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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: C19G

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00278

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

2.STATE VENDOR OR MEDICAID NO.
(L2) **309820600**

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 **06/30/2014** (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:
X A. In Compliance With Program Requirements
Compliance Based On:
1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A5*** (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):

Facility's request for a continuing waiver involving K0067 is recommended.

17. SURVEYOR SIGNATURE Date :
Sue Miller, HFE NE II 07/16/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 07/16/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00000
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/26/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5182

July 16, 2014

Ms. Heather Heijerman, Administrator
The Villa at St Louis Park
7500 West 22nd Street
Saint Louis Park, Minnesota 55426

Dear Ms. Heijerman:

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 June 25, 2014 the above facility is certified for or recommended for:

105 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 105 skilled nursing facility beds located in rooms

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K-0067.

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

July 16, 2014

Ms. Heather Heijerman, Administrator
The Villa at St Louis Park
7500 West 22nd Street
Saint Louis Park, Minnesota 55426

RE: Project Number S5182024

Dear Ms. Heijerman:

On May 28, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 16, 2014. 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 July 1, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 16, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 25, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 16, 2014, effective June 25, 2014 and therefore remedies outlined in our letter to you dated May 28, 2014, will not be imposed.

Your request for a continuing waiver involving the deficiency cited under K0067 at the time of the May 16, 2014 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 visit 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,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245182	A. Building B. Wing	06/30/2014

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **06/25/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **06/25/2014**	ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **06/25/2014**
ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **06/25/2014**	ID Prefix **F0332** Reg. # **483.25(m)(1)** LSC	Correction Completed **06/25/2014**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **06/25/2014**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **06/25/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **06/25/2014**	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GL/AK	07/16/2014	03023	06/30/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	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
5/16/2014			

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00278	A. Building B. Wing	06/30/2014

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20965** Reg. # **MN Rule 4658.0600 Subp.** LSC	Correction Completed **06/25/2014**	ID Prefix **21015** Reg. # **MN Rule 4658.0610 Subp.** LSC	Correction Completed **06/25/2014**	ID Prefix **21375** Reg. # **MN Rule 4658.0800 Subp.** LSC	Correction Completed **06/25/2014**
ID Prefix **21545** Reg. # **MN Rule 4658.1320 A.B.C** LSC	Correction Completed **06/25/2014**	ID Prefix **21565** Reg. # **MN Rule 4658.1325 Subp.** LSC	Correction Completed **06/25/2014**	ID Prefix **21810** Reg. # **MN St. Statute 144.651 Sul** LSC	Correction Completed **06/25/2014**
ID Prefix **22000** Reg. # **MN St. Statute 626.557 Su** LSC	Correction Completed **06/25/2014**	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GL/AK	07/16/2014	03023	06/30/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	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
5/16/2014			

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

July 16, 2014

Ms. Heather Heijerman, Administrator
The Villa at St Louis Park
7500 West 22nd Street
Saint Louis Park, Minnesota 55426

Re: Enclosed Reinspection Results - Project Number S5182024

Dear Ms. Heijerman:

On July 1, 2014 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 May 16, 2014. 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,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: C19G

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00278

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

2.STATE VENDOR OR MEDICAID NO.
(L2) **309820600**

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 **05/16/2014** (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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Sue Miller, HFE NE II 06/24/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 06/24/2014 (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.
00000
(L31)

30. REMARKS
AW K67 PDF_ACO 06/26/2014
Emailed CMS 06/26/2014

Posted 06/26/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5182

At the time of the standard survey completed 05/16/14, the facility was not in substantial compliance and the most serious deficiencies 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 as evidenced by the attached CMS-2567.

The facility's request for a continuing waiver involving the deficiency cited at K67 was previously forwarded. Approval of the waiver request was recommended.

The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 5088

May 28, 2014

Ms. Heather Heijerman, Administrator
The Villa at St Louis Park
7500 West 22nd Street
Saint Louis Park, Minnesota 55426

RE: Project Number S5182024

Dear Ms. Heijerman:

On May 16, 2014, 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.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - 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;

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

<u>Informal Dispute Resolution</u> - 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:

Gayle Lantto, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: gayle.lantto@state.mn.us
Telephone: (651) 201-3794
Fax: (651) 201-3790

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 25, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 25, 2014 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

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.

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 13, 2014 (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 13, 2014 (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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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 _____	05/15/2014

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

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F 000	INITIAL COMMENTS 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. 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.	F 000	RECEIVED JUN 13 2014 **F176** Resident # R87 has been reassessed for self administration of medications. Although he can not safely administer his own medications per his physician, he now has orders allowing him to use his nebulizer independently after set up by licensed staff. Weekly observation will be charted to ensure that he remains appropriate. The policy and procedure for Self medication was reviewed and updated. The IDT team and Medical director reviewed and accepted the new policy on 6/19/14 following June QA. The nursing staff initiated education on the self administration of medications on 5/29/14 with completion of all nursing staff by 6/20/14. The facility reviewed all current resident based on BIMS scores any residents scoring cognitively intact were reviewed for wishes to self medicate, these residents were assessed, and orders received and care plans updated.	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. POC accepted Stfanto 6/24/14 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the safe practice of self-administration of medications for 1 of 1 resident (R87) who was observed self-administering a nebulizer treatment. Findings include: On 5/14/14, at 11:03 a.m. a trained medication aide (TMA)-B was observed to set up a nebulizer (drug delivery system used to administer medication in form of a mist inhaled into the lungs) medication treatment for R87. The TMA-B was gave R87 the hand-held device, turned on the nebulizer machine and left the room. TMA-B	F 176		

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

Heather Hauger — Administrator — 6/12/14

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

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F 176	Continued From page 1 stated R87 was "pretty independent so I leave him and will check in about three minutes." At 11:12 a.m. R87 came out of his room and asked if someone could "check the bottle" (nebulizer). TMA-B reported it was empty, and the resident then left the room. R87's current physician's order dated 3/1/13, directed staff to administer ipratropium albuterol (for Duoneb for treatment of brochospasms) 0.5-3 mg/3 ml (milligram/milliliter) via nebulizer twice daily. R87's orders did not include approval by the physician for self-administration of medication. R87's Minimum Data Set (MDS) dated 7/26/13, indicated the resident had mental errors including sequencing problems incomplete performance and anxiety limitations. R87 also was noted for increased confusion, forgetfulness and a decline in cognitive status. The care plan for R87 dated 4/11/14, indicated the resident had diagnoses including chronic obstructive pulmonary disease (COPD) and was on hospice for hospice for end of life needs. Staff was directed to administer respiratory medications as ordered. The care plan did not indicate R87 was able to self-administer medication. On 5/15/14, at 8:30 a.m. the director of nursing (DON) explained that R87 had never been assessed to self-administer medications, nor did R87 have a doctor's order to self-administer medications. The Medication Administration General Guidelines policy revised 3/14, indicated	F 176	Upon admissions all new resident will be assessed using the facility policy. The policy includes monthly review by licensed staff to ensure that the self administration of medication remains appropriate. Results of audits will be reported to the QA committee monthly for 6 months then ongoing as needed. The director of nursing or designee is responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is 6/25/14.	

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F 176	Continued From page 2 residents were allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administering of medications.	F 176	F226 ADON was removed from the schedule and employment background check resubmitted 5/16/14. The policy and procedure for background screening has been reviewed and is accurate. Appropriate follow-up with responsible individual for completion of background check submission on 6/19/14. The New hire checklist has been updated and initiated on new hires going forward. Education on policy and procedure for background screening and new hire checklist has been completed on 6/12/14. Criminal Background Checks and Reference Checks Audits on 10 most recent hires completed 6/20/14 with results reported to Quality Assurance for ongoing compliance and will determine the need for further auditing. The Administrator or designee is responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is 6/25/14.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow its policy regarding completion of background checks on 1 of 5 employees' files (ADON) reviewed for new hire documentation. Findings include: A review of the facility's undated policy titled Background Screening Investigations indicated employment background checks and criminal conviction checks would be completed for individuals completing an employment application with the facility. However, this policy was not followed for 1 of 5 employees hired 12/5/13 to 5/5/14. A review of employee files revealed the facility failed to ensure a criminal background check for the assistant director of nurses (ADON), hired on 2/23/14, had been completed.	F 226		

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F 226	Continued From page 3 On 5/6/14, at 10:32 a.m. the administrator verified the facility did not have documentation of a criminal background check having been completed for the ADON. The administrator stated she had been informed by the outgoing administrator that the ADON's name had been submitted incorrectly, and upon rejection it had been resubmitted. However, the administrator stated they were unable to find the documentation.	F 226		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to adapt and accommodate the nocturnal lifestyle pattern of 1 of 1 resident (R7) who slept during normal mealtimes. Findings include: R7's past and current lifestyle was to sleep during the day and be awake at night. The facility failed to provide nutritional meals during the night time to meet the resident's his food preferences and nutritional needs. While the resident was encouraged to stay up in the morning for	F 246	**F 246** Resident R7 had his lifestyle and current weights, and labs all have been reviewed. Resident R7 received nutritional foods that meet his needs, on trays during the day and foods of his choice during his awake hours at night. Nursing staff encourage and monitor food intake during the night. Meal trays are offered and food items that Residents R7 may choose to keep for later are refrigerator for consumption. Foods are labeled and dated. Resident R7 has weekly monitoring of his weight with review by the Clinical team, along with food acceptance documentation and nurses notes. Through interview, weight review and use of Point of Care documentation the registered dietitian and director of nurses flagged all resident that had weight loss and food acceptance at less	

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F 246	Continued From page 4 breakfast, and an egg salad sandwich was provided for consumption during the night, all other meals were provided at traditional times at 11:20 a.m. and 5:05 p.m. A nursing health note completed on 5/4/14 at 3:26 p.m. revealed R7 had lost 20.8 pounds in the previous six months. The noted included a few of R7's food preferences were listed, as well as the provision of nutritional supplements. R7's Minimum Data Set (MDS) assessment dated 5/12/14 revealed he was cognitively intact, and did not present mood or behavioral issues. The resident was listed as 68 inches tall and weighed 138 pounds, down from 160 pounds from a previous assessment dated 12/14/13. R7 stated in an interview on 5/13/14, at 10:29 a.m. that he preferred to go to bed at 7:00 a.m. sleep through the day and then get up for the night at around 9:00 p.m. As far as food provided and his preferences, R7 said he loved omelets (on the menu that morning), ate cottage cheese, and family members provided pop and cheese snacks/crackers. He did not eat muffins or hot cereal that was typically served for breakfast. He usually slept through lunch and supper and staff left food trays at mealtimes should he wake up to eat. R7 stated he looked at the food on the tray and if he did not like it, he would not eat it. Every night he was to receive an egg salad sandwich on white bread, but no sandwich had been provided during the previous night. R7 stated on 5/15/14, at 6:35 a.m. that he again had not been provided a sandwich during the night, and had eaten Cheetos and pop. When asked if he planned to have breakfast he reported	F 246	than 25% more than 2 times a week. These resident have been addressed to ensure there needs are being met. Education provided to nursing staff on 5/29/14 with completion by all nursing staff by 6/20/14 related to both weight and Point of Care documentation to ensure that lifestyle choices are being addressed. The parameters of safe meal storage for later consumption were also addressed. The registered dietitian with the director of nursing will ensure the system for flagging residents are audited weekly for additional needs. Results of audits will be reported to the QA committee monthly for 6 months then ongoing as needed. The director of nursing or designee is responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is 6/25/14.	

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F 246	Continued From page 5	F 246		

he did not care for what was on the menu. When what he would liked to eat he said a ham and cheese omelet and sausages. At 6:37 a.m. LPN-A was informed of R7's request and LPN-A stated she would contact the kitchen. At 6:40 a.m. LPN-A stated she had called the kitchen and was told that the kitchen could not make R7's requested food items.

On 5/15/14, at 6:45 a.m. the dietary manager (DM) was interviewed about R7's request for an omelet and sausages. The DM explained that with advanced notice he could have made the omelet, and the sausages were frozen. When asked if R7 could have just received an omelet the DM said the kitchen staff was busy, but would be able to make it later. The DM was asked what he knew about R7 and stated, "not much." Cook (C)-A was present and reported knowing R7 had been losing weight, and a sandwich was prepared every day for the resident to eat at night. C-A was aware this was the resident's usual nighttime pattern. The DM then stated he would make the omelet for the resident. At 7:45 a.m. R7's omelet arrived with the unit breakfast trays and by 8:30 a.m. R7 had consumed the entire omelet.

On 5/15/14 at 6:50 a.m. LPN-B stated she knew R7 liked egg salad sandwiches, but when she arrived to work at 11:00 p.m. on 5/14/15, there was no sandwich available. LPN-B stated that during the night R7 had consumed Cheetos, pop, chocolate mint patties and two glasses of Boost. LPN-B was unaware whether the option of saving meals to reheat later had been discussed. LPN-B said she had known R7 since his admission more than a year ago, and he had always slept during the day.

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F 246	Continued From page 6 RD-A was interviewed regarding R7 on 5/15/14, at 9:33 a.m. Mealtimes had not been accommodated to promote good nutrition and in accordance with R7's preferred lifestyle with the exception of adding the nighttime sandwich, which RD-A was unaware was sometimes unavailable. R7 was usually served items what was listed on the menu, and the only breakfast preferences RD-A was aware of was Fruit Loops and cottage cheese. According to facility policy, special requests were prepared for a resident with advance notice, but RD-A did not define what was considered advance notice. Food likes/dislikes were printed out on dietary cards as special requests, and the notation of preferences was only available through the dietary department's computer system. RD-A stated R7's meals were sent up during the day only and, "It's something we need to address." On 5/15/14, from 12:00 to 2:00 p.m. a meal tray consisting of an egg salad sandwich, cottage cheese, apple juice and milk was observed on an over-bed tray table in R7's room. R7 was lying in bed with his eyes closed and had not responded to the knock on the door or to his name being called out. The food had not been consumed during this observed time period.	F 246		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and	F 325	**F325** Resident R7 had his lifestyle and current weight, labs all have been reviewed. Resident R7 has weekly monitoring of his weight with review by the clinical team, along with food acceptance documentation and nurses notes. Resident R7 care plan has been updated to address current interventions.	

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F 325	Continued From page 7 (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate measures were implemented to maximize nutrition and minimize weight loss for 1 of 3 residents (R7) identified as experiencing weight loss. Findings include: R7's weights documented in the electronic health record revealed that in six months, from 11/4/13 to 5/7/14, R7 experienced a significant 15.9% weight loss and from 4/1 to 5/7/14 an 8.7% weight loss. R7's monthly weights documented in the electronic health record were as follows: 11/4/13--150 pounds (#); 12/8/13--157#; 1/2/14--150.6#; 2/1/14--147#; 3/1/14--156.6#; 4/1/14--150.2#; and 5/7/14--138.2#. The care plan revised 2/17/14, indicated R7's weight loss could have been due to a history of excessive fluid intake, as well as pop and junk food in place of meals. Prior to the weight loss it was noted R7 had been above his ideal body weight. The plan was for staff to monitor food intake, sleep patterns and activity in the building. There was no documentation in the care plan indicating R7 had been made aware of the risks of eating junk food in place of meals. The care plan also did not include the approach of additional nutrtional supplementation.	F 325	Through interview, weight review and use of Point of Care documentation the registered dietitian and director of nurses flagged all resident that had weight loss and food acceptance at less than 25% more than 2 times a week. These resident have been addressed to ensure there needs are being met. Education provided to nursing staff initiated on 5/29/14 with all staff to be completed by 6/20/14 related to both weight and Point of Care documentation to ensure that weight loss are being identified timely. The registered dietitian with the director of nursing will ensure a system for flagging residents are audited weekly for additional needs. Results of audits will be reported to the QA committee monthly for 6 months then ongoing as needed. The Registered Dietitian or designee is responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is 6/25/14.	

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F 325	Continued From page 8 An health note by a registered dietitian (RD) on 2/18/14, revealed R7 had shown mild weight loss, was within usual body weight, staff documentation showed good meal intake and the resident consumed snacks and pop. "No new nutritional interventions at this time." If weight loss continued an assessment for nutritional support would be needed. Although the resident experienced weight loss after 2/18/14, no further nutritional assessments had been completed by the RD. A physician's noted R7's weight loss on 3/12/14 and ordered a laboratory (lab) work up. The results of the lab work was relayed to the physician according to a handwritten note on the 3/12/14 lab report. The lab results revealed R7's albumin was low at 2.4 (normal listed as 3.4-5, low hemoglobin of 10.2 (normal 13.4-17.5) and low hematocrit of 31.8 (normal 39-51). Previous physician orders revealed an order dated 1/9/13, for Cerovite Advanced Formula vitamin, 1 tablet daily and a calcium supplement of Oscal 550 milligrams with vitamin D, 1 tablet twice daily. However, here were no new physician orders based on the low albumin result and no order for a nutritional supplement (such as Boost or Mighty Shake). A health note written by the assistant director of nurses (ADON) on 5/4/14, at 3:26 p.m. revealed R7 had lost 20.8 pounds in the previous six months. Food likes were identified as: hamburger and chicken patties, tuna and egg salad sandwiches, and R7 received Boost and Mighty Shake supplements. While R7 was served breakfast and lunch, those meals were not consumed as R7 "was asleep." It was noted the	F 325		

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F 325	Continued From page 9	F 325		

resident was without teeth, refused to wear dentures, and had declined offers for dental visits. The plan was to suggest kitchen staff provide tuna or egg salad sandwiches and encourage the resident to eat the sandwich and consume the Boost/Mighty Shakes. Staff was to document R7's food intake.

Despite ADON's request for the dietary staff to provide a nightly sandwich, there were documented times when the sandwich was unavailable, but it had not been determined why. A health note dated 5/7/13, at 2:34 a.m. revealed there had been no egg or tuna salad sandwiches available on the night shift and instead a turkey sandwich was offered. R7 declined the sandwich explaining he could not chew it. A message was left for the dietary manager to make sure R7 had tuna or egg salad sandwiches every night. The following day a health note at 6:59 a.m. read that there was "no food available on the nurses floor for resident" and dietary staff was asked to prepare food for R7 to eat at night.

R7's Minimum Data Set (MDS) assessment dated 5/12/14 revealed he was cognitively intact, and did not present mood or behavioral issues. The resident was listed as 68 inches tall and weighed 138 pounds, down from 160 pounds from a previous assessment dated 12/14/13.

R7 stated in an interview on 5/13/14, at 10:29 a.m. that his preference was to go to bed at 7:00 a.m. sleep through the day, and then get up for the night at around 9:00 p.m. As far as food provided and his preferences, R7 said he loved omelets (on the menu that morning), ate cottage cheese, and family members provided pop and cheese snacks/crackers. He did not eat muffins

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 325	Continued From page 10	F 325		

or hot cereal that was typically served for breakfast. He usually slept through lunch and supper. Facility staff left food trays in his room at meal times of 11:20 a.m. and 5:05 p.m. should he wake up to eat. R7 stated he looked at the food on the tray and if he did not like it, he would not eat it. Every night he was to receive an egg salad sandwich on white bread, but no sandwich had been provided during the previous night.

A note on 5/14/14, at 6:20 a.m. revealed R7's egg salad sandwich had not been available during the night and R7 had consumed Cheetos and two cans of pop. On 5/14/14, at 4:30 p.m. an egg salad sandwich wrapped in plastic and bearing R7's name was observed in the unit snack refrigerator. The presence of the sandwich was verified by licensed practical nurse (LPN)-C and nursing assistant (NA)-B. The sandwich was again noted as unavailable during the nightshift 11:00 p.m. 5/14/14 to 7:00 a.m. 5/15/14.

R7 stated on 5/15/14, at 6:35 a.m. that he had not been provided a sandwich during the night, and had eaten Cheetos and pop. When asked if he planned to have breakfast he reported he did not care for what was on the menu. When what he would liked to eat he said a ham and cheese omelet and sausages. At 6:37 a.m. LPN-A was informed of R7's request and LPN-A stated she would contact the kitchen. At 6:40 a.m. LPN-A stated she had called the kitchen and was told that the kitchen could not make R7's requested food items.

At 6:45 a.m. the dietary manager (DM) was then interviewed about making the omelet and sausages for R7. The DM explained that if they had received advance notice he could made the

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 _____	05/15/2014

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 325	Continued From page 11 omelet, and the sausages were frozen. When asked if R7 could have just received an omelet, the DM said the kitchen staff was busy, but would be able to make it later. The DM was asked what he knew about R7 and stated, "not much." Cook (C)-A was present and reported knowing R7 had been losing weight, and a sandwich was prepared every day for the resident to eat at night. C-A was aware this was the resident's usual nighttime pattern. The DM then stated he would make the omelet for the resident. At 7:45 a.m. R7's omelet arrived with the unit breakfast trays and by 8:30 a.m. R7 had consumed the entire omelet. On 5/15/14 at 6:50 a.m. LPN-B stated she knew R7 liked egg salad sandwiches, but when she arrived to work at 11:00 p.m. on 5/14/15, there was no sandwich available. LPN-B then left a message for dietary staff to that effect. LPN-B stated that during the night R7 had consumed Cheetos, pop, chocolate mint patties and two glasses of Boost. LPN-B stated attempts were made to encourage R7 to stay up later and to eat breakfast because of weight loss. When asked whether saving prepared noon and/or evening meals for R7 to reheat and consume later, LPN-B was unaware whether the option had been discussed. On 5/15/14 at 2:30 p.m. LPN-C was asked if R7 had consumed the sandwich before the night shift had arrived at 11:00 p.m. on 5/14/14. LPN-C stated NA-B had offered the sandwich to R7 at 10:15 p.m., but R7 had declined the sandwich stating he planned to eat it during the night. LPN-C did not know what had happened to the sandwich between 10:15-11:00 p.m. the night of 5/14/14.	F 325		

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	245182	A. BUILDING _____ B. WING _____	05/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 325	Continued From page 12 RD-A was interviewed regarding R7 on 5/15/14, at 9:33 a.m. RD-A reported she was aware of the loss and considered it to be "mild," and at the time of the 2/18/14 assessment R7 had adequate nutrtional needs. R7's weight had been discussed weekly during "Grand Rounds," however, a nutritional reassessment including recent losses and abnormal laboratory results had not been completed. RD-A stated that on 5/5/14 a trial of 1/2 an egg salad sandwich for a night time snack was initiated. Based on night shift documentation R7 was consuming the sandwich, it was increased on 5/9/14, to a whole sandwich with cottage cheese added to meal trays per the resident's request. RD-A said the nutritional risks of largely eating cheese snacks and pop had not been discussed with the resident. RD-A stated R7's meals were sent up during the day only and, "It's something we need to address." Meal consumption was recorded by NAs at the end of each meal. RD-A did not know if nursing staff had offered to hold a tray from the daytime meals for reheating. RD-A was aware R7 sometimes slept through the day, and staff had R7 to stay up for breakfast. Mealtimes had not been accommodated to promote good nutrition and in accordance with R7's preferred lifestyle with the exception of adding the nighttime sandwich, and RD-A was unaware the sandwich was not always unavailable. R7 was usually served items what was listed on the menu, and the only breakfast preferences RD-A was aware of was Fruit Loops and cottage cheese. According to facility policy, special requests were prepared for a resident with advance notice, but RD-A did not define what was considered advance notice. R7's meal intake documentation dated 3/5 to	F 325		

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	245182	A. BUILDING _____ B. WING _____	05/15/2014

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

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F 325	Continued From page 13 5/14/14, revealed that of 209 traditionally served meals, 72 meals were marked as refused, and 89 meals were marked as R7 having consumed from 0-25%. According to the medical director on 5/14/14, at approximately 2:00 p.m. R7's low albumin level of 2.4 was related to poor nutrition.	F 325	F332 Residents R65 and R87 have had their medications sheets updated to include appropriate instructions. TMA-B had additional education r/t timing of medication on 6/13/14.	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were administered at an error rate of no more than 5% for 2 of 4 residents (R65, R87) whose medication administration was observed. The facility medication error rate was 8.75%. Findings include: During the medication pass observed on 5/14/14, at 8:10 a.m. a trained medication aide (TMA)-B prepared medications for R65. TMA-B the administered levothyroxine as well as six other oral medications to R65. The 5/14 current physician's order sheet revealed an order written 11/24/13, for levothyroxine (used to regulate thyroid function) 100 micrograms (mcg) by mouth daily "before breakfast." At 8:32 a.m. TMA-B prepared nine medications	F 332	The facility pharmacy reviewed all medication orders and identified resident with medications need specific administration times. June medication sheets now reflect times of administration medication per manufacture directions. All nursing staff and medical records staff reviewed information related to timing of medications 5/29/14 with all staff to be completed by 6/20/14. The facility added additional hours to licensed staff to facilitate the need for additional medication passes. The facility pharmacy will provide updated list of resident on specific medications monthly. The DON or designee will review medication sheets monthly for compliance.	

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	245182	A. BUILDING _____ B. WING _____	05/15/2014

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F 332	Continued From page 14 for R87 including omeprezole (for gastroesophageal reflux disease) and levothyroxine. The 5/14 current physician's order sheet revealed an order for omeprezole 20 milligrams (mg) by mouth daily--"take 30 minutes before a meal" and an order for levothyroxine sodium 50 mcg by mouth daily. Both orders were written 3/1/13. During an interview on 5/14/14, at 8:45 a.m. TMA-B verified R65 and R87 had received their medications after having eaten breakfast versus before a meal as prescribed. TMA-B stated that although he tried to give R65's levothyroxine and R87's omeprezole before breakfast, it "gets hectic" and he was not always able to do so. He explained that facility policy prohibited medication administration while residents were eating, therefore, he had to occasionally wait until a resident was finished eating breakfast and had left the dining room. TMA-B stated he was never instructed to administer levothyroxine to R87 prior to eating breakfast. On 5/14/14, at 2:00 p.m. the director of nursing (DON) stated she expected TMAs to follow physician orders as written on the medication administration record, and to report and clarify with the licensed nurse in charge if there were questions. The DON expected levothyroxine to be given prior to breakfast. Nursing staff was to be aware and clarify orders that did not follow that practice. Product information at https://www.synthroid.com/prescription/tips.aspx revealed levothyroxine should have been taken on an empty stomach, and it was best to take the medication 30 to 60 minutes before eating	F 332	The DON or designee will do a 10% audit of medication passes per month. Results of audits will be reported to the QA committee monthly for 6 months then ongoing as needed. The director of nursing or designee is responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is 6/25/14.	

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	245182	A. BUILDING _____ B. WING _____	05/15/2014

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 332	Continued From page 15 breakfast.	F 332	**F371**	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure food was prepared and distributed under sanitary conditions related to poor equipment cleaning and dish washing temperatures not documented on a daily basis. This had the potential to affect all 70 residents in the facility served from the kitchen. Findings include: On 5/12/14, at 12:00 p.m. the initial kitchen tour was conducted with the interim dietary director (DD). The insides and outsides of four ovens and two stove tops were unclean, with a build up of food, grease and grime. The DD stated, "They are a work in progress and need to be deep cleaned." Flooring throughout the general kitchen area, as well as in the walk-in cooler and freezer was dirty and had not been routinely cleaned. The DD verified the facility did not have a routine cleaning schedule, and was unable to verify the	F 371	The facility ensures that food is prepared and distributed under sanitary conditions. Equipment cleaning and dish washing temperatures are documented on a daily basis. In-services have been taught to the staff related to Sanitation, 3 compartment sink, and dish machine. These in-services included why we do these things, how to do them and when they should be done. Education was initiated on 6/10/14 with all current staff to be completed by 6/20/14. Deep clean schedules have been posted and monitored to ensure that sanitation is being done. Staff has been educated on clean as you go procedure. Daily audits to ensure that the floors (in all areas) and logs are being completed, as well as general sanitation. Sanitation and unit inspection are also done on a monthly basis.	

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	245182	A. BUILDING _____ B. WING _____	05/15/2014

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 371	Continued From page 16 last time the ovens, stoves, and flooring had been cleaned. On 5/14/14, at 11:00 a.m. the DD provided a documented titled, Area and Equipment Cleaning Frequency that directed staff to clean the ovens and stove tops daily, as well as with grease cutter or oven cleaner weekly. Floors were to be cleaned daily.	F 371	Results of audits will be reported to the QA committee monthly for 6 months then ongoing as needed. The Registered Dietitian or designee is responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is 6/25/14.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431	**F 431** All expired medication were removed and reordered during the survey. R 46, R47, R67 R76, R99, R126, and R128 had new two step Manitou's completed. R127 discharged from the facility before completed.	

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F 431	Continued From page 17 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper handling of multi-use injectable medications for 1 of 1 resident (R40) whose insulin had expired, and potentially affecting 8 of 9 recently admitted residents (R46, R47, R67, R76, R99, R126, R127, R128) who were tested for tuberculosis. Findings include: On 5/12/14, at 12:38 p.m. the facility's medication storage system was observed. The medication cart on unit 4 had one opened vial of Lantus insulin (used to treat diabetes) for R40. The insulin was dated 4/9/14. A licensed practical nurse (LPN)-F verified the date and stated Lantus was effective for 32 to 36 days after opening. LPN-F also verified no other insulin was available in the facility for R40. An interview on 5/12/14, at approximately 2:15 p.m. with the assistant director of nursing (ADON) she clarified Lantus was effective for 28 days after opening, and should be discarded after 28 days. The ADON verified R40 had received the expired Lantus insulin from 5/8/14 through 5/11/14. The Omnicare Recommended Minimum	F 431	Nursing Staff reviewed the Omnicare Recommended minimum Medication Storage Parameters and the need to date medications when opening them at the 5/29/14 meeting with all staff to have reviewed no later than 06/20/14. The facility now does whole house expired medication audits q week. This is completed by licensed staff on each station. The DON or designee will audit medication cart bi weekly. Results of audits will be reported to the QA committee monthly for 6 months then ongoing as needed. The director of nursing or designee is responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is 6/25/14.	

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F 431	Continued From page 18 Medication Storage Parameters (based on manufacturer guidance) Injectable Medications, revised 3/31/14, directed staff to date Lantus when opened and discard unused portions after 28 days. The unit 2 nursing station refrigerator was observed to contain Aplisol serum (used to aid in diagnosing tuberculosis) on 5/12/14, at 4:00 p.m. The serum, lot number 699227, was not marked when opened and had minimal solution remaining in the vial. LPN-E verified the presence of Aplisol left in the vial and stated all newly admitted residents, as well as newly hired employees had received the serum, unless contraindicated. On 5/12/14, at 4:45 p.m. the administrator stated Aplisol, lot number 699227, was received in the facility on 3/11/14, and no other tuberculin testing solutions had been used through 5/12/14. The administrator provided a list of new admissions of R46, R47, R67, R76, R99, R126, R127, R128, who had all received the Aplisol, lot number 699227. The administrator stated all multi-use medications were to be dated when opened, discarded per house policy and manufacturer's guidelines. She verified Aplisol should have been discarded 30 days after opening. The Omnicare Recommended Minimum Medication Storage parameters (based on manufacturer guidance) Injectable Medications, revised 3/31/14, directed staff to date Aplisol when opened and discard unused portion after 30 days. On 5/13/14, at 12:25 p.m. the consulting pharmacist from Omnicare was interviewed regarding the dating of multi-dose medications.	F 431		

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	245182	A. BUILDING _____ B. WING _____	05/15/2014

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F 431	Continued From page 19 The consulting pharmacist explained that Omnicare guidelines directed staff to date all multi-use medications after opening and discard unused portions after the effective date, and Aplisol and Lantus insulin should have been discarded 28 days after opening.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	**F441** The Facility reviewed the policy and procedure for blood sugar testing and current manufactures recommendations. The supplemental staff most responsible was addressed on 5/15/14 personally and with her agency. The director of nurses completed the assure platinum operator certification training on 6/10/14 with the Arkry representative. Education was initiated with licensed staff on 5/29/14. Nurses through the use of the Manufactures competency checklist to be completed by 6/20/14. When supplemental staff are used the House Charge or DON/designee will complete the Manufactures competency checklist, the completed competency will be retained in the House charge book.	

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

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F 441	Continued From page 20 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the multi-use glucometer (device used to obtain blood-glucose levels) was disinfected according to acceptable standards minimize the spread of infection for observations of glucose testing for 3 of 3 residents (R8, R57, R121), as well as potentially affecting two other residents on the unit who had glucose testing. Findings include: The multi-use glucometer was not disinfected in accordance with acceptable standards and facility policy between residents' use. In addition, proper hand washing technique was not followed to minimize the potential for spread of infection. On 5/12/14, at 5:33 p.m. a licensed practical nurse (LPN)-D washed her hands, donned gloves and performed a blood glucose test for R121. When finished she removed the gloves and left the room without washing her hands. She placed the glucometer in the top drawer of the medication cart without disinfecting it. At 5:38 p.m. LPN-D removed the glucometer from the top drawer of the medication cart and proceeded into R8's room. She donned gloves	F 441	The DON or designee will audit cleaning of glucometers on one unit bi weekly. Results of audits will be reported to the QA committee monthly for 6 months then ongoing as needed. The director of nursing or designee is responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is 6/25/14	

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	245182	A. BUILDING _____ B. WING _____	05/15/2014

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

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F 441	Continued From page 21 without washing her hands. The surveyor intervened to stop LPN-D prior to testing for R8 at 5:41 p.m. LPN-D said she was unaware of the facility's policy regarding proper disinfecting of glucometers between resident use. She reported that in other facilities where she had worked, the nightshift staff cleaned the glucometers. LPN-D reported she had not received any education or training regarding the use and cleaning of glucometers used by more than one resident, and was a pool nurse who had worked at the facility in the past. LPN-D then cleaned the glucometer with Super Sani Wipes, allowing the germicide to remain on the meter for greater than two minutes. LPN-D again entered R-8's room at 5:48 p.m. washed hands, donned gloves and performed a glucometer check for R-8. LPN-D removed the gloves and washed her hands and left the room. Without first disinfecting the glucometer, LPN-D placed it in the top drawer of the medication cart. At 5:53 p.m. LPN-D entered R57's room, washed her hands, and donned gloves. At 5:56 p.m. the surveyor again intervened to stop the procedure, and LPN-D was informed the glucometer had not been cleaned between R8 and R57. LPN-D asked, "It wasn't?" The glucometer was then taken to the medication cart and cleaned with Super Sani Wipes, allowing the solution to remain on the meter for two minutes. An interview with the assistant director of nursing (ADON) on 5/12/14, at 7:20 p.m. revealed the expectation was for staff to clean glucometers with Super Sani disinfectant wipes. The machines were to be cleaned after each use because they were used for more than one resident. The ADON also expected staff to wash their hands before	F 441		

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	245182	A. BUILDING _____ B. WING _____	05/15/2014

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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) COMPLETION DATE
F 441	Continued From page 22 and after each glove change. The facility's Policy and Procedure For Blood Sugar Test updated 2/11/10, directed staff to: Wash hands, put on clean gloves, perform test, remove gloves, wash hands, put on clean gloves use germicidal wipe to clean glucometer, place meter into drawer, remove gloves and wash hands.	F 441		

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

F5182024

PRINTED: 05/27/2014
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 _____	05/19/2014

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

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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. At the time of this survey, Westwood Health Care Center 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 By email to:	K 000	**K067** There are smoke detectors, heat detectors, and sprinklers throughout the building. Staff are drilled monthly on responding to fires. A waiver is requested for K067 and is attached. POC ok w/AW for K67 TS 6-19-14 RECEIVED JUN 17 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Dq: 6-25-14

EXIT 5-16-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nicole Heyer	Administrator	6/12/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245182	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**05/19/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Barbara.Lundberg@state.mn.us and Marian.Whitney@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. Westwood Health Care Center 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 102 beds and had a census of 74 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
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	K 067		

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 _____	**05/19/2014**

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

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K 067	Continued From page 2 This STANDARD is not met as evidenced by: Based on observations and 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 residents. Findings include: On facility tour between 9:30 AM and 11:00 AM on 05/19/2014, 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 maintenance director at the time of the inspection.	K 067		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 5088

May 28, 2014

Ms. Heather Heijerman, Administrator
The Villa at St Louis Park
7500 West 22nd Street
Saint Louis Park, Minnesota 55426

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5182024

Dear Ms. Heijerman:

The above facility was surveyed on May 12, 2014 through May 16, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring 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:

Gayle Lantto, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: gayle.lantto@state.mn.us
Telephone: (651) 201-3794
Fax: (651) 201-3790

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure(s)
cc: Original - Facility
Licensing and Certification File

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Thursday, June 19, 2014 10:35 AM
To: 'rochi_lsc@cms.hhs.gov'
Cc: robert.rexeisen@state.mn.us; 'Heather Heijerman'; Dietrich, Shellae (MDH); 'Fiske-Downing, Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Kleppe, Anne (MDH); Leach, Colleen (MDH); Meath, Mark (MDH); Zwart, Benjamin (MDH)
Subject: The Villa at St Louis Park (245182) 2014 K67 Annual Waiver Requst - Previously Approved - No Changes

This is to inform you that The Villa at St Louis Park is again requesting an annual waiver for K67, corridors as a plenum. The exit date was 5-16-14.

I am recommending that CMS approve this waiver request.

Patrick Sheehan, Fire Safety Supervisor
Office: 651-201-7205 Cell: 651-470-4416
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division Est. 1905
445 Minnesota St., Suite 145, St Paul, MN 55101-5145
FAX: 651-215-0525
Web: fire.state.mn.us

Name of Facility **2000 CODE**

The 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
K84 K67 The building Heating, Ventilation and Air Conditioning (HVAC) Equipment does not comply with the Life Safety Code (00), Section 9.2, and NFPA 90A, 1999 Edition, because the corridors are being used as a plenum. 1 of 2	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 6/11/14. is $448,000.00 and will include the upgrade of the following systems; Install 3 new rooftop units and reconfigure one existing unit. Duct work to run on rook and penetrate above resident rooms. Plus an additional $23,000.00 to install sheetrock enclosures and 23 verticle ducts in resident rooms. 2. Installing a complying HVAC system will force disruption to the facility residents by displacing durign 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 b e nagatively 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 past five years. Additionally, per Minnesota code, 2 elevator jacks must be replaced by 2015. This cannot be delayed or canceled and is scheduled for 2014. The current estimate for this project is $66,000. 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 5% over 20 years would add $261,548 in interest to the cost of the project. The annual cash burden for this load would be $35,479.20. 5. The building is 44 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 openings resist the passage of smoke. 3. The following life safety features are installed; Notifier fire alarms throughout, Reliable and Tyco brand

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title **Fire Safety Supervisor**	Office **State Fire Marshal**	Date 6-19-14

Name of Facility
The Villa at St. Louis Park

2000 CODE

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
K84 K67 The building Heating, Ventilation and Air Conditioning (HVAC) Equipment does not comply with the Life Safety Code (00), Section 9.2, and NFPA 90A, 1999 Edition, because the corridors are being used as a plenum. 7 of 2	*Continued from previous page* An annual/continuing waiver is being requested for K-67. 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. 5. There are 4 smoke compartments per floor of the facility. 6. Current facility staff to resident ratio is 3.03. 7. The facility is of two floor concrete, spancrete, and brick construction 8. Our building is two floors with about 10 on the first floor and 63 on the 2nd floor. We do have a TCU unit on the first floor and Long-term care on the 2nd floor. 9. The closest fire department is 1 mile away and has an average response time of five minutes or less.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title Fire Safety Supervisor	Office State Fire Marshal	Date

GILBERT

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

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

Company:	The Villa at Saint Louis Park	Date:	06/11/14 (revised from 04/29/13)
Street:	7500 West 22nd Street	Project:	Westwood Health Care – Ducted
City/State:	Saint Louis Park, MN 55426		Fresh Air to Resident Rooms
ATTN:	Kent Netzer	Pages	2

Proposal

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

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

Amount: $448,000.00 (budget price)

Add: $600.00 to $1,600.00 for structural engineering. This should not be necessary but the city may require it.

Add: $23,000.00 (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 $5,000.00?)

Exclusions:
Work to be performed during normal working hours.
We have not included any asbestos abatement.
Pricing is based on 2014 installation costs.

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

Proposed By:
Gilbert Mechanical Contractors, Inc.

Date: 6/11/14

Ed Dahlgren
Vice President, PE

Accepted By:

Date:_____

Print Name:_____