΗΕ ΡΔΡΚ	4415 WE	ST 36 1/2 STREET		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  21565  Continued From page 50  2:56 p.m., R3 was lying in bed semi-upright, her plate of spaghetti fully eaten on the bedside table. A medication cup containing several pills was sitting next to the food tray. R3 stated the nurse gave the pills to her earlier but she was throwing things up and unable to swallow them, so they set them there until she could get the pills down. One container of anti-fungal powder approximately 25 percent full sat on R3's nightstand. R3 stated sometimes staff left the powder there so she could put it on herself. R3 procedded to take the medication without incident.  During interview on 11/6/23 at 3:09 p.m., RN-C stated it was not unusual for R3 to have a cough and they gave her some anti-nausea medication for it. They stated sometimes she took her medication with applesauce, and it could take a long time for her to take her medications, however R3 had an order to allow her pills to be left at bedside. They stated a resident needed to be assessed before handing the medications off to make sure the resident could take them but	TITE VILL	AS AT THE PARK	SAINT L	OUIS PARK, MN 5	5416	
2:56 p.m., R3 was lying in bed semi-upright, her plate of spaghetti fully eaten on the bedside table. A medication cup containing several pills was sitting next to the food tray. R3 stated the nurse gave the pills to her earlier but she was throwing things up and unable to swallow them, so they set them there until she could get the pills down. One container of anti-fungal powder approximately 25 percent full sat on R3's nightstand. R3 stated sometimes staff left the powder there so she could put it on herself. R3 procedded to take the medication without incident.  During interview on 11/6/23 at 3:09 p.m., RN-C stated it was not unusual for R3 to have a cough and they gave her some anti-nausea medication for it. They stated sometimes she took her medication with applesauce, and it could take a long time for her to take her medications, however R3 had an order to allow her pills to be left at bedside. They stated a resident needed to be assessed before handing the medications off to make sure the resident could take them but	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLETE
was unsure if there was any specific form for that assessment other than within the initial admission assessment. Upon review of R3's medical record, RN-C was unable to find an order or medication self-administration assessment.  During interview on 11/8/23 at 8:46 a.m., licensed practical nurse (LPN)-B stated if a resident wished to self-administer medications staff completed an assessment to make sure it was safe, provided resident education, and got an order from the provider. They stated R3 had an esophageal stricture and difficulty swallowing and identified it would not be appropriate for R3 to self-administer medications because she likely could have trouble swallowing them.	21565	2:56 p.m., R3 was lying plate of spaghetti fully. A medication cup consitting next to the food gave the pills to her exthings up and unable them there until she container of anti-fung percent full sat on R3 sometimes staff left the could put it on herself medication without incompleted it was not unusuand they gave her soft for it. They stated some medication with apple long time for her to tall however R3 had an oleft at bedside. They she assessed before her to make sure the residual was unsure if there was unsure if th	reaten on the bedside table. Itaining several pills was ditray. R3 stated the nurse arlier but she was throwing to swallow them, so they set could get the pills down. One all powder approximately 25 is nightstand. R3 stated he powder there so she is R3 procedded to take the cident.  1/6/23 at 3:09 p.m., RN-C sual for R3 to have a cough me anti-nausea medication metimes she took her isauce, and it could take a ke her medications, rder to allow her pills to be stated a resident needed to anding the medications off dent could take them but as any specific form for that in within the initial admission view of R3's medical record, and an order or medication sessment.  1/8/23 at 8:46 a.m., licensed is stated if a resident sessment.  1/8/23 at 8:46 a.m., licensed is stated if a resident seter medications staff ment to make sure it was ant education, and got an ear. They stated R3 had an and difficulty swallowing and be appropriate for R3 to ations because she likely	21565		

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Minnesota Department of Health

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					С
		00129	B. WING		11/09/2023
		00.120			1170372023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	
THE VILL	AS AT THE PARK		ST 36 1/2 STREET		
		SAINT LO	OUIS PARK, MN 5	5416	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETE THE APPROPRIATE DATE
21565	Continued From pag	e 51	21565		
	of nursing stated if a self-administer medican assessment, and stated R3 had a recesshould not self-administer choking. In addition,	cations staff would complete obtain a provider order. She ent esophageal dilation and nister due to the potential for it would be difficult to know taken, or if they were taken			
	resident is always of to ensure that the do In addition, residents medications when spattending physician a	ed 5/2022, included the oserved after administration ase was completely ingested. It can self-administer becifically authorized by the and in accordance with administration of medications.			
	dated 5/2022, indicated self-administer mediated conducted by the interestident's cognitive,	ion of Medications policy ted if a resident desires to cations, and assessment is erdisciplinary team of the physical, and visual ability to sibility in the care planning			
	administrator, director designee could reviet administration of medevidence based practises staff could be educated importance of ensuring administering their or quarterly, annually, or resident's physical or Nursing staff could a physician's order in president in	r mental ability to do so. Iso ensure there is a			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:	(X3) DATE SURVEY COMPLETED
	00129	B. WING	C <b>11/09/2023</b>

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE VILLAS AT THE PARK  SAINT LOUIS PARK, MN 55416							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)	(X5) COMPLETI DATE			
21565	Continued From page 52	21565					
	The DON or designee, could audit any/all resident's medical records, to ensure compliance with appropriate medication administration. The DON or designee could take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance.						
	TIME PERIOD FOR CORRECTION: Twenty one (21) days.						
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance	21685		1/9/24			
	Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program.						
	This MN Requirement is not met as evidenced by: During observation, interview and document review, the facility failed to assure that the kitchen dishwasher was maintained per the manufacturer's instructions, causing buildup of thick white residue on the outside of the machine. The had the potential to affect all 44 residents within the facility reviewed for essential equipment being maintained in a safe and operating condition.		Completed				
	Findings include:						
	During observation on 11/6/23, at 11:57 a.m., the kitchen dishwasher, which was a Hobart single tray door type commercial dishwasher, had 80%						

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					С
		00129	B. WING		11/09/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		4415 WES	ST 36 1/2 STREE		
THE VILL	AS AT THE PARK		OUIS PARK, MN		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
21685	Continued From page	÷ 53	21685		
	residue, the bottom of 100% covered in white front legs was covered raised residue.  During an interview work (CD), on 11/7/23, at 1 not know the recommendation cleaning schedule for that EcoLab comes to the dishwasher, and its content of the con				
	cleaning. CD stated the maintain the dishwash	ner because it is facility recall the last time the			
	Director (CCD) and Constated that staff are to the machine and help machine called Limes and CD-A state it is not constant.	th the Corporate Culinary D on 11/7/23, at 3:06 p.m., use a product that clings to s reduce limescale on the away. However, both CCD ot working and that the be delimed and decalcified.			
	p.m., kitchen staff did	n review on 11/7/23 at 3:08 not document a limescale the dishwasher from April f 2023.			
	stated that the water s malfunctioning since I was fixed on October the water softener is r	n 11/8/23, at 9:45 a.m., CD softener had been February of 2023 and that it 6th, 2023. He stated that running at 26 parts per installed on October 6th,			

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According to the Hobart dishwasher

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED
					С
		00129	B. WING		11/09/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATI	E, ZIP CODE	
THE VILL	AS AT THE PARK		ST 36 1/2 STREET OUIS PARK, MN <i>5</i>		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
21685	Continued From page	e 54	21685		
	dishwasher, the wate exceed 3°dH, if highe	mendations, to protect the r hardness should not er it is recommended to use ater softener/ treatment			
	and Care, dated 9/20 be free of lime buildured following guidelines: be used to remove an exterior of the dish m	on for dilution product use.			
	The director of nursing develop and implementated to dialysis. The provide training for all dishwasher preventated quality assessment a could perform random compliance. In additional develop and improcedures related to maintenance.	on, the DON or designee			

Minnesota Department of Health

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PRINTED: 12/06/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BUILDING 01 B. WING 245083 11/08/2023 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4415 WEST 36 1/2 STREET THE VILLAS AT THE PARK SAINT LOUIS PARK, MN 55416 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETION PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG **TAG** DEFICIENCY) K 000 INITIAL COMMENTS K 000 FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 11/08/2023. At the time of this survey, The Villas At The Park was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. (X6) DATE TITLE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

12/05/2023

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.

Facility ID: 00129

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		NSTRUCTION MAIN BUILDING 01	` '	TE SURVEY MPLETED
		245083	B. WING				1/08/2023
	ROVIDER OR SUPPLIER  AS AT THE PARK			4415	EET ADDRESS, CITY, STATE, ZIP CODE WEST 36 1/2 STREET NT LOUIS PARK, MN 55416		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOW CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 000	Healthcare Fire Inspectate Fire Marshal Divided Healthcare Fire Inspectate Fire Marshal Divided Healthcare Fire Inspectate Fire Marshal Divided Healthcare Fire Marshal Divided Healthcare St., S. St. Paul, MN 55101-58. By email to: FM.HC.Inspections@  THE PLAN OF CORF DEFICIENCY MUST FOLLOWING INFORM  1. A detailed descritaken or planned to construct the divided Healthcare for the place to ensure the divided Healthcare Fire Foreign Figure 1. Address the mean place to ensure the divided Healthcare Figure 1. Address the mean place to ensure the divided Healthcare Figure 1. Address the mean place to ensure the divided Healthcare Figure 1. Address the mean place to ensure the divided Healthcare Figure 1. Address the mean place to ensure the divided Healthcare Figure 1. Address the mean place to ensure the divided Healthcare Figure 1. Address the mean place to ensure the divided Healthcare Figure 1. Address the mean place to ensure the divided Healthcare Figure 1. Address the mean place figure 1. Address the mean	ections vision uite 145 5145, OR  estate.mn.us  RECTION FOR EACH INCLUDE ALL OF THE MATION:  ption of the corrective action orrect the deficiency.  esures that will be put in eficiency does not reoccur.  facility plans to monitor or ensure solutions are  esponsible for the corrective ag of compliance.  eposed date for completion of k is a 2 story building with ailding was constructed at 3	K	000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
		245083	B. WING		11/08/2023
	ROVIDER OR SUPPLIER		4	STREET ADDRESS, CITY, STATE, ZIP CODE 415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
K 000	facility was surveyed (000). The facility is for an automatic sprinkle	as one building, Type II ully protected throughout by r system and has a fire noke detection in corridors he corridors that is	K 000		
	The facility has a cap census of 43 at the time	acity of 52 beds and had a me of the survey.			
K 211 SS=E	The requirements at a are NOT MET as evid Means of Egress - George CFR(s): NFPA 101		K 211		1/9/24
	exit locations, and ac with Chapter 7, and the continuously maintain full use in case of em 18/19.2.2 through 18/19.2.2 through 18/19.2.1, 19.2.1, 7.1.10 This REQUIREMENT by:  Based on observation facility failed to maintain per NFPA 101 (2012 sections 19.2.2.2.1 and deficient findings coulon the residents within Findings include:	cesses are in accordance he means of egress is ned free of all obstructions to ergency, unless modified by /19.2.11. is not met as evidenced in and staff interview, the ain emergency egress doors edition), Life Safety Code, and 7.2.1.5.10.1. These Id have a patterned impact		<ul> <li>K211 – Egress Doors</li> <li>1. Keypads for identified doors have been lowered to 48" permitted height.</li> <li>2. Maintence Director educated to ensure all current and future keypads fegress doors are mounted to the regualted height.</li> <li>3. All keypads to egress doors to audweekly x4 weeks to enure appropriate height. Results will be brought to the Q</li> </ul>	for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	PLE CONSTRUCTION  IG 01 - MAIN BUILDING 01	` '	TE SURVEY MPLETED
		245083	B. WING _		1	1/08/2023
	ROVIDER OR SUPPLIER  AS AT THE PARK			STREET ADDRESS, CITY, STATE, ZIF 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 5541		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
K 211	emergency exit door mounted higher than  2. On 11/08/2023 at 0 observation that the I door after hours was maximum 48".  An interview with the and two Regional Maximum Maximum 48.	keypad that unlocks the GLE4A to the court yard was	K 2	committee monthly to revious opportunities for quality in 4. Maintenance Directors. 1/9/2024	mprovements.	
K 345 SS=E	CFR(s): NFPA 101  Fire Alarm System - A fire alarm system is accordance with an a with the requirements	Testing and Maintenance Testing and Maintenance Is tested and maintained in Improved program complying Is of NFPA 70, National IS FPA 72, National Fire Alarm IS Records of system	K 3	45		1/9/24
	acceptance, mainten available. 9.6.1.3, 9.6.1.5, NFP This REQUIREMENT by: Based on a review of and staff interview, the the fire alarm system edition), Life Safety Construction NFPA 72 (2010 editional Signaling Code sections	A 70, NFPA 72 T is not met as evidenced of available documentation ne facility failed to maintain ner NFPA 101 (2012 Code, section 9.6.1.3, and on), National Fire Alarm and on 14.2.1.2.2. This deficient patterned impact on the		<ol> <li>All devices identified</li> <li>Maintenance Director</li> <li>ensure routine sensitivity</li> <li>completed with replacement</li> <li>indicated.</li> <li>Safety committee to testing results for replace and monitor routine testing</li> <li>monthly.</li> <li>Maintenance Director</li> <li>1/9/2024</li> </ol>	reducated to testing is ent of devices as review sensitivity ement devices, and is up to date	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
		245083	B. WING _		11/08/2023
	ROVIDER OR SUPPLIER  AS AT THE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
K 345	On 11/08/2023 between it was revealed by a reducementation that the testing report that was reported that there we detectors, and the factors and the factors and the factors and two Regional Market	en 11:15 AM and 01:30 PM,	K 3	45	
K 901 SS=F	CFR(s): NFPA 101  Fundamentals - Build Building systems are 1 through 4 requirem	d personnel.	K 9	01	1/9/24
	by: Based on a review of and staff interview, the Risk Assessment per Health Care Facilities deficient finding could on the residents within Findings include:	f is not met as evidenced of available documentation he facility failed to provide a NFPA 99 (2012 edition), a Code, section 4.2. This have a widespread impact in the facility.		<ol> <li>NFPA99 Risk Assessment</li> <li>Maintenance Director educensure assessment is complete annually.</li> <li>Safety Committee to revieto reviewed NFPA 99 Risk Assecurrent.</li> <li>Maintenance Director</li> <li>1/9/2024</li> </ol>	cated to ed w monthly

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>\</b> \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		CONSTRUCTION 1 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
		245083	B. WING			11/08/2023
	ROVIDER OR SUPPLIER  AS AT THE PARK			4	TREET ADDRESS, CITY, STATE, ZIP CODE 415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416	•
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
K 901	facility could not prove assessment.  An interview with the and two Regional Ma	review of available It the time of the survey the	K	901		
K 918 SS=F	discovery. Electrical Systems - I CFR(s): NFPA 101	Essential Electric Syste	K	918		1/9/24
	Maintenance and Test The generator or oth and associated equip service within 10 sec criterion is not met du process shall be proved capability for the life of Maintenance and test transfer switches are with NFPA 110.  Generator sets are in under load 30 minuted day intervals, and extended and the conditions simulated cold start at transfer of all EES load competent personnel stored energy power accordance with NFP circuit breakers are in program for periodical components is establishmanufacturer required.	per alternate power source of supplying onds. If the 10-second uring the monthly test, a wided to annually confirm this safety and critical branches. Iting of the generator and performed in accordance aspected weekly, exercised as 12 times a year in 20-40 ercised once every 36 ous hours. Scheduled test include a complete and automatic or manual ads, and are conducted by 1. Maintenance and testing of sources (Type 3 EES) are in PA 111. Main and feeder aspected annually, and a ally exercising the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245083	B. WING			11/08/2023	
	ROVIDER OR SUPPLIER  AS AT THE PARK			44	REET ADDRESS, CITY, STATE, ZIP CODE  15 WEST 36 1/2 STREET  AINT LOUIS PARK, MN 55416		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SE COMPLETION	
K 918	readily available. EES circuits are marked, reseparate from normal the possibility of dame source is a design constallations. 6.4.4, 6.5.4, 6.6.4 (NI 111, 700.10 (NFPA 70 This REQUIREMENT by: Based on a review of and staff interview, the generators per NFPA Care Facilities Code, NFPA 110 (2010 edition Emergency and Standers 110 (2010 edition Emergency and Stander	S electrical panels and readily identifiable, and I power circuits. Minimizing age of the emergency power onsideration for new  FPA 99), NFPA 110, NFPA  O)  T is not met as evidenced  If available documentation ne facility failed to maintain a 99 (2012 edition), Health a section 6.4.4.1.1.3, and alon), Standard for addy Power Systems, section ding could have a nother residents within the section of available and the residents within the review of available at the time of the survey the ride a letter of reliability for		918	<ol> <li>Letter of reliability has been obtain and secured in facility's records.</li> <li>Director of Maintenance educated keeping letter of reliability in records.</li> <li>Administrator and/or designee to complete monthly audits x3 months to ensure letter of reliability is maintained preventative maintenance records. Auwill be brought to QAPI by Administrator designee to review trends and determine if audits need to continue.</li> <li>Maintenace Director</li> <li>1/9/2024</li> </ol>	l on l in dits	



#### Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered February 12, 2024

Administrator
The Villas At The Park
4415 West 36 1/2 Street
Saint Louis Park, MN 55416

RE: CCN: 245083

Cycle Start Date: November 9, 2023

Dear Administrator:

On December 13, 2023, we notified you a remedy was imposed. On February 8, 2024 the Minnesota Departments 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 January 9, 2024.

As authorized by CMS the remedy of:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective February 9, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of December 13, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 9, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on January 9, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: Melissa.Poepping@state.mn.us



### Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 12, 2024

Administrator
The Villas At The Park
4415 West 36 1/2 Street
Saint Louis Park, MN 55416

Re: Reinspection Results

Event ID: 6PCP12

#### Dear Administrator:

On January 17, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 9, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: Melissa.Poepping@state.mn.us