



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 22, 2025

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

RE: CCN: 245182
Cycle Start Date: January 9, 2025

Dear Administrator:

On January 9, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Stefanie Salberg, Regional Operations Supervisor
Metro B District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by April 9, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 9, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

The Villas At St Louis Park

January 22, 2025

Page 4

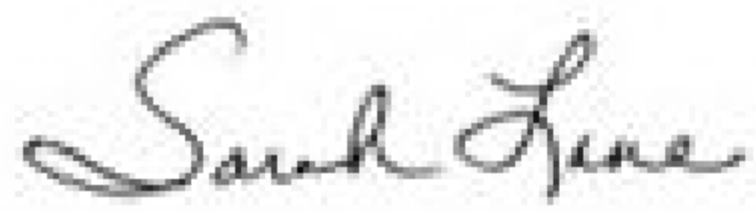
A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 22, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: CHMP11

Dear Administrator:

The above facility was surveyed on January 6, 2025 through January 9, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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

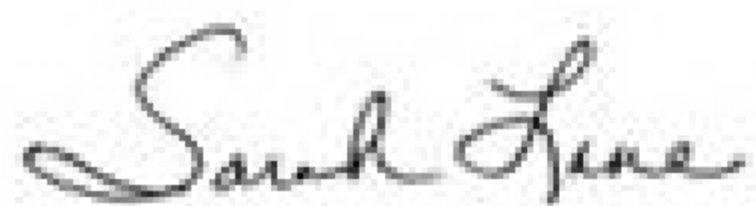
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting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

Stefanie Salberg, Regional Operations Supervisor
Metro B District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

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

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments On 1/6/25 - 1/9/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS On 1/6/25 - 1/9/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H51826428C (MN00100294) H56297162C (MN00101015) H51826427C (MN00101739) H51826425C (MN00103001, MN00103061) H51823843C (MN00107458) H51824484C (MN00109672) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/28/2025

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

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

PRINTED: 02/03/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	Continued From page 1	F 000			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656			2/14/25

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

PRINTED: 02/03/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245182		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page 2 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive, person-centered care plan was developed to assure individualized interventions and resident-specific targeted behavior monitoring was completed for 1 of 2 residents (R32) reviewed for mood and behavior. Findings include: R32's admission Minimum Data Set (MDS) dated 12/20/24, indicated R32 was cognitively intact, had no behaviors or rejection of cares, was independent with eating and rolling left and right, and required substantial and/or maximum assistant with lower body dressing and personal hygiene. R32's MDS did not identify R32 took antipsychotic medications. R32's care plan reviewed 1/6/25, indicated they had an alteration in mood and behavior focus area, and directed staff to document mood state and/or behaviors upon occurrence, redirect prn [as needed], provide emotional support,			F 656	Plan of Correction F656 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident discharged from the facility on 1/7 How will the facility identify other residents potentially affected by the same deficient practice? All residents taking psychotropic medications have the potential to be affected by this deficient practice The measures the facility will take or systems the facility will alter to ensure that		

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

PRINTED: 02/03/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page 3 validation, and comfort measures prn, and MDS section D and/or PHQ 9 [patient health questionnaire which screens for depression] would be conducted per regulation and PRN. The care plan lacked individualized interventions and resident-specific target behaviors to be monitored to determine effectiveness. R32's physician orders identified: -Resident specific targeted behaviors of dry mouth, agitation, headaches, abnormal involuntary movements with directions to chart non-pharmacological interventions, such as redirect and provide one to one time and/or validation, and outcome if interventions were effective or not, with start date of 12/16/24. R32's medication administration record identified medications which included: - Haloperidol (an antipsychotic) oral tablet 2.5 milligrams (mg) by mouth every eight hours as needed for agitation or IM [intramuscular] three times a day as needed for agitation, with start date of 1/3/25 and discontinued 1/7/25. - Haloperidol oral tablet 2.5 milligrams (mg) by mouth every eight hours as needed for agitation or IM [intramuscular] three times a day as needed for agitation for 14 days, with start date of 1/7/25. R32's encounter note with the provider on 12/16/24, indicated R32 was a new patient and took olanzapine (an antipsychotic) oral tablet 2.5 mg at bedtime for dementia with behaviors, with active date of 12/14/24. R32's encounter note with the provider on 12/27/24, indicated R32's olanzapine order had an end date of 12/28/24.	F 656	the problem will be corrected and will not occur: The facility will audit all residents with prescribed antipsychotic to ensure that a person-centered care plan has been developed and individualized interventions are documented. Nurse leadership and the social service department will be educated on target behavior – personalized care plan and monitoring process – to ensure that personalized interventions were included in the residents plan of care and that resident specific target behaviors must be monitored. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Members of the IDT team, including Social Services and Nurse leadership will participate in Target behavior meetings monthly to audit and verify that residents taking psychotropic medications have personalized and applicable interventions and monitoring orders in place. The facility will audit care plans of all new admissions who are prescribed antipsychotics to ensure that a person-centered care plan has been developed and individualized interventions are documented x1 a week for x4 weeks The facility will review the effectiveness of		

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

PRINTED: 02/03/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page 4 During interview on 1/8/25 at 9:13 a.m., nursing assistant (NA)-E stated R32 had mood swings, scratched staff and refused cares. NA-E stated R32 spoke about preaching and religious topics and then would switch to another topic. NA-E was not aware of anything specific to help R32 and tried to talk to R32 and reapproached when R32 had behaviors. During interview on 1/8/25 at 9:00 a.m., licensed practical nurse (LPN)-C stated R32 refused to eat and drink and threw medications and food trays. R32 had paranoia and dementia and thought staff were the "devil". LPN-C stated they tried to talk to R32 calmly and ask another staff to reapproach or updated the provider when R32 had behaviors. LPN-C stated they wrote notes about resident behaviors for providers and other staff to be aware of resident status. During interview on 1/9/25 at 8:33 a.m., NA-A stated behaviors were charted in the computer or in the care plan, or the nurse would tell them about agitated residents and what to do to help them. NA-A stated R32 hallucinated and refused meals and thought the medication and food were poisoned. NA-A stated they talked to R32, gave R32 water, and assisted R32 to watch television to calm them down. When interviewed on 1/9/25 at 9:19 a.m., social worker (SW) stated they were involved in resident's behaviors if reported to them, and their behaviors were discussed during morning meets, but SW mostly connected residents with ACP (associated clinic of psychology) services and updated care plans after ACP visits. SW stated R32 had an order for ACP but refused to sign the consent. SW stated R32 was impulsive and not	F 656	these monthly target behavior meetings and discuss trends and areas of improvement regarding this new process in our monthly QAPI meetings. Date Certain: 2/14/25		

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

PRINTED: 02/03/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245182		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page 5 aware of their surroundings and switched subjects often during conversations. SW was not aware of R32's recent refusals and behaviors. When interviewed on 1/9/25 at 10:48 a.m., clinical managers (CM)-B and CM-C stated they entered resident specific target behaviors into the medication or treatment administration record to monitor. CM-B and CM-C stated they assessed residents' target behaviors by looking at the consent form and reviewing if the resident got dry mouth, agitation, headaches, or other listed items with psychotropic medication use. When interviewed on 1/9/25 at 1:48 p.m., the director of nursing (DON) expected staff to interview residents or representative about target behaviors for psychotropic medications and place monitoring into the treatment administration record and update the care plan. DON agreed the target behaviors listed in R32's orders were medication side effects and stated examples of target specific behaviors included delusions or hallucinations. DON stated documentation of target behaviors were used to monitor if a psychotropic medication was effective. The facility Psychotropic Medication Use policy dated 11/2024, Indicated the care plan would reflect pharmacological and individualized non-pharmacological interventions along with monitoring for efficacy. The care plan will also include monitoring for drug specific side effects such as gait disorders, movement disorders, cognitive or behavioral changes, signs of hypotension or dry mouth.			F 656			
F 684 SS=D	Quality of Care CFR(s): 483.25			F 684			2/14/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page 6 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure interventions of Prevalon boots to both feet were in place for 1 of 1 residents (R44) reviewed for non-pressure skin conditions. Findings include: A diabetic ulcer is an ulcer, often on the foot, caused by a combination of poor circulation and nerve damage in patients with diabetes. R44's quarterly Minimum Data Set (MDS) dated 12/4/24, identified R44 was cognitively impaired, had diagnosis of diabetes mellitus (DM) and dementia, had one stage 2 pressure ulcer, and was dependent on staff for activities of daily living (ADL) and mobility. R44's care plan dated 6/10/24, indicated R44 had an alteration on skin integrity related to a diabetic ulcer due to a diabetic ulcer on the left heel. An intervention revised 12/10/24 indicated R44 was to have Prevalon boot on both heels while in bed. R44's Braden scale assessment dated 12/10/24, identified R44 had slightly limited mobility and	F 684	Plan of Correction F-684 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: R44 Nursing staff have been educated on importance of following resident care plan, to ensure prevlon boots are on both feet while in bed. New care guides implemented on residents' station to indicate prevlon boots needed. Reminder sign was placed in residents' room to have prevlon boots on while in bed. How will the facility identify other residents potentially affected by the same deficient practice? Facility audit, 1 other resident identified who has an intervention of prevalon boots The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page 7 was at risk of developing pressure ulcers. R44's Kardex report undated, indicated R44 was to have Prevalon boots to left and right feet while in bed. R44's clinical physician orders indicated the following orders and start dates: - 12/10/24, Prevalon boot to right and left foot when in bed - 1/7/25, left heel pressure, cleanse with wound cleaner, apply iodine to wound bed, apply gauze and wrap with kerlix daily. R44's wound note dated 12/31/24, identified diabetic ulcer to left heel was stable and measured 0.1 cubic centimeters (cm) x 0.6 cm and had a depth of 0.1 c.m. During an observation on 1/6/25 at 2:51 p.m., R44 was lying on her back in bed, both feet were bare and resting directly on the mattress, and two blue boots were lying in the recliner across the room. During an observation on 1/6/25 at 7:17 p.m., R44 was lying on her back in bed, both feet were bare and resting directly on the mattress, and the two blue boots continued to be lying in a recliner across the room. During an observation on 1/7/25 at 7:55 a.m., R44 was lying on her back in bed, both feet were bare and resting directly on the mattress, and the two blue boots continued to be lying in a recliner across the room. During a joint interview on 1/7/25 ay 7:57 a.m.,	F 684	occur: New care guides created for each nursing station. Prevalon boot intervention will remain on the care guides to ensure that interventions are in place Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: DON or designee will randomly audit residents with prevlon boots to ensure they are on while in bed 2x per week for 2 weeks, and then 1x per week for 2 weeks. Quality Assurance Process Improvement Committee will review this for the next 6 months Date Certain: 2/14		

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

PRINTED: 02/03/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245182		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page 8 nursing assistant (NA)-A and nurse manager (NM)-A verified R44 was lying in bed with both feet directly on the mattress and did not have any boots on her heels. NM stated the expectation was that R44 was to have boots on while she was in bed to heal the current wound on her left heel and prevent any further wounds to her heels. During an interview on 1/7/25 at 11:44 nurse practitioner stated it was very important for R44 to have the heel boots on while in bed to protect and heal her current wound on the left heel and to prevent further skin breakdown to her heels. During an interview on 1/8/25 at 9:33 a.m., director of nursing (DON) verified R44 had a diabetic ulcer to her left heel. DON stated her expectation was that R44 would have had the Prevalon boots to both heels while she was in bed to prevent further skin breakdown. A facility policy titled Skin Assessment and Wound Management revised 7/18, identified when a significant alteration in skin is noted such as a pressure or diabetic ulcer staff would update care plan and implement interventions.			F 684			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.			F 695			2/14/25

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

PRINTED: 02/03/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245182		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 695	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to transcribe and follow an oxygen order consistent with current professional standards of practice for 1 of 1 (R17) resident reviewed for oxygen use. Findings include: R17's quarterly MDS dated 12/5/24, indicated R17 had intact cognition, was dependent on staff for toileting hygiene, required substantial and/or maximal assistance to roll left and right, and had diagnoses of heart failure, urinary tract infection in the last 30 days, asthma, and respiratory failure. The MDS did not note R17's oxygen use. R17's care plan printed 1/7/25, indicated R17 had a focus area of alteration in oxygen and/or gas exchange, respiratory status related to COPD [chronic obstructive pulmonary disease; long disease which causes restricted airflow and breath problems], chronic respiratory failure with hypoxia, restrictive lung disease, and oxygen use. Interventions included monitor oxygen saturation as ordered and prn, administer oxygen as ordered, keep MD [medical doctor] informed of changes, monitor for cyanosis, accessory muscle use, shortness of breath, increased respirations, and difficulty coughing up sputum, head of bed elevated while in bed, encourage frequent rest periods, assist with ADL's [activities of daily living] and mobility as needed, inhaler per MD order, provide diuretic per MD order. An intervention under the focus area of oxygen therapy related to chronic respiratory failure with hypoxia, included continuous oxygen via nasal cannula at 3 liters per minute. Further, a focus area indicated R17			F 695	Plan of Correction F-695 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: R17 Physician order obtained for oxygen, Treatment Administration Record (TAR) and Care Plan have been updated to reflect the current order How will the facility identify other residents potentially affected by the same deficient practice? All residents who returned to the facility from hospital The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The health information department and nurse managers will be educated on the facility process for transcribing hospital orders upon transfer back to the facility. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: DON or designee will randomly audit		

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

PRINTED: 02/03/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245182		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 695	Continued From page 10 had a self-care deficit related to chronic hypoxia with respiratory failure on 4L NC [4 liters via nasal cannula]. R17's physician orders were reviewed on 1/7/25 at 1:46 p.m., lacked an order for oxygen use. R17's discharge orders from North Memorial Health signed 11/29/24, indicated R17 should have had continuous oxygen via cannula with a flow of 3L. During observation and interview on 1/7/25 at 3:17 p.m., R17 was in bed with oxygen on via nasal cannula at 3 liters. R17 stated their oxygen liter flow should be at 3L. During observation and interview on 1/8/25 at 1:30 p.m., licensed practical nurse (LPN)-A stated they provided residents' oxygen according to physician's orders. LPN-B stated R17's oxygen therapy should be at 4 liters per minute (LPM), since R17's oxygen saturation dropped when not at 4 LPM. R17 was in bed with nasal cannula on and head of bed raised, and LPN-A noted R17's oxygen therapy at 2.5 LPM. R17 stated they were not short of breath when LPN-A asked. During interview on 1/9/25 at 1:05 p.m., clinical manager (CM)-A stated R17 had an order for oxygen which was reviewed quarterly and was not sure how the order "disappeared" from the chart. During interview on 1/9/25 at 1:48 p.m., the director of nursing (DON) stated R17 had continuous oxygen and went to the hospital and returned to the facility with oxygen equipment still in their room and verified R17 did not have			F 695	residents returning to facility to ensure order accuracy. 2x per week for 2 weeks, and then 1x per week for 2 weeks. Quality Assurance Process Improvement Committee will review for the next 6 months Date Certain: 2/14		

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

PRINTED: 02/03/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 695	Continued From page 11 current oxygen orders in their chart. DON stated oxygen orders were important to make sure staff knew the appropriate oxygen setting for R17. The Oxygen Policy dated 11/19, indicated if the home care agency accepted responsibility for the ordering, refilling, and administration of oxygen, then oxygen shall be managed in the same manner as an ordered medication, including requiring a physician order.	F 695			
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758			2/14/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245182		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 758	Continued From page 12 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess and identify target behaviors to determine the effectiveness of psychotropic medication for 1 of 1 (R32) resident reviewed for mood and/or behavior. Findings include: R32's admission Minimum Data Set (MDS) dated 12/20/24, indicated R32 was cognitively intact, had no behaviors or rejection of cares, was independent with eating and rolling left and right, and required substantial and/or maximum assistant with lower body dressing and personal hygiene. R32's MDS did not identify R32 took			F 758	Plan of Correction F758 Plan of Correction: How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident discharged from the facility on 1/7 How will the facility identify other residents potentially affected by the same deficient		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 758	Continued From page 13 antipsychotic medications. During document review of R32's care plan on 1/6/25, a focus area indicated R32 had an alteration in mood and behavior. The care plan directed staff to document mood state and/or behaviors upon occurrence, redirect prn [as needed], provide emotional support, validation, and comfort measures prn, and MDS section D and/or PHQ 9 [patient health questionnaire which screens for depression] would be conducted per regulation and PRN. The care plan did not identify Target Behaviors to be monitored. R32's physician orders identified: -Resident specific targeted behaviors of dry mouth, agitation, headaches, abnormal involuntary movements with directions to chart non-pharmacological interventions, such as redirect and provide one to one time and/or validation, and outcome if interventions were effective or not, with start date of 12/16/24. R32's medication administration record identified medications which included: - Haloperidol (an antipsychotic) oral tablet 2.5 milligrams (mg) by mouth every eight hours as needed for agitation or IM [intramuscular] three times a day as needed for agitation, with start date of 1/3/25 and discontinued 1/7/25. - Haloperidol oral tablet 2.5 milligrams (mg) by mouth every eight hours as needed for agitation or IM [intramuscular] three times a day as needed for agitation for 14 days, with start date of 1/7/25. R32's progress notes indicated: -On 12/19/24, R32 refused care, treatments, and evening medications. -On 12/27/24, R32 threw drinks on the floor.	F 758	practice? All residents who are prescribed antipsychotic medication have the potential to be affected by this deficient practice. 21 residents currently residing at the facility The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: Social service department and nurse managers will be educated on the facility's new target behavior meeting format and the meeting process. Target behavior forms will be completed for the residents discussed during the target behavior meeting. Completion of these forms will ensure that the residents are comprehensively assessed, and that the facility has identified target behaviors to determine the effectiveness of psychotropic medication. The facility will audit all residents' who have target behavior monitoring to comprehensively assess and identify target behaviors to determine the effectiveness of psychotropic medication After initial audit, facility representatives will audit all new residents with prescribed		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 758	Continued From page 14 -On 1/3/25, R32 spat medications and threw food on the floor. -On 1/4/25, R32 refused morning medications. -On 1/5/25, R32 refused dinner and medications. -On 1/6/25, R32 refused scheduled medications and cares. R32's encounter note with the provider on 12/16/24, indicated R32 was a new patient and took olanzapine (an antipsychotic) oral tablet 2.5 mg at bedtime for dementia with behaviors, with active date of 12/14/24. R32's encounter note with the provider on 12/27/24, indicated R32's olanzapine order had an end date of 12/28/24. During interview on 1/8/25 at 9:13 a.m., nursing assistant (NA)-E stated R32 had mood swings, scratched staff and refused cares. NA-E stated R32 spoke about preaching and religious topics and then would switch to another topic. NA-E was not aware of anything specific to help R32 and tried to talk to R32 and reapproached when R32 had behaviors. During interview on 1/8/25 at 9:00 a.m., licensed practical nurse (LPN)-C stated R32 refused to eat and drink and threw medications and food trays. R32 had paranoia and dementia and thought staff were the "devil". LPN-C stated they tried to talk to R32 calmly and ask another staff to reapproach or updated the provider when R32 had behaviors. LPN-C stated they wrote notes about resident behaviors for providers and other staff to be aware of resident status. During interview on 1/9/25 at 8:33 a.m., NA-A stated behaviors were charted in the computer or	F 758	psychotropics weekly for 4x weeks Orders are added to residents TAR schedule for Nurses to monitor and document during day-to-day care. Floor staff charting reports will be run during target behavior meetings for IDT to evaluate Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Members of the IDT team, including Social Services and Nurse leadership will participate in Target behavior meetings monthly to audit and verify that residents taking psychotropic medications have been comprehensively assessed to identify target behaviors to determine the effectiveness of psychotropic medication The facility will review the effectiveness of these monthly target behavior meetings and discuss trends and areas of improvement regarding this new process in our monthly QAPI meetings.		

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

PRINTED: 02/03/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 758	Continued From page 15 care plan, or the nurse would tell them about agitated residents and what to do to help them. NA-A stated R32 hallucinated and refused meals and thought the medication and food were poisoned. NA-A stated they talked to R32, gave R32 water, and assisted R32 to watch television to calm them down. When interviewed on 1/9/25 at 9:19 a.m., social worker (SW) stated they were involved in resident's behaviors if reported to them, and their behaviors were discussed during morning meets, but SW mostly connected residents with ACP (associated clinic of psychology) services and updated care plans after ACP visits. SW stated R32 had an order for ACP but refused to sign the consent. SW stated R32 was impulsive and not aware of their surroundings and switched subjects often during conversations. SW was not aware of R32's recent refusals and behaviors. When interviewed on 1/9/25 at 10:48 a.m., clinical managers (CM)-B and C stated they entered resident specific target behaviors into the medication or treatment administration record to monitor. CM-B and C stated they assessed residents' target behaviors by looking at the consent form and reviewing if the resident got dry mouth, agitation, headaches, or other listed items with psychotropic medication use. When interviewed on 1/9/25 at 1:48 p.m., the director of nursing (DON) expected staff to interview residents or representative about target behaviors for psychotropic medications and place monitoring into the treatment administration record and care plan. DON agreed the target behaviors listed in R32's orders were medication side effects and stated examples of target	F 758			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 758	Continued From page 16 specific behaviors included delusions or hallucinations. DON stated documentation of target behaviors were used to monitor if a psychotropic medication was effective. The facility Psychotropic Medication Use policy dated 11/2024, Indicated the care plan would reflect pharmacological and individualized non-pharmacological interventions along with monitoring for efficacy. The care plan will also include monitoring for drug specific side effects such as gait disorders, movement disorders, cognitive or behavioral changes, signs of hypotension or dry mouth.	F 758			
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was served at a palatable and appetizing temperature for 2 of 2 residents (R39, R51) reviewed for food palatability. This deficient practice had the potential to affect all 93 residents residing in the facility who consumed food from the facility main kitchen. Findings include:	F 804	Plan of Correction F-804 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: R39 and R51 will be included in the audits for continued compliance.		2/14/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 804	Continued From page 17 R39's quarterly Minimum Data Set (MDS) dated 11/17/24, indicated R39 had intact cognition and required supervision to eat. R51's quarterly MDS dated 11/3/24, indicated R1 had intact cognition and was able to feed herself after staff set up her tray. During an interview on 1/6/25 at 1:43 p.m., R51 stated the food did not taste very good and the hot items were usually served cold and the cold items were served warm. During an interview on 1/6/25 at 2:08 p.m., R39 stated the hot food is always cold and the cold food usually is not cold. During an observation on 1/6/25 at 5:45 p.m., multiple trays were being placed on a cart from the main kitchen. At 6:08 p.m., as the last plates were being passed from the cart a test tray was requested from dietary aide DA-A. The meal consisted of a cold roast beef sandwich, mashed potatoes, gravy, and pureed corn. The tray was tested for temperatures and results were as follows: -cold roast beef sandwich was 158 degrees Fahrenheit (F). -mashed potatoes were 115 degrees F. -gravy was 129 degrees F. -pureed corn was 113 degrees F. Surveyor tasted the food from the tray: the cold roast beef sandwich was warm, the mashed potatoes, gravy, and pureed corn were cold. During an interview on 1/6/25 at 7:05 p.m., R39 stated the roast beef was not very cold and the	F 804	How will the facility identify other residents potentially affected by the same deficient practice? All residents have the potential to be affected. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: All Dietary staff were educated on proper food temps and holding temperature also cooling of foods and cooling logs and recording of meal temps at beginning of meal and also at end of meal. All meals go out on temp appropriate plates to hold appropriate temp. Audits will be completed 1 time each meal weekly for 4 weeks Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Administrator or Designee will do random audits weekly to assure compliance Audits will be brought to QAPI for review		

PRINTED: 02/03/2025
FORM APPROVED
OMB NO. 0938-0391

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: CHMP11 Facility ID: 00278 If continuation sheet Page 19 of 29

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

PRINTED: 02/03/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245182		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page 19 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.			F 880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page 20 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a shared glucometer (blood glucose meter) was disinfected after use for one resident (R71), and failed to performed hand hygiene after removing soiled gloves and prior to donning clean gloves and completing clean tasks during perineal care for 2 of 3 residents (R10, R17) observed during change of incontinent product. Additionally, the facility failed to ensure staff performed hand hygiene between assisting multiple residents in the dining area for 3 of 5 residents (R71, R40, R49) observed in a dining area. Findings include: HH DURING PERINEAL CARE	F 880	Plan of Correction F-880 Handwashing, glove changing How corrective action will be accomplished for those residents found to have been affected by the deficient practice: All nursing staff educated regarding infection control; proper hand washing methodology., glove changing methodology. Education includes a return demonstration, visual schedule for hand washing, glove changing How will the facility identify other residents potentially affected by the same deficient practice?		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page 21 R10's admission Minimum Data Set (MDS) dated 11/27/24, indicated R10 had intact cognition, required substantial and/or maximal assistance for toileting hygiene and partial and/or moderate assistance to roll left and right, and had diagnoses of cancer, heart failure, hypertension (high blood pressure), renal disease, diabetes mellitus, and respiratory failure. R17's quarterly MDS dated 12/5/24, indicated R17 had intact cognition, was dependent on staff for toileting hygiene, required substantial and/or maximal assistance to roll left and right, and had diagnoses of heart failure, urinary tract infection in the last 30 days, asthma, and respiratory failure. During observation on 1/7/25 at 3:55 p.m., nursing assistant (NA)-B and NA-C had gloves on and assisted R10 with perineal cares. R10 had a saturated incontinent product, and NA-C used wipes to provide perineal care to the front side and back side of R10. NA-C used the same gloves to tuck in clean linen used as a draw sheet and a clean incontinent product under R10. During observation on 1/7/25 at 4:10 p.m., NA-B and NA-C had gloves on and assisted R17 with perineal cares. R17 had incontinent bowel movement, and NA-B assisted R17 with perineal cares. NA-B had feces on gloves, removed gloves, did not perform hand hygiene, applied clean gloves, and moved R17's pillow to the wheelchair. NA-B tucked in the dirty bed linen under R17 and further cleaned bowel movement from R17. NA-B tucked the clean incontinent product under R17 with the same gloves. NA-B removed gloves, did not perform hand hygiene,	F 880	All residents have potential for impact. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: Visual reminders placed at handwashing stations, dining rooms, and care guides Nursing staff received one on one education including return demonstrations. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: DON or designee will randomly audit staff while providing peri care, assisting residents during meals to ensure proper handwashing and glove changing occurs 2x per week for 2 weeks, 1x per week for 2 weeks. Quality Assurance Process Improvement Committee will review for the next 6 months to track action plan progress Plan of Correction F-880 Infection Prevention (Glucometer disinfection) How corrective action will be accomplished for those residents found to have been affected by the deficient		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page 22 and rubbed a towel against R17's back per request. NA-B left the room and performed hand hygiene prior to grabbing clean supplies from the supply closet. NA-B re-entered R17's room, applied gloves, and wiped the front perineal area of R17. NA-B did not change gloves or perform hand hygiene and velcroed R17's incontinent product, applied clean bed linen, repositioned R17, and placed a pillow behind R17's head. NA-B removed gloves and did not perform hand hygiene, pushed R17's bedside table towards R17, and brought bagged dirty items to the soiled linen room. During interview on 1/7/25 at 4:32 p.m., NA-C stated their gloves were not visibly soiled, so they did not change their gloves or perform hand hygiene between perineal care and tucking in R10's clean incontinent product. During interview on 1/7/25 at 4:44 p.m., NA-B stated they should have removed gloves and performed hand hygiene when gloves removed prior to touching clean items. During interview on 1/8/25 at 2:26 p.m., clinical manager (CM)-B, who worked with the director of nursing (DON) as the infection preventionist, expected staff to remove gloves and perform hand hygiene between dirty and clean tasks to prevent cross-contamination. During interview on 1/9/25 at 12:39 p.m., CM-A agreed staff needed to remove gloves and perform hand hygiene after dirty tasks and before clean tasks. The facility Gloves policy dated 12/19, directed staff to wash hands before applying gloves and	F 880	practice: Nurses trained on the procedure to cleaning and disinfecting glucometer started 1/28/25 and will be completed by 2/14/25. All nursing stations provided a 2nd glucometer to ensure workflow uninterrupted. How will the facility identify other residents potentially affected by the same deficient practice? All residents who have their blood tested by a glucometer The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: One page fact sheet posted at each nursing station on Instructions on how to clean and disinfect glucometers Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: DON or designee will randomly audit medication carts during blood sugar checks to ensure proper cleaning and disinfecting of glucometers 2x per week for 2 weeks, and then 1x per week for 2 weeks.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page 23 wash hands after removing gloves. The Toileting Assistance policy dated 11/19, directed staff to gather incontinent supplies as needed, wash hands and apply gloves, change incontinence product as needed, perform pericare, assist with clothing and incontinence product adjustments as needed, discard soiled incontinence products, and remove gloves and wash hands. GLUCOMETER DISINFECTION R71's quarterly MDS dated 10/4/24, indicated R71 had severe cognitive impairment, required supervision or touching assistance with eating, and had diagnoses of hypertension, diabetes mellitus, cerebrovascular accident, dementia, malnutrition, and hemiplegia or hemiparesis. R71's order with start date of 11/23/23, directed staff to check R71's blood sugar before meals for DM II [diabetes mellitus two]. During observation on 1/7/25 at 5:08 p.m., licensed practical nurse (LPN)-B brought a bin with clean supplies, such as packets of alcohol wipes and bottle of test strips, into R71's room. LPN-B checked R71's blood sugar and placed the glucometer into a plastic cup which sat in the bin of clean supplies. LPN-B removed gloves, performed hand hygiene, and returned to the medication chart at the nursing station with the glucometer and supplies. LPN-B used a glove to remove the used test strip from the glucometer and placed the glucometer on top of the clean alcohol wipes without disinfecting.	F 880	Quality Assurance Process Improvement Committee will review for the next 6 months to ensure that the facility continues to be in compliance with practice. Date Certain: 2/14		

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

PRINTED: 02/03/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245182		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page 24 During interview on 1/7/25 at 5:33 p.m., LPN-B stated the glucometer and bin with supplies were shared between residents in station three. LPN-B stated they usually disinfected the glucometer after use inside the resident's room but rushed so they could write down items they needed to order before they forgot. During interview on 1/8/25 at 2:26 p.m., CM-B expected staff to disinfect glucometers after use before leaving the resident room or putting back in clean supply bin. IP stated it was important to prevent the spread of bloodborne pathogens. During interview on 1/9/25 at 12:39 p.m., CM-A stated glucometers were disinfected before placed back in a clean area. During interview on 1/9/25 at 1:48 p.m., the director of nursing (DON) expected staff to disinfectant and cover shared glucometers for two minutes after use to prevent spread of bloodborne illness. Infection Prevention and Control Program policy dated 11/24, indicated staff were to be educated and follow proper techniques and procedures for prevention of infection. The policy did not specifically address glucometer disinfection. HAND HYGIENE DURING MEAL ASSISTANCE R40's quarterly MDS dated 10/3/24, indicated R40 had severe cognitive impairment, required substantial and/or maximal assistance with eating, and had diagnoses of diabetes mellitus, cerebrovascular accident (stroke; when blood flow to the brain is interrupted), dementia, malnutrition, and hemiplegia or hemiparesis			F 880			

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

PRINTED: 02/03/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245182		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page 25 (complete loss of movement or weakness in one side of the body). R49's annual MDS dated 12/24/24, indicated R49 had severe cognitive impairment, required partial/moderate assistance with eating, and had diagnoses of atrial fibrillation (heart condition which causes an irregular and rapid heartbeat), hypertension (high blood pressure), diabetes mellitus, arthritis, dementia, and cerebrovascular accident. R71's quarterly MDS dated 10/4/24, indicated R71 had severe cognitive impairment, required supervision or touching assistance with eating, and had diagnoses of hypertension, diabetes mellitus, cerebrovascular accident, dementia, malnutrition, and hemiplegia or hemiparesis. During observation on 1/8/25 at 8:18 a.m., R71 sat in wheelchair at a dining room table and mixed their oatmeal with their spoon without eating more than a couple bites. LPN-A approached R71 and fed R71 the oatmeal with their spoon without wearing gloves. LPN-A brought juice up to R71's mouth, R71 refused to swallow, and LPN-A wiped R71's mouth with a napkin. LPN-A did not perform hand hygiene and approached R49, who was in a wheelchair at another table, wiped R49's mouth with a napkin and no glove, and assisted R49 to eat pancakes and eggs using R49's silverware. LPN-A did not perform hand hygiene and approached R40 at the same table and assisted R40 with their breakfast using R40's silverware. During interview on 1/8/25 at 8:31 a.m., LPN-A stated they washed their hands before assisting in the dining area and verified they did not			F 880			

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

PRINTED: 02/03/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page 26 perform hand hygiene between assisting residents. LPN-A stated they were touching bowls and utensils and had not touched the food so did not need to wash their hands. During interview on 1/8/25 at 2:26 p.m., CM-B expected staff to wash their hands between assisting different residents in the dining area or expected staff to use one hand to help one resident and the other hand to help the second resident. IP stated staff should avoid cross-contamination. During interview on 1/9/25 at 12:39 p.m., CM-A stated staff needed to use a different hand for each resident they assisted with eating in the dining area or perform hand hygiene between assisting residents or ask other staff for help. During interview on 1/9/25 at 1:48 p.m., the director of nursing (DON) expected staff to wash their hands prior to meal service and in between residents or designate one hand per resident. Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices policy dated 10/17, directed staff to wash hands after engaging in activities which contaminate the hands.	F 880			
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from-	F 919			2/14/25

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

PRINTED: 02/03/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 919	Continued From page 27 §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure call lights were accessible for 1 of 2 residents (R51) who were reviewed for call light accessibility. Findings include: R51's quarterly Minimum Data Set (MDS) dated 11/3/24, identified R44 was cognitively intact and had diagnosis of anxiety and depression. Identified R51 was dependent on staff for activities of daily living (ADLs) and mobility. R51's care plan dated 8/22/24, identified R51 had an alteration in behaviors and yelled out, with an intervention dated 12/4/24, to ensure call light was within reach and to answer promptly as this helped reassure R51. During an interview on 1/6/25 at 1:30 p.m., R51 was seated in her wheelchair about 3 ft. away from her bed. The call light was on the floor under R51's bed. R51 stated her call light was left out of reach often and asked to get staff to help her because she could not reach the call light. During an observation on 1/6/25 at 1:40 p.m., licensed practical nurse (LPN)-A entered R51's room, talked with R51, picked up the call light from the floor, and handed it to R51. During an observation on 1/7/25 at 8:52 a.m., R51 was seated in her wheelchair about 5 ft. from her bed. R51's call light was attached to the bed	F 919	Plan of Correction F919 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Education completed with all staff to ensure that R51 and all other residents always have their call light accessible to them when they are in their room. How will the facility identify other residents potentially affected by the same deficient practice? All residents have the potential to be affected by this deficient practice The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: All staff have been educated on January 27th and 28th during all staff meetings on the importance and the requirement that all residents need to have their call light accessible to them when they are in their room.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 919	Continued From page 28 rail. R51 stated she could not reach her call light again. During an interview on 1/7/25 at 8:55 a.m., nursing assistant (NA)-A stated R51 was able to use the call light. NA-A further stated R51 was a fall risk so staff should always place R51's call light within reach. During an interview on 1/7/25 at 9:00 a.m., nurse manager (NM)-A entered R51's room and verified R51's call light attached to the bed rail and was not within reach of R51. NM-A stated R51 was able to use the call light and her expectation was that R51's call light was within reach. During an interview on 1/8/25 at 9:38 a.m., director of nursing (DON) verified R51 was able to use the call light. DON stated her expectations were that resident's call lights were within reach at all times so residents could call for assistance when needed. Facility policy titled Call Light Policy revised 4/25/23, identified when residents were in their rooms, they would have a means of directly contacting caregivers. The policy further identified the facility would have ensured the system was functioning properly.	F 919	Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Administrator or designee will audit random resident rooms to ensure that the residents call light is accessible to the resident. At least 5 rooms will be audited 2x a week for 2 weeks and 1x a week for 2x additional weeks to verify compliance. Deficient practice and the performance improvement plan will be added to the monthly QAPI agenda for at least 6 months to ensure that corrections are permanent. Date Certain: 2/14		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00278	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/6/25 - 1/9/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000			

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

01/28/25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00278	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey with no licensing orders issued: H51826428C (MN00100294) H56297162C (MN00101015) H51826427C (MN00101739) H51826425C (MN00103001, MN00103061) H51823843C (MN00107458) H51824484C (MN00109672) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading	2 000			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00278	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 000	Continued From page 2 completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000			
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive, person-centered care plan was developed to assure individualized interventions and resident-specific targeted behavior monitoring was completed for 1 of 2 residents (R32) reviewed for mood and behavior. Findings include: R32's admission Minimum Data Set (MDS) dated 12/20/24, indicated R32 was cognitively intact, had no behaviors or rejection of cares, was independent with eating and rolling left and right,	2 565	Corrected		2/14/25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00278	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 565	Continued From page 3 and required substantial and/or maximum assistant with lower body dressing and personal hygiene. R32's MDS did not identify R32 took antipsychotic medications. R32's care plan reviewed 1/6/25, indicated they had an alteration in mood and behavior focus area, and directed staff to document mood state and/or behaviors upon occurrence, redirect prn [as needed], provide emotional support, validation, and comfort measures prn, and MDS section D and/or PHQ 9 [patient health questionnaire which screens for depression] would be conducted per regulation and PRN. The care plan lacked individualized interventions and resident-specific target behaviors to be monitored to determine effectiveness. R32's physician orders identified: -Resident specific targeted behaviors of dry mouth, agitation, headaches, abnormal involuntary movements with directions to chart non-pharmacological interventions, such as redirect and provide one to one time and/or validation, and outcome if interventions were effective or not, with start date of 12/16/24. R32's medication administration record identified medications which included: - Haloperidol (an antipsychotic) oral tablet 2.5 milligrams (mg) by mouth every eight hours as needed for agitation or IM [intramuscular] three times a day as needed for agitation, with start date of 1/3/25 and discontinued 1/7/25. - Haloperidol oral tablet 2.5 milligrams (mg) by mouth every eight hours as needed for agitation or IM [intramuscular] three times a day as needed for agitation for 14 days, with start date of 1/7/25. R32's encounter note with the provider on	2 565			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00278	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 565	Continued From page 4 12/16/24, indicated R32 was a new patient and took olanzapine (an antipsychotic) oral tablet 2.5 mg at bedtime for dementia with behaviors, with active date of 12/14/24. R32's encounter note with the provider on 12/27/24, indicated R32's olanzapine order had an end date of 12/28/24. During interview on 1/8/25 at 9:13 a.m., nursing assistant (NA)-E stated R32 had mood swings, scratched staff and refused cares. NA-E stated R32 spoke about preaching and religious topics and then would switch to another topic. NA-E was not aware of anything specific to help R32 and tried to talk to R32 and reapproached when R32 had behaviors. During interview on 1/8/25 at 9:00 a.m., licensed practical nurse (LPN)-C stated R32 refused to eat and drink and threw medications and food trays. R32 had paranoia and dementia and thought staff were the "devil". LPN-C stated they tried to talk to R32 calmly and ask another staff to reapproach or updated the provider when R32 had behaviors. LPN-C stated they wrote notes about resident behaviors for providers and other staff to be aware of resident status. During interview on 1/9/25 at 8:33 a.m., NA-A stated behaviors were charted in the computer or in the care plan, or the nurse would tell them about agitated residents and what to do to help them. NA-A stated R32 hallucinated and refused meals and thought the medication and food were poisoned. NA-A stated they talked to R32, gave R32 water, and assisted R32 to watch television to calm them down. When interviewed on 1/9/25 at 9:19 a.m., social	2 565			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00278	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 565	Continued From page 5 worker (SW) stated they were involved in resident's behaviors if reported to them, and their behaviors were discussed during morning meets, but SW mostly connected residents with ACP (associated clinic of psychology) services and updated care plans after ACP visits. SW stated R32 had an order for ACP but refused to sign the consent. SW stated R32 was impulsive and not aware of their surroundings and switched subjects often during conversations. SW was not aware of R32's recent refusals and behaviors. When interviewed on 1/9/25 at 10:48 a.m., clinical managers (CM)-B and CM-C stated they entered resident specific target behaviors into the medication or treatment administration record to monitor. CM-B and CM-C stated they assessed residents' target behaviors by looking at the consent form and reviewing if the resident got dry mouth, agitation, headaches, or other listed items with psychotropic medication use. When interviewed on 1/9/25 at 1:48 p.m., the director of nursing (DON) expected staff to interview residents or representative about target behaviors for psychotropic medications and place monitoring into the treatment administration record and update the care plan. DON agreed the target behaviors listed in R32's orders were medication side effects and stated examples of target specific behaviors included delusions or hallucinations. DON stated documentation of target behaviors were used to monitor if a psychotropic medication was effective. The facility Psychotropic Medication Use policy dated 11/2024, Indicated the care plan would reflect pharmacological and individualized non-pharmacological interventions along with monitoring for efficacy. The care plan will also	2 565			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00278	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 565	Continued From page 6 include monitoring for drug specific side effects such as gait disorders, movement disorders, cognitive or behavioral changes, signs of hypotension or dry mouth. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 565			
21025	MN Rule 4658.0615 Food Temperatures Potentially hazardous food must be maintained at 40 degrees Fahrenheit (four degrees centigrade) or below, or 150 degrees Fahrenheit (66 degrees centigrade) or above. "Potentially hazardous food" means any food subject to continuous time and temperature controls in order to prevent the rapid and progressive growth of infectious or toxigenic microorganisms. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was served at a palatable and appetizing temperature for 2 of 2 residents (R39, R51) reviewed for food palatability. This deficient practice had the potential to affect all 93 residents residing in the facility who consumed food from the facility main kitchen. Findings include:	21025	Corrected		2/14/25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00278	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
21025	Continued From page 7 R39's quarterly Minimum Data Set (MDS) dated 11/17/24, indicated R39 had intact cognition and required supervision to eat. R51's quarterly MDS dated 11/3/24, indicated R1 had intact cognition and was able to feed herself after staff set up her tray. During an interview on 1/6/25 at 1:43 p.m., R51 stated the food did not taste very good and the hot items were usually served cold and the cold items were served warm. During an interview on 1/6/25 at 2:08 p.m., R39 stated the hot food is always cold and the cold food usually is not cold. During an observation on 1/6/25 at 5:45 p.m., multiple trays were being placed on a cart from the main kitchen. At 6:08 p.m., as the last plates were being passed from the cart a test tray was requested from dietary aide DA-A. The meal consisted of a cold roast beef sandwich, mashed potatoes, gravy, and pureed corn. The tray was tested for temperatures and results were as follows: -cold roast beef sandwich was 158 degrees Fahrenheit (F). -mashed potatoes were 115 degrees F. -gravy was 129 degrees F. -pureed corn was 113 degrees F. Surveyor tasted the food from the tray: the cold roast beef sandwich was warm, the mashed potatoes, gravy, and pureed corn were cold. During an interview on 1/6/25 at 7:05 p.m., R39 stated the roast beef was not very cold and the mashed potatoes and gravy were cold.	21025			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00278	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
21025	Continued From page 8 During an interview on 1/6/25 at 7:20 p.m., R51 stated the cold roast beef was not very cold and the mashed potatoes and gravy were so cold that they couldn't eat them. During an interview on 1/6/25 at 6:32 p.m., dietary aide (DA)-A stated the process is to plate the food, cover it, place it on a tray, and then the trays are passed to all residents who eat in their room. DA-A stated the holding temps of hot food should be at least 135 degrees F and cold food should be served no warmer than 41 degrees F. During an interview on 1/6/25 at 6:37 p.m., culinary director (CD) stated the normal process was to plate the food either from the steam tables in the dining room or from the main kitchen for residents who eat in their room, cover the food, and place on a cart for staff to pass to residents. CD stated the holding temp of cold food should be 41 degrees F and hot food should be at least 135 degrees F. Review of a facility policy titled Test Tray Evaluation Procedure undated, indicated facility would test last tray delivered, and identified cold food should have been at or below 50 degrees F and hot food at or above 140 degrees F. SUGGESTED METHOD OF CORRECTION: The dietary manager or designee could could develop, review, and/or revise policies and procedures, inservice staff regarding proper holding procedures of foods for resident consumption, and audit for compliance.	21025			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00278	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
21025	Continued From page 9	21025	Corrected		2/14/25
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a shared glucometer (blood glucose meter) was disinfected after use for one resident (R71), and failed to performed hand hygiene after removing soiled gloves and prior to donning clean gloves and completing clean tasks during perineal care for 2 of 3 residents (R10, R17) observed during change of incontinent product. Additionally, the facility failed to ensure staff performed hand hygiene between assisting multiple residents in the dining area for 3 of 5 residents (R71, R40, R49) observed in a dining area. Findings include: HH DURING PERINEAL CARE R10's admission Minimum Data Set (MDS) dated 11/27/24, indicated R10 had intact cognition, required substantial and/or maximal assistance for toileting hygiene and partial and/or moderate assistance to roll left and right, and had diagnoses of cancer, heart failure, hypertension (high blood pressure), renal disease, diabetes	21375			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00278	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
21375	Continued From page 10 mellitus, and respiratory failure. R17's quarterly MDS dated 12/5/24, indicated R17 had intact cognition, was dependent on staff for toileting hygiene, required substantial and/or maximal assistance to roll left and right, and had diagnoses of heart failure, urinary tract infection in the last 30 days, asthma, and respiratory failure. During observation on 1/7/25 at 3:55 p.m., nursing assistant (NA)-B and NA-C had gloves on and assisted R10 with perineal cares. R10 had a saturated incontinent product, and NA-C used wipes to provide perineal care to the front side and back side of R10. NA-C used the same gloves to tuck in clean linen used as a draw sheet and a clean incontinent product under R10. During observation on 1/7/25 at 4:10 p.m., NA-B and NA-C had gloves on and assisted R17 with perineal cares. R17 had incontinent bowel movement, and NA-B assisted R17 with perineal cares. NA-B had feces on gloves, removed gloves, did not perform hand hygiene, applied clean gloves, and moved R17's pillow to the wheelchair. NA-B tucked in the dirty bed linen under R17 and further cleaned bowel movement from R17. NA-B tucked the clean incontinent product under R17 with the same gloves. NA-B removed gloves, did not perform hand hygiene, and rubbed a towel against R17's back per request. NA-B left the room and performed hand hygiene prior to grabbing clean supplies from the supply closet. NA-B re-entered R17's room, applied gloves, and wiped the front perineal area of R17. NA-B did not change gloves or perform hand hygiene and velcroed R17's incontinent product, applied clean bed linen, repositioned R17, and placed a pillow behind R17's head.	21375			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00278	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
21375	Continued From page 11 NA-B removed gloves and did not perform hand hygiene, pushed R17's bedside table towards R17, and brought bagged dirty items to the soiled linen room. During interview on 1/7/25 at 4:32 p.m., NA-C stated their gloves were not visibly soiled, so they did not change their gloves or perform hand hygiene between perineal care and tucking in R10's clean incontinent product. During interview on 1/7/25 at 4:44 p.m., NA-B stated they should have removed gloves and performed hand hygiene when gloves removed prior to touching clean items. During interview on 1/8/25 at 2:26 p.m., clinical manager (CM)-B, who worked with the director of nursing (DON) as the infection preventionist, expected staff to remove gloves and perform hand hygiene between dirty and clean tasks to prevent cross-contamination. During interview on 1/9/25 at 12:39 p.m., CM-A agreed staff needed to remove gloves and perform hand hygiene after dirty tasks and before clean tasks. The facility Gloves policy dated 12/19, directed staff to wash hands before applying gloves and wash hands after removing gloves. The Toileting Assistance policy dated 11/19, directed staff to gather incontinent supplies as needed, wash hands and apply gloves, change incontinence product as needed, perform pericare, assist with clothing and incontinence product adjustments as needed, discard soiled incontinence products, and remove gloves and wash hands.	21375			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00278	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
21375	Continued From page 12 GLUCOMETER DISINFECTION R71's quarterly MDS dated 10/4/24, indicated R71 had severe cognitive impairment, required supervision or touching assistance with eating, and had diagnoses of hypertension, diabetes mellitus, cerebrovascular accident, dementia, malnutrition, and hemiplegia or hemiparesis. R71's order with start date of 11/23/23, directed staff to check R71's blood sugar before meals for DM II [diabetes mellitus two]. During observation on 1/7/25 at 5:08 p.m., licensed practical nurse (LPN)-B brought a bin with clean supplies, such as packets of alcohol wipes and bottle of test strips, into R71's room. LPN-B checked R71's blood sugar and placed the glucometer into a plastic cup which sat in the bin of clean supplies. LPN-B removed gloves, performed hand hygiene, and returned to the medication chart at the nursing station with the glucometer and supplies. LPN-B used a glove to remove the used test strip from the glucometer and placed the glucometer on top of the clean alcohol wipes without disinfecting. During interview on 1/7/25 at 5:33 p.m., LPN-B stated the glucometer and bin with supplies were shared between residents in station three. LPN-B stated they usually disinfected the glucometer after use inside the resident's room but rushed so they could write down items they needed to order before they forgot. During interview on 1/8/25 at 2:26 p.m., CM-B expected staff to disinfect glucometers after use before leaving the resident room or putting back	21375			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00278	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
21375	Continued From page 13 in clean supply bin. IP stated it was important to prevent the spread of bloodborne pathogens. During interview on 1/9/25 at 12:39 p.m., CM-A stated glucometers were disinfected before placed back in a clean area. During interview on 1/9/25 at 1:48 p.m., the director of nursing (DON) expected staff to disinfectant and cover shared glucometers for two minutes after use to prevent spread of bloodborne illness. Infection Prevention and Control Program policy dated 11/24, indicated staff were to be educated and follow proper techniques and procedures for prevention of infection. The policy did not specifically address glucometer disinfection. HAND HYGIENE DURING MEAL ASSISTANCE R40's quarterly MDS dated 10/3/24, indicated R40 had severe cognitive impairment, required substantial and/or maximal assistance with eating, and had diagnoses of diabetes mellitus, cerebrovascular accident (stroke; when blood flow to the brain is interrupted), dementia, malnutrition, and hemiplegia or hemiparesis (complete loss of movement or weakness in one side of the body). R49's annual MDS dated 12/24/24, indicated R49 had severe cognitive impairment, required partial/moderate assistance with eating, and had diagnoses of atrial fibrillation (heart condition which causes an irregular and rapid heartbeat), hypertension (high blood pressure), diabetes mellitus, arthritis, dementia, and cerebrovascular accident.	21375			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00278	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
21375	Continued From page 14 R71's quarterly MDS dated 10/4/24, indicated R71 had severe cognitive impairment, required supervision or touching assistance with eating, and had diagnoses of hypertension, diabetes mellitus, cerebrovascular accident, dementia, malnutrition, and hemiplegia or hemiparesis. During observation on 1/8/25 at 8:18 a.m., R71 sat in wheelchair at a dining room table and mixed their oatmeal with their spoon without eating more than a couple bites. LPN-A approached R71 and fed R71 the oatmeal with their spoon without wearing gloves. LPN-A brought juice up to R71's mouth, R71 refused to swallow, and LPN-A wiped R71's mouth with a napkin. LPN-A did not perform hand hygiene and approached R49, who was in a wheelchair at another table, wiped R49's mouth with a napkin and no glove, and assisted R49 to eat pancakes and eggs using R49's silverware. LPN-A did not perform hand hygiene and approached R40 at the same table and assisted R40 with their breakfast using R40's silverware. During interview on 1/8/25 at 8:31 a.m., LPN-A stated they washed their hands before assisting in the dining area and verified they did not perform hand hygiene between assisting residents. LPN-A stated they were touching bowls and utensils and had not touched the food so did not need to wash their hands. During interview on 1/8/25 at 2:26 p.m., CM-B expected staff to wash their hands between assisting different residents in the dining area or expected staff to use one hand to help one resident and the other hand to help the second resident. IP stated staff should avoid cross-contamination.	21375			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00278	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
21375	Continued From page 15 During interview on 1/9/25 at 12:39 p.m., CM-A stated staff needed to use a different hand for each resident they assisted with eating in the dining area or perform hand hygiene between assisting residents or ask other staff for help. During interview on 1/9/25 at 1:48 p.m., the director of nursing (DON) expected staff to wash their hands prior to meal service and in between residents or designate one hand per resident. Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices policy dated 10/17, directed staff to wash hands after engaging in activities which contaminate the hands. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should re-educate nursing staff to appropriately implement correct hand hygiene when assisting residents in the dining room and with perineal cares. The DON or designee could educate all staff on existing or revised policies to ensure appropriate disinfection of glucometers. The DON or designee could review and revise related policies to ensure appropriateness. The DON or designee should perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21375			

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

PRINTED: 01/29/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245182	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/08/2025. At the time of this survey, The Villas At St Louis Park was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/28/2025

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: 245182	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Villa at St. Louis Park is a 2-story building with a partial basement. It was built in 1971 and was determined to be of Type II(222) construction. The building has a total of eight separate smoke compartments and is divided into four smoke compartments on each sleeping floor. The building is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department	K 000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245182		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2025	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 000	Continued From page 2 notification.			K 000			
	The facility has a capacity of 100 beds and had a census of 95 at the time of the survey.						
K 211 SS=D	The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain clear path of egress per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, 19.2.3.4, and 7.1.10.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 01/08/2025 at 11:12 AM, it was revealed by observation that there was a bench, pallet, and carts being stored in the corridor on the lower level near room B58 environmental services office. An interview with the Regional Maintenance			K 211			2/14/25
					K211 Bench, pallet and carts in corridor will be removed. Education will be completed with MD and IDT on ensuring corridors are clear from obstructions Audits will be completed weekly x4 weeks by MD or designee. Audits will be brought to QAPI by NHA or designee to review trends.		

PRINTED: 01/29/2025
FORM APPROVED
OMB NO. 0938-0391

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: CHMP21 Facility ID: 00278 If continuation sheet Page 4 of 7

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

PRINTED: 01/29/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245182	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.	K 363		2/14/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245182	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 363	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5 and 19.3.6.3.10. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 01/08/2025 at 11:09 AM, it was revealed by observation that the beauty shop door B50 was propped open with a cement block. An interview with the Regional Maintenance Director and the Maintenance Director verified this deficient finding at the time of discovery.	K 363	K363 Beauty shop door was immediately closed when identified on 1/8/25 No other doors are being propped open. Education will be provided to beautician and IDT team to ensure doors are not left propped open. Audits will be completed weekly x 4 weeks by MD or designee. Audits will be brought to QAPI by NHA or designee.		
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a	K 920			2/14/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245182	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2025
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 920	Continued From page 6 substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 01/08/2025 at 11:31 AM, it was revealed by observation that there were two extension cords being used as permanent wiring in resident room 214, and one of them was plugged into a power strip. 2. On 01/08/2025 at 11:31 AM, it was revealed by observation that one of the vending machines in the day room near the employee entrance was plugged into an extension cord. An interview with the Regional Maintenance Director and the Maintenance Director verified these deficient findings at the time of discovery.	K 920	K920 Extension cords were immediately removed on 1/8/25 when identified. Other rooms will be reviewed to ensure no other cords are present in the facility that do not meet Life Safety Code. Education will be provided to vending machine provider, MD and staff. Audits will be completed by MD or designee weekly x 4 weeks. Audits will be brought to QAPI by NHA or designee to review trends.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
February 27, 2025

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

RE: CCN: 245182
Cycle Start Date: January 9, 2025

Dear Administrator:

On February 19, 2025, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 27, 2025

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

Re: Reinspection Results
Event ID: CHMP12

Dear Administrator:

On February 19, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 9, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us