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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: C0C2
Facility ID: 00278

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

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

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

4. TYPE OF ACTION: 7 (L8)

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

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

6. DATE OF SURVEY **07/26/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **105** (L18)

13.Total Certified Beds **105** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A, 5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	105			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
CCN-24 5182
Documentation supporting the facility's request for a continuing waiver involving LSC K67 had been recommended and forwarded to CMS for approval.

17. SURVEYOR SIGNATURE Date :
Lou Anne Page, HFE NE II 9/19/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 9/19/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245182

September 21, 2016

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

Dear Ms. McCurdy:

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

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

Effective July 25, 2016 the above facility is certified for:

105 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 105 skilled nursing facility beds.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K67

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Sincerely,

Kamala Fiske-Downing

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

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

August 9, 2016

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

RE: Project Number S5182026, and Complaint Numbers H5182062, H5182058, H5182059, and H5182060

Dear Ms. McCurdy:

On June 3, 2016 we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 19, 2016. The most serious deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On July 21, 2016, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective August 19, 2016. (42 CFR 488.417 (b))

Also, we notified you in our letter of July 21, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 19, 2016.

This was based on the deficiencies cited by this Department for a standard survey completed on May 19, 2016, that included an investigation of complaint number H5182062, H5182058, H5182059, and H5182060, and lack of verification of substantial compliance with the health deficiencies at the time of our July 21, 2016 notice. This revisit found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D) whereby corrections were required.

On July 26, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 19, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 24, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 19, 2016, as of July 25, 2016.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of July 21, 2016. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective August 19, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective August 19, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective August 19, 2016, is to be rescinded.

In our letter of July 21, 2016, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 19, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on July 25, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Your request for a continuing waiver involving the deficiency cited under K67 at the time of the May 19, 2016 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

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

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7013 3020 0001 8869 1265

July 21, 2016

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

RE: Project Number S5182026, and Complaint Numbers H5182062, H5182058, H5182059, and H5182060

Dear Ms. McCurdy:

On June 3, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 19, 2016 that included an investigation of complaint Numbers H5182062, H5182058, H5182059, and H5182060. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On June 24, 2016, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 19, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 24, 2016. Based on our visit, we have determined that your facility has achieved substantial compliance with the Life Safety Code (LSC) deficiencies.

However, compliance with the health deficiencies issued pursuant to the May 19, 2016 standard survey has not yet been verified. The most serious health deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective August 19, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective August 19, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 19, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, The Villa At St Louis Park is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective August 19, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

Your request for a continuing waiver involving the deficiency cited under K67 at the time of the May 19, 2016 standard survey has been forwarded to CMS for their review and determination. Your facilities compliance is based on pending CMS approval of your request for waiver.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

than sixty (60) days after receiving this letter, by mailing to the following address:

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 19, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day

period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

Feel free to contact me if you have questions.

Sincerely,

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245182		7/26/2016

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 07/25/2016	ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	Correction Completed 07/25/2016	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 07/25/2016
ID Prefix F0318 Reg. # 483.25(e)(2) LSC	Correction Completed 07/25/2016	ID Prefix F0333 Reg. # 483.25(m)(2) LSC	Correction Completed 07/25/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GD/kfd	DATE 8/8/2016	SIGNATURE OF SURVEYOR 31591	DATE 7/26/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
5/19/2016	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245182	A. Building 01 - MAIN BUILDING 01 B. Wing	6/24/2016

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0052	Correction Completed 05/20/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	07/21/2016	37009	6/24/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
5/17/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

August 9, 2016

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

Re: Enclosed Reinspection Results - State Nursing Home Licensing Orders - Project Number S5182026 and Complaint Numbers H5182062, H5182058, H5182059, and H5182060

Dear Ms. McCurdy:

On July 26, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 26, 2016, that included an investigation of complaint number H5182062, H5182058, H5182059, and H5182060. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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

Please feel free to call me with any questions.

Sincerely,

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

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00278 (Y1)	A. Building B. Wing (Y2)	7/26/2016 (Y3)

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

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20560 Reg. # MN Rule 4658.0405 Subp. 2 LSC	Correction Completed 07/25/2016	ID Prefix 20565 Reg. # MN Rule 4658.0405 Subp. 3 LSC	Correction Completed 07/25/2016	ID Prefix 20570 Reg. # MN Rule 4658.0405 Subp. 4 LSC	Correction Completed 07/25/2016
ID Prefix 20895 Reg. # MN Rule 4658.0525 Subp. 2.B LSC	Correction Completed 07/25/2016	ID Prefix 21426 Reg. # MN St. Statute 144A.04 Subd. 3 LSC	Correction Completed 07/25/2016	ID Prefix 21545 Reg. # MN Rule 4658.1320 A.B.C LSC	Correction Completed 07/25/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GD/kfd	DATE 8/8/2016	SIGNATURE OF SURVEYOR 31591	DATE 7/26/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 5/19/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

 EVENT ID: C0C212

STATE FORM: REVISIT REPORT (11/06)

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: C0C2
Facility ID: 00278

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245182**
2. STATE VENDOR OR MEDICAID NO. (L2) **242478000**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **08/01/2013**
6. DATE OF SURVEY **05/19/2016** (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital **05 HHA** **09 ESRD** **13 PTIP** **22 CLIA**
02 SNF/NF/Dual **06 PRTF** **10 NF** **14 CORF**
03 SNF/NF/Distinct **07 X-Ray** **11 ICF/IID** **15 ASC**
04 SNF **08 OPT/SP** **12 RHC** **16 HOSPICE**

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **105** (L18)
13.Total Certified Beds **105** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B,5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	105			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
CCN-24 5182

Documentation supporting the facility's request for a continuing waiver involving LSC K67 is being recommended and forwarded to CMS for approval.

17. SURVEYOR SIGNATURE Date :
Magdalene Jares, HFE NE II 06/14/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 07/22/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

25. LTC EXTENSION DATE:
(L27)

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7013 3020 0001 8869 1043

June 3, 2016

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

RE: Project Numbers S5182026, H5182062, H5182058, H5182059, and H5182060

Dear Ms. Johnsrud:

On May 19, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the May 19, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5182062. The complaint was substantiated and deficiency cited at F333. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the May 19, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5182058, H5182059, H5182060, that were found to be unsubstantiated.

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

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

> Opportunity to Correct - **the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> Plan of Correction - **when a plan of correction will be due and the information to be contained in that document;**

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

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

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

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
gloria.derfus@state.mn.us
Telephone: (651) 201-3792 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 28, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 19, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the

identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 19, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

Received 6-14-16

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

FORM APPROVED
OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
245182	A. BUILDING B. WING	05/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER: THE VILLA AT ST LOUIS PARK

STREET ADDRESS, CITY, STATE, ZIP CODE: 7500 WEST 22ND STREET, SAINT LOUIS PARK, MN 55426

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
	The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance.	F279		
	Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.		1. R173 had a care plan for his Celexa developed on 6/6/16 With interventions. 2. Other residents on psychotropic medications will be reviewed to ensure Care plan and interventions are in place. IDT will also Review in house residents to ensure care plans are In place by 6/24/16.	
	"A recertification survey was conducted and complaint investigation(s) were also completed at the time of the standard survey."		3. Social Services and licensed staff will be educated On facilities care plan policy and the need to care plan Psychotropic medications and interventions. Education Will be completed by June 24th.	
	An investigation of complaint #H5182058 was completed and found not to be substantiated.		4. Audits will be conducted weekly on new patients To ensure anyone on a psychotropic medication has A care plan and interventions are in place. Audits will Be conducted by DON or designee.	
	An investigation of complaint #H5182059 was completed and found not to be substanitated.		5. Results of audits will be brought to monthly QAPI by NHA Or designee.	
	An investigation of complaint #H5182060 was completed and found not to be substantiated.			
	An investigation of complaint #H5182062 was completed. The complaint was substantiated and deficiency cited at F333.			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS			
	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.			
	The facility must develop a comprehensive care plan for each resident that includes measurable			

accepted 6-14-16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: NHA — (X6) DATE: 6/14/16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245182	A. BUILDING ______ B. WING ______	05/19/2016

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

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F 279	Continued From page 1 objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a plan of care related to the use of an antidepressant medication for 1 of 5 residents (R173) reviewed for unnecessary medications. Findings include: On 5/19/16, at 1:29 p.m. R173 was observed seated on his wheelchair outside by the main entrance. When asked about his mood, R173 indicated he was sad and wanted to go home but was not physically able for now. During the conversation R173 appeared alert and oriented and maintained eye contact and smiled. R173's diagnoses included depression, aphasia, hemiplegia or hemiparesis and seizure disorder obtained from the 14 day schedule assessment MDS dated 4/27/16.	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 2 R173's physician orders dated 4/13/16, revealed R173 had an order for Citalopram 20 mg 1 tablet by mouth daily every 24 hours for Major depressive disorder. The Care Area Assessment (CAA) related to psychotropic drug use dated 4/26/16, indicated R173 was taking psychotropic medications due to diagnosis of depression. The CAA directed staff to administer medications as ordered, monitor for side effects effectiveness and update medical doctor (MD) as needed. No interventions were noted on the plan of care associated with the CAA. R173's Medication Administration Record (MAR) for 4/8/16 through 5/19/16, revealed R173 had received Celexa (Citalopram- an antidepressant) 20 milligram (mg) daily; however, no care plan had been developed for Celexa use. The May 2016 MAR for the Celexa indicated "Medication has boxed warning." The MAR for May 2016 lacked evidence of what the boxed warning entailed nor did the plan of care. During review of the care plan initiated 4/13/16, R173's care plan did not identify the use of Celexa, lacked any focus area related to depression and/or lacked any non-pharmacological interventions. On 5/19/16, at 10:27 a.m. registered nurse/unit manager (RN)-B and licensed social worker (LSW) verified R173's care plan did not address the anti-depressant medication. Both staff verified R173 had been at the facility since 4/8/16. LSW stated the Minimum Data Set (MDS) RN would usually develop the care plan if a resident was on any psychotropic medications and the	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 3 behaviors associated with the treatment. LSW also stated that during review of resident assessments, if any signs or symptoms of depression are exhibited, she would add it to the plan of care. LSW further stated she was not sure who was responsible for developing nursing care plans as RN-B had just recently taken on the role of the nurse manager. On 5/19/16, at 1:48 p.m. the director of nursing (DON) stated the MDS nurse was responsible for the initiation of care plans. The DON acknowledged the resident care plan for R173 should have addressed the antidepressant use and associated symptoms. The facility Care Plan-Comprehensive policy revised October 2010, directed "An individual comprehensive care plan that includes measurable objective and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident."	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245182	A. BUILDING ______ B. WING ______	05/19/2016

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F 280	Continued From page 4 disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to revise the plan of care to include an home exercise program (HEP) for 1 of 2 residents (R127) reviewed for limitations of range of motion (ROM). Findings include: The Admission Record dated 5/19/16, indicated R127 had diagnoses that included dementia, osteoarthritis and seizures. The physical therapy (PT) progress note indicated PT treatment was initiated on 1/29/16, and R127 was discharged from PT on 2/26/16; with discharge plan and instructions "D/C [discharge] to same SNF [skilled nursing facility] with staff assist and support." The PT progress note indicated R127 was referred to PT due to complaints of left knee and right elbow pain. Review of R127's medical record revealed a PT progress note and discharge summary dated 2/26/16. During interview on 5/19/16, at 11:30 a.m. the physical therapist (PT) stated she was the therapist who was working with R127 during PT	F 280 F280	1. R127's care plan was updated on 6/7/16 to include ROM to lower extremities. 2. All residents on a ROM program will be reviewed to ensure their care plan reflects their ROM program. 3. Nursing will be educated on R127's ROM program. IDT team will be educated on ensuring a care plan is developed within 7 days after the completion of the assessment. Therapy will be educated to notify nursing Management with new ROM programs by 6/24/16. New ROM programs will be brought to morning stand up for review. 4. Audits will be completed weekly on residents with ROM programs in place to ensure care plan reflects program and program is being completed by DON or designee. 5. Audits will be brought to monthly QAPI by NHA or designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page 5 treatment sessions and at the end of PT treatment R127 placed on an independent HEP to the left knee. When questioned whether the HEP was communicated to nursing at the end of therapy, the PT stated "do not know if I gave the sheet but they know he [R127] has an exercise program." The PT further stated she would expect the HEP to be included in the plan of care. The PT then verified the HEP was not included in R127's plan of care. R127's care plan revised on 3/16/16, indicated R127 was dependent upon staff for all activities of daily living (ADLs). The care plan indicated R127 had impaired cognition function, short and long term memory deficits. The care plan directed staff to provide cueing and prompting to ensure R127 made attempts at own cares before offering assistance. The plan of care did not match the MDS dated 3/7/16, for the cognition level. R127's quarterly Minimum Data Set (MDS) assessment dated 3/7/16, indicated R127 required total staff assistance with bathing, extensive staff assistance with transfers, bed mobility, dressing, toileting and locomotion on and off unit. The MDS also identified that R127 had no ROM limitations on the hip, knee ankle, and foot. R127 was evaluated according to the Brief Interview for Mental Status (BIMS) dated 3/7/16, with a score of 13/15, indicating intact cognition. However, a subsequent BIMS assessment dated 3/8/16, revealed R127 had score of 9/15, indicating moderately impaired cognition. On 5/18/16, at 1:04 p.m. nursing assistant (NA)-A stated he provided care for R127 regularly and had been working at the facility for about ten years. NA-A stated R127 was dependent on staff	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245182	A. BUILDING ______ B. WING ______	05/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 280	Continued From page 6 for all of his ADLs and did not receive any ROM or other special treatments. On 5/19/16, at 12:14 p.m. registered nurse (RN)-D stated the expectation was for HEP to be included in resident's plan of care. RN-D verified HEP was not included in R127's plan of care. During a joint interview on 5/19/16, at 12:21 p.m. with the director of nursing (DON) and regional nurse consultant (RNC), the DON stated the expectation was for the HEP to be included in plan of care. DON further stated she would not expect residents with cognitive impairment to be placed on an independent HEP. The DON acknowledged R127 would need to have staff assistance for cueing and supervision for HEP due to his impaired cognition. The facility provided additional information on 5/23/16, however, the additional information provided referred to an old injury to R127's right elbow. The facility's Care Plan Policy revised April 2011, directed "Goals and objectives to be entered on the resident's care plan so that all disciplines have access to such information and are able to report whether or not the desired outcomes are being achieved." The facility's Rehabilitative Nursing Care Policy revised April 2007, indicated rehabilitative nursing care was provided for each resident admitted. The policy lacked evidence of how the facility defined what a HEP was, how the program was going to be carried out for resident's with impaired cognition or if they met the criteria for HEP, and lacked how the facility was going	F 280		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 7 implement the services.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282	F282	

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to provide range of motion (ROM) per the written plan of care for 1 of 2 residents (R127) reviewed for limitations in ROM.

Findings include:

R127's Admission Record dated 5/19/16, indicated R127 had diagnoses that included dementia, osteoarthritis and seizures.
During observations with registered nurse (RN)-D on 5/16/16, at 6:22 p.m. R127's was observed to have a contracture to his right hand and right hand ring finger. Upon request, R127 was unable to fully extend his right hand fingers. When asked the how long R127's hand had been like that, RN-D stated she was unaware of any contracture on the right hand and further stated this was the first time she noticed the contracture on right hand.
On 5/18/16, at 12:36 p.m. R127 was observed lying in bed awake wearing a black glove on his right hand for warmth. R127 removed the glove from his right hand and was noted to have his right hand in a closed fist position. When R127

F282 (Provider's plan of correction):

1. R127 will be provided ROM services per his care plan.
2. All residents on ROM programs will be reviewed To ensure care plan is accurate and is being followed By staff.
3. Nursing staff will be educated on following care plan And group sheets to preform ROM when indicated. ROM Programs will be put in Point of Care for staff to Document completion. Group sheets will be updated To reflect resident ROM program.
4. Audits will be completed weekly on residents who Are on ROM programs to ensure ROM is being completed. Audits will be completed by DON or designee.
5. Results of audits will be brought to QAPI for review By NHA or designee.

Completion date: 6/24/16 GS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245182	A. BUILDING ______ B. WING ______	05/19/2016

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

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F 282	Continued From page 8 was asked if he could open his hand and extend his fingers, R127 was able to extend his right hand fingers to about 90 degrees and the right ring finger was noted to be contracted at the knuckle. When asked how long his hand had been like that he replied "fingers have been like that for quite a long time." R127's care plan revised on 3/16/16, indicated R127 was dependent upon staff for all activities of daily living. The care plan directed staff to monitor, and report any contractures and to provide gentle range of motion (ROM) as tolerated with daily cares. R127 did not receive range of motion services to minimize limitations in ROM per the plan of care. The nursing assistant (NA) assignment sheet dated 5/9/16, was reviewed and the NA assignment sheet did not direct NA staff to provide ROM services for R127. On 5/18/16, at 1:04 p.m. NA-A stated he cared for R127 regularly and NA-A had been working there for about ten years. NA-A indicated R127 had weakness on his right hand for a long time. NA-A further stated R127 did not receive any ROM special treatment from nursing assistants for treatment of the weakness on the right hand. When interviewed on 5/18/16, at 1:08 p.m. RN-C stated R127's right hand has always been like that since he was admitted to the facility related to an old injury to his right upper arm. RN-C further stated R127 does not use his right hand nor receive any restorative ROM services. During interview on 5/19/16, at 12:14 a.m. RN-D verified the NA assignment sheet did not direct staff to provide ROM services for R127. When	F 282		

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F 282	Continued From page 9 asked what joints staff are to provide gentle ROM to, RN-D stated R127 does not currently have any restorative ROM program provided by nursing staff. During a joint interview on 5/19/16, at 12:21 p.m. with the facility's director of nursing (DON) and regional nurse consultant (RNC), the DON stated the expectation was for staff to offer gentle ROM services with cares and when asked what joints staff needed to offer ROM services for R127; the DON stated "staff would need to know a little more details before that is implemented." DON further stated the expectation was for all cares to be included in the NA assignment sheet. The facility's Rehabilitative Nursing Care Policy revised April 2007, indicated that rehabilitative nursing care was provided for each resident admitted. The policy indicated that nursing rehabilitative program was developed and coordinated through the resident's care plan. The policy directed that rehabilitative nursing care is provided daily for those residents who require such services and the program was designed to assist each resident to achieve and maintain an optimal level of self-care and independence.	F 282		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318		

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	245182	A. BUILDING ____ B. WING ____	05/19/2016

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F 318	Continued From page 10	F 318		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review the facility failed to provide range of motion (ROM) exercises to maintain ROM for 1 of 2 residents (R127) reviewed with limitations in ROM.

Findings include:

The Admission Record dated 5/19/16, indicated R127 had diagnoses that included dementia, osteoarthritis and seizures. The physical therapy (PT) progress note indicated PT treatment was initiated on 1/29/16, and discharged from on 2/26/16; with discharge plan and instructions as noted: "D/C [discharge] to same SNF [skilled nursing facility] with staff assist and support." The PT progress note indicated R127 was referred to PT due to complaints of left knee and right elbow pain.

During interview on 5/19/16, at 11:30 a.m. the physical therapist (PT) stated she was the therapist who was working with R127 during PT treatment sessions and at the end of PT treatment R127 placed on an independent HEP to the left knee. When questioned whether the HEP was communicated to nursing at the end of therapy, the PT stated "do not know if I gave the sheet but they know he [R127] has an exercise program." The PT further stated she would expect the HEP to be communicated with staff and included in the plan of care. The PT verified the HEP was not included in R127's plan of care

R127's care plan revised on 3/16/16, indicated R127 was dependent upon staff for all activities of

F318

1. R127 was assessed by therapy and ROM program is in place.
2. All residents in house to be reviewed by therapy to identify any HEP or variance for the residents last date of service of their last screen.
3. Residents with therapy recommendations will be brought to the am stand up meeting for review with the IDT team.
4. Therapy and MDS staff will review all of the residents in house to validate current MDS codes against the residents clinical status. Residents with identified discrepancies to be reviewed by the IDT team for appropriate follow up.
5. Nursing staff and IDT will be educated on the communication process of therapy guidelines and recommendations by 6/24/16.
6. Therapy caseload and dc orders will be reviewed quarterly with the validation of order implementation by MDS.
7. Audits to be brought to QAPI by NHA or designee for review.

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

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F 318	Continued From page 11	F 318		

daily living (ADLs). The care plan indicated R127 had impaired cognition function, short and long term memory deficits. The care plan directed staff to provide cueing and prompting to ensure R127 made attempts at own cares before offering assistance. The care plan directed staff to monitor, and report any contractures and to provide gentle range of motion as tolerated with daily cares.

R127's quarterly Minimum Data Set (MDS) assessment dated 3/7/16, indicated R127 required total staff assistance with bathing, extensive staff assistance with transfers, bed mobility, dressing, toileting and locomotion on and off unit. The MDS also identified that R127 had no ROM limitations on the hip, knee ankle, and foot. R127 was evaluated according to the Brief Interview for Mental Status (BIMS) dated 3/7/16, with a score of 13/15, indicating intact cognition. However, a subsequent BIMS assessment dated 3/8/16, revealed R127 had score of 9/15, indicating moderately impaired cognition.

On 5/18/16, at 1:04 p.m. nursing assistant (NA)-A stated he provided care for R127 regularly and had been working at the facility for about ten years. NA-A stated R127 was dependent on staff for all of his ADLs and did not receive any ROM or other special treatments.

A nursing assistant (NA) assignment sheet dated 5/9/16, was reviewed and the NA assignment sheet did not include directions for the NA staff to provide any ROM exercises for R127.

On 5/19/16, at 12:14 p.m. registered nurse (RN)-D stated the expectation was for HEP to be included in the resident's plan of care. RN-D

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F 318	Continued From page 12 verified these exercises had not been included in R127's plan of care. During a joint interview on 5/19/16, at 12:21 p.m. with the director of nursing (DON) and regional nurse consultant (RNC), the DON stated the expectation was for the HEP to be included in plan of care. DON further stated she would not expect residents with cognitive impairment to be placed on an independent HEP. The DON acknowledged R127 would need to have staff assistance for cueing and supervision for HEP due to his impaired cognition. The facility's Rehabilitative Nursing Care Policy revised April 2007, indicated rehabilitative nursing care was provided for each resident admitted. The policy indicated that nursing rehabilitative program was developed and coordinated through the resident's care plan. The policy directed that rehabilitative nursing care is provided daily for those residents who require such services and the program was designed to assist each resident to achieve and maintain an optimal level of self-care and independence.	F 318		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to administer Coumadin (a blood thinner) and complete an INR according to the physician's orders for 1 of 1 resident (R139)	F 333	F333 1. R139 was discharged from the facility at the time the omission was discovered. R139 did not suffer actual harm due to the omission.	

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F 333	Continued From page 13 reviewed.	F 333		

Findings include:

R139's diagnoses included history of pulmonary embolism and high risk for venous thromboembolism and degenerative joint disease (DJD) with left knee arthroplasty obtained from the Pharmacy Warfarin Dosing Note dated 12/24/16. The interim care plan dated 12/24/15, indicated R139 received anticoagulants.

During review of the Anticoagulation Discharge Summary Note And Transfer Orders dated 12/24/15, directed "Dosing until Next INR [international normalized ratio]: You received your dose of Warfarin today before you left the hospital. You do not need to take any more Warfarin today. You should take 5 mg of Warfarin tomorrow (12/25/16). Date of Next INR: Saturday 12/26/15..."
During review of the December 2015 "Anti-coagulation" Medication Administration Record (MAR) for R139 revealed an order dated 12/24/15, and the INR was identified as scheduled for 12/26/15 (Saturday); However, it was never signed off/initialed by staff as completed. During further review of the MAR it was noted that Coumadin had not been initialed by staff as given on 12/25/15 and 12/26/15. The dosage was not identified for the two days identified nor was documentation evident that R139 received Coumadin on 12/15/15 and 12/26/15.
During review of complete History and Physician Nurse Practitioner (NP) progress notes dated 12/28/16, the NP documented that R139 had a history of pulmonary embolism and was upset during the visit as her Coumadin was missed.

2. The facility will identify all resident's currently in the facility that are receiving Coumadin via a pharmacy audit and examination of the facility MAR's by 6/24/16 to ensure order is being given correctly.
3. Coumadin tracking sheets will be used by Nurse Unit Managers to ensure that INR's are conducted as ordered and Coumadin orders are received and transcribed accurately and timely.
In this case, a Coumadin dosage was not clarified upon admission. The facility will have 2 qualified professionals check and sign off on all new admission order sets to ensure accuracy of orders.
4. Licensed staff and HUC's to be educated on new Coumadin order process by 6/24/16.
5. Coumadin tracking sheets will be audited weekly by the DON or designee. New admission order sets will be audited weekly by the Nurse Unit Manager to ensure that all order sets have been signed and checked by 2 qualified professionals.
6. Audits will be brought to QAPI by Administrator or designee for review monthly.

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F 333	Continued From page 14	F 333		

Review of the laboratory tests revealed R139's INR had not been checked on 12/26/15, as per the physician discharge orders. No other physician orders were documented to indicate the laboratory order had been changed. The Coumadin dosage was ordered for 12/25/15 and 12/26/15.

During review of all the progress notes located in R139's medical records from admission on 12/24/15 thru the discharge date on 1/2/16, documentation was lacking to indicate R139 had questioned staff related to the lack of Coumadin being given as ordered (12/25 & 12/16), the omitted lab test (INR) nor whether the concern expressed by R139 to the NP had been followed-up with facility staff. Review of the complaint documents submitted by the facility lacked any mention of R139's complaint of missed medication doses.

The admission Minimum Data Set (MDS) assessment dated 12/31/15, indicated R139 was a cognitively intact 65 yr old recovering from knee replacement surgery.

On 5/18/16, at 12:31 p.m. the director of nursing (DON) and the regional nurse consultant were interviewed and questioned whether they had knowledge of the medication and INR laboratory omissions. The DON stated "not to her re-collection." The DON reviewed the MAR's, progress notes, lab results, hospital discharge paperwork and verified the physician orders. She acknowledged the Coumadin had not been documented as given on 12/25/15 and 12/26/15. In addition, the DON acknowledged and verified documentation was lacking to indicate the INR

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F 333	Continued From page 15 blood level had been checked on 12/26/15. DON explained that laboratory orders were written in a calendar book at the nurses station and usually the facility received a slip/confirmation from the lab. The DON further stated she would have expected the NP who had received the concern about the omitted Coumadin, to have communicated with her immediately. The DON added that after this concern had been brought to her attention by the surveyor, she had conducted several staff interviews and failed to report any further information as it had been a challenge for staff to remember due to the length of time passed since the described incident. On 5/19/16, at 12:08 p.m. the NP who had documented the concerns expressed by R139 was contacted by phone but a return call was not received. On 5/19/16, at 12:57 p.m. via a telephone voice message R139 stated she had questioned the licensed practical nurse (LPN) who was working with her about the Coumadin and the nurse indicated she was not on Coumadin. R139 also stated she indicated to the nurse she was sure she was supposed to receive Coumadin as her INR was being monitored but the nurse again indicated R139 did not have orders. R139 stated at the time she may have been groggy; however, was certain she was on Coumadin. When interviewed on 5/19/16, at 1:59 p.m. the administrator stated she would hold the NP to the same standards as the facility staff to report any concerns expressed by a resident who reported the Coumadin incident. The facility undated Orders for Anticoagulants	F 333		

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F 333	Continued From page 16 policy directed: 5. When a lab is scheduled (INR/PT) results must be called into the MD [medical doctor] prior to the administration of the next dose. 6. Coumadin and Anticoagulants must be reviewed and tracked for compliance..."	F 333		

F5182026

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

APPROVED By Tom Linhoff at 12:06 pm, Jun 13, 2016

PRINTED: 06/03/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245182	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/17/2016

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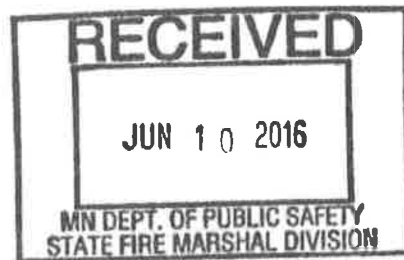
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOU VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on May 17, 2016. At the time of this survey, The Villa at St. Louis Park was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K 000	The Villa of St.Louis Park submits this plan of correction Because it is required by State and Federal Regulation and is not a legal admission that this statement of deficiencies is correctly cited, and is not to be construed as an admission against the interest by the Center, the Administrator or any employees, agents or other individuals who draft or may be discussed in the response and plan of correction. The Villa of St. Louis Park respectfully submits this plan of correction and our allegation of compliance as of June 24th, 2016.  RECEIVED JUN 10 2016 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: NHA | (X6) DATE: 6/7/16

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.

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

PRINTED: 06/03/2016
FORM APPROVED
OMB NO. 0938-0391

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	245182	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/17/2016

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Villa at St. Louis Park is a 2-story building with a partial basement. The building was constructed in 1971 and was determined to be of Type II(222) construction. The building has automatic fire sprinkler protection throughout as of March 2009. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 105 beds and had a census of 77 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000	K52 1. The firm alarm system was checked on 5/20/16 and Is in good working order. 2. Maintenance Director will be educated on fire alarm system requirement by 6/24/16.	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved	K 052		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245182	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/17/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 052	Continued From page 2 maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility's fire alarm system is not maintained in accordance with NFPA 72, (99). This deficient practice could affect all 77 residents. Findings include: On a facility tour between 9:30 AM and 1:30 PM on May 17, 2016, observation revealed that the fire alarm system has exceeded 365 days since the last annual inspection was conducted. This deficient practice was verified by the Director of Environmental Services at the time of the inspection.	K 052		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation and staff interviews, it could not be verified that the facility's general ventilating and air conditioning system (HVAC) is installed in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 2-3.11. A noncompliant HVAC system could affect all 77 residents. Findings include: On a facility tour between 9:30 AM and 1:30 PM	K 067	K67 1. A waiver has been requested and is attached.	

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K 067	Continued From page 3 on May 17, 2016, observation revealed that the ventilation system has supply ducts serving the resident corridors without return ducts in the corridors. It appears that the only return is through the continuous operation of the resident room bathroom fans. Date of building construction is 1971. This deficient practice was verified by the Director of Environmental Services at the time of the inspection.	K 067		

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

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

Company:	The Villa at Saint Louis Park	Date:	05/20/16 (revised from 05/01/15)
Street:	7500 West 22nd Street	Project:	Westwood Health Care Ducted Fresh Air to Resident Rooms
City/State:	Saint Louis Park, MN 55426		
ATTN:	Kent Netzer	Pages	2

Proposal

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

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

Amount: $485,000.00 (budget price)

Add: $650.00 to $1,720.00 for structural engineering. This should not be necessary but the city may require it.
Add: $25,000.00 (rough approximate price) to have a general contractor install sheet rock enclosures around each of approximately 23 vertical ducts in the resident rooms as a result of this project. You may also want to have a contingency fund for patching and painting at penetrations (approximately $7,000.00?)

Whitney, Marian (DPS)

From: Linhoff, Tom (DPS)
Sent: Monday, June 13, 2016 12:27 PM
To: Dehler, Robert (MDH); Dietrich, Shellae (MDH); Henderson, Mary (MDH); Fiske-Downing, Kamala (MDH); Johnston, Kate (MDH); Leach, Colleen (MDH); Meath, Mark (MDH); Whitney, Marian (DPS); rochi_lsc@cms.hhs.gov
Subject: FW: POC for The Villa at St. Louis Park
Attachments: POC The Villa at St Louis Park-signed.pdf; Villa of St. Louis Park - Waiver.pdf

This is to inform you that The Villa of St. Louis Park MN, 245182, is again requesting annual waivers for K- K067. The exit date was 05-17-2016. No changes.

I am recommending the CMS approve this waiver request.

Respectfully,
Tom Linhoff
Fire Safety Supervisor

MN State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Office phone: 651-201-7205
Phone: 651.430.3012
Fax: 651.430.3012
Cell: 651-769-7778
Email: Tom.Linhoff@state.mn.us
Web: www.fire.state.mn.us

From: Whitney, Marian (DPS)
Sent: Monday, June 13, 2016 8:31 AM
To: Linhoff, Tom (DPS) <tom.linhoff@state.mn.us>
Subject: POC for The Villa at St. Louis Park

Please review and return to me.

Thanks.

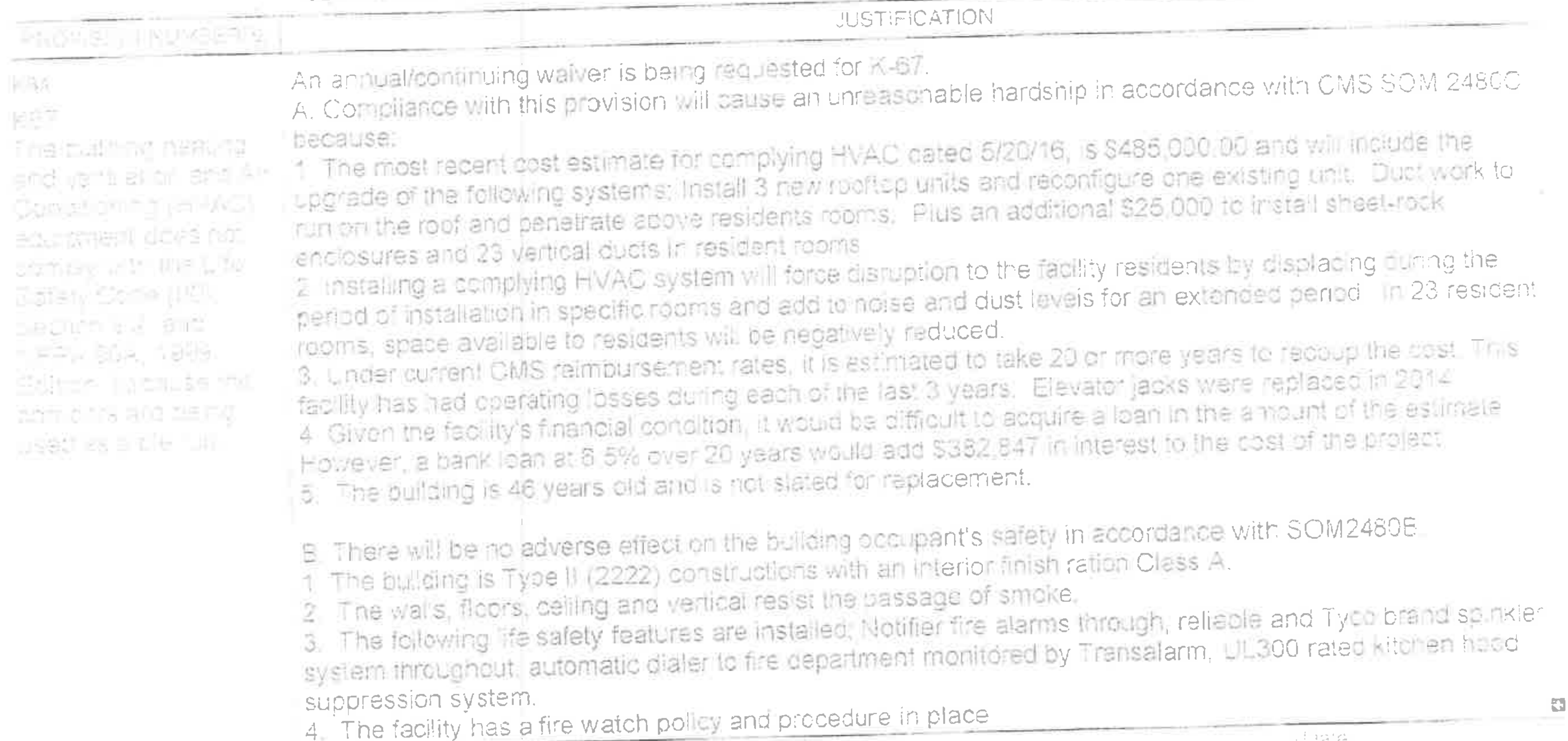
Marian Whitney
State Fire Marshal Division
Healthcare Section
651-201-7213
fax 651-215-0525

2000 CODE

Name of Facility
Villa at St. Louis Park

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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



[illegible]	JUSTIFICATION
K67 [illegible]	An annual/continuing waiver is being requested for K-67. A. Compliance with this provision will cause an unreasonable hardship in accordance with CMS SOM 2480C because: 1. The most recent cost estimate for complying HVAC dated 5/20/16, is $485,000.00 and will include the upgrade of the following systems: Install 3 new rooftop units and reconfigure one existing unit. Duct work to run on the roof and penetrate above residents rooms. Plus an additional $25,000 to install sheet-rock enclosures and 23 vertical ducts in resident rooms. 2. Installing a complying HVAC system will force disruption to the facility residents by displacing during the period of installation in specific rooms and add to noise and dust levels for an extended period. In 23 resident rooms, space available to residents will be negatively reduced. 3. Under current CMS reimbursement rates, it is estimated to take 20 or more years to recoup the cost. This facility has had operating losses during each of the last 3 years. Elevator jacks were replaced in 2014. 4. Given the facility's financial condition, it would be difficult to acquire a loan in the amount of the estimate. However, a bank loan at 6.5% over 20 years would add $382,847 in interest to the cost of the project. 5. The building is 46 years old and is not slated for replacement. B. There will be no adverse effect on the building occupant's safety in accordance with SOM2480B. 1. The building is Type II (2222) constructions with an interior finish ration Class A. 2. The walls, floors, ceiling and vertical resist the passage of smoke. 3. The following life safety features are installed: Notifier fire alarms through, reliable and Tyco brand sprinkler system throughout, automatic dialer to fire department monitored by Transalarm, UL300 rated kitchen hood suppression system. 4. The facility has a fire watch policy and procedure in place

[illegible]	Title	Office	Date
		[illegible] Fire	
[signature]	FIRE SAFETY SUPERVISOR	STATE FIRE MARSHAL	6-13-2016

2000 CODE

Name of Facility
Villa at St Louis Park

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

PROVISION NUMBER(S)	JUSTIFICATION
K64 K67 The building heating and ventilation [illegible]	An annual/continuing waiver is being requested for K-67 Continued from previous page. 5. There are 4 smoke compartments per floor in the facility. 6. Current facility staff to resident ratio 3.28. 7. The facility is of two floor concrete, spancrete, and brick construction. 8. our building is two floors with 24 on our first floor TCU and 54 on our second floor which is long term 9. The closest fire department is 1 mile away and has an average response time of five minutes or less

Signature	Title	Office	Date
	Deputy State Fire Marshal	State Fire Marshal	
[illegible signature]	FIRE SAFETY SUPERVISOR	STATE FIRE MARSHAL	6-13-2016

Protecting, maintaining and improving the health of all Minnesotans

Certified Mail # 7013 3020 0001 8869 1043

June 3, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Numbers S5182026, H5182062, H5182058, H5182059, and H5182060

Dear Ms. Johnsrud:

The above facility was surveyed on May 16, 2016 through May 19, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H518062 that was substantiated. The team also investigated complaint numbers H5182058, H5182059, H5182060 that were found to be unsubstantiated. 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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 after the statement, "This Rule 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.

When all orders are corrected, the order form should be signed and returned to:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
gloria.derfus@state.mn.us
Telephone: (651) 201-3792 Fax: (651) 215-9697

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 contact Gloria Derfus, Unit Supervisor at (651) 201-3792.

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

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

Please feel free to call me with any questions.

Sincerely,

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

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00278	A. BUILDING: ______ B. WING ______	05/19/2016

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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: Investigation of complaint #H5182062 was completed. The complaint was substantiated related to #H5182062. Correction Order issued at State Licensing MN Rule 4658.1320 Subp. B. The complaints related to #H5182058, #H5182059 and #H5182060 were not substantiated.	2 000	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.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE　　TITLE　　(X6) DATE

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2 000	Continued From page 1 When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Office of Health Facility Complaints; 85 East Seventh Place, Suite 220, St. Paul, Minnesota, 55164-0970.	2 000	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 which are in violation of the state statute after the statement, "This Rule 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.	
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan	2 560		

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2 560	Continued From page 2 required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to develop a plan of care related to the use of an antidepressant medication for 1 of 5 residents (R173) reviewed for unnecessary medications. Findings include: On 5/19/16, at 1:29 p.m. R173 was observed seated on his wheelchair outside by the main entrance. When asked about his mood resident, R173 indicated he was sad as he wanted to go home but was not physically able for now. During the conversation R173 appeared alert and oriented and maintained eye contact and smiled. R173's diagnoses included depression, aphasia, hemiplegia or hemiparesis and seizure disorder obtained from the 14 day schedule assessment MDS dated 4/27/16. The physician orders dated 4/13/16, revealed R173 had an order for Citalopram 20 mg 1 tablet by mouth daily every 24 hours for Major depressive disorder. The Care Area Assessment (CAA) related to psychotropic drug use dated 4/26/16, indicated R173 was taking psychotropic medications due to diagnosis of depression. The CAA directed staff to administer medications as ordered, monitor for side effects/effectiveness and update medical doctor (MD) as needed. No interventions were noted on the plan of care associated with the CAA.	2 560		

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2 560	Continued From page 3	2 560		

R173's Medication Administration Record (MAR) for 4/8/16 through 5/19/16, revealed R173 had received Celexa (Citalopram- an antidepressant) 20 milligram (mg) daily; however, no care plan had been developed for Celexa use. The May 2016 MAR for the Celexa indicated "Medication has boxed warning." The MAR for May of 2016 lacked evidence of what the boxed warning entailed nor did the plan of care.

During review of the care plan initiated 4/13/16, R173's care plan did not identify the use of Celexa, lacked any focus area related to depression and lacked any non-pharmacological interventions.

On 5/19/16, at 10:27 a.m. registered nurse/unit manager (RN)-B and licensed social worker (LSW) verified R173's care plan did not address the anti-depressant medication. Both staff verified R173 had been at the facility since 4/8/16. LSW stated the Minimum Data Set (MDS) RN would usually develop the care plan if a resident was on any psychotropic medications and the behaviors associated with the treatment. LSW also stated that during review of resident assessments, if any signs or symptoms of depression are exhibited, she would add it to the plan of care. LSW further stated she was not sure who was responsible for developing nursing care plans as RN-B had just recently taken on the role of the nurse manager.

On 5/19/16, at 1:48 p.m. the director of nursing (DON) stated the MDS nurse was responsible for the initiation of care plans. The DON acknowledged the resident care plan for R173 should have addressed the antidepressant use and associated symptoms.

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2 560	Continued From page 4 The facility Care Plan-Comprehensive policy revised October 2010, directed "An individual comprehensive care plan that includes measurable objective and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to the care plan. The DON or designee, could provide training for all nursing staff related to the development of the care plan based on the assessment. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide range of motion (ROM) per the written plan of care for 1 of 2 residents (R127) reviewed for limitations in ROM.	2 565		

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2 565	Continued From page 5 Findings include: R127's Admission Record dated 5/19/16, indicated R127 had diagnoses that included dementia, osteoarthritis and seizures. During observations with registered nurse (RN)-D on 5/16/16, at 6:22 p.m. R127's was observed to have a contracture to his right hand and right hand ring finger. Upon request, R127 was unable to fully extend his right hand fingers. When asked the how long R127's hand had been like that, RN-D stated she was unaware of any contracture on the right hand and further stated this was the first time she noticed the contracture on right hand. On 5/18/16, at 12:36 p.m. R127 was observed lying in bed awake wearing a black glove on his right hand for warmth. R127 removed the glove from his right hand and was noted to have his right hand in a closed fist position. When R127 was asked if he could open his hand and extend his fingers, R127 was able to extend his right hand fingers to about 90 degrees and the right ring finger was noted to be contracted at the knuckle. When asked how long his hand had been like that he replied "fingers have been like that for quite a long time." R127's care plan revised on 3/16/16, indicated R127 was dependent upon staff for all activities of daily living. The care plan directed staff to monitor, and report any contractures and to provide gentle range of motion (ROM) as tolerated with daily cares. R127 did not receive range of motion services to minimize limitations in ROM per the plan of care. The nursing assistant (NA) assignment sheet dated 5/9/16, was reviewed and the NA assignment sheet did not direct NA staff to	2 565		

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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
2 565	Continued From page 6	2 565		

provide ROM services for R127.

On 5/18/16, at 1:04 p.m. NA-A stated he cared for R127 regularly and NA-A had been working there for about ten years. NA-A indicated R127 had weakness on his right hand for a long time. NA-A further stated R127 did not receive any ROM special treatment from nursing assistants for treatment of the weakness on the right hand.

When interviewed on 5/18/16, at 1:08 p.m. RN-C stated R127's right hand has always been like that since he was admitted to the facility related to an old injury to his right upper arm. RN-C further stated R127 does not use his right hand nor receive any restorative ROM services.

During interview on 5/19/16, at 12:14 a.m. RN-D verified the NA assignment sheet did not direct staff to provide ROM services for R127. When asked what joints staff are to provide gentle ROM to, RN-D stated R127 does not currently have any restorative ROM program provided by nursing staff.

During a joint interview on 5/19/16, at 12:21 p.m. with the facility's director of nursing (DON) and regional nurse consultant (RNC), the DON stated the expectation was for staff to offer gentle ROM services with cares and when asked what joints staff needed to offer ROM services for R127; the DON stated "staff would need to know a little more details before that is implemented." DON further stated the expectation was for all cares to be included in the NA assignment sheet.

The facility's Rehabilitative Nursing Care Policy revised April 2007, indicated that rehabilitative nursing care was provided for each resident admitted. The policy indicated that nursing

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2 565	Continued From page 7 rehabilitative program was developed and coordinated through the resident's care plan. The policy directed that rehabilitative nursing care is provided daily for those residents who require such services and the program was designed to assist each resident to achieve and maintain an optimal level of self-care and independence. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced	2 570		

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by:
Based on interview and document review the facility failed to revise the plan of care to include an home exercise program (HEP) for 1 of 2 residents (R127) reviewed for limitations of range of motion (ROM).

Findings include:

The physical therapy (PT) Progress Note indicated PT treatment was initiated on 1/29/16, and R127 was discharged from PT on 2/26/16; with discharge plan and instructions "D/C [discharge] to same SNF [skilled nursing facility] with staff assist and support."

Review of R127's medical record revealed a PT Progress Note and discharge summary dated 2/26/16. The PT Progress Note indicated R127 was referred to PT due to complaints of left knee and right elbow pain.

R127's quarterly Minimum Data Set (MDS) assessment dated 3/7/16, indicated R127 required total staff assistance with bathing, extensive staff assistance with transfers, bed mobility, dressing, toileting and locomotion on and off unit. The MDS also identified that R127 had no ROM limitations on the hip, knee ankle, and foot. R127 was evaluated according to the Brief Interview for Mental Status (BIMS) dated 3/7/16, with a score of 13/15, indicating intact cognition. However, a subsequent BIMS assessment dated 3/8/16, revealed R127 had score of 9/15, indicating moderately impaired cognition.

R127's care plan revised on 3/16/16, indicated R127 was dependent upon staff for all activities of daily living (ADLs). The care plan indicated R127 had impaired cognition function, short and long

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2 570	Continued From page 9 term memory deficits. The care plan directed staff to provide cueing and prompting to ensure R127 made attempts at own cares before offering assistance. The plan of care did not match the MDS dated 3/7/16, for the cognition level. The Admission Record dated 5/19/16, indicated R127 had diagnoses that included dementia, osteoarthritis and convulsions. On 5/18/16, at 1:04 p.m. nursing assistant (NA)-A stated he provided care for R127 regularly and had been working at the facility for about ten years. NA-A stated R127 was dependent on staff for all of his ADLs and did not receive any ROM or other special treatments. During interview on 5/19/16, at 11:30 a.m. the physical therapist (PT) stated she was the therapist who was working with R127 during PT treatment sessions and at the end of PT treatment R127 placed on an independent HEP to the left knee. When questioned whether the HEP was communicated to nursing at the end of therapy, the PT stated "do not know if I gave the sheet but they know he [R127] has an exercise program." The PT further stated she would expect the HEP to be included in the plan of care. The PT then verified the HEP was not included in R127's plan of care. On 5/19/16, at 12:14 p.m. registered nurse (RN)-D stated the expectation was for HEP to be included in resident's plan of care. RN-D verified HEP was not included in R127's plan of care. During a joint interview on 5/19/16, at 12:21 p.m. with the director of nursing (DON) and regional nurse consultant (RNC), the DON stated the expectation was for the HEP to be included in	2 570		

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plan of care. DON further stated she would not expect residents with cognitive impairment to be placed on an independent HEP. The DON acknowledged R127 would need to have staff assistance for cueing and supervision for HEP due to his impaired cognition.

The facility provided additional information on 5/23/16, however, the additional information provided referred to an old injury to R127's right elbow.

The facility's Care Plan Policy revised April 2011, directed "Goals and objectives to be entered on the resident's care plan so that all disciplines have access to such information and are able to report whether or not the desired outcomes are being achieved."

SUGGESTED METHOD OF CORRECTION: The director of nursing (or designee) could review and make any necessary changes to care planning policies and provide education on revision of care plans. The facility then could audit care plans for accuracy and update as necessary. The facility then could develop and auditing system as part of their quality assurance program to maintain compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion	2 895		

Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the

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comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:

B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to provide range of motion (ROM) exercises to maintain ROM for 1 of 2 residents (R127) reviewed who had limitations in ROM.

Findings include:

The Admission Record dated 5/19/16, indicated R127 had diagnoses that included dementia, osteoarthritis and seizures. The physical therapy (PT) progress note indicated PT treatment was initiated on 1/29/16, and R127 was discharged from PT on 2/26/16; with discharge plan and instructions "D/C [discharge] to same SNF [skilled nursing facility] with staff assist and support." The PT progress note indicated R127 was referred to PT due to complaints of left knee and right elbow pain.

During interview on 5/19/16, at 11:30 a.m. the physical therapist (PT) stated she was the therapist who was working with R127 during PT treatment sessions and at the end of PT treatment R127 placed on an independent HEP to the left knee. When questioned whether the HEP was communicated to nursing at the end of

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2 895	Continued From page 12	2 895		

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therapy, the PT stated "do not know if I gave the sheet but they know he [R127] has an exercise program." The PT further stated she would expect the HEP to be included in the plan of care and then verified the HEP was not included in R127's plan of care.

R127's care plan revised on 3/16/16, indicated R127 was dependent upon staff for all activities of daily living (ADLs). The care plan indicated R127 had impaired cognition function, short and long term memory deficits. The care plan directed staff to provide cueing and prompting to ensure R127 made attempts at own cares before offering assistance. The care plan directed staff to monitor, and report any contractures and to provide gentle range of motion as tolerated with daily cares.

R127's quarterly Minimum Data Set (MDS) assessment dated 3/7/16, indicated R127 required total staff assistance with bathing, extensive staff assistance with transfers, bed mobility, dressing, toileting and locomotion on and off unit. The MDS also identified that R127 had no ROM limitations on the hip, knee ankle, and foot. R127 was evaluated according to the Brief Interview for Mental Status (BIMS) dated 3/7/16, with a score of 13/15, indicating intact cognition. However, a subsequent BIMS assessment dated 3/8/16, revealed R127 had score of 9/15, indicating moderately impaired cognition.

On 5/18/16, at 1:04 p.m. nursing assistant (NA)-A stated he provided care for R127 regularly and had been working at the facility for about ten years. NA-A stated R127 was dependent on staff for all of his ADLs and did not receive any ROM or other special treatments.

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A nursing assistant (NA) assignment sheet dated 5/9/16, was reviewed and the NA assignment sheet did not include directions for the NA staff to provide any ROM services for R127.

On 5/19/16, at 12:14 p.m. registered nurse (RN)-D stated the expectation was for HEP to be included in the resident's plan of care. RN-D verified these exercises had not been included in R127's plan of care.

During a joint interview on 5/19/16, at 12:21 p.m. with the director of nursing (DON) and regional nurse consultant (RNC), the DON stated the expectation was for the HEP to be included in plan of care. DON further stated she would not expect residents with cognitive impairment to be placed on an independent HEP. The DON acknowledged R127 would need to have staff assistance for cueing and supervision for HEP due to his impaired cognition.

The facility's Rehabilitative Nursing Care Policy revised April 2007, indicated rehabilitative nursing care was provided for each resident admitted. The policy indicated that nursing rehabilitative program was developed and coordinated through the resident's care plan. The policy directed that rehabilitative nursing care is provided daily for those residents who require such services and the program was designed to assist each resident to achieve and maintain an optimal level of self-care and independence.

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice nursing staff regarding implementation of the care plan to include completing range of motion as directed, and then audit to ensure

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2 895	Continued From page 14 compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
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 4 of 5 residents (R259, R261, R262, R263) and 3 of 5 employees (E-1, E-2, E-3) had tuberculin skin test (TST's) and a symptom screening completed as recommended per State Tuberculosis (TB) guidelines.	21426		

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Findings include:

Residents
R259 was admitted to the facility on 5/6/16. R259's medical record indicted resident had not had the TB symptom screening, step one and step two TST completed.

R261 was admitted to the facility on 5/13/16. R261 received a first step TST on 5/15/16, and was read 5/17/16, as negative however lacked the induration.

R262 was admitted to the facility on 5/7/16. R259 received a first step TST on 5/7/16, and was read 5/9/16, as negative however lacked the induration in millimeters (mm).

R263 was admitted to the facility on 5/13/16. R263 received the first step TST on 5/13/16, however TST results were never read.

Employees
E-1 was hired by the facility on 4/18/16. The personnel file revealed E-1 had received a first step TST on 4/22/16, however had never been read. In addition, E-1 had not received the second step by the time of the survey.

E-2's personnel file revealed a hire date of 4/18/16. E-2's file indicated a step one TST had been administered on 4/22/16, however was never read 48-72 hours later and yet E-2 continued to provide care. In addition, E-2 never received the second step TST.

E-3's personnel file revealed a hire date of 1/11/16. E-3's file indicated a step one TST had been administered on 2/2/16, and read 2/4/16, as

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0 mm and negative interpretation; however, second step was administered on 2/17/16, read 2/19/16, and had neither induration nor interpretation documented.

On 5/18/16, at 9:56 a.m. the director of nursing (DON) stated she had read E-1's TST at another sister facility however never documented it even though she intended to document it. DON also stated she would expect step one and symptom screening to be completed before a staff was placed on a work assessment. When asked who would be responsible for making sure all employees were appropriately screened DON stated the assistant director of nursing (ADON) who was in-charge of the facility infection control program. DON also verified the other personnel files had not been properly been screened per guidelines.

On 5/18/16, at 1:13 p.m. licensed practical nurse (LPN)-A verified R261's step one results recorded in the medication administration record (MAR) had no induration. LPN-A stated the results were supposed to be document both with an induration and interpretation.

On 5/18/16, at 2:00 p.m. registered nurse (RN)-B and RN-A verified the medical records lack proper TB screening for all the residents (R259, R262, R262) per the State regulations.

On 5/19/16, at 1:52 p.m. DON stated she would have expected all the residents and staff to have been properly screened for TB per the State regulations.

The facility Tuberculosis Infection Control Plan revised May 2014, directed "1. Healthcare Workers (HCW) will have a pre-placement and

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annual tuberculin skin test (TST, also commonly called a Mantoux). New employees will provide records of annual screening or receive the second step TST. Records of the TB blood test may be provided instead of the TST ... " In addition, the policy directed for resident screening "1. Residents must receive baseline TB testing within 3 months prior to or 72 hours after admission. This TB screening will consist of 3 components: a. Assessing for current symptoms of active TB disease, AND b. Assessing the resident's risk factors for TB, AND c. Testing for the presence of TB infection by administering either a two-step TST or a single TB blood test ..."

Minnesota Department of Health, Regulations for Tuberculosis Control in Minnesota Health Care Settings, A guide for implementing tuberculosis infection control regulation in your facility, dated July 2013, directed:
Page 10, Screening Health Care Workers, General principles, "TST documentation should include the date of the test (i.e. month, day, year), the number of millimeters of induration (if no induration, document "0" mm) and interpretation (i.e., positive or negative). Baseline TB screening, "An employee may begin working with patients after a negative TB symptom screen and a negative IGRA or TST (i.e., first step) dated within 90 days before hire.
Page 23, Screening Residents, General principles, "Screening should be initiated within 72 hours of admission or 90 days prior to admission...TST documentation for residents should include the date (i.e., month, date, year), the number of millimeters of induration (if no induration, document "0" mm), and interpretation (i.e., positive or negative).

SUGGESTED METHOD OF CORRECTION: The

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21426	Continued From page 18 director of nursing could review tuberculosis policies and procedures to ensure compliance. The director of nursing could educate nursing staff to their policies and procedures for employee and resident tuberculosis skin tests and tuberculosis screens and provide all staff ongoing tuberculosis training. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as	21545		

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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 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 interview and document review the facility failed to administer Coumadin (a blood thinner) and complete an INR according to the physician's orders for 1 of 1 resident (R139) reviewed.

Findings include:

R139's diagnoses included history of pulmonary embolism and high risk for venous thromboembolism and degenerative joint disease (DJD) with left knee arthroplasty obtained from the Pharmacy Warfarin Dosing Note dated 12/24/16. The interim care plan dated 12/24/15, indicated R139 received anticoagulants.

During review of the Anticoagulation Discharge Summary Note And Transfer Orders dated

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	00278	A. BUILDING: ____ B. WING ____	05/19/2016

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

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12/24/15, directed "Dosing until Next INR [international normalized ratio]: You received your dose of Warfarin today before you left the hospital. You do not need to take any more Warfarin today. You should take 5 mg of Warfarin tomorrow (12/25/16). Date of Next INR: Saturday 12/26/15..."
During review of the December 2015 "Anti-coagulation" Medication Administration Record (MAR) for R139 revealed an order dated 12/24/15, and the INR was identified as scheduled for 12/26/15 (Saturday); However, it was never signed off/initialed by staff as completed. During further review of the MAR it was noted that Coumadin had not been initialed by staff as given on 12/25/15 and 12/26/15. The dosage was not identified for the two days identified nor was documentation evident that R139 received Coumadin on 12/15/15 and 12/26/15.
During review of complete History and Physician Nurse Practitioner (NP) progress notes dated 12/28/16, the NP documented that R139 had a history of pulmonary embolism and was upset during the visit as her Coumadin was missed.

Review of the laboratory tests revealed R139's INR had not been checked on 12/26/15, as per the physician discharge orders. No other physician orders were documented to indicate the laboratory order had been changed. The Coumadin dosage was ordered for 12/25/15 and 12/26/15.

During review of all the progress notes located in R139's medical records from admission on 12/24/15 thru the discharge date on 1/2/16, documentation was lacking to indicate R139 had questioned staff related to the lack of Coumadin being given as ordered (12/25 & 12/16), the

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omitted lab test (INR) nor whether the concern expressed by R139 to the NP had been followed-up with facility staff. Review of the complaint documents submitted by the facility lacked any mention of R139's complaint of missed medication doses.

The admission Minimum Data Set (MDS) assessment dated 12/31/15, indicated R139 was a cognitively intact 65 yr old recovering from knee replacement surgery.

On 5/18/16, at 12:31 p.m. the director of nursing (DON) and the regional nurse consultant were interviewed and questioned whether they had knowledge of the medication and INR laboratory omissions. The DON stated "not to her re-collection." The DON reviewed the MAR's, progress notes, lab results, hospital discharge paperwork and verified the physician orders. She acknowledged the Coumadin had not been documented as given on 12/25/15 and 12/26/15. In addition, the DON acknowledged and verified documentation was lacking to indicate the INR blood level had been checked on 12/26/15. DON explained that laboratory orders were written in a calendar book at the nurses station and usually the facility received a slip/confirmation from the lab. The DON further stated she would have expected the NP who had received the concern about the omitted Coumadin, to have communicated with her immediately. The DON added that after this concern had been brought to her attention by the surveyor, she had conducted several staff interviews and failed to report any further information as it had been a challenge for staff to remember due to the length of time passed since the described incident.

On 5/19/16, at 12:08 p.m. the NP who had

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documented the concerns expressed by R139 was contacted by phone but a return call was not received.

On 5/19/16, at 12:57 p.m. via a telephone voice message R139 stated she had questioned the licensed practical nurse (LPN) who was working with her about the Coumadin and the nurse indicated she was not on Coumadin. R139 also stated she indicated to the nurse she was sure she was supposed to receive Coumadin as her INR was being monitored but the nurse again indicated R139 did not have orders. R139 stated at the time she may have been groggy; however, was certain she was on Coumadin.

When interviewed on 5/19/16, at 1:59 p.m. the administrator stated she would hold the NP to the same standards as the facility staff to report any concerns expressed by a resident who reported the Coumadin incident.

The facility undated Orders for Anticoagulants policy directed:
5. When a lab is scheduled (INR/PT) results must be called into the MD [medical doctor] prior to the administration of the next dose.
6. Coumadin and Anticoagulants must be reviewed and tracked for compliance..."

SUGGESTED METHOD OF CORRECTION: The director or nursing could educate staff on the importance of monitoring significant medications which require blood tests. An audit could be developed to ensure lab reports ordered by the physician to monitor medication efficacy would be completed as ordered. The result of the audit could be reviewed at the quarterly quality assurance committee meetings.

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21545	Continued From page 23 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545		