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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

Please note that the failure to complete the informal dispute resolution process will not delay the

dates specified for compliance or the imposition of remedies.

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

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
travis.ahrens@state.mn.us
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

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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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245083	A. BUILDING _____ B. WING _____	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 FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 11/6/23 - 11/9/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1),	E 041		1/9/24

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

Electronically Signed | 12/01/2023

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.

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E 041	Continued From page 1 §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the	E 041		

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E 041	Continued From page 2 material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..	E 041		

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E 041	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 4.2. This deficient finding could have a widespread impact on all residents within the facility. Findings include: Facility documentation reviewed on 11/08/2023 between 11:15 a.m. and 1:30 p.m., lacked evidence of reliability for the natural gas which fuels the emrgency generator. During interview on 11/08/2023 between 11:15 a.m. and 1:30 p.m., the Maintenance Supervisor and two Regional Maintenance supervisors verified these deficient findings at the time of discovery.	E 041	1. Letter of reliability has been obtained and secured in facility's records. 2. Letter to be kept with preventative maintenance records. 3. Director of Maintenance educated on keeping letter of reliability in records. 4. Administrator and/or designee to complete monthly audits x3 months to ensure letter of reliability is maintained in preventative maintenance records. Audits will be brought to QAPI by Administrator or designee to review trends and determine if audits need to continue.	
F 000	INITIAL COMMENTS On 11/6/23 - 11/9/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was IN NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H50836890C (MN95910) The following complaints were reviewed: H50836889C (MN97850) with a deficiency cited	F 000		

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F 000	Continued From page 4 at F770. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This 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. 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.	F 554	1. R3 was assessed and no adverse impact due to this deficient practice. R3 remains unsafe to Self-administer medications. Anti-fungal power is being kept in the medication cart. R3 is currently being seen by speech. 2.This practice has the potential to affect other like residents. Residents were reviewed to ensure other prescription medications and creams are not being left at bedside without appropriate assessment and order. 3. Education will be completed with	1/9/24

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F 554	Continued From page 5 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 with Vitamins) one tablet one time per day for supplement -Duloxetine HCl Delayed Release, 90 milligrams (mg) one time per day for major depressive disorder -Meloxicam Tablet 7.5 mg, one tablet once per day for chronic pain syndrome -Oxybutynin Chloride ER 10 mg, one tablet one time per day for urinary leakage -Lamotrigine tablet, 200mg two times per day for bipolar -Gabapentin Oral Capsule, 900 mg by mouth three times per day for neuropathy -Levetiracetam Oral Tablet 500 mg, Give 500 mg by mouth three times per day for seizures. The report also included and order for Ondansetron HCl Oral Tablet 4 mg, one tablet every eight hours as needed for nausea and vomiting.	F 554	nursing staff to watch patients take all medications unless nursing evaluation and the order has been received by the provider. Education will be completed with nursing staff to not leave prescription powders/creams at bedside unless nursing evaluation and the order has been received by the provider. 4. Director of Nursing and/or Designee will complete five audits weekly for four weeks and then twice weekly for four weeks. Audits will be brought to QAPI by Administrator and/or designee to review trends and determine if audits need to continue. Director of Nursing and/or designee is responsible for 100% compliance.	

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F 554	Continued From page 6 During observation and interview on 11/6/23 at 1:09 p.m., R3 was lying in bed with a full plate of spaghetti and a salad on her bedside table. R3 stated she started coughing and couldn't eat it because it was getting stuck on the way down. She stated she recently had surgery to open her esophagus but sometimes thing still got stuck. R3 was observed coughing periodically during interview, and stated she would ask for anti-nausea medication to see if it would help. 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 where she was heard coughing, and then left. During observation and interview on 11/6/23 at 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,	F 554		

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F 554	Continued From page 7 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 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. During interview on 11/8/23 at 9:04 a.m., director of nursing stated if a resident wished to self-administer medications staff would complete an assessment, and obtain a provider order. She stated R3 had a recent esophageal dilation and should not self-administer due to the potential for choking. In addition, it would be difficult to know what time they were taken, or if they were taken at all. The Medication Administration - General Guideline policy dated 5/2022, included the resident is always observed after administration to ensure that the dose was completely ingested. In addition, residents can self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications.	F 554		

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	245083	A. BUILDING _____ B. WING _____	C 11/09/2023

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F 554	Continued From page 8 The Self-Administration of Medications policy dated 5/2022, indicated if a resident desires to self-administer medications, and assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out this responsibility in the care planning process.	F 554		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide hygienic nail care to 2 of 3 residents (R35 and R19) reviewed for dependent activities of daily living (ALD's). R19's annual Minimum Data Set (MDS) assessment dated 8/7/23, included R19 was severely cognitively impaired, had diagnoses of dementia and aphasia (difficulty speaking), and no behavioral concerns. R19's Cognitive Loss/Dementia Care Area Assessment dated 8/21/23, included he required assistance with ADLs. R19's ADL Functional/Rehabilitation Potential was not assessed or triggered. R19's ADL care plan dated 4/20/20, indicated he often used his hands to eat and required set-up and encouragement for personal hygiene, but lacked nail care assistance needs. His	F 677	1. R35 and R19 were provided with nail care. The residents care plan was updated to reflect nail care to be offered on bath days for both residents. 2.The resident population that requires assistance with ADLS could be impacted by this practice. All of these residents had nail care provided/offered, and care plans updated to reflect nail care to be offered on bath days. 3. Education will be completed with all nursing staff to ensure nail care is being provided on bath days or when visibly soiled. 4. Director of Nursing and/or designee is responsible for 100% compliance. Nail care will be audited on resident bath days twice a week x4 weeks. The Director of	1/9/24

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F 677	Continued From page 9 behavioral focus dated 4/1/22, included R19 had behaviors of putting fecal matter on his plates/trays at mealtimes. 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 hygiene. 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. During observation on 11/7/23 at 10:36 a.m., R19 was seated on a chair in the hallway by the nurses' station. His fingernails were noted to be several millimeters long with brown crusted matter filling the underside of all nails. During observation on 11/7/23 at 12:18 p.m., R19 was seated in a chair in his room with a tray table in front of him containing a plate of what	F 677	Nursing and/or Designee will be bring audits to the QAPI committee monthly to review for continued opportunities for quality improvements.	

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F 677	Continued From page 10	F 677		

appeared to be rice, sweet potatoes, and another unidentified food item. R19 used his fingers on his left hand to pick up food bites and place them in his mouth throughout the meal until it was gone.

During interview on 11/7/23 at 1:07 p.m., nursing assistant (NA)-D stated NAs completed and documented nail care on bath days unless a resident was diabetic, and if a resident refused, they charted it. They stated R19 ate on his own after set-up, and had dementia and some behaviors, including resisting cares and defecating and urinating is his room and smearing feces around, but if in a good mood would let staff wash his hands and trim his nails.

During observation and interview on 11/7/12 at 1:37 p.m. license practical nurse (LPN)-B stated NAs completed nail care for non-diabetic residents on bath days and charted both completions and refusals. LPN-B observed R19's fingernails and confirmed they were long and soiled and described them as "not great". They asked R19 if they could get someone to cut them and R19 expressed willingness. LPN-B stated staff should have attempted to clean and trim them and document it in the record and was unsure why it was identified as unnecessary in the chart. They stated it was important to keep them clean and trimmed for infection control purposes and to prevent scratching and skin integrity concerns.

Findings include:

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F 677	Continued From page 11 R35's Face Sheet form, printed 11/7/23, indicated R35 had diagnoses that includes metabolic encephalopathy, intellectual disabilities, type 2 diabetes, and delusional disorders R35's admission Minimum Data Set (MDS), dated 6/27/23, indicated the assessment of daily and activity preference was not conducted by staff. Additionally, R35 is dependent of staff for showering/bathing and toileting. R35's quarterly MDS, dated 9/26/23, indicated R35 was moderately cognitively impaired and did not refuse care. R35's Care Area Assessment (CAA), dated 6/27/23, indicated that the ADL functional assessment was not completed or triggered. R35's care plan, dated 6/23/23, indicated that R35 required assistance of two staff for bathing and assistance of one staff for personal hygiene. R35's orders, dated 10/27/23, directed licensed nurses to document R35's skin inspection weekly, every day shift Saturday and to document any refusals. R35's bath and nail care assessment, dated 11/4/23, indicated staff performed and assisted the resident with bathing and nail care. R35's treatment administration record (TAR), printed 11/7/23, indicated that on 11/4/2023, staff assisted the resident with bathing. The electronic medical record (EMR) did not indicate the resident refused bathing or nailcare assistance from staff.	F 677		

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F 677	Continued From page 12 During an observation on 11/7/12 at 8:47 a.m., all 10 of R35's fingernails were approximately 1/2" in length with a buildup of dark black residue underneath the fingernail bed. R35 indicated that he would like them trimmed and cleaned. During an interview on 11/7/23 at 12:55 p.m., CNA-A stated that if R35 needed his nails trimmed and cleaned, she will call a nurse because the resident is diabetic. CNA-A went to visit R35 in his room, looked at the residents' fingernails and indicated that they were too long and dirty and if not cleaned properly, could cause an infection. During an interview on 11/8/23 at 8:00 a.m., 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 attempt to provide nail care. If CNA-C was unsuccessful, she would inform the Registered Nurse (RN). During an interview on 11/7/23 at 1:37 p.m., the nurse manager (LPN-B) stated that on bath days, residents are to have their nails trimmed and cleaned by a certified nursing assistant (CNA). If the resident is diabetic, a licensed nurse is required to trim the nails. LPN-B stated that R35's nails are "pretty long" and soiled and should be trimmed. During an interview on 11/8/23 at 12:38 p.m., the Director of Nursing (DON) stated that she would expect staff to follow the care plans for the residents and provide care in a timely manner per the resident's preferences. She expected that nail trimming be performed on shower/ bath days and as needed. If they are visibly dirty, staff should be	F 677		

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F 677	Continued From page 13 sure to clean underneath the nailbed. If residents refuse nail care, staff are expected to reapproach the resident three additional times, inform the nurse of any refusals, and document refusals. A policy titled, Activities of Daily Living (ADL's)/ Maintain Abilities, dated 3/31/23, indicates that a resident who is unable to carry out their own ADLs, that staff will assist them as necessary to maintain good nutrition, grooming, and personal and oral hygiene.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to schedule a follow-up gastrointestinal procedure for 1 of 1 residents (R3) reviewed who had difficulty swallowing. 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.	F 684	1. R3 was sent to GI on 11/30/2023; and clinic advised that follow up appointment was no longer needed for second endoscopy and resident was sent back to facility. 2. 100% of current residents in house have the potential to be affected. Residents who have gone out to appointments in the last 30 days have been reviewed to ensure any follow up appointments are scheduled as needed.	1/9/24

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F 684	Continued From page 14 R3's care plan dated 10/10/23, 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 hospital Upper GI (gastrointestinal) Endoscopy (a procedure used to visually examine the upper digestive system with the help of a tiny camera on the end of a long, flexible tube) note dated 10/25/23, indicated she had an esophageal dilation procedure to widen two severely narrowed areas in her esophagus, and included an order to "Repeat upper endoscopy with MAC [monitored anesthesia care - sleeping but able to breathe without a machine] in Purple OR [operating room] in 1-2 weeks for retreatment". R3's record lacked evidence of scheduling or completion of a second endoscopy procedure. During observation and interview on 11/6/23 at 1:09 p.m., R3 was lying in bed with a full plate of food on her bedside table. R3 stated she started coughing and couldn't eat it because it was getting 'stuck' on the way down. She stated she recently had surgery to open her esophagus but sometimes thing still got stuck. R3 was observed coughing periodically during interview, and stated she would ask for anti-nausea medication to see if it would help. During observation on 11/6/23 at 1:21 p.m. R3 continued to cough. During observation and interview on 11/6/23 at 2:56 p.m. R3 was lying in bed semi-upright, her food fully eaten on the bedside table. A medication cup containing several pills was sitting	F 684	3. Medical Records Director and nursing will be educated on process for post appointment paperwork review to ensure appointments are not missed. 4. Director of Nursing and/or designee to complete audits of post appointment notes to be done weekly for 4 weeks and monthly thereafter to ensure that follow-up appointments are scheduled as needed. They will review all residents that went out to an appointment during the audit week. The Director of Nursing and/or designee is responsible for 100% compliance. The Director of Nursing and/or designees will bring audit results to the QAPI committee monthly to review for continued opportunities for quality improvements.	

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F 684	Continued From page 15	F 684		

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.

During interview on 11/6/23 at 3:09 p.m., registered nurse (RN)-C stated it was not unusual for R3 to have a cough and they gave her some anti-nausea medication for it, and sometimes she took her medication with applesauce to help it go down easier.

During interview om 11/8/23 at 2:12 p.m., R3 stated she could swallow better some of the time since her dilation procedure, but still had trouble and was trying to figure out what was going on. She stated she was supposed to go back for follow-up, and the facility had not sent her back yet.

During interview on 11/9/23 at 8:24 a.m., licensed practical nurse (LPN)-A stated if a resident returned from an appointment with paperwork or if post-appointment documents were faxed to the facility, they reviewed them for orders and if a follow-up appointment was needed, sent it to the medical records director (MRD) who made the arrangements.

During interview on 11/9/23 at 8:48 a.m., MRD stated any post-appointment paperwork was given first to the nurse to enter orders, and then came to them. They stated the nurses read all the papers and alerted them to the need for future appointments before sending the papers to MRD for scanning, but if MRD happened to see a recommended appointment in the paperwork, MRD addressed it. They stated R3 had a procedure on 10/25/23, and a follow-up

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F 684	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.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		1/9/24

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F 689	Continued From page 17 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed implement care planned fall interventions, perform a comprehensive post-fall root cause analysis, and initiate and implement subsequent fall interventions for 1 of 4 residents (R4) reviewed for falls. Findings include: R4's quarterly Minimum Data Set (MDS) dated 10/24/23, indicated R4 was cognitively intact, had lower extremity impairment on one side, and used a wheelchair for mobility. R4 had diagnoses of fracture, depression, and schizophrenia, took antipsychotic, antidepressant, opioid, and hypoglycemic medications, was occasionally incontinent of bladder and frequently incontinent of bowel, and not on a toileting program. R4's Falls Care Area Assessment dated 8/2/23, indicated R4 was at risk for falls due to balance problems. R4 was only able to stabilize with staff assistance when moving from seated to standing position and on and off toilet and was admitted with a history of falling. R4's ADL (activities of daily living)/Functional Rehabilitation Care Area Assessment dated 8/2/23, indicated she required 1-2 staff for	F 689	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 have 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 interventions and completion of root cause analysis to be conducted weekly x4 weeks. Director of Nursing and/or designee will bring results to the QAPI committee monthly to review for continued opportunities for quality improvements.	

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F 689	Continued From page 18 toileting and transfers due to recent spinal fusion and repair of left ankle fracture and was at risk for falls. R4's Urinary Incontinence and Indwelling Catheter Care Area Assessment dated 8/2/23 indicated R4 was frequently incontinent of urine and required extensive assistance of 1-2 persons for toileting and was at risk for falls. R4's progress note dated 6/7/23, indicated she had a fall on 6/7/23, while self-transferring from wheelchair to bed. A progress note dated 6/8/23, indicated R4 was provided a bedside commode to allow more room for toileting. A progress note dated 6/17/23, indicated R4 was found on the floor after coming from the bathroom. R4's falls care plan updated 6/19/23, included R4 was at risk for falls related to ankle fracture and had a fall while self-transferring on 6/7/23. Interventions included provision of bedside commode. R4's elimination care plan focus dated 6/19/23, included R4 required assist of 2 with toileting and offer every 2-3 hours. R4's MHM Balance/ROM 3.0 dated 10/24/23, indicated R4 was not steady but able to stabilize without staff assistance when moving from a seated to standing position, walking, turning while walking, moving off the toilet, and when transferring from surface to surface, The form identified R4 had lower extremity impairment on	F 689		

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F 689	Continued From page 19 one side. R4's progress note dated 11/3/23 at 8:44 a.m., indicated R4 fell while pulling up her pants after using the bathroom and was assisted into her wheelchair using a mechanical lift and two staff. The note indicate R4 stated she needed to use the bathroom and when she was pulling up her pants, she felt her legs go weak and she fell. The note indicated R4 told staff she fell because she could not get her wheelchair into the bathroom and wanted a commode. A progress note dated 11/3/23 at 10:04 a.m. indicated the interdisciplinary team met regarding R4's fall and lacked indication of immediate intervention to prevent further falls, nor acknowledgement of R4's inability to get into her bathroom. 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. R4's MHM Incident Review and Analysis dated 11/6/23, indicated R4 fell from the toilet while ambulating on 11/3/23. The boxes for physical, occupational, and speech therapy were selected, as well as Psych referral as possible fall interventions. The form lacked identification of immediate interventions to prevent future falls, or acknowledgement of R4's inability to get into her bathroom. During observation and interview on 11/6/23 at	F 689		

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F 689	Continued From page 20	F 689		

12:47 p.m., R4 stated her legs were 'bad' and she wanted a commode by her bed. She stated she had one and it was taken away and staff told her she could walk to the bathroom, but she wasn't able to walk because she had to drag her left leg due to a broken ankle. She stated her wheelchair did not fit through the door to the bathroom, and at night it was hard to transfer from the door to the toilet and she fell a couple of days prior. R4 did not have a commode in her room.

During observation and interview on 11/8/23 at 10:20 a.m., nursing assistant (NA)-F observed R4 attempt to self-propel her wheelchair through the bathroom door where it got stuck in the doorway. NA-F verified it did not fit through the door, and confirmed R4 would need to ambulate approximately 4 feet to get to the toilet. R4 stated she fell there before because the rails on the wheels of her chair didn't fit, and she used to have a commode, but the facility took it away.

During interview on 11/8/23 at 10:23 a.m., NA-G stated there was a list of residents who were at risk for falls and it was identified on the residents' care plans. They stated R4 was independent with toileting and was not able to walk.

During interview on 11/9/23 at 8:15 a.m., NA-H stated residents' care plans identified any resident who was at greater risk of falling, and those at risk had mats on the floor, lower beds, and needed to be checked more often. They stated R4 could get to the bathroom by herself safely, but sometimes called for help. R4 was not a falls risk, pivot transferred, and did not walk.

During interview on 11/9/23 at 8:24 a.m., licensed practical nurse (LPN)-A stated for every fall the

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F 689	Continued From page 21 nurse completed a risk management form, added a new intervention based upon the specifics of the fall, and managers added interventions to the care plan. They stated R4 was sometimes independent, but sometimes used her call light to ask for assistance to the bathroom. They did not think R4 was at high risk for falling and had never seen her walk. During interview on 11/9/23 at 8:30 a.m., occupational therapist (OT) stated she believed R4 pivot transferred and was resistant to using her toilet in her bathroom. They did not know if R4 could ambulate. During observation and interview on 11/9/23 at 9:02 a.m., LPN-B stated after a resident fell the nurse implemented an intervention based upon the specifics of the fall using nursing judgment. The IDT team then completed a post-fall analysis, adjusted the intervention if needed, and added it to the care plan and the NA care guide. LPN-B stated R4 was non-ambulatory but could get to the toilet in her wheelchair and usually went to the bathroom herself. LPN-B went to R4's room where R4 attempted to wheel herself into the bathroom. LPN-B confirmed R4's wheelchair did not fit through the bathroom door and R4 would have to walk 4 or 5 steps to get to the toilet and sink. R4 told LPN-B she had trouble getting to the bathroom and had a hard time standing up, and used to have a commode but it was taken away. LPN-B stated R4 needed to be able to get through the bathroom door in her wheelchair to decrease fall risk and episodes of incontinence and increase independence and was not made aware of the issue. LPN-B confirmed R4's care plan did not contain updated interventions.	F 689		

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F 689	Continued From page 22 During interview on 11/9/23 at 10:57 a.m., director of nursing (DON) stated fall risk assessments were completed at admission, quarterly, annually, with significant changes, and as needed. They stated if a resident fell, they expected the nurse to complete a fall evaluation and implement immediate interventions, and the IDT team would meet later to review the fall and adjust the intervention as needed. She stated she expected a new intervention after each fall for resident safety and was not aware R4's wheelchair could not fit through the bathroom door. The Fall Prevention and Management policy dated 9/2023, indicated staff will identify interventions related to the resident's specific risks and causes to prevent the resident from falling and try to minimize complications from falling. If falling recurs, staff will implement additional or different interventions based on the nature of the fall.	F 689		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755		1/9/24

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F 755	Continued From page 23 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure stock medications (i.e., medication used for multiple patients) were tracked and re-ordered timely to prevent disruption in supply and potential complication for 1 of 1 resident (R38) observed to need medications which weren't available. Findings include: R38's Order Summary Report, dated 10/11/23, identified R38's current physician-ordered medications and treatments. This included an order for, "Sennalax-S Tablet 8.6-50 MG (Sennosides-Docusate Sodium) ... 1 tablet by mouth two times a day," with a listed start date of 9/15/23. On 11/06/23 at 7:42 p.m., licensed practical nurse (LPN)-A prepared R38's medications at a mobile	F 755	1. R38 stock medication was restocked on 11/6/23. Resident received correct medication after restocking. There was no adverse impact to R38 having to wait longer to receive the stock medication. MD updated. 2. 100% of current residents have the potential to be affected. Inventory of house stock medications completed with all medications needed available. 3. Licensed staff educated on timeliness of medication ordering for over the counter medications, and the appropriate steps to take if medication is not available. 4. Director of Nursing and/or designee is responsible for 95% or greater compliance. Audit of medication	

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F 755	Continued From page 24 cart in the hallway using R25's electronic Medication Administration Record (MAR) which outlined the same order for Sennalax-S as listed on R38's Order Summary Report (dated 10/11/23). However, LPN-A removed an opened bottle of Senna (labeled sennosides only) from the cart, placed one brown-colored tablet into the cup with R38's other medications, and attempted to administer the medications before being stopped by the surveyor (see F759). LPN-A acknowledged the medication they were going to provide was not the same medication which had been ordered. LPN-A searched the medication cart for the sennosides-docusate sodium (i.e., Senna-S), however, was unable to locate any supply of the medication. At this time, licensed practical nurse unit manager (LPN)-B presented to the medication cart and verified the brown-colored sennosides tablet was not the same medication ordered because Senna-S was an orange-colored tablet. LPN-B stated the pharmacy, at times, did not always send the right medications for the "stock" supply, so they would look for some quick. LPN-B returned after several minutes and expressed they did not have any of the medication on-hand, so they were sending an employee to the local drug store quick to get some. During follow-up interview, on 11/08/23 at 10:58 a.m., LPN-B stated the Senna-S was a stock medication and, typically, was re-ordered by "the scheduler" who was assigned to review the medication room and "based on that" re-order the needed supply from the dispensing provider. LPN-B verified they had reviewed the campus and there had been no supply the evening of 11/06/23 (as observed). LPN-B explained the facility had, at times, some "supply chain issues"	F 755	availability to be completed weekly x4 weeks to monitor compliance. Director of Nursing and/or designee will bring results to the QAPI committee monthly to review for continued opportunities for quality improvements.	

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F 755	Continued From page 25 with getting medications supplied timely stating this had been happening "on and off for awhile." LPN-B stated multiple people in management (i.e., HR, scheduler) were aware of this issue and, to their knowledge, were looking into it. On 11/08/23 at 11:43 a.m., the director of nursing (DON) was interviewed. DON explained there was a staff member assigned to monitor supply and, when needed, re-order stock medications. DON acknowledged they had run out of supply for R38's ordered stock medication and, as a result, they sent staff to the drug store and purchased some on 11/06/23. DON stated if there were supply chain issues, they typically would be notified of such, however, she "wasn't aware of it" until Monday when alerted (i.e., the surveyor observation). Further, the DON stated she would have ensured a supply of the medication was available had someone told her it was gone. A provided Medication Ordering and Receiving From Pharmacy policy, dated 1/2018, identified medications and related products would be received from the dispensing pharmacy on a timely basis. A procedure was listed for re-ordering medications not automatically filled by the pharmacy, including use of a medication order form, however, lacked specific instructions for monitoring supply or re-ordering stock medications at the nursing home; nor any information on how this would be accomplished to ensure no lapse in supply.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that	F 758		1/9/24

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F 758	Continued From page 26 affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.	F 758		

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F 758	Continued From page 27 §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure appropriate side effect monitoring was completed, in accordance with the care plan and standard of care, related to psychotropic (i.e., antipsychotic) medication use for 2 of 5 residents (R29, R4); and failed to ensure as-needed (i.e., PRN) antipsychotic medication use was limited or re-evaluated after 14 days for 1 of 5 residents (R19) reviewed for unnecessary medication use. Findings include: SIDE EFFECT MONITORING: A National Library of Medicine (NIH) Management of Commons Adverse Effects of Antipsychotic Medication article, dated 9/2018, identified the elderly were at risk of adverse effects (i.e., falls) of antipsychotic medication. The article outlined, "All antipsychotics carry some risk of orthostatic hypotension [which can] lead to dizziness, syncope, falls." It should be evaluated by both historical and routine measurement. R29's admission Minimum Data Set (MDS), dated 8/22/23, identified R29 had intact cognition and required substantial assistance with bed mobility actions (i.e., lying to sitting, sitting to standing). Further, the MDS outlined R29 had several medical diagnoses including anemia and atrial	F 758	1. 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. 2. All residents currently on psychotropic 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 when appropriate. 3. All licensed nurses are educated on the importance of completing side effect monitoring and obtaining stop dates for PRN psychotropic medication. 4. Director of Nursing and/or designee is responsible for 100% compliance. Nursing leadership will complete audits on psychotropic side effect monitoring weekly 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 are part of the psychotropic medication review process for the facility monthly, and will let	

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F 758	Continued From page 28 fibrillation, and consumed antipsychotic medication on a routine basis. R29's Order Summary Report, dated 10/11/23, identified R29's current physician ordered medications and treatments. This included an order for olanzapine (an antipsychotic medication) 2.5 milligrams (mg) by mouth twice a day for dementia with behavioral disturbance with a listed start date of 9/14/23. Further, the signed orders included a section labeled, "Other," with a treatment listed reading, "Monitor Orthostatic Blood Pressure while resident is receiving antipsychotic medications ... Every day shift every 1 month(s) ...," with a listed start date 10/19/23. R29's care plan, dated 9/11/23, identified R29 was at risk for falls, had an alteration in cognition due to dementia, and required assistance of one with movement in and out of bed. Further, the care plan outlined R29 was at risk for psychoactive medication adverse effects due to daily use of such medications and listed an intervention reading, "Monthly orthostatis blood pressure." This interventions listed an initiation date of 8/18/23. R29's Blood Pressure Summary, printed 11/9/23, identified R29's collected blood pressures since admission (8/2023) with several low readings being recorded including 105/68 (10/3/23), 87/59 (10/24/23), and 85/58 (11/7/23). However, the summary lacked evidence a series of orthostatic blood pressures (i.e., lying, sitting, standing) had been attempted or completed. R29's Treatment Administration Record (TAR), dated 10/2023, identified a treatment which read, "Monitor Orthostatic Blood Pressure monthly ...	F 758	the facility know if any residents on psychotropic medications would be appropriate for dose reductions, medication discontinuation, and verifying appropriateness of the side effect monitoring and frequency.	

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F 758	Continued From page 29 every day shift every 1 month(s) ...," with a listed start date 10/09/23. However, the order also listed a discontinuation date which read 10/27/23, and the only space provided to record the values (i.e., pressure) demonstrating it had been completed were answered, "NA." R29's subsequent TAR, dated 11/2023, lacked any treatments or results demonstrating collection or review of R29's orthostatic blood pressures. When interviewed on 11/7/23 at 2:58 p.m., nursing assistant (NA)-A stated they had worked with R29 several times, and described R29 as being needy and total assistance for most cares. NA-A stated R29 had just recently signed onto hospice care, demonstrated "off and on" cognition, and rarely, if ever, ambulated; however, did still physically transfer from her bed to the wheelchair at times with help. NA-A stated R29 had never complained about being lightheaded or dizzy with transfers, to their knowledge. R29's Consultant Pharmacist's Medication Regimen Review, dated 8/21/23, identified R29 admitted with orders for depakote and olanzapine. The recommendation included, "Please ensure the following is completed ... Ortho bp monitoring (this monitoring is not required if unable to stand, please care plan)." The dictation had a black-colored checkmark written next to it along with a column labeled, "Follow-Through," which had a red-colored "Scanned" stamp and a date written, "9/11/23." However, R29's medical record was reviewed and lacked evidence any orthostatic blood pressure readings had been attempted or collected despite R29 still physically transferring, at times, from their bed to the wheelchair; consuming daily antipsychotic medication; and,	F 758		

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F 758	Continued From page 30 recommendations from the consulting pharmacist to ensure such monitoring was in place (dated 9/21/23). In addition, there was no physician order located to demonstrate such monitoring had been discontinued or determined as not needed. On 11/08/23 at 10:47 a.m., licensed practical nurse unit manager (LPN)-B was interviewed. 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 attained despite the care plan directing to complete such monitoring. LPN-B stated they would typically be recorded in the Blood Pressure Summary, however added, "I do not see those." LPN-B stated R29 was unlikely able to ambulate or stand without physical help, however, acknowledged a lying-to-sitting orthostatic blood pressure could still be attained to help determine what, if any, potential symptoms were present. LPN-B stated it was important to ensure appropriate side effect monitoring, including orthostatic blood pressures, was completed to monitor R29's cardiac status and "[it] can alert us to changes if medication [i.e., antipsychotic] is not appropriate for them." R4 R4's quarterly Minimum Data Set (MDS) assessment dated 10/24/23, indicated R4 was cognitively intact, had diagnoses of depression and schizophrenia, and identified R4 was taking antipsychotic and antidepressant medications on a routine basis. R4 could stand and transfer independently. R4's Psychotropic Drug Use Care Area	F 758		

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F 758	Continued From page 31 Assessment (CAA) dated 8/2/23, indicated she received antidepressant and antipsychotic medications to manage a diagnosis of paranoid schizophrenia and depression and was at risk for adverse reactions to these medications, and included a goal to have no drug related side effects. R4's care plan dated 5/25/23, included potential for adverse drug reactions related to daily use of psychotropic medication, and directed staff to monitor orthostatic blood pressure. The care plan indicated R4 was unable to stand at that time. R4's Order listing Report dated 11/9/23, included: -Lamotrigine Oral Tablet, 300 milligrams (mg) at 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,	F 758		

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	245083	A. BUILDING _____ B. WING _____	C 11/09/2023

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F 758	Continued From page 32 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 triggered. R19's Psychotropic Drug Use CAA indicated he used antipsychotic and antidepressant medications to manage a diagnosis of depressive disorder, and he was at risk for reactions to these medications. The assessment indicated a goal to have no drug-related side effects. R19's care plan dated 12/31/23, included R3 had a mood problem related to stroke, dementia and depression, and instructed staff to administer medication as ordered and monitor/document side effects. The care plan also included R3 used antipsychotic medications and instructed staff to monitor/document side effects, including orthostatic hypotension. R3's activities of daily living (ADL) focus included he could stand and transfer independently. R19's Order Review History Report dated 11/9/23, included: -Escitalopram Oxalate Tablet 10 milligrams (mg),	F 758		

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F 758	Continued From page 33 Give 10 mg once per day for major depression starting 1/17/23. -Seroquel Oral Tablet 25 mg, give one tablet two times daily for major depression AND -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 date. -Psychotropic Monitoring- Antidepressant Medication, Monitor for side effects including orthostatic hypotension symptoms, weekly, every shift, every Monday starting 2/27/23. -Psychotropic Monitoring- Antipsychotic Medication, Monitor for side effects including orthostatic hypotension symptoms, weekly, every shift, every Monday starting 2/27/23. R19's Blood Pressure Summary dated 11/7/23, 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 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	F 758		

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F 758	Continued From page 34 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.	F 758		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were administered in accordance with physician orders and manufacturer guidelines for 3 of 6 residents (R25, R38, R45) observed to received medication. A total of four (4) errors out of 31 opportunities were identified resulting in a 12.9% (percent) facility' error rate. Findings include: R25's Order Summary Report, dated 10/11/23, identified R25's current physician-ordered medications and treatments. This included an order for acetaminophen 500 milligrams (mg) by mouth every six hours as needed (PRN) for pain. The order had a listed start date of 9/26/23. On 11/06/23 at 2:19 p.m., registered nurse (RN)-A prepared R25's medications at a mobile cart in the hallway by the nurses' station. R25 was standing next to the cart and, upon being asked,	F 759	1. R25, R38, and R45 were not administered the incorrect medication due to surveyor intervention prior to administration. Nurse that completed these errors received an education on Medication Administration. 2. 100% of current residents have the potential to be affected. All residents are receiving medications per MD orders. 3. All licensed nurses to be educated on the medication administration process. 4. Director of Nursing and/or designee is responsible for 95% or greater compliance. Three medication administration observations to be completed weekly x4. The Director of Nursing and/or designee will bring results to the QAPI committee monthly to review for continued opportunities for quality	1/9/24

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F 759	Continued From page 35 rated their pain an "eight [out of 10]." R25 then returned to their room while RN-A continued preparing R25's medications for administration at the cart. RN-A reviewed R25's electronic Medication Administration Record (MAR) which outlined the same order for acetaminophen as listed on R19's Order Summary Report (dated 10/11/23). However, RN-A removed an opened bottle of acetaminophen from the cart and placed two 500 mg tablets (i.e., 1000 mg) into the medication cup with R25's other oral medications. RN-A then picked up the cup of medications, locked the MAR screen on their cart, and turned to walk to R25's room. RN-A was then stopped by the surveyor and verified the medications in the cup were ready for administration. RN-A stated they were "pretty sure" the MAR directed to give two 500 mg tablets of acetaminophen to R25 and returned to the medication cart to review the order. RN-A verified R25's MAR and verified it directed to only provide one 500 mg tablet and not two as they had prepared. RN-A added, "That's exactly how easy it [error] can happen." RN-A then removed one tablet of the acetaminophen from the prepared medications and returned to R25's room to provide them. R38's Order Summary Report, dated 10/11/23, identified R38's current physician-ordered medications and treatments. This included an order for, "Sennalax-S Tablet 8.6-50 MG (Sennosides-Docusate Sodium) ... 1 tablet by mouth two times a day," with a listed start date of 9/15/23. On 11/06/23 at 7:42 p.m., licensed practical nurse (LPN)-A prepared R38's medications at a mobile cart in the hallway using R25's electronic Medication Administration Record (MAR). This	F 759	improvements.	

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F 759	Continued From page 36 outlined the same order for Sennalax-S as listed on R38's Order Summary Report (dated 10/11/23). LPN-A removed an opened bottle of Senna (labeled sennosides only) from the cart and placed one brown-colored tablet into the cup with R38's other medications. LPN-A then picked up the cup from the cart, locked the MAR screen on their cart, and turned to walk down to R38's room. LPN-A was then stopped by the surveyor and verified the medications in the cup were ready for administration. LPN-A returned to the medication cart and reviewed R38's current orders. LPN-A verified the medication order directed to give sennosides with docusate sodium (i.e., Senna-S) and inspected the medication cart, however, was unable to locate any supply of that medication. At this time, licensed practical nurse unit manager (LPN)-B presented to the medication cart and reviewed LPN-A's medications which remained in the cup. LPN-B verified the brown-colored sennosides tablet was not the same medication ordered because Senna-S was an orange-colored tablet. LPN-B stated the pharmacy, at times, did not always send the right medications for the "stock" supply, so they would look for some quick. LPN-B returned after several minutes and expressed they did not have any of the medication on-hand, so they were sending an employee to the local drug store quick to get some. LPN-A then removed the brown-colored sennosides tablet from R38's prepared medications and went to his room to administer the remainder of them. R45's Interagency Physician Discharge Orders/Instructions, dated 10/30/23, identified R45 had been hospitalized for several medical conditions, including diabetes mellitus, and was being discharged to the nursing home. The	F 759		

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F 759	Continued From page 37 orders directed to monitor R45's blood glucose three times a day prior to meals, along with other numerous medication orders including Lispro insulin (i.e., Humalog) one to five units subcutaneous three times a day per sliding scale and Vitamin D3 50 micrograms (mcg) by mouth once daily. On 11/8/23 at 7:47 a.m., RN-A prepared R45's medications at a mobile cart in the hallway. RN-A then removed several punch-pack style cards with R45's oral medications from the cart and started to prepare them for administration while referencing the MAR which included the same order for Vitamin D3 as outlined on R45's orders (dated 10/30/23). RN-A removed an opened bottle of Vitamin D3 25 mcg capsules from the top of the cart, however, RN-A only placed one capsule (i.e., 25 mcg) in the cup for administration. RN-A then locked their MAR screen, and turned to enter R45's room down the hallway. RN-A was then stopped by the surveyor and verified the prepared medications were ready for administration. RN-A returned to the medication cart and reviewed R45's Vitamin D3 orders in the MAR. RN-A verified the MAR directed to administer 50 mcg of the medication, however, they had only placed 25 mcg of the medication in the cup for administration (i.e., error). RN-A then added another 25 mcg capsule to the cup and returned to R45's room to provide the medications. RN-A checked R45's blood glucose using a community glucometer which resulted "301." RN-A stated they would retrieve R45's insulin and return. RN-A returned to the 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 were	F 759		

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F 759	Continued From page 38 to administer four units for a blood glucose of 301, and removed a new Assure Duo Pro needle from a box in another medication cart parked adjacent. RN-A then picked up the insulin pen and walked towards R45's room while dialing the insulin pen to four units. RN-A was stopped just prior to entering R45's room by the surveyor and questioned on the need to prime the insulin needle prior to delivery of the ordered dose. RN-A stated the pen was "already primed" as it only had to be done once when the pen was first opened. RN-A then entered R45's room and delivered the medication using the un-primed needle and 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." 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	F 759		

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F 759	Continued From page 39 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 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 "best practice" and also in accordance with the manufacturer guidelines. On 11/9/23 at 10:41 a.m., a subsequent interview with DON was held. DON verified they had a chance to follow-up on the reported administration errors and review each involved resident' medical record. DON stated the potential for an error "was there" with each administration and they were going to follow-up with education to the involved staff members. DON stated had the residents' actually received the medications (instead of the surveyor stopping them) then they would "follow the policy for a med error," however, since the residents' didn't actually receive the wrong medication or doses, they reiterated a need for education. DON stated it was important to ensure the correct medication and doses were given to for "resident safety." A provided Medication Administration - General Guidelines policy, dated 5/2022, identified medications would be administered as prescribed in accordance with good nursing principles and practices. The policy outlined, "FIVE RIGHTS - Right resident, right drug, right dose, right route, and right time, are applied for each medication being administered," adding, "A triple check of these 5 Rights is recommended at three steps in	F 759		

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F 759	Continued From page 40 the process of preparation of a medication ... "	F 759		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a fast-acting insulin Flexpen and newly attached needle was primed and administered in accordance with manufacturer instructions to facilitate complete dosing of the medication for 1 of 1 resident (R45) observed to receive insulin. This had potential to modify the dose of insulin being delivered and constituted a significant medication error. Findings include: R45's Interagency Physician Discharge Orders/Instructions, dated 10/30/23, identified R45 had been hospitalized for several medical conditions, including diabetes mellitus, and was being discharged to the nursing home. The orders directed to monitor R45's blood glucose three times a day prior to meals, along with other numerous medication orders including Lispro insulin (i.e., Humalog) one to five units subcutaneous three times a day per sliding scale. R45's Blood Sugar Summary, printed 11/9/23, identified R45's collected blood sugars since admission to the nursing home (11/2/23). R45's blood glucose was collected three times daily and ranged 185 - 318 mg/dl (milligrams per deciliter) on the report, however, of the total 19 blood	F 760	1. R45 resident was assessed by checking blood sugars and vital signs, Blood glucose was within normal range, MD was notified. No new orders given continue with current orders. No adverse side effects noted. Medication error report has been completed. Nurse educated. 2. All residents with insulin pens have the potential to be affected by this practice. All current residents receiving insulin via flex pen had their orders reviewed and changes made as needed. Blood glucose ranges reviewed and provider updated of any abnormal ranges as needed. 3. All licensed nurses to be educated on the insulin pen administration process, and checking resident blood glucose to ensure it is within range and steps to take when not in range. 4. Director of Nursing and/or designee is responsible for 100% compliance. Three insulin pen administration observations to be completed weekly x4 weeks. Director of Nursing and/or Designee will bring results to the QAPI committee monthly to review for continued opportunities for	1/9/24

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F 760	Continued From page 41 sugars recorded only three of them were below 200 mg/dl. On 11/8/23 at 7:47 a.m., RN-A prepared R45's medications at a mobile cart in the hallway. RN-A removed several punch-pack style cards with R45's oral medications from the cart and prepared them for administration. RN-A brought the medications to R45 who was seated in their room on the bed. RN-A then used a community-based glucometer to check R45's blood glucose and stated aloud it resulted, "301." RN-A returned to the medication cart in the hallway 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 were to administer four units for a blood glucose of 301, and removed a new Assure Duo Pro needle from a box in another medication cart parked adjacent. RN-A then picked up the insulin pen and walked towards R45's room while dialing the insulin pen to four units. RN-A was stopped just prior to entering R45's room by the surveyor and questioned on the need to prime the insulin needle prior to delivery of the ordered dose. RN-A stated the pen was "already primed" as it only had to be done once when the pen was first opened. RN-A then entered R45's room and delivered the medication using the un-primed needle and 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,	F 760	quality improvements.	

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F 760	Continued From page 42 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." 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. DON stated insulin pens should be primed with "the two units" before each administration. This was "best practice" and also in accordance with the manufacturer guidelines. A provided Medication Administration - General Guidelines policy, dated 5/2022, identified medications would be administered in accordance with written providers' orders. However, the policy lacked information on insulin Flexpen administration directions including what, if any, manufacturer guidelines should be followed with administration of such. A policy on insulin and/or Flexpen administration was not provided.	F 760		
F 770 SS=D	Laboratory Services	F 770		1/9/24

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F 770	Continued From page 43 CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure orders to obtain and process urinary analysis' and cultures (UA/UC) were acted upon, collected, and transported to the offsite laboratory for processing in a timely manner to reduce the risk of complication (i.e., worsening infection) for 2 of 2 residents (R11, R3) reviewed who had signs of potential urinary-based infections. Findings include: R11's admission Minimum Data Set (MDS), dated 10/17/23, identified R11 had intact cognition and was frequently incontinent of urine. Further, the MDS outlined R11 had several medical conditions including dementia and anemia, however, R11 did not have a current or previous (within 30 days) urinary tract infection (UTI). R11's care plan, dated 10/18/23, identified R11 had an alteration in elimination and mobility. The care plan listed several goals for R11's care including, "Resident will be free from signs/symptoms of UTI," along with interventions to help meet these goals including assistance	F 770	1. R11 & R3 are currently free of infection. R11 & R3 urine samples were sent to the lab, provider ordered antibiotics, and facility administered medication until symptoms were resolved. UTI care plans reviewed for R11 & R3 and updated as needed. Nurse educated. 2. All residents with signs and symptoms with an order for UA/UC collection have the potential to be affected. All residents that have an order for a UA/UC sample is collected timely, results uploaded to EMAR, and provider updated. Care plan reviewed and updated as needed. 3. All licensed nurses educated on collection process of UA/UC urine samples timely per MD orders. 4. Director of Nursing and/or designee is responsible for 100% compliance. Residents with orders for UA/UC collections to be audited weekly x4 to ensure timely collection of samples are sent to lab, and lab results reviewed by	

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F 770	Continued From page 44 with toileting, providing assistance with peri-cares and incontinence products, and assisting to change such products every two to three hours and as needed. On 11/6/23 at 12:36 p.m., R11 was interviewed and reported, "They [family] think I have a bladder infection." R11 explained they had a history of bladder infections and when their family member had visited the week prior, they had noticed some "blood when I pee'd" which caused concern. As a result, the staff reached out to the physician who ordered some testing be completed. R11 stated she recalled having to use a bed pan to get a urine sample, however, had not heard back yet on what, if any, treatment was to be done (i.e., antibiotics). R11 endorsed still having urinary symptoms adding she now felt there was "burning" while voiding which had not been present beforehand. A Grievance Report, dated 11/1/23, was filed with various concerns listed. This included, "Over the weekend [family] thought she saw some blood in [R11's] urine, and they were concerned about a possible UTI infection. Explained that provider has been updated with her symptoms." R11's medical record was reviewed and identified the following: R11's progress note, dated 11/2/23, identified R11 had an order for a UA/UC and was asked, by the nurse, how to obtain the sample (i.e., bedpan, catheterization). R11 wanted to attempt to use the bedpan to void, however, did not have enough expressed urine to collect an adequate sample. The note concluded, "TCP [provider] updated and a request for an order for straight cath was sent."	F 770	IDT to ensure care plan, EMAR, and provider are updated. The Director of Nursing and/or designee will bring audit results to the QAPI committee monthly to review for continued opportunities for quality improvements.	

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F 770	Continued From page 45 A subsequent TCP order, dated 11/3/23, identified an electronically signed physician order which read, "OK to straight cath to collect UA/UC." This order had a handwritten check mark along with a symbol (i.e., staff initials) present on the bottom of the page. R11's Medication Administration Record (MAR), dated 11/2023, identified a one-time order which read, "UA/UC in the evening ...," along with a checkmark and initials which indicated it was completed. A subsequent progress note, dated 11/7/23 (five days later), identified the director of nursing (DON) was asked by R11 when the UA results would be back the day prior (11/6/23). The DON called the laboratory who reported they did not yet have a sample. DON spoke with the nurse working who verbalized a previous shift nurse had reported R11 refused to give a sample. DON then visited with R11 who reported wanting to attempt a bedpan, however, again, was unable to provide an adequate sample so R11 agreed to a straight catheterization. The sample was collected on the evening shift for the laboratory service to pick up on 11/7/23 (morning). On 11/7/23 at 10:22 a.m., nursing assistant (NA)-A was interviewed. NA-A explained they had worked with R11 several times and described her as nearly always incontinent of urine. NA-A stated R11 had been complaining about urinary symptoms as recently as "the day before yesterday [11/5/23]" and, as a result, the nurse collected a urine sample "this morning [11/7/23]" to send to the laboratory for testing. R11's medical record was reviewed and lacked evidence or rationale (i.e., refusals) why R11's	F 770		

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F 770	Continued From page 46 ordered UA/UC had not been acted upon and obtained prior to 11/7/23, despite R11 having potential symptoms of an infection nearly a week prior (i.e., blood in the urine on 11/1/23) and direct care staff reporting those symptoms remained several days later (i.e., 11/5/23). When interviewed on 11/07/23 at 11:20 a.m., registered nurse (RN)-B stated they worked for a nursing agency and were assigned care for R11 that day. RN-B stated they were unaware R11 had reported any urinary symptoms adding, "Not that I know of [reported symptoms]." RN-B stated they received report from the previous nurse the sample had been collected and was in the fridge still (on 11/7/23) and awaiting pick-up from the laboratory. RN-B stated they were going to contact the laboratory to see why it had not been picked up adding it was "on my to do list." RN-B stated, typically, laboratory specimens should be collected and sent off "immediately," but they were unsure of the process at this facility. RN-B reiterated orders for a sample should be done "within 24 hours" and sent off to the laboratory but, again, also reiterated, "I don't know about here [this facility] though." RN-B stated it was important to act on laboratory specimen orders timely as the potential infection or symptoms could worsen and "they [resident] become septic." On 11/7/23 at 11:39 a.m., the DON was interviewed and explained the UA/UC order was obtained on 11/2/23 and, at that time, they directed the floor staff to collect it. However, R11 wanted to attempt to void in the bedpan instead of being catheterized for it which happened for attempts to collect it. The DON stated before she left the building on 11/3/23, she had told the floor nurses to ensure the sample was collected and	F 770		

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F 770	Continued From page 47 sent off adding she expressed, "Let's get this done." However, when the DON returned to work on 11/6/23 (three days later), R11 asked her where the results were for her test which caused her (DON) to contact the lab, however, they voiced no sample had ever been sent to them. DON acknowledged the medical record lacked rationale or explanation for the delay in obtaining the urine sample and subsequent laboratory processing and stated, "I am asking the same questions you are." DON added, "Why wasn't this followed through on the weekend?" Further, DON verified orders for laboratory testing should be collected and acted upon timely adding such was important to prevent worsening infection symptoms. R3's quarterly Minimum Data Set (MDS), dated 9/26/23, indicated R3 was cognitively intact, was independent with toileting, occasionally incontinent of urine and bowel, and had diagnoses of diabetes, seizure disorder, and traumatic brain injury. R3's Urinary Incontinence Care Area Assessment (CAA) dated 4/12/23, included R4 was frequently incontinent of urine and required extensive assist of one to two staff for toileting, and indicated she was at risk for urinary infection (UTI). R3's care plan dated 2/9/23, included alteration in elimination related to not wanting to get up with a goal of R3 will be free from signs and symptoms of UTIs and directed staff to provide assistance as needed with peri-cares. A progress note dated 10/9/23 at 8:27 p.m.,	F 770		

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indicated R3 complained of burning sensation during urination. She was concerned about becoming septic.

A Provider note dated 10/10/23, indicated R3 was last hospitalized for sepsis from a UTI, and identified R3 was concerned she had a UTI due to burning on urination, frequency, and urgency, and had a history of UTIs with sepsis in the past. The note included "Urinary tract infection, site not specified: Urinalysis and urine culture".

A progress note dated 10/13/23 at 9:20 p.m., included R3 had no antibiotics ordered, was free from signs/symptoms of pain, resident has signs/symptoms of infection, urgency, and dysuria (pain on urination). The note includes R3 stated "It hurts and burns when I pee and I have urges". Staff encouraged fluids and notified on-call provider and [obtained] new order for UA/UC (urinalysis/urine culture).

A progress note dated 10/14/23 at 7:45 a.m., indicated the order for R3's urine culture was sent to the lab by the evening nurse. The lab came that morning, but staff could not find the specimen in the refrigerator and the lab was canceled but would be reordered by Monday [10/16/23].

A progress note dated 10/17/23 at 1:54 p.m., indicated R3 complained of burning sensation when urinating, appeared confused, and was weak. Staff called provider and obtained an order for UA/UC.

A provider note dated 10/17/23, indicated R3 was seen for a possible UTI. The note indicated R3 asked to be seen "but presents dramatically

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changed in the last week". She was repetitive in her speech, confused and wasn't sure who the provider was despite multiple visits. The note indicated the provider ordered a UA/UC on 10/10/23 and "the results were not forthcoming and probably weren't done". The note indicated the change in mental status would be typical of her and a urinary tract infection. R3 was "clearly confused" and a UA/UC was reordered.

A provider note dated 10/18/23, indicated R4 had a confirmed UTI, continued to have burning when voiding with frequency and urgency, and was less confused but still forgetful.

R3's Order Listing Report indicated she had an order for Bactrim DS tablet 800-160, give one tablet two times per day for five days starting 10/18/23.

A progress note dated 10/18/23 at 10:03 p.m., indicated R3 was alert and oriented and had no antibiotics ordered.

During interview on 11/8/23 at 2:12 p.m., R3 stated she had a UTI recently with symptoms of pain and urgency and was on an antibiotic.

During interview on 11/9/23 at 10:25 a.m., licensed practical nurse (LPN)-A stated when a provider visited a resident, they did not always give the facility the note right away, and if orders were written they were usually faxed to the facility and the nurse entered in into the computer.

During interview on 11/9/23 at 10:43 a.m., LPN-B stated nurses reviewed provider lab orders, entered them in the medical record, obtained the sample, entered them into the lab system, and

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F 770	Continued From page 50 the lab came to pick up the sample. She stated the provider did not always give them their note the same day, but someone should have followed up on R3's UTI concerns as she had a history of UTIs, and a delay in treatment could result in sepsis and/or hospitalization. During interview on 11/9/23 at 10:57 a.m., director of nursing stated she expected staff to follow up on transcribing orders, communicate with other staff and the provider as needed, and document accordingly to ensure residents are taken care of to keep them safe and healthy. A facility' policy on laboratory testing and sample collection was requested, however, none was received.	F 770		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and	F 791		1/9/24

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F 791	Continued From page 51 (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: 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 8/22/23, identified R29 had intact cognition and no dental issues (i.e., broken teeth, missing teeth).	F 791	1. R29 oral cavity assessed and hospice provider updated with no new orders. R24 scheduled for extraction. This is documented in R24s medical record. 2. All residents have the potential to be affected by this practice. Residents not seen by dental since admission had oral assessments completed with provider updated for referral to dental as needed. 3. Licensed nurses provided with education to ensure oral assessment is completed upon admission. Social	

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F 791	Continued From page 52 On 11/6/23 at 4:30 p.m., R29 was observed laying in bed while in her room. R29 was interviewed and expressed she had never been asked about her dental care or needs (i.e., appointments) since she admitted to the nursing home several months' prior. R29 stated she had some missing teeth "in the back" of her mouth which she attributed to osteoporosis causing them to "fall out." R29 stated she would like to see a dentist as her teeth, in general, were not "in the best shape" but reiterated nobody had addressed it with her since she admitted. On 11/7/23 at 1:52 p.m., R29's family member (FM)-A was interviewed. FM-A explained R29 had been "kind of recluse" in her previous living situation and, as a result, FM-A was involved and 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 record denture use and a field labeled, "Last dental visit and Pysicians [sic] Name," and,	F 791	Services educated to offer dental services at quarterly care conferences. Clinical IDT educated on reviewing initial evaluations on all new admits for compliance with dental evaluation being completed. 4. Director of Nursing and/or designee is responsible for 100% compliance. 100% of new admissions to be audited for oral assessments weekly x4 weeks. Care conference documentation to be audited weekly x4 weeks to ensure dental is being offered as needed. Director of Nursing and/or designee will bring results to the QAPI committee monthly to review for continued opportunities for quality improvements.	

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F 791	Continued From page 53 "Dental Summary." However, all of these sections were left blank and not completed. R29's MHM IDT (interdisciplinary team) Care Conference Form V-4, dated 8/29/23, identified R29's admission care conference was held and listed several sections to record various information (i.e., medication use, restraint use, etc.) This included a section labeled, "Exams," which provided spaces to record R29's last dental examination and eye examination, however, neither section was completed and both were left blank. The form was signed by several staff members including licensed practical nurse manager (LPN)-B. R29's subsequent MHM Admission/Initial Data Collection V-4, dated 10/17/23, identified R29 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, again, these spaces were left blank and no data	F 791		

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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.

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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F 791	Continued From page 55 dental pain to the floor staff had been evaluated or acted upon to ensure appropriate follow-up. On 11/8/23 at 12:52 p.m. LPN-B was interviewed. LPN-B verified they had reviewed R29's medical record and her dentition and oral health needs 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 scheduled for an onsite dental visit "the next time they are out here [onsite dental]." LPN-B stated it was important to ensure dental status and needs were assessed and, if needed, referred to a dental provider timely as poor teeth can impact their ability to eat, their nutritional status and possibly cause an infection. R24's quarterly minimum data set (MDS) dated 8/16/23, identified R24 with intact cognition, a need for extensive assistance with personal hygiene and no broken teeth. R24's diagnoses dated 4/1/23, include type 2 diabetes with neuropathy, acute respiratory failure, generalized muscle weakness, morbid obesity. R24's care plan dated 9/1/22, identified a focus on oral/dental health problems, with a goal of being cooperative with dental appointments, and an intervention to coordinate arrangements for outside dental care and transportation as needed. During an interview dated 11/6/23, at 1:46 p.m., R24 stated that she has had chronic pain in two teeth on the upper right behind the incisors (#11 and #12) R24 also stated being advised two	F 791		

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F 791	Continued From page 56 years ago by the dentist that these two teeth that 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 poor condition of teeth with moderate soft plaque/food debris buildup, moderate swollen gums, and poor periodontal condition. Exam also indicated to arrange for a referral to an oral surgeon for extraction of teeth #11/#12 also indicating this was noted in 7/2022. Exam was done at bedside by HealthDrive dentist. R24's dental exam dated 7/14/23, indicated for referral out for extraction of teeth #11/#12. R24's dental exam dated 7/25/23, indicated for referral out for extraction of teeth #11/#12, R24's progress note dated 7/19/23, indicated that R24 declined to attend dental appointment scheduled for 7/19/23. During an interview dated 11/07/23, at 10:21 a.m., a registered nurse (RN)-C stated that a resident request to see a dentist for a non-acute appointment is placed on list to be seen when the contracted dentist from HealthDrive comes to the facility. RN-C also stated that if a referral is needed for dental care beyond what the contract dentist can provide, the referral is sent to the medical records director (MRD) to arrange the outside appointment, and the nurse placed the order/referral into the resident's chart.	F 791		

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F 791	Continued From page 57 During an interview dated 11/7/23, at 10:29 a.m., 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 residents, and any refusals by residents should be documented. DON also states there is no policy on scheduling outside dental appointments.	F 791		
F 808 SS=D	Therapeutic Diet Prescribed by Physician	F 808		1/9/24

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F 808	Continued From page 58 CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a therapeutic diet of thickened liquids was followed and implemented for 1 of 1 resident (R21) reviewed for therapeutic diets. Findings include: R21's face sheet dated 8/24/21, included diagnoses of chronic obstructive pulmonary disease (COPD), non-dominant sided weakness and paralysis following a stroke, difficulty swallowing following a stroke, and generalized muscle weakness. R21's care plan last reviewed 7/26/23 and initiated on 5/4/23, included a swallowing problem after a stroke, with a goal of not having injury related to aspiration through the review date (12/27/23). The intervention initiated 7/15/2022, was to monitor, document, and report as needed any signs or symptoms of difficulty swallowing, refusing to eat, or appearing concerned during meals. R21's quarterly minimum data set (MDS) dated	F 808	1. R21 did not have any adverse effects from 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. 2. All residents on thickened liquids and have the potential to be affected. Meal tickets reviewed to match MD orders and resident preferences. Care plans were reviewed and updates made as needed. 3. Education provided to all staff on utilizing the meal tickets before serving any resident to ensure appropriate liquid consistencies are being served. IDT is educated to verify care plan, order, and meal ticket to all match when a new diet order is received. 4. Administrator and/or designee is responsible for 100% compliance. Four meal serving observations to be completed weekly x4 to verify correct liquid consistency on 20% of the	

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F 808	Continued From page 59 09/26/23, indicated intact cognition, supervised eating, and mechanically altered diet. The functional status portion of the MDS dated 10/10/23, indicated there should be someone with resident during meals to assist with eating. R21's Clinical Nutrition Evaluation completed on 9/26/23, indicated a regular mechanical soft textured diet with nectar thick liquids. R21's diet change form dated 10/18/23, completed by the speech language pathologist (SLP), indicated mechanical soft consistency and honey thick liquids. R21's orders dated 10/19/23, identified honey consistency beverage thickness. R21's Kardex (the record in which staff know what care interventions to implement to care for residents) printed 11/7/23, latest revision date of 1/3/23 indentified to "serve diet as ordered." During an observation on 11/7/23, at 8:26 a.m., R21 received a glass of milk from the administrator during breakfast meal pass. The milk appeared to be thin (non-thickened). R21 took several sips of the milk and coughed after each sip. During an interview on 11/7/23, at 8:30 a.m., nursing assistant (NA)-E confirmed the milk had not been thickened and removed the milk from the room. During an interview on 11/7/23, at 8:35 a.m., the administrator stated meal tickets should identify if and how liquids are thickened. R21's meal ticket indicated liquids are to be honey thick and	F 808	population. The Administrator and/or designee will bring audit results to the QAPI committee monthly to review for continued opportunities for quality improvements.	

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F 808	Continued From page 60 admitted to serving non-thickened milk by mistake. During an interview on 11/7/23, at 8:53 a.m., the nurse manager (LPN-B) stated the order for beverage consistency would be in the resident's chart, and the meal ticket on the tray would indicate if the beverage needs thickening. Nurses and NAs are the primary staff to deliver beverages to residents. During an interview on 11/7/23, at 9:02 a.m. the culinary director (CD) stated some administration or department managers may, at times, pass trays as they were also trained on resident therapeutic diets. During an interview on 11/7/23, at 1:35 p.m., the director of nursing (DON) stated the diet, food consistency, and beverage thickness should all match the meal ticket. Nursing staff pass trays and beverages, sometimes others also. DON expects all servers to be trained to ensure safety for the residents to prevent such instances, like choking, from happening. During an interview on 11/8/23, at 8:34 a.m., the registered dietician (RD) identified R21's diet order as mechanical soft with honey thick liquids from the electronic medical record. RD also stated that staff are supposed to follow what is listed on the meal ticket that comes on the residents meal tray, and the RD or CD update the tickets when new orders are received from the provider. During an interview on 11/8/23 at 12:56 p.m., NA-B provided a resident care delivery guide (CDG) for the unit and R21's beverage was listed	F 808		

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F 808	Continued From page 61 on the CDG as nectar thick. NA-B stated the resident's Kardex is another source to identify the diet description. However, NA-B stated that the meal ticket is the primary source that staff should follow to assure the correct diet is received by the resident, and the Kardex or CDG are only used if the meal ticket was missing. During an interview on 11/9/23 at 9:25 a.m., LPN-B stated the Kardex is pulled from information in the care plan and should be up to date. LPN-B also stated the CDG is manually entered to a spreadsheet and should reflect the Kardex. However, neither the CDG nor the Kardex reflected the updated order of honey thick beverages. During an interview on 11/9/23 at 9:30 a.m., DON stated expecting the provider to enter new or changed diet orders, RD or CD to update the meal ticket in the kitchen and nursing or therapy to update the care plan which should then update the Kardex and CDG, and that the meal ticket, Kardex, and CDG should all indicate the same meal plan. DON also stated following an ordered meal plan can reduce the risk for aspiration of food by the resident which could cause pneumonia or choking.	F 808		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		1/9/24

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F 880	Continued From page 62 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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F 880	Continued From page 63 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a community-use glucometer was properly cleaned and disinfected between patient' uses for 1 of 1 resident (R45) observed to have their blood glucose checked. This had potential to affect 4 of 4 residents (R45, R41, R246, R35) who were diabetic on the same unit. In addition, the facility failed to ensure appropriate hand hygiene was 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 registered nurse (RN)-A present. RN-A removed a	F 880	F880- Hand Hygiene & Glucometer 1. R45 currently resides in center with no adverse reactions. R246 remains in the center with no adverse reactions noted. Nurses were educated on shared glucometer cleaning process. NARs and Nurses educated on hand hygiene. 2. All residents that have blood glucose monitoring or receive personal cares have the potential to be affected. 3. All licensed staff educated on cleaning shared glucometers between use for infection prevention. All staff educated on performing hand hygiene when providing personal cares for infection prevention.	

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F 880	Continued From page 64 black-colored, zip-style (closed) bag from the medication cart and placed it on top of the cart before preparing R45's oral pills. When finished, RN-A picked up the zipped bag from the cart along with R45's prepared oral pills and brought them to her room. Inside the room, RN-A opened the zipped bag and removed an Assure Platinum glucometer from it. RN-A retrieved and donned a pair of gloves from the bathroom, and inserted a new strip into the device to test R45's blood glucose. RN-A then used a lancet to pierce R45's finger exposing a visible blood flash. RN-A touched the exposed blood droplet to the strip which had been inserted into the glucometer. A reading was obtained with RN-A stating aloud, "301." RN-A removed the strip from the glucometer and disposed of it in the trash. RN-A then placed the glucometer back into the black-colored bag and zipped it closed without any attempt to clean or sanitize the device. RN-A returned to the medication cart with the zipped-closed bag and placed it on top of the cart. RN-A prepared and administered R45's insulin, and then again returned to the cart to start another resident' medication administration. There was no attempt to remove or clean the used glucometer. When interviewed on 11/08/23 at 8:16 a.m., RN-A verified they had not cleaned or sanitized the device after use but added, "Technically I should [clean it]." RN-A stated the device was used for all the patients on the unit and should be cleaned with "purple wipes [i.e. sani-wipes]," however, there weren't any to use. RN-A then looked around and observed a container with an orange-colored lid (i.e., bleach wipes) and expressed they could maybe use those instead but weren't sure. RN-A verified blood product was	F 880	4. Director of Nursing and/or designee is responsible for 100% compliance. Glucometer cleaning to be observed on 4 residents that have orders for glucometer checks and audited weekly x4 weeks for compliance. Hand hygiene competencies to be completed on personal cares weekly x4 weeks across three shifts. Director of Nursing and/or designee will bring results to the QAPI committee monthly to review for continued opportunities for quality improvements.	

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F 880	Continued From page 65 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 working on the floor with any directions or facility' process on how to clean or sanitize the device. RN-A added, "I showed up and worked." RN-A stated, in hindsight, they should have cleaned the device so "we don't spread germs to other patients." An Ark Care Technical Brief, dated 9/2019, identified directions listed for, "Cleaning and Disinfecting the Assure Platinum Blood Glucose 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 transmitting blood-borne pathogens adding, "The meter should be cleaned and disinfected after use on each patient." Further, the brief listed several chemicals (i.e., germicidal wipes, sani-wipes) which could be used. A provided electronic mail (i.e., e-mail) correspondence from the nursing home administrator, dated 11/8/23, identified a total of four diabetic residents (R45, R41, R246, R35) resided on the unit where RN-A had been observed to use the community glucometer without cleaning or sanitizing the device. On 11/08/23 at 11:43 a.m., the director of nursing (DON) was interviewed. DON stated the glucometer should be cleaned and disinfected between each patient use using sani-wipes. DON stated they had not personally completed any competencies for the agency nurses' on the cleaning of the glucometer but expressed maybe another department (i.e., HR) did but added, "I	F 880		

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F 880	Continued From page 66 don't know for sure." Further, DON verified the glucometer should have been cleaned for proper "infection control" adding, "That's how infections spread." A facility' policy on glucometer use and cleaning was requested, however, none was received. 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 gloves. NA-C then took out a clean sanitary wipe and handed it to NA-D who assisted R246 clean perinium area and backside and placed the soiled sanitary wipe and doffered his gloves into the plastic garbage bag. Without performing hand hygiene, NA-D then donned a new pair of gloves. NA-C assisted the resident to roll to his right side and NA-D placed a new brief on the resident with the help of NA-C. NA-D then went to R246's closet, while still wearing gloves, and retrieved one pair of black pants and a pair of grey pants for the resident to choose from to wear. During an interview on 11/8/23, at 8:16 a.m., NA-D stated that when helping a resident with a	F 880		

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F 880	Continued From page 67 brief change, and going from dirty to clean tasks, they are to wash hands prior to placing new gloves on hands and touching the resident, in-between performing a dirty to clean task and placing clean gloves on hands. NA-D stated that performing hand hygiene properly helps reduce resident infections. Did NA-D indicate if he did hand sanitize when completing this task and if not why? During an interview on 11/9/23, at 2:18 p.m., the DON stated she expects that when staff go from dirty to clean tasks, they would dispose of their glove, sanitize their hands, and place new gloves and do that in-between each dirty to clean task.	F 880		
F 908 SS=C	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This 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. 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%	F 908	1. Dishwasher de-scaled and water softener hardness level has been lowered to 3dH to meet manufacturer guidelines. 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 how to input one-time requests into TELS if they are experiencing issues. Culinary	1/9/24

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	245083	A. BUILDING _____ 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

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F 908	Continued From page 68 of the top covered in white and yellow peeked residue, the bottom of the inside and sprayer was 100% covered in white residue and 40% of the front legs was covered in a thick, bumpy, and raised residue. During an interview with the Culinary Director (CD), on 11/7/23, at 11:28 a.m., stated that he did not know the recommended maintenance or cleaning schedule for the dishwasher. CD stated that EcoLab comes to the facility and assesses the dishwasher, and it is the facilities responsibility to call Hobart for maintenance and cleaning. CD stated that Hobart refuses to maintain the dishwasher because it is facility owned. CD could not recall the last time the dishwasher was last cleaned or serviced. During an interview with the Corporate Culinary Director (CCD) and CD on 11/7/23, at 3:06 p.m., stated that staff are to use a product that clings to the machine and helps reduce limescale on the machine called Limeaway. However, both CCD and CD-A state it is not working and that the dishwasher needs to be delimed and decalcified. During documentation review on 11/7/23 at 3:08 p.m., kitchen staff did not document a limescale cleaner was used on the dishwasher from April through September of 2023. During an interview on 11/8/23, at 9:45 a.m., CD stated that the water softener had been malfunctioning since February of 2023 and that it was fixed on October 6th, 2023. He stated that the water softener is running at 26 parts per million since it was reinstalled on October 6th, 2023.	F 908	Director educated on the maintenance schedule. 4. Culinary Director and/or designee is responsible for 100% compliance. Culinary Director and/or designee to complete monthly audits to ensure compliance with preventative maintenance schedule. Audit to be completed 3 shifts per week to inspect dishwasher is in good standing. Culinary Director and /or designee to bring results to the QAPI committee monthly to review for continued opportunities for quality improvements.	

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F 908	Continued From page 69 According to the Hobart dishwasher manufactures recommendations, to protect the dishwasher, the water hardness should not exceed 3°dH, if higher it is recommended to use a Hobart Hydroline water softener/ treatment system. According to a policy titled, Dish Machine Use and Care, dated 9/2012, the dish machine should be free of lime buildup. The facility is to follow the following guidelines: 1. Chemical de-limer should be used to remove any buildup on the interior and exterior of the dish machine. Follow manufacture's direction for dilution product use. 2. Frequency for use is determined by LivingCenter need.	F 908		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/6/23 - 11/9/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	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 <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 Minnesota Department of Health.	2 000		

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2 000	Continued From page 2 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/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General 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	2 830		1/9/24

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2 830	Continued From page 3 plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed implement care planned fall interventions, perform a comprehensive post-fall root cause analysis, and initiate and implement subsequent fall interventions for 1 of 4 residents (R4) reviewed for falls. Findings include: R4's quarterly Minimum Data Set (MDS) dated 10/24/23, indicated R4 was cognitively intact, had lower extremity impairment on one side, and used a wheelchair for mobility. R4 had diagnoses of fracture, depression, and schizophrenia, took antipsychotic, antidepressant, opioid, and hypoglycemic medications, was occasionally incontinent of bladder and frequently incontinent of bowel, and not on a toileting program. R4's Falls Care Area Assessment dated 8/2/23, indicated R4 was at risk for falls due to balance problems. R4 was only able to stabilize with staff assistance when moving from seated to standing position and on and off toilet and was admitted with a history of falling. R4's ADL (activities of daily living)/Functional Rehabilitation Care Area Assessment dated	2 830	completed	

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2 830	Continued From page 4 8/2/23, indicated she required 1-2 staff for toileting and transfers due to recent spinal fusion and repair of left ankle fracture and was at risk for falls. R4's Urinary Incontinence and Indwelling Catheter Care Area Assessment dated 8/2/23 indicated R4 was frequently incontinent of urine and required extensive assistance of 1-2 persons for toileting and was at risk for falls. R4's progress note dated 6/7/23, indicated she had a fall on 6/7/23, while self-transferring from wheelchair to bed. A progress note dated 6/8/23, indicated R4 was provided a bedside commode to allow more room for toileting. A progress note dated 6/17/23, indicated R4 was found on the floor after coming from the bathroom. R4's falls care plan updated 6/19/23, included R4 was at risk for falls related to ankle fracture and had a fall while self-transferring on 6/7/23. Interventions included provision of bedside commode. R4's elimination care plan focus dated 6/19/23, included R4 required assist of 2 with toileting and offer every 2-3 hours. R4's MHM Balance/ROM 3.0 dated 10/24/23, indicated R4 was not steady but able to stabilize without staff assistance when moving from a seated to standing position, walking, turning while walking, moving off the toilet, and when transferring from surface to surface, The form identified R4 had lower extremity impairment on	2 830		

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2 830	Continued From page 5 one side. R4's progress note dated 11/3/23 at 8:44 a.m., indicated R4 fell while pulling up her pants after using the bathroom and was assisted into her wheelchair using a mechanical lift and two staff. The note indicate R4 stated she needed to use the bathroom and when she was pulling up her pants, she felt her legs go weak and she fell. The note indicated R4 told staff she fell because she could not get her wheelchair into the bathroom and wanted a commode. A progress note dated 11/3/23 at 10:04 a.m. indicated the interdisciplinary team met regarding R4's fall and lacked indication of immediate intervention to prevent further falls, nor acknowledgement of R4's inability to get into her bathroom. 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. R4's MHM Incident Review and Analysis dated 11/6/23, indicated R4 fell from the toilet while ambulating on 11/3/23. The boxes for physical, occupational, and speech therapy were selected, as well as Psych referral as possible fall interventions. The form lacked identification of immediate interventions to prevent future falls, or acknowledgement of R4's inability to get into her bathroom. During observation and interview on 11/6/23 at 12:47 p.m., R4 stated her legs were 'bad' and she	2 830		

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2 830	Continued From page 6 wanted a commode by her bed. She stated she had one and it was taken away and staff told her she could walk to the bathroom, but she wasn't able to walk because she had to drag her left leg due to a broken ankle. She stated her wheelchair did not fit through the door to the bathroom, and at night it was hard to transfer from the door to the toilet and she fell a couple of days prior. R4 did not have a commode in her room. During observation and interview on 11/8/23 at 10:20 a.m., nursing assistant (NA)-F observed R4 attempt to self-propel her wheelchair through the bathroom door where it got stuck in the doorway. NA-F verified it did not fit through the door, and confirmed R4 would need to ambulate approximately 4 feet to get to the toilet. R4 stated she fell there before because the rails on the wheels of her chair didn't fit, and she used to have a commode, but the facility took it away. During interview on 11/8/23 at 10:23 a.m., NA-G stated there was a list of residents who were at risk for falls and it was identified on the residents' care plans. They stated R4 was independent with toileting and was not able to walk. During interview on 11/9/23 at 8:15 a.m., NA-H stated residents' care plans identified any resident who was at greater risk of falling, and those at risk had mats on the floor, lower beds, and needed to be checked more often. They stated R4 could get to the bathroom by herself safely, but sometimes called for help. R4 was not a falls risk, pivot transferred, and did not walk. During interview on 11/9/23 at 8:24 a.m., licensed practical nurse (LPN)-A stated for every fall the nurse completed a risk management form, added a new intervention based upon the specifics of	2 830		

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2 830	Continued From page 7 the fall, and managers added interventions to the care plan. They stated R4 was sometimes independent, but sometimes used her call light to ask for assistance to the bathroom. They did not think R4 was at high risk for falling and had never seen her walk. During interview on 11/9/23 at 8:30 a.m., occupational therapist (OT) stated she believed R4 pivot transferred and was resistant to using her toilet in her bathroom. They did not know if R4 could ambulate. During observation and interview on 11/9/23 at 9:02 a.m., LPN-B stated after a resident fell the nurse implemented an intervention based upon the specifics of the fall using nursing judgment. The IDT team then completed a post-fall analysis, adjusted the intervention if needed, and added it to the care plan and the NA care guide. LPN-B stated R4 was non-ambulatory but could get to the toilet in her wheelchair and usually went to the bathroom herself. LPN-B went to R4's room where R4 attempted to wheel herself into the bathroom. LPN-B confirmed R4's wheelchair did not fit through the bathroom door and R4 would have to walk 4 or 5 steps to get to the toilet and sink. R4 told LPN-B she had trouble getting to the bathroom and had a hard time standing up, and used to have a commode but it was taken away. LPN-B stated R4 needed to be able to get through the bathroom door in her wheelchair to decrease fall risk and episodes of incontinence and increase independence and was not made aware of the issue. LPN-B confirmed R4's care plan did not contain updated interventions. During interview on 11/9/23 at 10:57 a.m., director of nursing (DON) stated fall risk assessments were completed at admission, quarterly, annually,	2 830		

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2 830	Continued From page 8 with significant changes, and as needed. They stated if a resident fell, they expected the nurse to complete a fall evaluation and implement immediate interventions, and the IDT team would meet later to review the fall and adjust the intervention as needed. She stated she expected a new intervention after each fall for resident safety and was not aware R4's wheelchair could not fit through the bathroom door. The Fall Prevention and Management policy dated 9/2023, indicated staff will identify interventions related to the resident's specific risks and causes to prevent the resident from falling and try to minimize complications from falling. If falling recurs, staff will implement additional or different interventions based on the nature of the fall. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining	2 860		1/9/24

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2 860	Continued From page 9 adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide hygienic nail care to 2 of 3 residents (R35 and R19) reviewed for dependent activities of daily living (ALD's). R19's annual Minimum Data Set (MDS) assessment dated 8/7/23, included R19 was severely cognitively impaired, had diagnoses of dementia and aphasia (difficulty speaking), and no behavioral concerns. R19's Cognitive Loss/Dementia Care Area Assessment dated 8/21/23, included he required assistance with ADLs. R19's ADL Functional/Rehabilitation Potential was not assessed or triggered. R19's ADL care plan dated 4/20/20, indicated he 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. 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	2 860	completed	

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2 860	Continued From page 10 hygiene. 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. During observation on 11/7/23 at 10:36 a.m., R19 was seated on a chair in the hallway by the nurses' station. His fingernails were noted to be several millimeters long with brown crusted matter filling the underside of all nails. During observation on 11/7/23 at 12:18 p.m., R19 was seated in a chair in his room with a tray table in front of him containing a plate of what appeared to be rice, sweet potatoes, and another unidentified food item. R19 used his fingers on his left hand to pick up food bites and place them in his mouth throughout the meal until it was gone. During interview on 11/7/23 at 1:07 p.m., nursing assistant (NA)-D stated NAs completed and documented nail care on bath days unless a resident was diabetic, and if a resident refused, they charted it. They stated R19 ate on his own after set-up, and had dementia and some	2 860		

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2 860	Continued From page 11 behaviors, including resisting cares and defecating and urinating is his room and smearing feces around, but if in a good mood would let staff wash his hands and trim his nails. During observation and interview on 11/7/12 at 1:37 p.m. license practical nurse (LPN)-B stated NAs completed nail care for non-diabetic residents on bath days and charted both completions and refusals. LPN-B observed R19's fingernails and confirmed they were long and soiled and described them as "not great". They asked R19 if they could get someone to cut them and R19 expressed willingness. LPN-B stated staff should have attempted to clean and trim them and document it in the record and was unsure why it was identified as unnecessary in the chart. They stated it was important to keep them clean and trimmed for infection control purposes and to prevent scratching and skin integrity concerns. R35's Face Sheet form, printed 11/7/23, indicated R35 had diagnoses that includes metabolic encephalopathy, intellectual disabilities, type 2 diabetes, and delusional disorders R35's admission Minimum Data Set (MDS), dated 6/27/23, indicated the assessment of daily and activity preference was not conducted by staff. Additionally, R35 is dependent of staff for showering/bathing and toileting. R35's quarterly MDS, dated 9/26/23, indicated R35 was moderately cognitively impaired and did not refuse care. R35's Care Area Assessment (CAA), dated 6/27/23, indicated that the ADL functional assessment was not completed or triggered.	2 860		

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2 860	Continued From page 12 R35's care plan, dated 6/23/23, indicated that R35 required assistance of two staff for bathing and assistance of one staff for personal hygiene. R35's orders, dated 10/27/23, directed licensed nurses to document R35's skin inspection weekly, every day shift Saturday and to document any refusals. R35's bath and nail care assessment, dated 11/4/23, indicated staff performed and assisted the resident with bathing and nail care. R35's treatment administration record (TAR), printed 11/7/23, indicated that on 11/4/2023, staff assisted the resident with bathing. The electronic medical record (EMR) did not indicate the resident refused bathing or nailcare assistance from staff. During an observation on 11/7/12 at 8:47 a.m., all 10 of R35's fingernails were approximately 1/2" in length with a buildup of dark black residue underneath the fingernail bed. R35 indicated that he would like them trimmed and cleaned. During an interview on 11/7/23 at 12:55 p.m., CNA-A stated that if R35 needed his nails trimmed and cleaned, she will call a nurse because the resident is diabetic. CNA-A went to visit R35 in his room, looked at the residents' fingernails and indicated that they were too long and dirty and if not cleaned properly, could cause an infection. During an interview on 11/8/23 at 8:00 a.m., 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	2 860		

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2 860	Continued From page 13 attempt to provide nail care. If CNA-C was unsuccessful, she would inform the Registered Nurse (RN). During an interview on 11/7/23 at 1:37 p.m., the nurse manager (LPN-B) stated that on bath days, residents are to have their nails trimmed and cleaned by a certified nursing assistant (CNA). If the resident is diabetic, a licensed nurse is required to trim the nails. LPN-B stated that R35's nails are "pretty long" and soiled and should be trimmed. During an interview on 11/8/23 at 12:38 p.m., the Director of Nursing (DON) stated that she would expect staff to follow the care plans for the residents and provide care in a timely manner per the resident's preferences. She expected that nail trimming be performed on shower/ bath days and as needed. If they are visibly dirty, staff should be sure to clean underneath the nailbed. If residents refuse nail care, staff are expected to reapproach the resident three additional times, inform the nurse of any refusals, and document refusals. A policy titled, Activities of Daily Living (ADL's)/ Maintain Abilities, dated 3/31/23, indicates that a resident who is unable to carry out their own ADLs, that staff will assist them as necessary to maintain good nutrition, grooming, and personal and oral hygiene. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to activities of daily living - nail care. The DON or designee, could provide training for all nursing staff related to nail care. The quality assessment and assurance committee could	2 860		

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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	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser 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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21325	Continued From page 15 8/22/23, identified R29 had intact cognition and no dental issues (i.e., broken teeth, missing teeth). On 11/6/23 at 4:30 p.m., R29 was observed laying in bed while in her room. R29 was interviewed and expressed she had never been asked about her dental care or needs (i.e., appointments) since she admitted to the nursing home several months' prior. R29 stated she had some missing teeth "in the back" of her mouth which she attributed to osteoporosis causing them to "fall out." R29 stated she would like to see a dentist as her teeth, in general, were not "in the best shape" but reiterated nobody had addressed it with her since she admitted. On 11/7/23 at 1:52 p.m., R29's family member (FM)-A was interviewed. FM-A explained R29 had been "kind of recluse" in her previous living situation and, as a result, FM-A was involved and 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	21325		

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21325	Continued From page 16 record denture use and a field labeled, "Last dental visit and Pysicians [sic] Name," and, "Dental Summary." However, all of these sections were left blank and not completed. R29's MHM IDT (interdisciplinary team) Care Conference Form V-4, dated 8/29/23, identified R29's admission care conference was held and listed several sections to record various information (i.e., medication use, restraint use, etc.) This included a section labeled, "Exams," which provided spaces to record R29's last dental examination and eye examination, however, neither section was completed and both were left blank. The form was signed by several staff members including licensed practical nurse manager (LPN)-B. R29's subsequent MHM Admission/Initial Data Collection V-4, dated 10/17/23, identified R29 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,	21325		

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21325	Continued From page 17 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. 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	21325		

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21325	Continued From page 18 dental pain to the floor staff had been evaluated or acted upon to ensure appropriate follow-up. On 11/8/23 at 12:52 p.m. LPN-B was interviewed. LPN-B verified they had reviewed R29's medical record and her dentition and oral health needs 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 scheduled for an onsite dental visit "the next time they are out here [onsite dental]." LPN-B stated it was important to ensure dental status and needs were assessed and, if needed, referred to a dental provider timely as poor teeth can impact their ability to eat, their nutritional status and possibly cause an infection. R24's quarterly minimum data set (MDS) dated 8/16/23, identified R24 with intact cognition, a need for extensive assistance with personal hygiene and no broken teeth. R24's diagnoses dated 4/1/23, include type 2 diabetes with neuropathy, acute respiratory failure, generalized muscle weakness, morbid obesity. R24's care plan dated 9/1/22, identified a focus on oral/dental health problems, with a goal of being cooperative with dental appointments, and an intervention to coordinate arrangements for outside dental care and transportation as needed. During an interview dated 11/6/23, at 1:46 p.m., R24 stated that she has had chronic pain in two teeth on the upper right behind the incisors (#11 and #12) R24 also stated being advised two years ago by the dentist that these two teeth that	21325		

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21325	Continued From page 19 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 poor condition of teeth with moderate soft plaque/food debris buildup, moderate swollen gums, and poor periodontal condition. Exam also indicated to arrange for a referral to an oral surgeon for extraction of teeth #11/#12 also indicating this was noted in 7/2022. Exam was done at bedside by HealthDrive dentist. R24's dental exam dated 7/14/23, indicated for referral out for extraction of teeth #11/#12. R24's dental exam dated 7/25/23, indicated for referral out for extraction of teeth #11/#12, R24's progress note dated 7/19/23, indicated that R24 declined to attend dental appointment scheduled for 7/19/23. During an interview dated 11/07/23, at 10:21 a.m., a registered nurse (RN)-C stated that a resident request to see a dentist for a non-acute appointment is placed on list to be seen when the contracted dentist from HealthDrive comes to the facility. RN-C also stated that if a referral is needed for dental care beyond what the contract dentist can provide, the referral is sent to the medical records director (MRD) to arrange the outside appointment, and the nurse placed the order/referral into the resident's chart. During an interview dated 11/7/23, at 10:29 a.m.,	21325		

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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 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 residents, and any refusals by residents should 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 review applicable policies to ensure the timely assessment and acting upon dental needs; then	21325		

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21325	Continued From page 21 inservice staff on expectations and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21325		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced	21390		1/9/24

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21390	Continued From page 22 by: Based on observation, interview and document review, the facility failed to ensure a community-use glucometer was properly cleaned and disinfected between patient' uses for 1 of 1 resident (R45) observed to have their blood glucose checked. This had potential to affect 4 of 4 residents (R45, R41, R246, R35) who were diabetic on the same unit. In addition, the facility failed to ensure appropriate hand hygiene was 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 registered 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 cart before preparing R45's oral pills. When finished, RN-A picked up the zipped bag from the cart along with R45's prepared oral pills and brought them to her room. Inside the room, RN-A opened the zipped bag and removed an Assure Platinum glucometer from it. RN-A retrieved and donned a pair of gloves from the bathroom, and inserted a new strip into the device to test R45's blood glucose. RN-A then used a lancet to pierce R45's finger exposing a visible blood flash. RN-A touched the exposed blood droplet to the strip which had been inserted into the glucometer. A reading was obtained with RN-A stating aloud, "301." RN-A removed the strip from the glucometer and disposed of it in the trash. RN-A then placed the glucometer back into the black-colored bag and zipped it closed without any attempt to clean or sanitize the device. RN-A	21390	Completed	

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(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
21390	Continued From page 23 returned to the medication cart with the zipped-closed bag and placed it on top of the cart. RN-A prepared and administered R45's insulin, and then again returned to the cart to start another resident' medication administration. There was no attempt to remove or clean the used glucometer. When interviewed on 11/08/23 at 8:16 a.m., RN-A verified they had not cleaned or sanitized the device after use but added, "Technically I should [clean it]." RN-A stated the device was used for all the patients on the unit and should be cleaned with "purple wipes [i.e. sani-wipes]," however, there weren't any to use. RN-A then looked around and observed a container with an orange-colored lid (i.e., bleach wipes) and expressed they could maybe use those instead but weren't sure. RN-A verified blood product was 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 working on the floor with any directions or facility' process on how to clean or sanitize the device. RN-A added, "I showed up and worked." RN-A stated, in hindsight, they should have cleaned the device so "we don't spread germs to other patients." An Ark Care Technical Brief, dated 9/2019, identified directions listed for, "Cleaning and Disinfecting the Assure Platinum Blood Glucose 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 transmitting blood-borne pathogens adding, "The meter should be cleaned and disinfected after use on each patient." Further, the brief listed several chemicals (i.e., germicidal wipes,	21390		

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21390	Continued From page 24 sani-wipes) which could be used. A provided electronic mail (i.e., e-mail) correspondence from the nursing home administrator, dated 11/8/23, identified a total of four diabetic residents (R45, R41, R246, R35) resided on the unit where RN-A had been observed to use the community glucometer without cleaning or sanitizing the device. On 11/08/23 at 11:43 a.m., the director of nursing (DON) was interviewed. DON stated the glucometer should be cleaned and disinfected between each patient use using sani-wipes. DON stated they had not personally completed any competencies for the agency nurses' on the cleaning of the glucometer but expressed maybe another department (i.e., HR) did but added, "I don't know for sure." Further, DON verified the glucometer should have been cleaned for proper "infection control" adding, "That's how infections spread." A facility' policy on glucometer use and cleaning was requested, however, none was received. 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	21390		

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21390	Continued From page 25 gloves. NA-C then took out a clean sanitary wipe and handed it to NA-D who assisted R246 clean perinium area and backside and placed the soiled sanitary wipe and doffered his gloves into the plastic garbage bag. Without performing hand hygiene, NA-D then donned a new pair of gloves. NA-C assisted the resident to roll to his right side and NA-D placed a new brief on the resident with the help of NA-C. NA-D then went to R246's closet, while still wearing gloves, and retrieved one pair of black pants and a pair of grey pants for the resident to choose from to wear. During an interview on 11/8/23, at 8:16 a.m., NA-D stated that when helping a resident with a brief change, and going from dirty to clean tasks, they are to wash hands prior to placing new gloves on hands and touching the resident, in-between performing a dirty to clean task and placing clean gloves on hands. NA-D stated that performing hand hygiene properly helps reduce resident infections. Did NA-D indicate if he did hand sanitize when completing this task and if not why? During an interview on 11/9/23, at 2:18 p.m., the DON stated she expects that when staff go from dirty to clean tasks, they would dispose of their glove, sanitize their hands, and place new gloves and do that in-between each dirty to clean task. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to hand hygiene. The DON or designee, could provide training for all nursing staff related to hand hygiene. The quality assessment and assurance committee could perform random audits to ensure compliance. In addition the DON	21390		

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21390	Continued From page 26 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.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure tuberculosis (TB) screening for history, risk factors, and symptoms was completed for 1 of 5 residents (R29) and 3 of	21426	Completed	1/9/24

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21426	Continued From page 27 5 staff [nursing assistant (NA)-E, dietary aide (DA)-A, NA-A], and failed to ensure TB testing [Tuberculin skin testing (TST), chest x-ray, or TB blood test] was completed according to the Centers for Disease Control & Prevention (CDC) guidelines for 3 of 5 residents (R20, R29, R35) and 4 of 5 staff (NA-E, administrator, DA-A, NA-A) reviewed for TB screening and testing. Further, the facility failed to ensure annual TB education was completed for 2 of 5 staff (DA-A, administrator). Findings include: Residents R20's quarterly Minimum Data Set (MDS) assessment dated 8/3/23, indicated R20 was severely cognitively impaired and had diagnoses of heart failure and dementia. R20's MHM-TB Symptom and History Evaluation Version 3 dated 11/7/23, instructed staff to record TST administration and result or TB blood test results on the medical record. R20's medical record lacked evidence of TST, chest x-ray, or TB blood test results. R29's admission MDS dated 8/22/23, indicated she was cognitively intact and had diagnoses of pneumonia and dementia. R29's medical record included an x-ray result dated 8/24/23 which lacked identification of TB findings and indicated R29 required follow-up. R29's medical record lacked evidence of TB history and symptom screening. R35's quarterly MDS dated 9/26/23, indicated R35 was cognitively impaired and had diagnoses	21426		

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21426	Continued From page 28 of diabetes and psychotic 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. During interview on 11/8/23 at 8:46 a.m. licensed practical nurse (LPN)-B stated residents were evaluated for TB history and symptoms at admission and given either a two-step TST or chest x-ray to rule out TB and the results were documented in the medical record. She was unsure why screening and testing was not complete for the identified residents. During interview on 11/8/23 at 9:06 a.m. director of nursing stated TB screening and testing was completed at residents' admission to ensure anyone with active TB received appropriate treatment, and did not spread it to other residents throughout the facility. She identified staff were screened and tested through the human resources department, and there had been recent staff changes. Staff The facility was unable to provide evidence of TB screening for history, risk factors, and symptoms for NA-E, and DA-A, and NA-A. The facility was unable to provided TB testing results for NA-E, administrator, and DA-A. NA-A's TB blood test dated 6/8/23, indicated "M. tuberculosis infection status cannot be determined. Repeat testing recommended." No	21426		

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21426	Continued From page 29 other results were provided. In an email dated 11/9/23, administrator attached TB education completion certificates for 3 staff, and confirmed it was "what we have for TB education." The attachment lacked evidence of TB education for administrator and DA-A, During interview on 11/8/23 at 8:12 a.m. administrator confirmed she followed-up with human resources and there was no additional TB documentation available for NA-E, administrator, DA-A, and NA-E. The Tuberculosis Screening and Prevention-Residents policy dated 7/31/23, indicated resident TB screening will be performed within 90 days prior to admission or within 72 hours after admission and will include a TB risk assessment, symptom evaluation, and TB testing. The Tuberculosis Screening and Prevention-Employees policy dated 7/31/23, indicated employees will be screened upon hire, to include a TB risk assessment, including a TB symptom screen, and a TB test. Annual TB education is to be provided to all health care personnel. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and infection preventionist could review and revise policies and procedures for proper monitoring of TB screenings for history, risk factors, symptoms, and TB testing according to the CDC guidelines. The DON or designee, along with the infection preventionist, could audit TB screenings for history, risk factors, symptoms, and TB testing on	21426		

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21426	Continued From page 30 a regular basis to ensure compliance. TIMEFRAME FOR CORRECTION: Twenty-one (21) days.	21426		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure appropriate side effect monitoring was completed, in accordance with the care plan and standard of care, related to	21535	Completed	1/9/24

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21535	Continued From page 31 psychotropic (i.e., antipsychotic) medication use for 2 of 5 residents (R29, R4); and failed to ensure as-needed (i.e., PRN) antipsychotic medication use was limited or re-evaluated after 14 days for 1 of 5 residents (R19) reviewed for unnecessary medication use. Findings include: SIDE EFFECT MONITORING: A National Library of Medicine (NIH) Management of Commons Adverse Effects of Antipsychotic Medication article, dated 9/2018, identified the elderly were at risk of adverse effects (i.e., falls) of antipsychotic medication. The article outlined, "All antipsychotics carry some risk of orthostatic hypotension [which can] lead to dizziness, syncope, falls." It should be evaluated by both historical and routine measurement. R29's admission Minimum Data Set (MDS), dated 8/22/23, identified R29 had intact cognition and required substantial assistance with bed mobility actions (i.e., lying to sitting, sitting to standing). Further, the MDS outlined R29 had several medical diagnoses including anemia and atrial fibrillation, and consumed antipsychotic medication on a routine basis. R29's Order Summary Report, dated 10/11/23, identified R29's current physician ordered medications and treatments. This included an order for olanzapine (an antipsychotic medication) 2.5 milligrams (mg) by mouth twice a day for dementia with behavioral disturbance with a listed start date of 9/14/23. Further, the signed orders included a section labeled, "Other," with a treatment listed reading, "Monitor Orthostatic Blood Pressure while resident is receiving	21535		

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21535	Continued From page 32 antipsychotic medications ... Every day shift every 1 month(s) ...," with a listed start date 10/19/23. R29's care plan, dated 9/11/23, identified R29 was at risk for falls, had an alteration in cognition due to dementia, and required assistance of one with movement in and out of bed. Further, the care plan outlined R29 was at risk for psychoactive medication adverse effects due to daily use of such medications and listed an intervention reading, "Monthly orthostatis blood pressure." This interventions listed an initiation date of 8/18/23. R29's Blood Pressure Summary, printed 11/9/23, identified R29's collected blood pressures since admission (8/2023) with several low readings being recorded including 105/68 (10/3/23), 87/59 (10/24/23), and 85/58 (11/7/23). However, the summary lacked evidence a series of orthostatic blood pressures (i.e., lying, sitting, standing) had been attempted or completed. R29's Treatment Administration Record (TAR), dated 10/2023, identified a treatment which read, "Monitor Orthostatic Blood Pressure monthly ... every day shift every 1 month(s) ...," with a listed start date 10/09/23. However, the order also listed a discontinuation date which read 10/27/23, and the only space provided to record the values (i.e., pressure) demonstrating it had been completed were answered, "NA." R29's subsequent TAR, dated 11/2023, lacked any treatments or results demonstrating collection or review of R29's orthostatic blood pressures. When interviewed on 11/7/23 at 2:58 p.m., nursing assistant (NA)-A stated they had worked with R29 several times, and described R29 as being needy and total assistance for most cares.	21535		

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21535	Continued From page 33 NA-A stated R29 had just recently signed onto hospice care, demonstrated "off and on" cognition, and rarely, if ever, ambulated; however, did still physically transfer from her bed to the wheelchair at times with help. NA-A stated R29 had never complained about being lightheaded or dizzy with transfers, to their knowledge. R29's Consultant Pharmacist's Medication Regimen Review, dated 8/21/23, identified R29 admitted with orders for depakote and olanzapine. The recommendation included, "Please ensure the following is completed ... Ortho bp monitoring (this monitoring is not required if unable to stand, please care plan)." The dictation had a black-colored checkmark written next to it along with a column labeled, "Follow-Through," which had a red-colored "Scanned" stamp and a date written, "9/11/23." However, R29's medical record was reviewed and lacked evidence any orthostatic blood pressure readings had been attempted or collected despite R29 still physically transferring, at times, from their bed to the wheelchair; consuming daily antipsychotic medication; and, recommendations from the consulting pharmacist to ensure such monitoring was in place (dated 9/21/23). In addition, there was no physician order located to demonstrate such monitoring had been discontinued or determined as not needed. On 11/08/23 at 10:47 a.m., licensed practical nurse unit manager (LPN)-B was interviewed. 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 attained despite the care plan directing to complete such monitoring. LPN-B stated they would typically be recorded in the Blood Pressure	21535		

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21535	Continued From page 34 Summary, however added, "I do not see those." LPN-B stated R29 was unlikely able to ambulate or stand without physical help, however, acknowledged a lying-to-sitting orthostatic blood pressure could still be attained to help determine what, if any, potential symptoms were present. LPN-B stated it was important to ensure appropriate side effect monitoring, including orthostatic blood pressures, was completed to monitor R29's cardiac status and "[it] can alert us to changes if medication [i.e., antipsychotic] is not appropriate for them." R4 R4's quarterly Minimum Data Set (MDS) assessment dated 10/24/23, indicated R4 was cognitively intact, had diagnoses of depression and schizophrenia, and identified R4 was taking antipsychotic and antidepressant medications on a routine basis. R4 could stand and transfer independently. R4's Psychotropic Drug Use Care Area Assessment (CAA) dated 8/2/23, indicated she received antidepressant and antipsychotic medications to manage a diagnosis of paranoid schizophrenia and depression and was at risk for adverse reactions to these medications, and included a goal to have no drug related side effects. R4's care plan dated 5/25/23, included potential for adverse drug reactions related to daily use of psychotropic medication, and directed staff to monitor orthostatic blood pressure. The care plan indicated R4 was unable to stand at that time. R4's Order listing Report dated 11/9/23, included: -Lamotrigine Oral Tablet, 300 milligrams (mg) at	21535		

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21535	Continued From page 35 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	21535		

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21535	Continued From page 36 triggered. R19's Psychotropic Drug Use CAA indicated he used antipsychotic and antidepressant medications to manage a diagnosis of depressive disorder, and he was at risk for reactions to these medications. The assessment indicated a goal to have no drug-related side effects. R19's care plan dated 12/31/23, included R3 had a mood problem related to stroke, dementia and depression, and instructed staff to administer medication as ordered and monitor/document side effects. The care plan also included R3 used antipsychotic medications and instructed staff to monitor/document side effects, including orthostatic hypotension. R3's activities of daily living (ADL) focus included he could stand and transfer independently. R19's Order Review History Report dated 11/9/23, included: -Escitalopram Oxalate Tablet 10 milligrams (mg), Give 10 mg once per day for major depression starting 1/17/23. -Seroquel Oral Tablet 25 mg, give one tablet two times daily for major depression AND -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 date. -Psychotropic Monitoring- Antidepressant Medication, Monitor for side effects including orthostatic hypotension symptoms, weekly, every shift, every Monday starting 2/27/23. -Psychotropic Monitoring- Antipsychotic Medication, Monitor for side effects including orthostatic hypotension symptoms, weekly, every shift, every Monday starting 2/27/23. R19's Blood Pressure Summary dated 11/7/23,	21535		

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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 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	21535		
21545	MN Rule 4658.1320 A.B.C Medication Errors	21545		1/9/24

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21545	Continued From page 38 A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the	21545		

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21545	Continued From page 39 resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were administered in accordance with physician orders and manufacturer guidelines for 3 of 6 residents (R25, R38, R45) observed to received medication. A total of four (4) errors out of 31 opportunities were identified resulting in a 12.9% (percent) facility' error rate. Findings include: R25's Order Summary Report, dated 10/11/23, identified R25's current physician-ordered medications and treatments. This included an order for acetaminophen 500 milligrams (mg) by mouth every six hours as needed (PRN) for pain. The order had a listed start date of 9/26/23. On 11/06/23 at 2:19 p.m., registered nurse (RN)-A prepared R25's medications at a mobile cart in the hallway by the nurses' station. R25 was standing next to the cart and, upon being asked, rated their pain an "eight [out of 10]." R25 then returned to their room while RN-A continued preparing R25's medications for administration at the cart. RN-A reviewed R25's electronic Medication Administration Record (MAR) which outlined the same order for acetaminophen as listed on R19's Order Summary Report (dated 10/11/23). However, RN-A removed an opened bottle of acetaminophen from the cart and placed two 500 mg tablets (i.e., 1000 mg) into the	21545	Completed	

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21545	Continued From page 40 medication cup with R25's other oral medications. RN-A then picked up the cup of medications, locked the MAR screen on their cart, and turned to walk to R25's room. RN-A was then stopped by the surveyor and verified the medications in the cup were ready for administration. RN-A stated they were "pretty sure" the MAR directed to give two 500 mg tablets of acetaminophen to R25 and returned to the medication cart to review the order. RN-A verified R25's MAR and verified it directed to only provide one 500 mg tablet and not two as they had prepared. RN-A added, "That's exactly how easy it [error] can happen." RN-A then removed one tablet of the acetaminophen from the prepared medications and returned to R25's room to provide them. R38's Order Summary Report, dated 10/11/23, identified R38's current physician-ordered medications and treatments. This included an order for, "Sennalax-S Tablet 8.6-50 MG (Sennosides-Docusate Sodium) ... 1 tablet by mouth two times a day," with a listed start date of 9/15/23. On 11/06/23 at 7:42 p.m., licensed practical nurse (LPN)-A prepared R38's medications at a mobile cart in the hallway using R25's electronic Medication Administration Record (MAR). This outlined the same order for Sennalax-S as listed on R38's Order Summary Report (dated 10/11/23). LPN-A removed an opened bottle of Senna (labeled sennosides only) from the cart and placed one brown-colored tablet into the cup with R38's other medications. LPN-A then picked up the cup from the cart, locked the MAR screen on their cart, and turned to walk down to R38's room. LPN-A was then stopped by the surveyor and verified the medications in the cup were ready for administration. LPN-A returned to the	21545		

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21545	Continued From page 41 medication cart and reviewed R38's current orders. LPN-A verified the medication order directed to give sennosides with docusate sodium (i.e., Senna-S) and inspected the medication cart, however, was unable to locate any supply of that medication. At this time, licensed practical nurse unit manager (LPN)-B presented to the medication cart and reviewed LPN-A's medications which remained in the cup. LPN-B verified the brown-colored sennosides tablet was not the same medication ordered because Senna-S was an orange-colored tablet. LPN-B stated the pharmacy, at times, did not always send the right medications for the "stock" supply, so they would look for some quick. LPN-B returned after several minutes and expressed they did not have any of the medication on-hand, so they were sending an employee to the local drug store quick to get some. LPN-A then removed the brown-colored sennosides tablet from R38's prepared medications and went to his room to administer the remainder of them. R45's Interagency Physician Discharge Orders/Instructions, dated 10/30/23, identified R45 had been hospitalized for several medical conditions, including diabetes mellitus, and was being discharged to the nursing home. The orders directed to monitor R45's blood glucose three times a day prior to meals, along with other numerous medication orders including Lispro insulin (i.e., Humalog) one to five units subcutaneous three times a day per sliding scale and Vitamin D3 50 micrograms (mcg) by mouth once daily. On 11/8/23 at 7:47 a.m., RN-A prepared R45's medications at a mobile cart in the hallway. RN-A then removed several punch-pack style cards with R45's oral medications from the cart and	21545		

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21545	Continued From page 42 started to prepare them for administration while referencing the MAR which included the same order for Vitamin D3 as outlined on R45's orders (dated 10/30/23). RN-A removed an opened bottle of Vitamin D3 25 mcg capsules from the top of the cart, however, RN-A only placed one capsule (i.e., 25 mcg) in the cup for administration. RN-A then locked their MAR screen, and turned to enter R45's room down the hallway. RN-A was then stopped by the surveyor and verified the prepared medications were ready for administration. RN-A returned to the medication cart and reviewed R45's Vitamin D3 orders in the MAR. RN-A verified the MAR directed to administer 50 mcg of the medication, however, they had only placed 25 mcg of the medication in the cup for administration (i.e., error). RN-A then added another 25 mcg capsule to the cup and returned to R45's room to provide the medications. RN-A checked R45's blood glucose using a community glucometer which resulted "301." RN-A stated they would retrieve R45's insulin and return. RN-A returned to the 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 were to administer four units for a blood glucose of 301, and removed a new Assure Duo Pro needle from a box in another medication cart parked adjacent. RN-A then picked up the insulin pen and walked towards R45's room while dialing the insulin pen to four units. RN-A was stopped just prior to entering R45's room by the surveyor and questioned on the need to prime the insulin needle prior to delivery of the ordered dose. RN-A stated the pen was "already primed" as it only had to be done once when the pen was first opened. RN-A then entered R45's room and delivered the medication using the un-primed needle and	21545		

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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 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." 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 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 "best practice" and also in accordance with the manufacturer guidelines. On 11/9/23 at 10:41 a.m., a subsequent interview with DON was held.	21545		

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21545	Continued From page 44 DON verified they had a chance to follow-up on the reported administration errors and review each involved resident' medical record. DON stated the potential for an error "was there" with each administration and they were going to follow-up with education to the involved staff members. DON stated had the residents' actually received the medications (instead of the surveyor stopping them) then they would "follow the policy for a med error," however, since the residents' didn't actually receive the wrong medication or doses, they reiterated a need for education. DON stated it was important to ensure the correct medication and doses were given to for "resident safety." A provided Medication Administration - General Guidelines policy, dated 5/2022, identified medications would be administered as prescribed in accordance with good nursing principles and practices. The policy outlined, "FIVE RIGHTS - Right resident, right drug, right dose, right route, and right time, are applied for each medication being administered," adding, "A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication ... " SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures on ensuring timely and accurate delivery of medications; then inservice direct care staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21545		
21550	MN Rule 4658.1325 Subp. 1 Adminiatration of Medications; Pharmacy Serv.	21550		1/9/24

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21550	Continued From page 45 Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure stock medications (i.e., medication used for multiple patients) were tracked and re-ordered timely to prevent disruption in supply and potential complication for 1 of 1 resident (R38) observed to need medications which weren't available. Findings include: R38's Order Summary Report, dated 10/11/23, identified R38's current physician-ordered medications and treatments. This included an order for, "Sennalax-S Tablet 8.6-50 MG (Sennosides-Docusate Sodium) ... 1 tablet by mouth two times a day," with a listed start date of 9/15/23. On 11/06/23 at 7:42 p.m., licensed practical nurse (LPN)-A prepared R38's medications at a mobile cart in the hallway using R25's electronic Medication Administration Record (MAR) which outlined the same order for Sennalax-S as listed on R38's Order Summary Report (dated 10/11/23). However, LPN-A removed an opened bottle of Senna (labeled sennosides only) from the cart, placed one brown-colored tablet into the cup with R38's other medications, and attempted to administer the medications before being stopped by the surveyor (see F759). LPN-A acknowledged the medication they were going to	21550	Completed	

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21550	Continued From page 46 provide was not the same medication which had been ordered. LPN-A searched the medication cart for the sennosides-docusate sodium (i.e., Senna-S), however, was unable to locate any supply of the medication. At this time, licensed practical nurse unit manager (LPN)-B presented to the medication cart and verified the brown-colored sennosides tablet was not the same medication ordered because Senna-S was an orange-colored tablet. LPN-B stated the pharmacy, at times, did not always send the right medications for the "stock" supply, so they would look for some quick. LPN-B returned after several minutes and expressed they did not have any of the medication on-hand, so they were sending an employee to the local drug store quick to get some. During follow-up interview, on 11/08/23 at 10:58 a.m., LPN-B stated the Senna-S was a stock medication and, typically, was re-ordered by "the scheduler" who was assigned to review the medication room and "based on that" re-order the needed supply from the dispensing provider. LPN-B verified they had reviewed the campus and there had been no supply the evening of 11/06/23 (as observed). LPN-B explained the facility had, at times, some "supply chain issues" with getting medications supplied timely stating this had been happening "on and off for awhile." LPN-B stated multiple people in management (i.e., HR, scheduler) were aware of this issue and, to their knowledge, were looking into it. On 11/08/23 at 11:43 a.m., the director of nursing (DON) was interviewed. DON explained there was a staff member assigned to monitor supply and, when needed, re-order stock medications. DON acknowledged they had run out of supply for R38's ordered stock medication and, as a result,	21550		

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21550	Continued From page 47 they sent staff to the drug store and purchased some on 11/06/23. DON stated if there were supply chain issues, they typically would be notified of such, however, she "wasn't aware of it" until Monday when alerted (i.e., the surveyor observation). Further, the DON stated she would have ensured a supply of the medication was available had someone told her it was gone. A provided Medication Ordering and Receiving From Pharmacy policy, dated 1/2018, identified medications and related products would be received from the dispensing pharmacy on a timely basis. A procedure was listed for re-ordering medications not automatically filled by the pharmacy, including use of a medication order form, however, lacked specific instructions for monitoring supply or re-ordering stock medications at the nursing home; nor any information on how this would be accomplished to ensure no lapse in supply. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable procedures for re-ordering medications, including stock medications, to ensure quality; then inservice applicable staff members and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21550		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of	21565		1/9/24

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21565	Continued From page 48 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. 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	21565	Completed	

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(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
21565	Continued From page 49 with Vitamins) one tablet one time per day for supplement -Duloxetine HCl Delayed Release, 90 milligrams (mg) one time per day for major depressive disorder -Meloxicam Tablet 7.5 mg, one tablet once per day for chronic pain syndrome -Oxybutynin Chloride ER 10 mg, one tablet one time per day for urinary leakage -Lamotrigine tablet, 200mg two times per day for bipolar -Gabapentin Oral Capsule, 900 mg by mouth three times per day for neuropathy -Levetiracetam Oral Tablet 500 mg, Give 500 mg by mouth three times per day for seizures. The report also included and order for Ondansetron HCl Oral Tablet 4 mg, one tablet every eight hours as needed for nausea and vomiting. During observation and interview on 11/6/23 at 1:09 p.m., R3 was lying in bed with a full plate of spaghetti and a salad on her bedside table. R3 stated she started coughing and couldn't eat it because it was getting stuck on the way down. She stated she recently had surgery to open her esophagus but sometimes thing still got stuck. R3 was observed coughing periodically during interview, and stated she would ask for anti-nausea medication to see if it would help. 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 where she was heard coughing, and then left. During observation and interview on 11/6/23 at	21565		

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

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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 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
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 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		

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21565	Continued From page 51 During interview on 11/8/23 at 9:04 a.m., director of nursing stated if a resident wished to self-administer medications staff would complete an assessment, and obtain a provider order. She stated R3 had a recent esophageal dilation and should not self-administer due to the potential for choking. In addition, it would be difficult to know what time they were taken, or if they were taken at all. The Medication Administration - General Guideline policy dated 5/2022, included the resident is always observed after administration to ensure that the dose was completely ingested. In addition, residents can self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications. The Self-Administration of Medications policy dated 5/2022, indicated if a resident desires to self-administer medications, and assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out this responsibility in the care planning process. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for self administration of medication according to evidence based practices/procedures. Nursing staff could be educated as necessary to the importance of ensuring the resident is capable of administering their own medications initially, quarterly, annually, or with a change to a resident's physical or mental ability to do so. Nursing staff could also ensure there is a physician's order in place, prior to a nurse/medication aide administering medication.	21565		

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21565	Continued From page 52 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.	21565		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance 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. 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%	21685	Completed	1/9/24

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21685	Continued From page 53 of the top covered in white and yellow peeked residue, the bottom of the inside and sprayer was 100% covered in white residue and 40% of the front legs was covered in a thick, bumpy, and raised residue. During an interview with the Culinary Director (CD), on 11/7/23, at 11:28 a.m., stated that he did not know the recommended maintenance or cleaning schedule for the dishwasher. CD stated that EcoLab comes to the facility and assesses the dishwasher, and it is the facilities responsibility to call Hobart for maintenance and cleaning. CD stated that Hobart refuses to maintain the dishwasher because it is facility owned. CD could not recall the last time the dishwasher was last cleaned or serviced. During an interview with the Corporate Culinary Director (CCD) and CD on 11/7/23, at 3:06 p.m., stated that staff are to use a product that clings to the machine and helps reduce limescale on the machine called Limeaway. However, both CCD and CD-A state it is not working and that the dishwasher needs to be delimed and decalcified. During documentation review on 11/7/23 at 3:08 p.m., kitchen staff did not document a limescale cleaner was used on the dishwasher from April through September of 2023. During an interview on 11/8/23, at 9:45 a.m., CD stated that the water softener had been malfunctioning since February of 2023 and that it was fixed on October 6th, 2023. He stated that the water softener is running at 26 parts per million since it was reinstalled on October 6th, 2023. According to the Hobart dishwasher	21685		

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21685	Continued From page 54 manufactures recommendations, to protect the dishwasher, the water hardness should not exceed 3°dH, if higher it is recommended to use a Hobart Hydroline water softener/ treatment system. According to a policy titled, Dish Machine Use and Care, dated 9/2012, the dish machine should be free of lime buildup. The facility is to follow the following guidelines: 1. Chemical de-limer should be used to remove any buildup on the interior and exterior of the dish machine. Follow manufacture's direction for dilution product use. 2. Frequency for use is determined by LivingCenter need. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to dialysis. The DON or designee could provide training for all dietary staff related to dishwasher preventative maintenance. The quality assessment and assurance committee could perform random audits to ensure compliance. In addition, the DON or designee could develop and implement policies and procedures related to dishwasher preventative maintenance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685		

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	245083	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/08/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 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.	K 000		

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

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.

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Villas At The Park is a 2 story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1960 and was determined to be of Type II (111) construction. In 1970, an addition was constructed and was determined to be of Type II (000) construction. In 1998 an addition was constructed and was determined to be of Type II (111) construction. Because the original building and the 2 additions are of the same type of construction allowed for existing buildings, the	K 000		

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K 000	Continued From page 2 facility was surveyed as one building, Type II (000). The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 52 beds and had a census of 43 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain emergency egress doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.2.1 and 7.2.1.5.10.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 11/08/2023 at 12:52 PM, it was revealed by	K 211	K211 – Egress Doors 1. Keypads for identified doors have been lowered to 48” permitted height. 2. Maintence Director educated to ensure all current and future keypads for egress doors are mounted to the regualted height. 3. All keypads to egress doors to audited weekly x4 weeks to enure appropriate height. Results will be brought to the QAPI	1/9/24

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K 211	Continued From page 3 observation that the keypad that unlocks the emergency exit door GLE4A to the court yard was mounted higher than the maximum 48". 2. On 11/08/2023 at 01:23 PM, it was revealed by observation that the keypad that unlocks the front door after hours was mounted higher than the maximum 48". An interview with the Maintenance Supervisor and two Regional Maintenance supervisors verified these deficient findings at the time of discovery.	K 211	committee monthly to review for continued opportunities for quality improvements. 4. Maintenance Director 5. 1/9/2024	
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code section 14.2.1.2.2. This deficient finding could have a patterned impact on the residents within the facility. Findings include:	K 345	1. All devices identified replaced. 2. Maintenance Director educated to ensure routine sensitivity testing is completed with replacement of devices as indicated. 3. Safety committee to review sensitivity testing results for replacement devices, and monitor routine testing is up to date monthly. 4. Maintenance Director 5. 1/9/2024	1/9/24

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K 345	Continued From page 4 On 11/08/2023 between 11:15 AM and 01:30 PM, it was revealed by a review of available documentation that the smoke detector sensitivity testing report that was completed on 11/03/2022 reported that there were six (6) failed smoke detectors, and the facility could not provide documentation showing repairs had been made. An interview with the Maintenance Supervisor and two Regional Maintenance supervisors verified these deficient findings at the time of discovery.	K 345		
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to provide a Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/08/2023 between 11:15 AM and 01:30 PM,	K 901	1. NFPA99 Risk Assessment completed. 2. Maintenance Director educated to ensure assessment is completed annually. 3. Safety Committee to review monthly to reviewed NFPA 99 Risk Assessment is current. 4. Maintenance Director 5. 1/9/2024	1/9/24

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K 901	Continued From page 5 it was revealed by a review of available documentation that at the time of the survey the facility could not provide an NFPA 99 risk assessment. An interview with the Maintenance Supervisor and two Regional Maintenance supervisors verified these deficient findings at the time of discovery.	K 901		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and	K 918		1/9/24

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K 918	Continued From page 6 readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/08/2023 between 11:15 AM and 01:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide a letter of reliability for the natural gas that fuels the emergency generator. An interview with the Maintenance Supervisor and two Regional Maintenance supervisors verified these deficient findings at the time of discovery.	K 918	1. Letter of reliability has been obtained and secured in facility's records. 2. Director of Maintenance educated on keeping letter of reliability in records. 3. Administrator and/or designee to complete monthly audits x3 months to ensure letter of reliability is maintained in preventative maintenance records. Audits will be brought to QAPI by Administrator or designee to review trends and determine if audits need to continue. 4. Maintenace Director 5. 1/9/2024	

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

DEPARTMENT OF HEALTH

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
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Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us