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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: H7XW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00278

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

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

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

4. TYPE OF ACTION: **7**

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

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

6. DATE OF SURVEY **09/12/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A5*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE — Date:
Sue Reuss, Unit Supervisor — 09/27/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Douglas Larson, Enforcement Specialist — 09/27/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/06/2018
(L33)

DETERMINATION APPROVAL

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

Documentation supporting your request for a waiver of the following life safety code (LSC) deficiency:

K521 - HVAC

The facility's request has been forwarded to the CMS Region V Office for their review and determination.

Approval of the waiver has been recommended.

Electronically delivered

CMS Certification Number (CCN): 245182

September 27, 2018

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

Dear Administrator:

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

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

Effective September 12, 2018 the above facility is certified for:

105 Skilled Nursing Facility/Nursing Facility Beds

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

Your request for waiver of has been recommended based on the submitted documentation. You will receive notification from CMS only if they do not concur with our recommendation.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K521.

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

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

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

Please contact me if you have any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 27, 2018

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

RE: Project Number S5182028

Dear Administrator:

On August 14, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 27, 2018 that included an investigation of complaint number H5182068. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 12, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 27, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 12, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 27, 2018, effective September 12, 2018 and therefore remedies outlined in our letter to you dated August 14, 2018, will not be imposed.

Your request for a continuing waiver involving the deficiency(ies) cited under K521 at the time of the July 27, 2018 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist

Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Electronically delivered

September 27, 2018

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

Re: Reinspection Results - Project Number S5182028

Dear Administrator:

On September 12, 2018 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 12, 2018, with orders received by you on August 14, 2018. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: H7XW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00278

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

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

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

4. TYPE OF ACTION: **2** (L8)

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

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

6. DATE OF SURVEY **07/27/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Glenora Souther, HFE NE II — 08/27/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Douglas Larson, Enforcement Specialist — 09/04/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
August 14, 2018

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

RE: Project Number S5182028

Dear Ms. McCurdy:

On July 27, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the July 27, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number H5182068.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 5, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 5, 2018 the following remedy will be imposed:

- Civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the 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, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition

of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 27, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions

as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 27, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety

State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245182	A. BUILDING _____ B. WING _____	C 07/27/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on July 23- 27, 2018 during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted July 23, 2018, through July 27, 2018, and a complaint investigation was also completed at the time of the standard survey. At the time of the survey, an investigation of complaint #H5182068 was completed and was found to be substantiated at F684. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550		9/4/18

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

Electronically Signed | 08/20/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245182	A. BUILDING _____ B. WING _____	C 07/27/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 1 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dignified treatment for 1 of 4 residents (R24) reviewed during the survey who had reported concerns related to staff treatment.	F 550	1. Concern from R24 was addressed when notified. R24 has not had any further concerns. 2. Like residents will be asked if they are treated with dignity/respect by NHA or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245182	A. BUILDING _____ B. WING _____	C 07/27/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2 Findings include: R24's admission minimum data set dated 5/6/18, indicated he was cognitively intact, required extensive assistance for bed mobility, transfers and toileting, and was frequently incontinent of bowel. R24's care plan dated 5/2/18, identified a self care performance deficit related to activity intolerance and directed staff to assist with toileting and personal hygiene needs. During an interview on 7/23/18, at 4:21 p.m. R24 was observed lying in bed. R24 stated he did not feel all of the staff treated him with respect. R24 stated he did not appreciate the way staff spoke to him and explained that the other night, R24 had a bowel movement and had to be changed. He stated, the nursing assistant (NA) just put the incontinent product on the chair and he had to ask her for help. He stated the NA did finally help him and stated, "I don't' want to be here and it feels like I'm bothering them to do their job." R24 stated another night he had a bowel movement around 4:00 a.m. and turned on his call light for assistance. He stated he laid in his stool for an hour and 45 minutes before he was assisted. R24 stated a woman had come around with a questionnaire and he told her about it. He said she wrote it down and said she would pass it on. R24 stated no one had followed up with him regarding his concerns Review of a Resident Interview and Resdient Observation form dated 7/15/18, indicated R24 was interviewed by an intern in the facility. The interview form indicated R24 was asked if he was treated with dignity. The form had a check box indicating R24 said no. The form further indicated	F 550	designee. 3. Education of resident rights/dignity and notification of concerns was provided to intern on 8/2/18. All staff will be educated on dignity/respect and notifying their supervisor of any resident concerns timely. 4. Five random audits will be completed weekly to ensure patients are being treated with dignity/respect. Audits will be completed by Social Services or designee. 5. Audits will be brought to QAPI by NHA or designee monthly.	

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F 550	Continued From page 3 he reported to the intern he had to lay in his stool for and hour and a half around 4:00 a.m. During an interview on 7/27/18, at 11:55 a.m. the administrator stated an intern went around the facility with the questionnaire in preparation for the upcoming survey. She stated she was not aware of any concerns voiced by R24. At 3:39 a.m. the administrator stated she located a copy of the questionnaire filled out by the intern. She stated she had not been informed of R24's concerns related to the staff and stated the intern should have given her the information right away. A facility policy titled Villa Resident Rights, dated 11/28/17, indicated residents have the right to be treated with respect and dignity.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to determine if the practice of self-administration of medications (SAM) was safe for 1 of 1 resident (R142) observed to self-administer a nebulizer. Findings include: R142's diagnoses included chronic obstructive pulmonary disease (COPD), malignant neoplasm of unspecified part of right bronchus or lung and generalized muscle weakness obtained from	F 554	1. R142 discharged from facility on 8/1/18. 2. All resident with nebulizers that want to self administer nebs will have a self-administration assessment completed, MD orders obtained and care plan updated as appropriate based on assessment. 3. Licensed nursing staff have been educated on the self-medication policy and procedure. 4. Five random SAM audits will be	9/4/18

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F 554	Continued From page 4 Admission Record dated 7/26/18. R142's Physician Orders dated 7/11/17, directed to administer ipratropium/albuterol nebulizer (Duoneb, a respiratory medication) via nebulizer every six hours for shortness of breath and wheezing while awake. The Physician's Orders did not identify R142 could self-administer medications, including the nebulizer treatment. On 7/25/18, at 8:18 a.m. an audible noise of a nebulizer machine was heard when standing at the door of R142's shared room. Upon entering the room a hand held nebulizer chamber (a inhalation treatment device) was observed lying on top of the bedding to the left side in front of R142. R142 stated her roommate had just turned it off for her. -At 8:22 a.m. R142's roommate R9 stated she had turned the nebulizer off because "it is chaos here in the morning". R9 explained that if there is something that she can help with she does and said she turned the machine off so that the nurse wouldn't have to come back to do it. On 7/25/18, at 8:26 a.m. registered nurse (RN)-D acknowledged that she set up the nebulizer, stating, "the nebulizer was running on it's own and I am the one who goes and turns it off after 15 minutes. I did not go to turn it off. When I just went to the room with you, that was when I found it was not running." RN-D stated because R142 was alert and was able to inhale the mist after set up he did not need to stay with R142 the entire time." RN-D verified R142 did not have an order to self administer the nebulizer and did not have an assessment for it. R142's care plan dated 7/23/18, indicated R142	F 554	conducted weekly on patients to ensure self-med assessments are completed, order is updated and care plan is being followed. Audits will continue until no deficient practice is determined by QAPI review. 5. Audits will be brought to QAPI monthly for review by NHA or designee.	

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F 554	Continued From page 5 had altered respiratory status/difficulty breathing related to lung cancer/COPD/ history of smoking. The care plan directed staff to administer medication/puffers as ordered and to monitor for effectiveness and side effects. On 7/26/18, at 8:37 a.m. the director of nursing stated she would expect the nurse to make sure the resident had been assessed to self-administer medication and had an order for it. In addition, she stated if a resident was capable of self medication administration it would be addressed in the care plan.	F 554		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to have call light within reach for 1 of 18 residents (R11) reviewed in the initial survey sample for call lights. Findings include: R11's admission record dated 7/12/18, indicated diagnoses of multiple myeloma (cancer) and pathological fracture of left shoulder (bone fracture caused by disease). R11's quarterly Minimum Data Set (MDS) date 4/23/18, indicated R11 was able to make self understood and able to understand others, had intact cognition,	F 558	1. Call light clip was given to Rll immediately upon notification to ensure placement. R11 discharged from facility on 8/7/18. 2. All residents were given call light clips to secure placement and to prevent them from falling on the floor on 8/14/18. 3. Staff have been educated on ensuring call lights are within reach before leaving patient room and utilization of call light clips where appropriate to ensure call lights don't fall out of reach of resident.	9/4/18

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F 558	Continued From page 6 required supervision with one person physical assist for bed mobility and transfers and extensive assistance of one person for dressing. R11's care area assessment (CAA) dated 7/24/18, for urinary incontinence and indwelling catheter due to requiring extensive assistance for toileting. R11's care plan dated 4/21/18, indicated activities of daily living (ADL) self-care performance deficit related to weakness, immobility from disease process. Care plan directed facility staff to encourage participation from resident in regards to bed mobility and toileting with one person physical assist. R49 was to be encouraged to use the call light for assistance. During a random observation on 7/23/18, at 1:49 p.m. R11's call light was observed to be on the floor while resident was laying in bed. R11 attempted to use resident's own long handled grabber stick to try to grab the call light but was unable to. Surveyor offered to get assistance for resident since call light was not within reach. On 7/23/18, at 1:51 p.m. nursing assistant (NA)-I indicated R11 was able to use the call light. NA-I was observed to pick up the call light on the floor and place it over R11's head of bed under resident's pillow. NA-I further indicated R11's call light did not have a clip and probably fell off the bed. During an interview with the director of nursing (DON) on 7/26/18, at 12:30 p.m. confirmed residents capable of using the call lights should have their call light within reach. Facility policy for call light was requested but not received.	F 558	4. Five audits will be completed weekly to ensure call lights are within resident reach. Audits will be completed by Life Enrichment or designee. 5. Audits will be brought to monthly QAPI for review by NHA or designee.	

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F 578	Continued From page 7	F 578		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he	F 578		9/4/18

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F 578	Continued From page 8 or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to have the correct advanced directive available for staff reference in case of an emergency for 1 of 18 residents (R11) reviewed for advance directives. Findings include: R11's admission record dated 7/12/18, indicated diagnoses of multiple myeloma (cancer) and pathological fracture of left shoulder (bone fracture caused by disease). R11's quarterly Minimum Data Set (MDS) date 4/23/18, indicated R11 was able to make self understood and able to understand others, had intact cognition, required supervision with one person physical assist for bed mobility and transfers and extensive assistance of one person for dressing. R11's care area assessment (CAA) dated 7/24/18, for urinary incontinence and indwelling catheter due to requiring extensive assistance for toileting. R11's care plan dated 4/21/18, indicated activities of daily living (ADL) self-care performance deficit related to weakness, immobility from disease process. Care plan directed facility staff to encourage participation from resident in regards to bed mobility and toileting with one person physical assist. R49 was to be encouraged to use the call light for assistance. During document review R11 had two code status order in the electronic medical record, one for "Do	F 578	1. R11 discharged from facility on 8/7/18. 2. Facility has reviewed code status documentation for all residents and updated electronic record where appropriate. 3. Education has been completed with HUCS, SS and licensed staff to ensure there is only one code status in the computer and it matches paper form. 4. Five audits will be completed weekly by DON or designee to ensure compliance. 5. Audits will be brought to monthly QAPI by NHA or designee.	

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F 578	Continued From page 9 Not Resuscitate (DNR)DNAR [Do not Attempt Resuscitation]" and the other "Full Code" both dated 7/12/18. During an interview on 7/26/18, at 1:23 p.m. registered nurse (RN)-B confirmed R11's conflicting code status in the electronic medical record and verified R11's Physician Orders for Life-Sustaining Treatment (POLST) was "Full Code" and was not signed by the physician. RN-B indicated would confirm with resident about code status. During an interview on 7/26/18, at 1:29 p.m. assistant director of nursing (ADON) indicated R11 "Had left the facility and came back, someone just didn't discontinue one." ADON verified R11 had two code status in the electronic medical record and confirmed should not have two conflicting orders. ADON further indicated POLST should be signed by the physician by the next visit. Facility policy CPR-Cardiopulmonary Resuscitation with revised date of 5/11/18, indicated "The facility shall provide CPR to a resident who requires such emergency care prior to the arrival of emergency medical services, consistent with the resident's advance directives and physician orders."	F 578		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-	F 582		9/4/18

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F 582	Continued From page 10 (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or	F 582		

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F 582	Continued From page 11 resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) for 1 of 3 residents (R87) reviewed whose Medicare A coverage ended and then remained in the facility. Findings include: R87's Centers for Medicare and Medicaid Services (CMS)-Form CMS-10123, Notice of Medicare Non-Coverage form was signed by R87 as received on 7/9/18, with the last covered day (LCD) of 7/11/18, when R87's Medicare coverage would end. The CMS-10123 lacked facility staff initials of the person explaining appeal rights, as required on the form. During further review of R87's SNFABN form CMS-10055 (2018), form it was revealed the daily room and board costs would be $269.75. The option sections of the form was not marked indicating which option R87 or R87's representative had selected. Option 1, "I want the care listed above. I want Medicare to be billed for an official decision on payment, which will be sent to me on a Medicare Summary Notice (MSN)...." was blank. Option 2, "I want the care listed above, but don't bill Medicare ...." was blank. Option 3, "I don't want the care listed provided	F 582	1. Business Officer Manager had conversation with POA on 7/12/18 regarding R87's SNFABN. POA signed SNFABN form on 7/24/18. R87 discharged from facility. 2. Like residents from July 1st 2018 to August 20th 2018 will be reviewed to ensure options have been reviewed with responsible party and form has been completed in their entirety. 3. Education was completed on 8/2/18 regarding SNFABN requirement with Business Office Manager. NHA added denials/SNFABN notices to daily stand up to ensure appropriate communication to BOM. 4. Five audits will be conducted weekly by NHA or designee to ensure compliance. 5. Audits will be brought to monthly QAPI by NHR or designee.	

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F 582	Continued From page 12	F 582		

above ..." was blank.

In the signature box, for Patient (Pt.) or authorized Representative was a hand written note, "Pt, was to disch. [discharge] 7-12-18 Spoke to [Family Member-A], by phone & [and] sent her a bill-see attached.". During review of the documentation a statement dated 7/12/18, indicated the business office manager (BOM) had spoken with R87's family member who stated could send a bill but thought charges were ridiculous and on the statement it had been indicated a bill for four days would be sent to the family member.

Billing statement dated 7/12/18, indicated R87 was billed for four days room and board with an estimated discharge date of 7/16/18.

R87's medical record was reviewed and lacked any evidence that the SNFABN CMS 10055 (2018) form was given to R87 or sent to R87's family member, or the appeal options were explained to R87 or R87's family member.

When interviewed on 7/24/18, at 13:35 p.m. the BOM verified R87 had Medicare days remaining. The BOM stated, "I did not give the 10055 or cover options. I am sending it out today by registered mail."

Facility undated, Medicare/Medicare Advantage Denial Notices directed staff, "once a skilled stay has started, the facility must continue to assess if skilled coverage criteria are met. When it is determined that the skilled coverage criteria are no longer met, and there are days remaining in the benefit period, and the resident is going to remain in the facility, the SNFABN (CMS 100-55)

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F 582	Continued From page 13 and the Notice of Medicare Non-Coverage (CMS 10123-NOMNC) are issued."	F 582		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to give a bed hold notice to 2 of 6 residents (R49, R17) for each hospital stay who	F 625	1. R49 discharged from facility. Should R17 go out to the hospital, she will be given bed hold notice. (R47 did not go to	9/4/18

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 14 had been in the hospital. Findings include: R49's medical record was reviewed on 07/26/18, at 10:06 a.m. R47 had been in the hospital three times since admission, 3/20/18 through 3/24/18, 5/7/18 through 5/10/18, and 5/19/18 through 5/23/18 and had not been given a bed hold, nor had his guardian for each hospitalization. R47 was hospitalized on 3/20/18 through 3/24/18, for severe bilateral upper extremity pain and pain across his upper back according to the hospital discharge summary. R47 was hospitalized 5/7/18, and was found to have Proteus urinary tract infection (UTI) resistant to Cipro and Bactrim and treated with oral Cefuroxime. He had an extensive history of Clostridium difficile colitis and had been on oral Vancomycin to prevent recurrence of his Clostridium difficile colitis with antibiotic administration. R47 had been in the hospital from 5/7/18 through 5/10/18. The hospital discharge summary, dated 5/23/18, R47's active hospital problem list was: severe sepsis, spinal cord injury due to gun shot wound (GSW), neuropathic pain, neurogenic bowel, neurogenic bladder, insomnia, orthostatic hypotension, spasticity, ESBL (extended spectrum beta-lactamase) producing bacteria infection and autonomic dysreflexia. R47 had a history of spinal injury secondary to a gun shot wound in April 2017, autonomic dysreflexia, spasticity (on baclofen), recurrent UTI and Clostridium difficile colitis, neurogenic bladder, depression, anxiety, and insomnia who presents	F 625	the hospital during times noted on 2567. Verified error with MDH supervisor 8/14/18). 2. All residents who are transferring to the hospital are receiving a bed hold notice. 3. Social Services, HUCS and licensed staff have been educated on bed hold policy. 4. Audits will be completed weekly by NHA or designee to ensure bed hold notice is being given when someone transfers out. 5. Audits will be brought to monthly QAPI for review by NHA or designee.	

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with abdominal pain. R47 was hospitalized from 5/19/18 through 5/23/18.

LSW-A was interviewed on 07/26/18, at 10:59 AM. LSW-A confirmed R49 was admitted to the facility on 3/15/18. R49 was admitted to the hospital on 3/20/18, and discharged back to the nursing home on 3/24/18. R49 was then admitted to hospital on 5/7/18, and discharged back to the nursing home on 5/10/18, and admitted to hospital 5/19/18 and discharged to the NH on 5/23/18. LSW-A further confirmed R49 had no signed bedhold for the three hospitalization.

R49's medical record had a progress note from social services dated, 3/23/18, that indicated LSW spoke with R47's mother and informed her of 18 day bed hold with medical assistance. R47's mother acknowledged her understanding and was hopeful patient would be returning back to the nursing home.

The facility's Bed Hold Policy, 8/31/11, indicated the following: It is the policy of Villa Health Care to hold the bed of a current resident if he/she needed to be hospitalized or went on therapeutic leave. The resident/responsible party must be notified concerning the bed hold policy of Villa Health Care and sign the policy as evidence that they had been properly notified prior to being charged for any service. A copy of this policy will be sent with the resident when transferred to the hospital. Procedures: All Residents: 1. At the time of admission, the Villa Health Care representative will inform the current resident/responsible party of the bed hold policy. 2. At the time of transfer or therapeutic leave, staff would provide the current resident /

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responsible party with a copy of the policy. 3. In case of emergency transfer, staff will attempt to provide the resident with a copy and will notify the responsible part of the transfer and policy within twenty-four (24) hours. Staff would follow up with a phone call to clarify any questions concerning the policy on the next working business day.

R17 face sheet dated 7/26/18, indicated a diagnosis of end stage renal disease and malaise. Discharge Minimum Data Set (MDS) dated 4/20/18, indicated R17 had been discharged from the facility with return anticipated. The progress notes indicated R17 had been hospitalized from 4/12/18 to 4/20/18. The progress note dated 4/20/18, indicated a family member brought her back to the facility and R17 was in the same room. The medical record did not contain documentation a bed hold notice had been provided to R17 or the family member.

R17's discharge MDS dated 6/5/18, and progress notes indicated R17 was hospitalized from 5/31/18 to 6/4/18, for a planned surgical procedure, the record indicated the family member returned R17 to the facility. The medical record did not contain documentation of a bed hold notice being provided to R17 or the family member.

The administrator was interviewed on 7/26/18, at 12:00 p.m. and confirmed there were no records of a bed hold notice for the hospitalizations for R17. The administrator stated they were aware of a problem with bed holds and had been developing a new policy but had not yet implemented for nurses to provide a bed hold notice at the time the residents left the facility,

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F 625	Continued From page 17 and for social work to follow up. The facility undated Bed Hold and Return Guidelines indicated the facility would provide written information to the resident or resident representative before the resident was transferred to the hospital.	F 625		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting,	F 676		9/4/18

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F 676	Continued From page 18 §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide supervision and cues during meals for 1 of 1 resident (R142) who required staff direction for eating. In addition facility failed to develop alternate communication tools, as identified on the care plan, for 1 of 1 resident (R5) reviewed for communication. Findings include: R142's diagnoses included cancer, other fracture, generalized muscle weakness and gastro esophageal reflux disease (GERD) which was obtained from the admission Minimum Data Set (MDS) dated 7/13/18. In addition the MDS identified R142 had intact cognition and required supervision and physical assistance of one staff with eating. R142's Physician Order dated 7/23/18, at 1:00 p.m. indicated "Set-up all meal trays and offer hands on assistance with eating." R142's activities of daily living (ADL) Care Area Assessment (CAA) dated 7/13/18, indicated R142 received assistance with cares and mobility. R142's care plan dated 7/23/18, identified R142 had activities of daily living (ADL) / mobility	F 676	1. R142 discharged from facility. R5 was assessed by hospice OT for alternative communication methods. They provided a picture board for staff to use. 2. Residents requiring ADL assistance with dining and communication have been reviewed with care plans updated to ensure they are receiving appropriate care and services. 3. Education has been completed with nursing staff and social services in regard to ensuring appropriate care and services are being given per resident care plan. New residents will be reviewed in daily clinical start up to assess for appropriate care and services for feeding assistance and communication. 4. Five audits will be completed weekly by NHA or designee to ensure care plan of those who have alternative communication methods or feeding assistance is being followed. 5. Audits will be brought to monthly QAPI by NHA or designee.	

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self-care performance deficit related to activity intolerance, Musculoskeletal impairment following a right humerous fracture. The care plan directed staff for eating R142 was totally dependent on one staff for eating.

On 7/23/18, at 12:51 p.m. when asked how things were going with the coordination of services with the facility for R142's hospice, registered nurse (RN) stated she had identified R142 required assistance with meals due to the right humerus fracture and being immobile and was going to write an order for staff to assist her with meals as R142 had expressed not getting assistance with meals.

On 7/23/18, at 1:30 p.m. R142 laid in her bed with her right arm elevated with pillows. When approached and asked how she was doing, R142 stated stated she had recently fallen, sustained a fracture in her arm and was admitted to the facility and hospice. When asked if staff were providing her with the assistance she needed with eating R142 stated she had problems eating and staff were not assisting her with meals. R142 further stated "they bring the food and take the cover off and leave the tray there for me. It doesn't help to complain because it gets worse here. I can manage the finger food only" as she pointed to her right arm.
-At 1:34 p.m. a tray of food was observed on the counter by the door to the room and the plate of food which had pasta, peas and a slice of white meat, which had not been eaten. When asked if she had eaten anything for lunch, R142 stated she was not able to eat the food and no staff had assisted her. R142 stated "I need help and the staff came and set it there. I thought they would come back and nobody came and I was tired and

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F 676	Continued From page 20 dozed off." On 7/23/18, at 7:04 p.m. R142's tray with food was observed on the bedside pull table. R142 was observed laying in bed and was looking out the door. When approached and asked if she needed assistance, R142 stated she did as she was not able to eat the Taco salad with her fingers. -At 7:10 p.m. registered nurse (RN)-C was observed to go into the room with a cup of water and medications and shut the door. -At 7:12 p.m. RN-C came out of the room and left the door wide open. -At 7:40 p.m. surveyor went into the room with RN-A who verified the food tray from lunch was on the counter and had not been eaten. RN-A verified the bedside pull table was out of R142's reach and the tray with food was on the far end of the table. RN-A acknowledged R142 would not be able to reach it even if she wanted to attempt to eat or drink what had been served. RN-A then asked R142 if she needed assistance with eating but R142 declined. She offered soup but R142 decline and asked for ice chips and Ensure supplement. -At 7:45 p.m. as RN-A stated staff was supposed to take the tray out and were supposed to assist resident with meals due to the right arm fracture. RN-A said, "I will talk to the staff." -At 7:48 p.m. RN-C stated he did not know R142 had an order for setting up meals and to provide hands on assistance which had been written by the Hospice RN that same morning. When asked if he had offered to assist R142, RN-C stated R142 had stated she did not want to eat. When asked if she had asked why and if she had offered an alternate RN-C said, "No." RN-A stated she was going to educate the staff.	F 676		

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F 676	Continued From page 21 On 7/25/18, at 8:51 a.m. social worker was observed knock at the door and went into the room with a breakfast tray and left the door wide open. As social worker set the tray on the bedside pull table she stated "I have your breakfast tray." Social worker set the tray on the bedside table took the cover off applied butter on the toast. At 8:53 a.m. social worker left the room she shut the door behind her and never offered R142 any hands on assistance with eating or drinking. -At 9:17 a.m. to 9:26 a.m. no staff went to the room and R142 was observed reached over and grabbed a half piece of toast off the plate and was eating it. -At 9:26 a.m. R142 put the call light on and the staffing coordinator (SC) and surveyor went into the room. As SC approached R142 asked for a cup with a handle to drink out of as she was not able to reach for the glass. -At 9:27 a.m. as SC went towards the door R142 said, "she set the tray there. I can do good with finger foods am eating toast. I want something to drink am dying of thirst. I need a cup with handle" as she pointed to a two ounce glass of apple juice on the tray. R142 stated the bedside table was lower than bed to the left side which was hard to reach. -At 9:33 a.m. RN-A acknowledged staff was supposed to provide assistance per order written by the Hospice nurse "Am going to make sure the staff are clear on this. Yesterday I assisted her. I did put it on the care sheet. We will do better at lunch time." -At 9:35 a.m. to 9:42 a.m. NA-B remained in the room assisted R142 through breakfast as she talked to her and laughed with her. -At 9:43 a.m. NA-B came out with the breakfast	F 676		

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tray, when asked how much R142 had consumed NA-B stated 240 milliter (ml) of beverage and 20% which was two full pieces of toast.

On 7/25/18, at 10:20 a.m. R142's family member stated they had some serious concerns about R142's care at the home which included being assisted with meals among other care concerns.

On 7/25/18, at 1:40 p.m. social worker verified she had delivered R142's breakfast tray that morning. The social worker stated she was not aware R142 had an order to set up and provide hands on assistance with eating. She stated if she knew she would have sat down or gone out and gotten a staff to assist her.

On 7/26/18, at 8:19 a.m. the director of nursing stated she would have expected the staff to follow the orders, care plan and to have offered hands on assistance with meals.

Communication:
R5's communication care plan dated 8/4/16, indicated R5 had a communication problem and could be very soft spoken and hard to understand. The care plan indicated R5 had more difficulty communicating in the evening or when tired. Staff were instructed to allow adequate time for R5 to respond and to wait 30 seconds before providing words if R5 was having difficulty. The care plan also instructed staff to, "Use alternative communication tools as needed."

R5's quarterly MDS dated 4/18/18, indicated R5, was cognitively intact, hearing was ok, speech was unclear usually understood others and was

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usually understood.

During interview on 7/23/18, at 4:23 p.m., R5 stated staff talked over her and spoke down to her. R5 stated it made her feel very bad. R5 stated most of the staff did not understand her and did not try to do so.

During interview on 7/25/18, at 7:45 a.m. the hospice RN-B stated R5's speech was becoming more difficult to understand, and sometimes R5 did not have the energy to talk.

During observation on 7/25/18, at 9:13 a.m. NA-E explained to R5, his plan to assist her with eating in bed and then would get her dressed, because staff were assisting other residents. NA-E stated R5 was a two person mechanical lift transfer. NA-E asked R5 if that was ok, but instead of waiting for an answer, NA-E repeated what he had said.
-At 9:37 a.m., NA-E put R5's call light on for more water, while he continued to assist R5 with breakfast.
-At 9:42 a.m., NA-D knocked on the door and said the call light was on. NA-E asked for more water for R5 and stated R5's brand of water was at the nurse's station.
-At 9:45 a.m. NA-D brought a glass of thickened liquid in. The liquid was clear, not a little bit cloudy as previous glass of thickened water had been. R5 said, "that is the wrong water." NA-D stated it was R5's water. R5 tried one more time to tell NA-D that was not her water, and then looked at surveyor. Surveyor repeated R5's statement and verified that was what R5 had stated. NA-E stated he would get the box of water after he was done assisting R5.
-At 9:55 a.m., NA-E brought in a box of nectar

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thick lemon flavored water to R5. NA-E poured R5 a glass of thickened water that was cloudy in color. R5 drank entire glass of water. NA-E told R5 he would get her up when he had a second person. NA-E lowered head of bed part way. R5 asked for her feet to be lowered three times. NA-E stated he did not understand and asked surveyor what R5 wanted. Surveyor stated R5 asked for the foot of bed be lowered. NA-E lowered the foot of the bed and R5 said thank you.

During interview on 7/25/18, at 11:45 a.m., NA-E stated he could understand R5 some of the time but it was getting harder and sometimes R5 did not have the energy to talk. NA-E stated he could not understand R5 part of the time today while feeding her or doing her morning cares.

During interview on 7/25/18, at 12:38 p.m. NA-D stated she was unable to understand R5 most of the time.

During interview on 7/26/18, at 10:26 a.m. R5 stated most of the staff did not understand her and it was frustrating. R5 stated staff had not used alternate methods of communicating with her. R5 stated she would like some tool to help her communicate her wishes because she knew her ability was going to get worse over time.

During interview on 7/26/18, at 12:42 p.m. RN-A stated sometimes if staff were having a hard time understanding R5, they would ask others to come in and assist. RN-A stated she was unable to say what the alternative tools for communication on the care plan were. RN-A stated facility needed to get together as an interdisciplinary team to update the care plan and the strategies for

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F 676	Continued From page 25 communicating with R5. During interview on 7/27/18, at 8:35 a.m. RN-A stated had obtained orders for occupational therapy to look at communication tools.	F 676		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to investigate bruising for 1 of 4 residents (R29) reviewed for non-pressure related skin concerns. Findings include: R29's diagnoses included dementia and anxiety obtained from the quarterly Minimum Data Set (MDS) dated 5/22/18. In addition, the MDS indicated R29 required limited to extensive assistance for all activities of daily living and R29 had impaired memory problems. R29's care plan revised 5/17/18, identified resident had an actual activities of daily living (ADL) self-care performance deficit related to end stage dementia. The care plan directed staff to complete skin inspection with cares and staff was	F 684	1. Bruises on R29 were put on TAR for monitoring on 7/25/18. Geri sleeves were provided for waking hours for bruise prevention. Care plan was updated. 2. Residents will have a new skin assessment completed to ensure accurate documentation and to determine etiology for any new bruising or skin impairments. Care plans will be reviewed and updated. 3. Education has been provided to nurses on policy and procedure for skin documentation. Education has been completed with NARS to report any new skin areas to licensed nurse. 4. Five skin check audits will be done weekly by DON or designee to ensure compliance. 5. Audits will be brought to monthly QAPI	9/4/18

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

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F 684	Continued From page 26 to observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse. In addition, the care plan directed staff to identify/document potential causative factors and eliminate/resolve causes where possible. On 7/23/18, at 12:47 p.m. to 1:00 p.m. nursing assistant (NA)-B was observed to provide R29 with meal assistance. When approached R29 was observed with bruises on the left forearm, right forearm, right thumb, right index finger and on the right middle finger. All the bruises were different colors. -At 1:35 p.m. when approached and asked how he got the bruises R29 never responded. -At 6:30 p.m. R29 was observed in the dining seated on the wheelchair still wearing a short sleeved shirt and the bruises were visible and none of the staff in the area acknowledged the bruises. On 7/24/18, at 12:57 p.m. to 1:31 p.m. NA-C was observed assist R29 with the lunch meal. The bruises in the hands and finger observed were visible from standing 20 feet away and NA-C never acknowledged the bruises during the entire meal time. -At 1:40 p.m. to 2:11 p.m. R29 was observed seated on the wheelchair next to his bed and chatting continuously. -At 2:11 p.m. when asked if she had reported anything to the nurse regarding R29's skin NA-C stated the night shift usually got R29 dressed for the day and all she did was to transfer R29 to the wheelchair. NA-C further stated she had not seen any skin concerns. Review of R29's Progress Notes dated 7/5/18, through 7/24/18, lacked documentation that the	F 684	by NHA or designee.	

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F 684	Continued From page 27	F 684		

bruises had been assessed. A nursing Progress Note dated 7/24/18, (after concern had been brought to the attention of facility staff by the surveyor), indicated:
-Red-maroon colored bruising to back of left forearm varying in size 0.5 centimeter (cm) to 1.0 cm in diameter, same type of reddish bruising to back of right forearm also varying in size, the largest two measure 3 cm by 3 cm at base of right thumb and index finger and 1.5 cm by 1.5 cm at the base of right middle finger. The note further indicated R29 was unable to verbalize how he sustained the bruising.

On 7/24/18, at 2:14 p.m. registered nurse (RN)-A verified the visible bruises. RN-A stated the NA's were supposed to let the nurses know of any changes in skin so the nurse would assess them. RN-A reviewed the electronic medical record and verified the most recent skin audits completed on R29's shower on 7/5/18, and 7/19/19, and the progress notes had no documentation of the bruises.

On 7/24/18, at 2:23 p.m. RN-E stated the bruises on R29's arms are baseline as R29 grabbed his own arms and was combative at times. When asked if staff assessed or investigated the cause of the bruise, RN-E "usually I would assess when the skin is broken." RN-E further stated she had not gotten any report from the night staff or NA-C about a skin issue "it's a good idea to assess and measure the bruises."

On 7/24/18, at 2:50 p.m. the director of nursing stated she would expect the NA's to report all the bruises to the nurses so they were assessed. She acknowledged the root cause was supposed to be identified.

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F 684	Continued From page 28 On 7/24/18, at 12:04 p.m. NA-B stated staff was supposed to report bruising and any skin concerns to the nurse that was not normal for the resident. NA-B further stated the nurses did all the body checks with all the showers and would document the findings in the medical record. On 7/25/18, at 2:06 p.m. RN-A stated after concern was brought to the facility attention, she had investigated the bruises and she had found out staff including hospice were aware of the bruising however the medical record lacked documentation the bruises had been assessed and were being monitored.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions to reduce the risk for falls for 1 of 4 residents (R31) reviewed for falls. In addition, the facility failed to properly assess the use of a mechanical stand harness to ensure proper fit for 1 of 2 residents (R56) reviewed for accidents. Findings include:	F 689	1. R31's floor mats are in place. R56 was assessed by OT and appropriate sling is being used. 2. All residents using floor mats have floor mats in place. Licensed nurses will monitor for floor mat placement each shift. All residents using standing lift are being transferred by appropriate sling setting. All new residents who utilize standing lifts	9/4/18

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F 689	Continued From page 29 R31's admission minimum data set dated 5/23/18, indicated she was moderately cognitively impaired and required extensive assistance with all activities of daily living. R31's care plan dated 5/16/18 idenfied a self care deficit related to weakness, limited physical mobility and a history of falls on 6/17/18, 6/19/18, 7/17/18, and 7/23/18. The care plan directed staff to anticipate R31's needs, keep call light in reach and place fall mats on both sides of the bed. A review of R31's Fall Risk Evaluation dated 7/23/18, indicated she sustained a fall with major injury. A review of facility Progress Notes dated 7/23/18, indicated R31's fall was reviewed. She was found on the floor on her left side, appearing to have fallen out of bed. R31 sustained a dislocated left hip. Mats to be placed on floor next to bed to reduce the risk for injury. During an observation on 7/25/18, at 7:36 a.m. R31 was observed lying in her bed. A fall mat was on the floor on the right side of her bed but no mat was in place on the left side of the bed. A second fall mat was leaning up against the wall in R31's room. During interview on 7/25/18, at 7:43 a.m. nursing assistant (NA)-D stated she thought R31 had fallen and broken her hip. NA-D stated staff were directed to make sure R31's call light was in place, make sure she has fall mats by her bed and check on her constantly because she was a fall risk. NA-D entered R31's room and verified there was no fall mat on the left side of the bed. During observation on 7/26/18, at 5:15 a.m. two NA's were observed exiting R31's room. Upon entering the room R31 was in bed and appeared	F 689	will be reviewed by nursing to determine appropriate sling settings. Sling settings for each resident using the standing lift will be communicated to staff via care plan and care delivery guide. 3. Education has been completed with nursing staff on appropriate sized slings and where to locate slings. Education has been completed with nursing staff on ensuring fall floor mats are in place. 4. Five audits will be completed weekly by DON or designee to ensure fall interventions are in place. Five audits will be conducted to ensure appropriate sized sling is being used for each patient that requires them. 5. Audits will be brought to monthly QAPI by NHA or designee.	

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F 689	Continued From page 30	F 689		

to be sleeping. R31's floor mat was not on the floor next to her bed and was observed leaning against the wall next to her bed side table.

During interview on 7/25/18, at 7:51 a.m. registered nurse (RN)-A stated R31's most recent fall happened during the over night shift. RN-A stated R31 dislocated her hip when she fell. RN-A stated R31's fall interventions included placing fall mats on both sides of her bed and stated the intervention had been communicated to the NA's and the information updated on the NA care sheets.

A facility policy related to following the plan of care was requested but not received.

R56's admission minimum data set dated 5/23/18, indicated she was moderately cognitively impaired and required extensive assitance with transfers and toileting. R56's care plan dated 6/21/18, identified a self care deficit related to activity intolerance and directed staff to use a mechanical lift for transfers.

During an observation on 7/26/18, at 8:48 a.m. NA-F and NA-G entered R56's room to assist her to the toilet. NA-F and NA-G assisted R56 to lean forward in her chair and applied a mechanical stand harness, size extra large, around her waist. After the harness was connected to the mechanical stand NA-F raised R56 to a semi standing position. The sling did nut fit snugly around R56's waist and rode up under her arm pits as she was wheeled approximately 10 feet to the bathroom.

During an interview on 7/26/18, at 12:25 p.m. NA-G stated staff were directed to apply the

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F 689	Continued From page 31	F 689		

harness for the mechanical stand and adjust the strap to fit the resident. NA-G stated there was only one harness available for use on the unit and all the residents who used the stand used the same size harness.

During interview on 7/26/18, at 12:41 p.m. NA-F stated R56 had been using the mechanical stand since approximately three weeks after she admitted to the facility. NA-F stated the nurse communicated the information to her but did not give direction regarding what size harness to use. NA-F further stated she thought there was more than one harness available and stated, "the one on the unit is kind of big."

During interview on 7/26/18, at 1:00 p.m. registered nurse RN-F stated a care plan for each resident is kept inside their closets. RN-F stated he currently had R56 care planned to transfer with a mechanical lift but stated there had been a recent change and she now required assist of one staff. In regard to the use of the mechanical stand, RN-F was asked how staff were educated on what size harness to use, RN-F stated, "I would have to get that answer for you." RN-F stated the facility kept a small supply of harnesses downstairs near the laundry room.

During an interview on 7/26/18, at 1:08 p.m. the director of rehabilitation services stated three residents on the unit currently used a mechanical stand and the therapists educated staff on what size harness was appropriate for the resident. At 1:45 p.m. the director of rehabilitation services stated she had just assessed R56. She stated R56 should be wearing a regular sized sling and stated she was not a bariatric patient further stating she changed R56 to a regular sized sling.

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F 689	Continued From page 32 A facilty policy related to the use of mechanical stand devices was requested. A facility provided document titled Guideline on Sara and Maxi, undated, indicated a Sara is a mobile raising aide utilized for raising to a standing position and short transfer of residents such as standing to transition to a wheel chair or from wheel chair to bed. The document did not address sizing of the harness to the resident.	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 693	1. G-tube placement is being checked	9/4/18

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F 693	Continued From page 33 review, the facility failed to ensure gastrostomy tube (G-tube) placement was checked prior to medication administration for 1 of 2 residents (R64) receiving medications through a G-tube. In addition, the facility failed to ensure medications were given via gravity for 1 of 2 residents (R64) reviewed for medication administration Findings include: R64's quarterly Minimum Data Set (MDS) dated 6/28/18, indicated diagnoses that included dysphasia, aphasia and hemiplegia. In addition, the MDS indicated R64 received tube feeding. On 7/26/18, at 9:41 a.m. registered nurse (RN)-B set up R238's medications to give via G-tube. At 9:46 a.m. RN-B entered R64's room, approached R64 indicated she was going to administer medications and give her enteral feeding via G-tube. RN-B then pulled the bedside table and set a tote with all the medications on top. RN-A then obtained water in a graduate cylinder then excused herself briefly and left the room and went into the medication room then came back right away with a carton of Osmolite. At 9:52 a.m.after applying gloves RN-B was observed pick the G-tube, then removed the tab closure and inserted a syringe into the feeding port and aspirated 200 milliters (ml) of residual without checking tube placement. At 9:54 a.m. with stethoscope around the neck RN-B was observed draw 60 ml of the residual and pushed it into the G-tube feeding port without checking placement. At 9:56 a.m. before pushing the second 60 ml syringe of residual, RN-B removed gloves applied another pair then used a stethoscope to check placement. -At 9:57 a.m. to 10:08 a.m. RN-B was observed	F 693	and R64 is receiving medications per standard of practice. 2. All residents with G-tubes are receiving meds and treatments per standard of practice. 3. Nurse identified was educated on policy and procedure for medication administration and checking residuals. All licensed staff will be educated on enteral tube medication administration and checking residuals. 4. Five audits will be completed weekly until no deficient practice is identified. Audits will be conducted by DON or designee. 5. Audits will be brought to monthly QAPI by NHA or designee.	

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F 693	Continued From page 34 draw out medications mixed with five ml of water in seven separate small cups and pushed the liquid into the G-tube one at a time. During the observation, RN-B was observed give five ml of water between each medication administration and then gave 30 ml of water via pushing through the G-tube feeding port. On 7/26/18, at 10:21 a.m. RN-B stated G-tube placement was always supposed to be completed administering anything. When asked what the facility policy was for giving medications via G-tube RN-B stated she did not know. RN-B further stated because R64 did not have a specific order to give medications by either bolus or gravity that was why she had pushed all the medications using the syringe. On 7/26/18, at 10:35 a.m. the director of nursing stated the nurses were supposed to check placement before giving any medications or tube feeding and medications were supposed to be given via gravity. The director of nursing further stated if a resident was to get medications in a different way then what the facility policy directed, then staff would get an order for it. The facility Medication Administered Through an Enteral Tube Guideline dated 11/28/17, indicated staff should check the placement of G-tubes in accordance with facility policy. In addition the guideline directed staff to insert medication syringe in appropriate port then staff was to remix the medication and pour into the medication syringe to allow medication to flow down the syringe via gravity "Do not push medications through a tube."	F 693		
F 761	Label/Store Drugs and Biologicals	F 761		9/4/18

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F 761 SS=E	Continued From page 35 CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure unauthorized staff did not have access to 1 of 4 medication rooms where multiple stock and prescription medications were stored. Findings include: On 7/23/18, at 5:51 p.m. nursing assistant (NA)-A was observed approached registered nurse	F 761	1. Key that was hanging on the wall by medication room was immediately removed by DON on 7/26/18. Medications were removed from nonoperational medication room immediately upon notification on 7/23/18. No residents were adversely affected. DON took key from Maintenance Director immediately upon notification on 7/23/18. 2. There are no other non-operational	

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F 761	Continued From page 36 (RN)-C who was seated at the nursing station and requested access to the medication room. RN-C stood up grabbed a single key on a lanyard which was hanging on the wall next to the chart rack and opened the door to the medication room. NA-A then was observed go into the medication room and shut the door behind as RN-C hang the key back on the hook and came back sat at the nursing station. After about 20 seconds NA-A came out of the medication room carrying hygiene supplies. -At 5:54 p.m. when asked if the NA-A was a trained medication aide (TMA), RN-C stated most NA's were TMA's and he thought NA-A was a TMA "I have not worked here for a long time and thought he was a TMA." -At 5:55 p.m. RN-A stated RN-C was supposed to be in the medication room with the NA-A or get the supplied for him. During a brief tour to the medication room with RN-A, multiple stock over the counter medications in the cabinets and prescription refrigerated medications in containers were observed stored in the medication room. RN-A further stated "We just moved the medication refrigerator in there and will have to do education." -At 5:59 p.m. to 6:03 p.m. the single key in the lanyard for the medication room remained hanging on the hook and RN-C was not in the area. -At 6:04 p.m. RN-A was observed grab the medication key off the hook. When asked about the observation, RN-A stated where the key was stored was not an appropriate and she was going to put the single key with the rest of the medication cart keys. On 7/26/18, at 7:24 a.m. the director of nursing stated nurses were supposed to have medication	F 761	medication rooms. All other medication rooms were reviewed to ensure appropriate security. 3. Maintenance Director was educated on 7/23/18 regarding only licensed staff and pharmacy having keys to medication rooms. Nursing staff were educated on medication storage. 4. Five medication room audits will be conducted weekly to ensure rooms are locked appropriately and keys are only accessible by licensed staff. Audits will be conducted by DON or designee. 5. Audits will be brought to monthly QAPI by NHA or designee.	

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

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F 761	Continued From page 37	F 761		

room keys on them and only authorized staff was supposed to have access to the medication rooms.

The facility 5.3 Storage and Expiration of Medications, Biological, syringes and Needles policy revised 10/31/16, directed only authorized facility staff as determined by the facility was to have possession of the keys which opened medication storage areas.

On 7/23/18, at 6:43 p.m., outside the second floor dining room, a medication room door was observed to be propped open with an empty medication container. There were no staff members present in the area and several residents were eating the evening meal in the dining room. The room contained multiple cards of expired medications laying on top of a counter. The medications included but were not limited to Levothyroxine, Metformin, Atenolol Senna, Clopidogrel, Keppra, Digoxin, Trazadone, Lisinopril, Zofran, phoslo, Atorvastatin, Coumadin, Amoxicillin, Cyclobenzaprine and Gabapentin, metoprolol. Inside a cabinet in the room was a box labeled E-kit (emergency kit) which contained Haldol, naloxone and Clonidine along with various other medications.

During an interview on 7/23/18, at 6:43 p.m. RN-A stated the room was not currently in use and stated it was used when they had another nurses station open. She stated she did not know who opened the door and would investigate.

During interview on 7/23/18, at 7:01 p.m. the director of nursing stated the construction crew had left the door open. She stated the

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F 761	Continued From page 38 maintenance employee told her had unlocked the door for them and stated the station was no longer in use. The DON further stated the maintenance department should not have a key to access a room where medications were stored.	F 761		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide adaptive equipment in order to promote independence with eating for 1 of 1 resident (R50) observed with difficulty while eating during dining observations. Findings include: R50's annual Minimum Data Set (MDS) dated 6/18/18, identified R50 had moderately impaired cognition and diagnoses including dementia, cataract and unspecified blindness. In addition, the MDS indicated R50 required supervision with eating after setup help only with eating. R50's nutrition care plan dated 7/15/17, identified R50 had a nutritional problem or potential problem related to being legally blind and used a plate guard at all meals. In addition the care plan for vision dated 2/8/16, identified R50 had impaired visual function and directed staff to tell the resident where they placed items and to be	F 810	1. R50's plate guard is in place and is being utilized per care plan. Tray ticket updated to reflect the need for food orientation. 2. Like residents who require assistive devices/eating equipment will be reviewed to ensure items are in place, items are listed on tray ticket and care plan reflects need. Like residents who require food orientation have been reviewed to ensure care plan is being followed. 3. Education has been conducted with dietary staff to ensure assistive devices/eating equipment is being delivered to the floor. Education has been completed with nursing staff to ensure assistive devices/eating equipment are in place and group sheets are being followed to ensure proper assistance to residents. 4. Five audits will be conducted weekly to	9/4/18

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F 810	Continued From page 39 consistent." On 7/23/18, at 6:55 p.m. nursing assistant (NA)-A was observed approach R50 with a tray which had a regular flat plate of taco salad, beans and chips and set it in front of R50. At 6:56 p.m. NA-A then oriented R50 where the coffee and juice were then as he left the table R50 was heard ask three times what was on the plate however, NA-A never responded to R50 even though he was standing approximately five feet behind R50 arranging other resident food trays. -At 6:57 p.m. R50 stated in a loud voice "there is no dressing on the salad" as she took bites of the salad using her fingers but there was no staff at the dining room. R50 was observed feel the food using her right hand and as she did that the food was spilling off the plate to the food tray. -At 6:59 p.m. R50 was observed to feel the plate and grabbed a small container which had salsa and held the container in her left hand. R50 then was observed to dip one piece at a time of either the lettuce and tomatoes into the salsa until 7:15 p.m. never asked for any assistance. -At 7:16 p.m. R50 was observed to cough and registered nurse (RN)-A approached. R50 requested a ride to her room but as RN-A wheeled her away from the table R50 asked RN-A if she had eaten all her food and RN-A said, "No." R50 asked RN-A to bring her back to the table. RN-A then used the clock to re-orient R50 where the food was on the plate. R50 then was observed to attempt to eat the food with a spoon, but most of the food when she was reaching and feeling it, was spilling to the tray or the blanket on her lap. -At 7:21 p.m. again R50 asked if there was dessert and RN-A approached and indicated to R50 she had a cookie on the left side corner of	F 810	ensure residents plan of care related to assistive devices/eating equipment and eating assistance is being provided. By DON or designee. 5. Audits will be brought to monthly QAPI by NHA or designee.	

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F 810	Continued From page 40	F 810		

the tray however she was going to hand it to her. RN-A then was observed leave the dining room went outside the hallway and came back wearing a pair of gloves and picked the cookie off the tray and handed it to R50 who stated "thank you honey."
-At 7:26 p.m. R50 finished drinking the coffee then said, "Am cold."
-At 7:27 p.m. RN- came back to the dining room and asked R50 if she had completed eating and then wheeled R50 to her room.
-At 7:30 p.m. when asked how much R50 had consumed of the meal RN-A stated approximately 90% of the food with 480 milliliter (ml) of the beverages. RN-A verified R50 had spilled some of the food in the process of reaching and feeling for it. RN-A verified R50's plate had no plate guard "usually the plate comes with the guard from the kitchen. I will talk to them." RN-A stated the staff overall was supposed to use the clock to describe where the food was due to R50 being blind and staff was to tell R50 what was on the plate. RN-A further stated NA-A should have put the salsa on R50's salad or at least asked if she wanted it.
-At 7:32 p.m. NA-A stated he did not know R50 was supposed to have a plate guard. NA-A acknowledged he had not told R50 what had been served and he had not responded to R50 when she was asking about the dressing for the salad. NA-A stated he had gone to the kitchen to ask for the dressing however was told salsa was what had been served and he had returned to the dining room and observed R50 had located the salsa and never asked if she wanted it on the taco salad.

On 7/24/18, at 8:58 a.m. NA-B was observed place the breakfast tray with R50's food in front of

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F 810	Continued From page 41 her. NA-Caroline took the lid off and two pieces of toast with one hard boiled egg were observed at the center of the regular plate with no plate guard. NA- asked resident if she wanted milk in the oatmeal but R50 declined. On 7/24/18, 9:03 a.m. NA-B stated she was aware R50 required a plate guard at all meals and the kitchen was supposed to send it the food and thought at time the dietary staff forgot. On 7/26/18, at 12:33 p.m. the dietary manager (DM) said, "It should be our serving team person dishing the plates to make sure it's there." When asked about the plate guard for R50. The dietary manager stated after concern was brought to the facility attention she had found the plate guide in one of the drawer in the kitchen. The dietary manager acknowledged due to R50 being blind and not being able to see the food she needed the plate guard and she had talked to her staff to make sure they looked for it immediately or to let therapy be aware of it to provide the adaptive device.	F 810		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		9/4/18

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and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable 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

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F 880	Continued From page 43 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to perform appropriate hand hygiene for 5 of 8 residents (R56, R29, R77, R33, R5) observed during treatment and cares. in addition facility failed to sanitize shared resident equipment after use by residents on contact precautions for C-diff before returning equipment to storage usage for use by non infected for 2 of 2 residents (R56, R49) who were on contact precautions. In addition failed to clean the urine collection bag appropriately after emptying it for 2 of 4 residents (R33, R5) reviewed for a catheter. In addition, the facility failed to develop a system wide program to identify trends for infections specifically related to Clostridium difficile (C-Diff), a specific kind of bacterial infection that causes mild to life-threatening forms of diarrhea and colitis. Findings include: R56's admission minimum data set (MDS) dated 6/22/18, indicated she was moderately cognitively	F 880	1. Residents R56,R29, R77, R33 and R5 are receiving care and services with proper infection control technique. R49 discharged from facility on 8/6/18. 2. All residents are receiving proper care and services with proper infection control techniques. All multi resident use equipment is being sanitized per infection control policy and procedure. All shower rooms are being cleaned. All shower chairs are being cleaned between use. All urinary collection bags are being cared for utilizing appropriate infection control techniques. Mesh bags were added to all lifts and vital machines to hold disinfectant wipes for staff to clean equipment per policy. Locked cabinets were placed in each shower room to store virex cleaning solution. Designated vitals equipment bags have been provided for isolation rooms. Housekeeping manager will be cleaning lifts bi-weekly.	

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F 880	Continued From page 44 impaired, required extensive assitance for transfers and toileting and was frequently incontinent of bowel and bladder. R56's care plan dated 6/21/18, identified a self care deficit and directed staff to assist with all activities of daily living. A review of R56's Order Summary Report dated 7/27/18, identified the following orders: 7/20/18, Contact isolation every shift for C-diff. 7/20/18, Vancomycin solution 250 milligrams (mg) by mouth four times daily for C-diff. During observation on 7/23/18, at 5:05 p.m. R56 was noted to have an infection precaution cart outside the door to her room. Nursing assistant (NA)-F stated R56 had C-diff and stated a resident two doors down in room 134 also had C-diff. During the observation, a cart was also observed outside the door of room 122. During observation of the transitional care unit shower room on 7/26/18, at 5:33 a.m. a sign was posted on the wall directing staff to clean the shower room and shower chair with Virex cleanser. The sign indicated the cleanser was locked in a cabinet in the shower room. There was no cabinet in the shower room and no cleanser in the room. At 7:31 a.m. NA-F assisted a resident to the shower room. At 7:50 a.m. NA-F completed the shower and assisted the resident back to room. The shower room had linens on the floor next to the shower chair and no sanitizer was observed in the room. At 7:54 a.m. NA-F again entered the shower room. NA-F picked up linens from floor, placed them in bags, replaced the bags, turned off light and left room. There was still no sanitizer noted in shower room.	F 880	3. All staff have been re-educated regarding our infection control program including; proper hand washing, glove changes, isolation room procedures, cleaning of equipment, shower rooms and c-diff. NARS and nurses will be educated on empting catheters, ostomy bags and peri care. New process will be implemented by DON for better tracking and trending of infections in daily clinical start up. With every new infection mapping will be brought to IDT to better identify trends of locations and infection patterns. 4. Five cleaning of equipment audits will be completed weekly. Five peri care/ostomy audits will be conducted weekly. Five empting of urinary catheter bags will be completed weekly. Shower cabinets will be audited weekly to ensure virex solution is available. 5. Audits will be brought to monthly QAPI by NHA or designee.	

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F 880	Continued From page 45 During observation on 7/26/18, at 8:24 a.m. NA-F entered R56's room after applying a gown, gloves and shoe protectors. NA-F removed R56's incontinent product and used wipes to clean her perineum. At 8:30 a.m. R56 requested to use the toilet. NA-F stated she would need to get another NA to assist and applied a clean brief, removed her gloves and left the room without performing any hand hygiene. NA-F waked to the other side of the unit and retrieved a mechanical stand from the tub room and brought it to R56's room. NA-F then stated she had to look for the other NA on the unit. At 8:48 a.m. NA-F returned with NA-G. NA-F and NA-G applied gloves, gowns and shoe covers and entered R56's room with the mechanical stand. R56 was assisted to sit up on the side of the bed. The mechanical lift harness was placed around R56's waist, hooked to the machine and R56 was assisted to the toilet. At 8:53 a.m. while R56 was seated on the toilet, NA-F and NA-G removed the personal protective equipment (PPE). NA-F, without performing any hand hygiene, picked up R56's telephone and used it to call the kitchen. NA-G left the room and washed her hands. At 9:08 a.m. R56 put her call light on. NA-F and NA-G donned PPE and entered R56's room. NA-F removed R56's brief and wiped stool from her bottom with wet wipes. NA-G handed NA-F a tube of cream and NA-F, still wearing the same gloves, removed the cap, applied some cream to R56's bottom, replaced the cap and placed the tube on the hand rail behind the toilet. Without performing hand hygiene or changing gloves, NA-F applied a new brief. NA-F and NA-G re-applied the harness to R56's waist, hooked the harness to the lift and assisted R56 into her wheel chair. The harness was removed from around R56's waist and place on top of the	F 880		

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mechanical stand. NA-F, still without performing hand hygiene or removing gloves, grabbed the handles of the wheel chair and pushed R56 up to the sink in her room. NA-F and NA-G then removed the PPE and left the room without performing hand hygiene. NA-G took the mechanical lift down the hallway then returned to the sink and washed her hands. At 9:29 a.m. NA-G removed the stand from the hallway and placed it in the tub room of the unit and left the room without sanitizing the stand.

During interview on 7/26/18, at 9:30 a.m. NA-F stated she had not received training related to C-diff precautions since it had been identified on the unit. NA-F stated, "I know if you get it on you, it's not good." She stated hands should have been washed prior to going into the room, after changing the resident and after leaving the room. NA-F stated she had not received education regarding sanitizing the mechanical stand and further stated she had been employed in the facility for four months and had never used sanitizer to clean the shower and did not know where to find it.

During interview on 7/26/18, at 9:35 a.m. registered nurse (RN)-F stated there were currently three residents on the unit on precautions related to C-diff. RN-F stated two of the residents acquired C-diff while in the facility. RN-A stated the staff needed to wear PPE, wash their hands with soap and water and should sanitize all equipment going in and out of the room with bleach wipes. RN-A observed the tub room with surveyor and verified there was no sanitizer available for use in the room. Surveyor alerted RN-A the mechanical stand had not been sanitized. RN-A further stated the shower room

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should have been sanitized in between residents. RN-A located a bottle of sanitizer on a shelf in a utility room on the unit.

During interview on 7/26/18, at 12:25 p.m. NA-G stated she had received a brief education related to C-diff. NA-G stated staff were to wash hands prior to entering a room, wear PPE and wash hands any time they got dirty. NA-G stated there were sanitizing wipes available to wipe down the vitals machine but stated she had never been educated to wipe down the mechanical stand.

During interview on 7/26/18, at 12:31 p.m. registered nurse (NA)-F stated the mechanical stand shared between three residents on the unit was the only stand available for use on the unit.

During interview on 7/26/18, at 12:36 p.m. licensed practical nurse (LPN)-H stated R56 was still having loose stools. LPN-H stated there was not much training in the facility related to C-diff. She stated a cart was put outside the door but staff did not receive training related to sanitizing equipment that went in and out of the room. LPN-H stated she thought there should be a refresher training when there were new cases of C-diff. LPN -H further stated the two most recent cases were contracted while in the facility and stated one resident had been on antibiotics but R56 had not.

A review of facility documents titled Infections and Antibiotics dated January 2018 through July 2018 identified the following cases of C-Diff.

1/9/18 - R47, room 232
1/29/18 - R192, room 125

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F 880	Continued From page 48 2/14/18 - R192, room 134 (readmitted) 3/18/18 - R11, room 222 3/24/18 - R49, room 135 4/9/18 - R195, room 138 4/10/18 - R194, room 123 4/19/18 - R196, room 124 4/23/18 - R193, room 138 5/4/18 - R194, room 123 5/22/18 - R197, room 128 7/11/18 - R1, room 124 7/19/18 - R48, room 134 7/19/18 - R56, room 138 During an interview on 7/25/18, at 7:26 a.m. RN-F stated infections were tracked by RN-A and the director of nursing (DON). RN-F stated he did not track ongoing on the unit and stated, "as they happen I keep a mental note." During and interview on 7/26/18, at 12:04 p.m. RN-A stated infections were tracked on a monthly basis. RN-A stated she tracked who was started on and antibiotic, how long they were on the antibiotic and reviewed the infections monthly with the interdisciplinary team (IDT). RN-A stated the pharmacy sent out a monthly report of the antibiotics. RN-A stated she used a facility map to track the locations of the residents with infections and try to contain the infections. RN-A stated in the past year she had not identified any trends and stated in relation the to C-diff, some of the residents admitted to the facility and some acquired it while residing tin the facility. She stated the procedure followed after identifying a new infection was to place a cart outside the residents door with PPE and make sure everyone was aware of the precautions. RN-A stated she was unsure if there had been any recent training related to infection control precautions for C-diff.	F 880		

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During interview on 7/26/18, at 12:47 p.m. the director of nursing (DON) stated the IDT reviewed new antibiotics and new infections daily. The DON stated resident identified with C-diff were placed on precautions and stated the infections were tracked on a spread sheet. She stated the infections were reviewed in the quality assurance meetings and were reviewed with the medical director. The DON stated the facility mapped the locations of the infections and stated C-Diff was something the facility had a long standing issue with. She stated she did not recall a trend with facility acquired C-Diff but did identify the two most recent cases were acquired in house. The DON stated the facility had not looked at staff breaks in infection control and stated she expected staff to follow the appropriate precautions. During a subsequent interview on 7/27/18, at 3:01 p.m. the DON stated the IDT looked at the mapping and where the outbreaks were located and if they were in the same vicinity or same floor. She stated "looking back at the C-diff prior to this month, we haven't noticed any location trends as far as mapping," even though, 10 of 12 cases originated on the transitional care unit, station two.

A facility policy titled Villa, Infection Prevention and Control Guidance dated 11/28/17,was reviewed. The policy indicated the facility practiced infection prevention and control based upon information from the facility assessment and following national standards to prevent, recognize and control the onset and spread of infections. The policy identified the use of surveillance, reporting and the use of standard and transmission based precautions and directed staff to perform hand hygiene when providing direct

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care, handling resident care equipment and the environment.

R49's admission record dated 3/15/18, indicated diagnoses complete paraplegia. R49's quarterly Minimum Data Set (MDS) dated 6/18/18, indicated had the ability to understand others and make self understood, was cognitively intact.

During morning cares observation on 7/25/18, the following was observed, R49 was on contact precaution for Extended-Spectrum Beta-lactamase (ESBL)- a superbug resistant to antibiotic treatments:

-8:15 a.m. nursing assistant (NA)-I and NA-J entered R49's room to assist resident in morning cares.
-8:45 a.m. NA-I was observed to bring mechanical lift into R49's contact precaution room. NA-I placed the lift under R49's bed. NA-I and NA-J attached sling loops to the lift and R49 was lifted off the bed and lowered into wheelchair.
-9:15 a.m. NA-I removed the mechanical lift out of the room, placed it outside of R49's room, paralled to the wall next to R49's door. NA-I and NA-J proceeded to finish morning cares including chaning bed linens.
-9:26 a.m. mechaninal lift hallway.
-9:34 a.m. NA-J was observed to take mechanical lift to use for another resident. Surveyor stopped NA-J.

During an interview on 7/25/18, at 9:40 a.m. NA-I confirmed mechanical lift was not wiped down before taking out of R49's contact precaution room. NA-I further indicated the overnight shift cleaned it and was not aware of anything specific regarding the cleaning of equipment from a

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contact precaution room. NA-I proceeded to move the mechanincal lift back into R49's room and clean it with disinfecting wipes which was already in resident's room.

During an interview on 7/26/18, at 10:51 a.m. assistant director of nursing (ADON) verified that equipment should be cleaned after use in a contact precaution room.

On 7/25/18, at 7:24 a.m. NA-E was observed to provide R29 pericare to his bottom as R29 laid on his left side. During the observation, NA-E used several wipes to wipe off bowel movement from R29's bottom, then reached for a tube of skin barrier cream, took the cap off, and applied the cream to R29's bottom with the same gloves used to clean the bowel movement. NA-E with the same gloves applied a clean pad under R29's bottom and then removed the gloves. NA-E then applied another pair of gloves without washing hands, laid R29 on his back and provided pericare in the front using wipes. The used wipes were observed to have smears of stool. NA-E then fastened R29's pad.
-At 7:26 a.m. as NA-B came into the room, NA-E reached out and pulled the privacy curtain with the same gloves used to provide pericare. NA-E then turned resident to the right and left sides, adjusted the pants and applied the shoes still with the same gloves.
-At 7:31 a.m. as NA-E was going to assist R29 to sit on the edge of bed, surveyor intervened and requested NA-E to remove the gloves and wash his hands.
-At 7:33 a.m. NA-B and NA-E transferred R29 to the wheelchair using a transfer belt and then repositioned R29 on the wheelchair.
-At 7:38 a.m. applied gloves prior to combing

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R29's hair.
-At 7:41 a.m. NA-E removed gloves stated he was going to get more towels left the room without washing hands.
-At 7:43 a.m. NA-E came back to room, applied a pair of gloves shaved R29 and washed his face.
-At 7:58 a.m. NA-E was observed to brush R29's teeth and then had R29 rinse his mouth and spit on to a small basin. When R29 had completed rinsing his mouth NA-E was observed to dump the secretions in the sink, rinsed the basin and tooth brush then came back wiped R29's mouth and went over to the sink area gathered all the soiled linen and then removed the gloves the gloves.
-At 8:03 a.m. without washing his hands, NA-E was observed to go over to R29's roommate to assist with a transfer. At this point surveyor intervened and asked NA-E to wash his hands.

Cleaning catheter drainage bag tube:
On 7/23/18, at 2:16 p.m. a urine collection bag was observed to be hanging on the right side of the bed frame and a strong odor of urine was noted in the room.

On 7/24/18, at 1:47 p.m. NA-H applied gloves and went into the bathroom to obtain a graduate to drain the urine into. NA-H set the urinal on the floor, without barrier, drained the urine from the collection bag, clamped the tube and inserted the tip of the tube into the holder on the bag. NA-H took the urinal to the bathroom, poured the urine into the toilet, rinsed the urinal with water from the sink, poured the water into the toilet and set the urinal on the back of the toilet tank. NA-H removed gloves and washed her hands.
-At 2:03 p.m. NA-H acknowledged she had not

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used a barrier under the urinal when emptying the urine and she had not cleaned the tubing tip of the collection bag after emptying it. NA-H stated the bags were changed every so often and did not think she was supposed to wipe the tubing tip. When asked what the facility was, NA-H stated she was going to find out and would get back.
-At 2:06 p.m. NA-H approached stated the director of nursing was going to provide the policy.

On 7/24/18, at 2:51 p.m. the director of nursing stated she would expect the staff to clean the spout with an alcohol wipe before re-inserting it back into the holder on the bag.

The undated Emptying a Urinary Drainage Bag procedure directed staff, "5. After the urine has drained into the graduate, wipe the emptying spout with a alcohol wipe, re-clamp the emptying spout and return it to the holder."

Catheter Cares and Cleaning Catheter Bag Drainage Tube:
On 7/23/18, at 12:10 p.m. R5 was seated in a Broda wheelchair. R5 was asleep and the Foley catheter bag was observed lying on the floor. The urine was clear amber and urine was along the entire length of the tube.

On 7/23/18, at 6:47 p.m., R5 was observed in bed with Foley catheter bag lying on the floor. The urine was clear amber and urine was along the entire length of the tube. There was a privacy bag attached to the bed above the catheter bag.

During observation of morning cares on 7/25/18,

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at 10:26 a.m. nursing assistant (NA)-D put on gloves and went to the bathroom to get a urinal to empty R5's catheter bag. NA-D drained the urine from the Foley catheter bag into the urinal, clamped the tube and inserted the tip of the tube into the holder on the bag. NA-D took the urinal to the bathroom, poured the urine into the toilet, brought the urinal back into R5's room and rinsed the urinal with water from the sink. NA-D took the urinal to the bathroom, poured the water into the toilet, and set the urinal on the back of the toilet tank. NA-D removed gloves and washed her hands. NA-D washed R5's abdomen, peri-area and groin. NA-D moved R5's suprapubic catheter tubing but did not wipe it down.

During interview on 7/25/18, at 11:45 a.m. NA-E stated nursing assistants were supposed to clean the catheter tubing during morning and evening cares. NA-E stated he thought NA-D had done so when she washed R5's abdomen.

During interview on 7/25/18, at 12:38 a.m. NA-D verified she did not wipe the catheter tubing. NA-D verified she had not cleaned the tubing tip of the collection bag after emptying it.

During interview on 7/26/18, at 12:42 p.m. registered nurse (RN)-A stated staff were to do catheter cares with morning and evening cares. RN-A stated for a suprapubic catheter, staff were to wipe the catheter from the dressing to the connection to the urinary collection bag. RN-S stated nurses were to do the suprapubic dressing changes. RN-A stated staff were to clean the end of the drainage spout, drain the urine from the catheter bag, clean the end of the drainage spout and then reinsert it into the side of the catheter bag.

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F 880	Continued From page 55	F 880		

Hand hygiene with Colostomy care and Pericare
On 7/26/18, at 7:30 a.m. R77 said to licensed practical nurse (LPN)-A, "I need to have them change my colostomy bag" LPN-A checked R77's colostomy bag and told R77 that the bag was intact and that NA-K would empty the bag and get R77 dressed for the morning. NA-K entered the room, washed his hands and put gloves on. NA-K helped R77 get untangled from the blankets and put a transfer belt about her waist. NA-K assisted R77 to stand and transfer to a wheel chair. NA-K took R77 to the bathroom , assisted her to stand and removed a wet incontinence brief. R77 sat on the toilet and voided a small amount of urine into the toilet. NA-K unclipped the end of the colostomy bag and emptied the stool into the toilet. NA-K got a small drop of stool on R77's left thigh. NA-K wiped the stool off R77 thigh. NA-K removed his gloves, then without washing or using an alcohol based hand sanitizer put a clean pair of gloves on. NA-K got clothing out of the closet and had R77 choose a shirt and pair of pants to wear. NA-K put the shirt on R77 and put the pants on, and pulled them up to her knees, and put her shoes and socks on. R77 stood up and held on to the safety rail while NA-K performed pericare and wiped R77's bottom. NA-K put an incontinence brief on R77 and pulled her pants up. NA-K assisted R77 to the wheel chair and brought resident out to the sink. NA-K removed gloves and washed hands.

During interview on 7/26/18, at 8:18 a.m. registered nurse (RN)-F stated NA-K should have washed his hands between glove changes and should have changed his gloves after washing R77's peri area, before doing anything else.

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F 880	Continued From page 56 During interview on 7/26/18, at 1:15 p.m. the director of nurses (DON) stated catheter bags belong in privacy bags, not on the floor. The DON stated staff should do catheter care on residents during morning and evening cares. The DON stated were wash hands after changing their gloves. The DON stated staff should change gloves after performing peri-care.	F 880		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE 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. An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on July 30, 2018. At the time of this survey, The Villa 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. 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	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/22/2018

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

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K 000	Continued From page 1 IS NOT REQUIRED.	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
Marian.Whitney@state.mn.us and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

The Villa at St. Louis Park is a 2-story building with a partial basement. It was built in 1971 and was determined to be of Type II(222) construction. 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 notification.

The facility has a capacity of 105 beds and had a census of 89 at time of the survey.

The requirement at 42 CFR, Subpart 483.70(a) is

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility's heating, ventilation, and air conditioning in not in compliance with the 2012 LSC NFPA 101 9.2, 19.5.2.1 and NFPA 90A. This deficient practice could affect all 89 residents. Findings include: On a facility tour between the hours of 10:00 AM and 02:00 PM on July 30, 2018, it was revealed that the ventilation system has supply ducts serving the resident corridors without return ducts in the corridors. It appears that the only return is through the continuous operation of the resident room bathroom fans. Date of building construction is 1971. This deficient practice was verified by the Director of Maintenance at the time of discovery.	K 521	See attached K521 Waiver request documentation.	9/4/18

Electronically delivered
August 14, 2018

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

Re: State Nursing Home Licensing Orders - Project Number S5182028

Dear Ms. McCurdy:

The above facility was surveyed on July 23, 2018 through July 27, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number H5182068. 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . 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 Susanne Reuss at (651) 201-3793 or susanne.reuss@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00278	A. BUILDING: _____ B. WING _____	C 07/27/2018

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

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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: A licensing survey was conducted July 23, 2018, through July 27, 2018, and a complaint investigation was also completed at the time of the standard survey. At the time of the survey, an investigation of complaint #H5182068 was completed and was found to be substantiated at State Rule 4658.0520 Subp. 1 (0830)	2 000		

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2 000	Continued From page 1 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions to reduce the risk for falls for 1 of 4 residents (R31) reviewed for falls. In addition, the facility failed to properly assess the use of a mechanical stand harness to ensure proper fit for	2 830	Completion date 9/4/18.	9/4/18

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2 830	Continued From page 2 1 of 2 residents (R56) reviewed for accidents and based on observation, interview and document review, the facility failed to investigate bruising for 1 of 4 residents (R29) reviewed for non-pressure related skin concerns. Findings include: R31's admission minimum data set dated 5/23/18, indicated she was moderately cognitively impaired and required extensive assistance with all activities of daily living. R31's care plan dated 5/16/18 idenfied a self care deficit related to weakness, limited physical mobility and a history of falls on 6/17/18, 6/19/18, 7/17/18, and 7/23/18. The care plan directed staff to anticipate R31's needs, keep call light in reach and place fall mats on both sides of the bed. A review of R31's Fall Risk Evaluation dated 7/23/18, indicated she sustained a fall with major injury. A review of facility Progress Notes dated 7/23/18, indicated R31's fall was reviewed. She was found on the floor on her left side, appearing to have fallen out of bed. R31 sustained a dislocated left hip. Mats to be placed on floor next to bed to reduce the risk for injury. During an observation on 7/25/18, at 7:36 a.m. R31 was observed lying in her bed. A fall mat was on the floor on the right side of her bed but no mat was in place on the left side of the bed. A second fall mat was leaning up against the wall in R31's room. During interview on 7/25/18, at 7:43 a.m. nursing assistant (NA)-D stated she thought R31 had fallen and broken her hip. NA-D stated staff were directed to make sure R31's call light was in place, make sure she has fall mats by her bed	2 830		

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2 830	Continued From page 3 and check on her constantly because she was a fall risk. NA-D entered R31's room and verified there was no fall mat on the left side of the bed. During observation on 7/26/18, at 5:15 a.m. two NA's were observed exiting R31's room. Upon entering the room R31 was in bed and appeared to be sleeping. R31's floor mat was not on the floor next to her bed and was observed leaning against the wall next to her bed side table. During interview on 7/25/18, at 7:51 a.m. registered nurse (RN)-A stated R31's most recent fall happened during the over night shift. RN-A stated R31 dislocated her hip when she fell. RN-A stated R31's fall interventions included placing fall mats on both sides of her bed and stated the intervention had been communicated to the NA's and the information updated on the NA care sheets. A facility policy related to following the plan of care was requested but not received. R56's admission minimum data set dated 5/23/18, indicated she was moderately cognitively impaired and required extensive assitance with transfers and toileting. R56's care plan dated 6/21/18, identified a self care deficit related to activity intolerance and directed staff to use a mechanical lift for transfers. During an observation on 7/26/18, at 8:48 a.m. NA-F and NA-G entered R56's room to assist her to the toilet. NA-F and NA-G assisted R56 to lean forward in her chair and applied a mechanical stand harness, size extra large, around her waist. After the harness was connected to the mechanical stand NA-F raised R56 to a semi standing position. The sling did nut fit snugly	2 830		

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2 830	Continued From page 4 around R56's waist and rode up under her arm pits as she was wheeled approximately 10 feet to the bathroom. During an interview on 7/26/18, at 12:25 p.m. NA-G stated staff were directed to apply the harness for the mechanical stand and adjust the strap to fit the resident. NA-G stated there was only one harness available for use on the unit and all the residents who used the stand used the same size harness. During interview on 7/26/18, at 12:41 p.m. NA-F stated R56 had been using the mechanical stand since approximately three weeks after she admitted to the facility. NA-F stated the nurse communicated the information to her but did not give direction regarding what size harness to use. NA-F further stated she thought there was more than one harness available and stated, "the one on the unit is kind of big." During interview on 7/26/18, at 1:00 p.m. registered nurse RN-F stated a care plan for each resident is kept inside their closets. RN-F stated he currently had R56 care planned to transfer with a mechanical lift but stated there had been a recent change and she now required assist of one staff. In regard to the use of the mechanical stand, RN-F was asked how staff were educated on what size harness to use, RN-F stated, "I would have to get that answer for you." RN-F stated the facility kept a small supply of harnesses downstairs near the laundry room. During an interview on 7/26/18, at 1:08 p.m. the director of rehabilitation services stated three residents on the unit currently used a mechanical stand and the therapists educated staff on what size harness was appropriate for the resident. At	2 830		

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2 830	Continued From page 5 1:45 p.m. the director of rehabilitation services stated she had just assessed R56. She stated R56 should be wearing a regular sized sling and stated she was not a bariatric patient further stating she changed R56 to a regular sized sling. A facilty policy related to the use of mechanical stand devices was requested. A facility provided document titled Guideline on Sara and Maxi, undated, indicated a Sara is a mobile raising aide utilized for raising to a standing position and short transfer of residents such as standing to transition to a wheel chair or from wheel chair to bed. The document did not address sizing of the harness to the resident. R29's diagnoses included dementia and anxiety obtained from the quarterly Minimum Data Set (MDS) dated 5/22/18. In addition, the MDS indicated R29 required limited to extensive assistance for all activities of daily living and R29 had impaired memory problems. R29's care plan revised 5/17/18, identified resident had an actual activities of daily living (ADL) self-care performance deficit related to end stage dementia. The care plan directed staff to complete skin inspection with cares and staff was to observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse. In addition, the care plan directed staff to identify/document potential causative factors and eliminate/resolve causes where possible. On 7/23/18, at 12:47 p.m. to 1:00 p.m. nursing assistant (NA)-B was observed to provide R29 with meal assistance. When approached R29 was observed with bruises on the left forearm, right forearm, right thumb, right index finger and	2 830		

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2 830	Continued From page 6 on the right middle finger. All the bruises were different colors. -At 1:35 p.m. when approached and asked how he got the bruises R29 never responded. -At 6:30 p.m. R29 was observed in the dining seated on the wheelchair still wearing a short sleeved shirt and the bruises were visible and none of the staff in the area acknowledged the bruises. On 7/24/18, at 12:57 p.m. to 1:31 p.m. NA-C was observed assist R29 with the lunch meal. The bruises in the hands and finger observed were visible from standing 20 feet away and NA-C never acknowledged the bruises during the entire meal time. -At 1:40 p.m. to 2:11 p.m. R29 was observed seated on the wheelchair next to his bed and chatting continuously. -At 2:11 p.m. when asked if she had reported anything to the nurse regarding R29's skin NA-C stated the night shift usually got R29 dressed for the day and all she did was to transfer R29 to the wheelchair. NA-C further stated she had not seen any skin concerns. Review of R29's Progress Notes dated 7/5/18, through 7/24/18, lacked documentation that the bruises had been assessed. A nursing Progress Note dated 7/24/18, (after concern had been brought to the attention of facility staff by the surveyor), indicated: -Red-maroon colored bruising to back of left forearm varying in size 0.5 centimeter (cm) to 1.0 cm in diameter, same type of reddish bruising to back of right forearm also varying in size, the largest two measure 3 cm by 3 cm at base of right thumb and index finger and 1.5 cm by 1.5 cm at the base of right middle finger. The note further indicated R29 was unable to verbalize how	2 830		

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2 830	Continued From page 7 he sustained the bruising. On 7/24/18, at 2:14 p.m. registered nurse (RN)-A verified the visible bruises. RN-A stated the NA's were supposed to let the nurses know of any changes in skin so the nurse would assess them. RN-A reviewed the electronic medical record and verified the most recent skin audits completed on R29's shower on 7/5/18, and 7/19/19, and the progress notes had no documentation of the bruises. On 7/24/18, at 2:23 p.m. RN-E stated the bruises on R29's arms are baseline as R29 grabbed his own arms and was combative at times. When asked if staff assessed or investigated the cause of the bruise, RN-E "usually I would assess when the skin is broken." RN-E further stated she had not gotten any report from the night staff or NA-C about a skin issue "it's a good idea to assess and measure the bruises." On 7/24/18, at 2:50 p.m. the director of nursing stated she would expect the NA's to report all the bruises to the nurses so they were assessed. She acknowledged the root cause was supposed to be identified. On 7/24/18, at 12:04 p.m. NA-B stated staff was supposed to report bruising and any skin concerns to the nurse that was not normal for the resident. NA-B further stated the nurses did all the body checks with all the showers and would document the findings in the medical record. On 7/25/18, at 2:06 p.m. RN-A stated after concern was brought to the facility attention, she had investigated the bruises and she had found out staff including hospice were aware of the bruising however the medical record lacked	2 830		

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2 830	Continued From page 8 documentation the bruises had been assessed and were being monitored. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to the use of correct size standing lift sling and implementation of fall interventions. The DON or designee, could provide training for all nursing staff related to the development of the use of correct size standing lift sling and implementation of fall interventions. The DON or designee could also assure that resident bruises are investigated, staff are trained, and monitoring is conducted to assure causal factors for the bruises are identified.The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and	2 915		9/4/18

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2 915	Continued From page 9 (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide supervision and cues during meals for 1 of 1 resident (R142) who required staff direction for eating. In addition facility failed to develop alternate communication tools, as identified on the care plan, for 1 of 1 resident (R5) reviewed for communication and based on observation, interview and document review, the facility failed to provide adaptive equipment in order to promote independence with eating for 1 of 1 resident (R50) observed with difficulty while eating during dining observations. Findings include: R142's diagnoses included cancer, other fracture, generalized muscle weakness and gastro esophageal reflux disease (GERD) which was obtained from the admission Minimum Data Set (MDS) dated 7/13/18. In addition the MDS identified R142 had intact cognition and required supervision and physical assistance of one staff with eating. R142's Physician Order dated 7/23/18, at 1:00 p.m. indicated "Set-up all meal trays and offer hands on assistance with eating." R142's activities of daily living (ADL) Care Area Assessment (CAA) dated 7/13/18, indicated R142	2 915	completion date 9/4/18	

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2 915	Continued From page 10 received assistance with cares and mobility. R142's care plan dated 7/23/18, identified R142 had activities of daily living (ADL) / mobility self-care performance deficit related to activity intolerance, Musculoskeletal impairment following a right humerous fracture. The care plan directed staff for eating R142 was totally dependent on one staff for eating. On 7/23/18, at 12:51 p.m. when asked how things were going with the coordination of services with the facility for R142's hospice, registered nurse (RN) stated she had identified R142 required assistance with meals due to the right humerus fracture and being immobile and was going to write an order for staff to assist her with meals as R142 had expressed not getting assistance with meals. On 7/23/18, at 1:30 p.m. R142 laid in her bed with her right arm elevated with pillows. When approached and asked how she was doing, R142 stated stated she had recently fallen, sustained a fracture in her arm and was admitted to the facility and hospice. When asked if staff were providing her with the assistance she needed with eating R142 stated she had problems eating and staff were not assisting her with meals. R142 further stated "they bring the food and take the cover off and leave the tray there for me. It doesn't help to complain because it gets worse here. I can manage the finger food only" as she pointed to her right arm. -At 1:34 p.m. a tray of food was observed on the counter by the door to the room and the plate of food which had pasta, peas and a slice of white meat, which had not been eaten. When asked if she had eaten anything for lunch, R142 stated she was not able to eat the food and no staff had	2 915		

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2 915	Continued From page 11	2 915		

assisted her. R142 stated "I need help and the staff came and set it there. I thought they would come back and nobody came and I was tired and dozed off."

On 7/23/18, at 7:04 p.m. R142's tray with food was observed on the bedside pull table. R142 was observed laying in bed and was looking out the door. When approached and asked if she needed assistance, R142 stated she did as she was not able to eat the Taco salad with her fingers.
-At 7:10 p.m. registered nurse (RN)-C was observed to go into the room with a cup of water and medications and shut the door.
-At 7:12 p.m. RN-C came out of the room and left the door wide open.
-At 7:40 p.m. surveyor went into the room with RN-A who verified the food tray from lunch was on the counter and had not been eaten. RN-A verified the bedside pull table was out of R142's reach and the tray with food was on the far end of the table. RN-A acknowledged R142 would not be able to reach it even if she wanted to attempt to eat or drink what had been served. RN-A then asked R142 if she needed assistance with eating but R142 declined. She offered soup but R142 decline and asked for ice chips and Ensure supplement.
-At 7:45 p.m. as RN-A stated staff was supposed to take the tray out and were supposed to assist resident with meals due to the right arm fracture. RN-A said, "I will talk to the staff."
-At 7:48 p.m. RN-C stated he did not know R142 had an order for setting up meals and to provide hands on assistance which had been written by the Hospice RN that same morning. When asked if he had offered to assist R142, RN-C stated R142 had stated she did not want to eat. When asked if she had asked why and if she had

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 915	Continued From page 12 offered an alternate RN-C said, "No." RN-A stated she was going to educate the staff. On 7/25/18, at 8:51 a.m. social worker was observed knock at the door and went into the room with a breakfast tray and left the door wide open. As social worker set the tray on the bedside pull table she stated "I have your breakfast tray." Social worker set the tray on the bedside table took the cover off applied butter on the toast. At 8:53 a.m. social worker left the room she shut the door behind her and never offered R142 any hands on assistance with eating or drinking. -At 9:17 a.m. to 9:26 a.m. no staff went to the room and R142 was observed reached over and grabbed a half piece of toast off the plate and was eating it. -At 9:26 a.m. R142 put the call light on and the staffing coordinator (SC) and surveyor went into the room. As SC approached R142 asked for a cup with a handle to drink out of as she was not able to reach for the glass. -At 9:27 a.m. as SC went towards the door R142 said, "she set the tray there. I can do good with finger foods am eating toast. I want something to drink am dying of thirst. I need a cup with handle" as she pointed to a two ounce glass of apple juice on the tray. R142 stated the bedside table was lower than bed to the left side which was hard to reach. -At 9:33 a.m. RN-A acknowledged staff was supposed to provide assistance per order written by the Hospice nurse "Am going to make sure the staff are clear on this. Yesterday I assisted her. I did put it on the care sheet. We will do better at lunch time." -At 9:35 a.m. to 9:42 a.m. NA-B remained in the room assisted R142 through breakfast as she talked to her and laughed with her.	2 915		

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2 915	Continued From page 13 -At 9:43 a.m. NA-B came out with the breakfast tray, when asked how much R142 had consumed NA-B stated 240 milliter (ml) of beverage and 20% which was two full pieces of toast. On 7/25/18, at 10:20 a.m. R142's family member stated they had some serious concerns about R142's care at the home which included being assisted with meals among other care concerns. On 7/25/18, at 1:40 p.m. social worker verified she had delivered R142's breakfast tray that morning. The social worker stated she was not aware R142 had an order to set up and provide hands on assistance with eating. She stated if she knew she would have sat down or gone out and gotten a staff to assist her. On 7/26/18, at 8:19 a.m. the director of nursing stated she would have expected the staff to follow the orders, care plan and to have offered hands on assistance with meals. R50's annual Minimum Data Set (MDS) dated 6/18/18, identified R50 had moderately impaired cognition and diagnoses including dementia, cataract and unspecified blindness. In addition, the MDS indicated R50 required supervision with eating after setup help only with eating. R50's nutrition care plan dated 7/15/17, identified R50 had a nutritional problem or potential problem related to being legally blind and used a plate guard at all meals. In addition the care plan for vision dated 2/8/16, identified R50 had impaired visual function and directed staff to tell the resident where they placed items and to be consistent."	2 915		

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2 915	Continued From page 14 On 7/23/18, at 6:55 p.m. nursing assistant (NA)-A was observed approach R50 with a tray which had a regular flat plate of taco salad, beans and chips and set it in front of R50. At 6:56 p.m. NA-A then oriented R50 where the coffee and juice were then as he left the table R50 was heard ask three times what was on the plate however, NA-A never responded to R50 even though he was standing approximately five feet behind R50 arranging other resident food trays. -At 6:57 p.m. R50 stated in a loud voice "there is no dressing on the salad" as she took bites of the salad using her fingers but there was no staff at the dining room. R50 was observed feel the food using her right hand and as she did that the food was spilling off the plate to the food tray. -At 6:59 p.m. R50 was observed to feel the plate and grabbed a small container which had salsa and held the container in her left hand. R50 then was observed to dip one piece at a time of either the lettuce and tomatoes into the salsa until 7:15 p.m. never asked for any assistance. -At 7:16 p.m. R50 was observed to cough and registered nurse (RN)-A approached. R50 requested a ride to her room but as RN-A wheeled her away from the table R50 asked RN-A if she had eaten all her food and RN-A said, "No." R50 asked RN-A to bring her back to the table. RN-A then used the clock to re-orient R50 where the food was on the plate. R50 then was observed to attempt to eat the food with a spoon, but most of the food when she was reaching and feeling it, was spilling to the tray or the blanket on her lap. -At 7:21 p.m. again R50 asked if there was dessert and RN-A approached and indicated to R50 she had a cookie on the left side corner of the tray however she was going to hand it to her. RN-A then was observed leave the dining room went outside the hallway and came back wearing	2 915		

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2 915	Continued From page 15 a pair of gloves and picked the cookie off the tray and handed it to R50 who stated "thank you honey." -At 7:26 p.m. R50 finished drinking the coffee then said, "Am cold." -At 7:27 p.m. RN- came back to the dining room and asked R50 if she had completed eating and then wheeled R50 to her room. -At 7:30 p.m. when asked how much R50 had consumed of the meal RN-A stated approximately 90% of the food with 480 milliliter (ml) of the beverages. RN-A verified R50 had spilled some of the food in the process of reaching and feeling for it. RN-A verified R50's plate had no plate guard "usually the plate comes with the guard from the kitchen. I will talk to them." RN-A stated the staff overall was supposed to use the clock to describe where the food was due to R50 being blind and staff was to tell R50 what was on the plate. RN-A further stated NA-A should have put the salsa on R50's salad or at least asked if she wanted it. -At 7:32 p.m. NA-A stated he did not know R50 was supposed to have a plate guard. NA-A acknowledged he had not told R50 what had been served and he had not responded to R50 when she was asking about the dressing for the salad. NA-A stated he had gone to the kitchen to ask for the dressing however was told salsa was what had been served and he had returned to the dining room and observed R50 had located the salsa and never asked if she wanted it on the taco salad. On 7/24/18, at 8:58 a.m. NA-B was observed place the breakfast tray with R50's food in front of her. NA-Caroline took the lid off and two pieces of toast with one hard boiled egg were observed at the center of the regular plate with no plate guard. NA- asked resident if she wanted milk in the	2 915		

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2 915	Continued From page 16 oatmeal but R50 declined. On 7/24/18, 9:03 a.m. NA-B stated she was aware R50 required a plate guard at all meals and the kitchen was supposed to send it the food and thought at time the dietary staff forgot. On 7/26/18, at 12:33 p.m. the dietary manager (DM) said, "It should be our serving team person dishing the plates to make sure it's there." When asked about the plate guard for R50. The dietary manager stated after concern was brought to the facility attention she had found the plate guide in one of the drawer in the kitchen. The dietary manager acknowledged due to R50 being blind and not being able to see the food she needed the plate guard and she had talked to her staff to make sure they looked for it immediately or to let therapy be aware of it to provide the adaptive device. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to assisting residents with meals and following the care plan. The DON or designee, could provide training for all nursing staff related to the assisiting residents with meals and following the care plan based on the assessment. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		

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2 930	Continued From page 17	2 930		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure gastrostomy tube (G-tube) placement was checked prior to medication administration for 1 of 2 residents (R64) receiving medications through a G-tube. In addition, the facility failed to ensure medications were given via gravity for 1 of 2 residents (R64) reviewed for medication administration Findings include: R64's quarterly Minimum Data Set (MDS) dated 6/28/18, indicated diagnoses that included dysphasia, aphasia and hemiplegia. In addition, the MDS indicated R64 received tube feeding. On 7/26/18, at 9:41 a.m. registered nurse (RN)-B set up R238's medications to give via G-tube. At 9:46 a.m. RN-B entered R64's room, approached	2 930	completion date 9/4/18.	9/4/18

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2 930	Continued From page 18 R64 indicated she was going to administer medications and give her enteral feeding via G-tube. RN-B then pulled the bedside table and set a tote with all the medications on top. RN-A then obtained water in a graduate cylinder then excused herself briefly and left the room and went into the medication room then came back right away with a carton of Osmolite. At 9:52 a.m.after applying gloves RN-B was observed pick the G-tube, then removed the tab closure and inserted a syringe into the feeding port and aspirated 200 milliters (ml) of residual without checking tube placement. At 9:54 a.m. with stethoscope around the neck RN-B was observed draw 60 ml of the residual and pushed it into the G-tube feeding port without checking placement. At 9:56 a.m. before pushing the second 60 ml syringe of residual, RN-B removed gloves applied another pair then used a stethoscope to check placement. -At 9:57 a.m. to 10:08 a.m. RN-B was observed draw out medications mixed with five ml of water in seven separate small cups and pushed the liquid into the G-tube one at a time. During the observation, RN-B was observed give five ml of water between each medication administration and then gave 30 ml of water via pushing through the G-tube feeding port. On 7/26/18, at 10:21 a.m. RN-B stated G-tube placement was always supposed to be completed administering anything. When asked what the facility policy was for giving medications via G-tube RN-B stated she did not know. RN-B further stated because R64 did not have a specific order to give medications by either bolus or gravity that was why she had pushed all the medications using the syringe. On 7/26/18, at 10:35 a.m. the director of nursing	2 930		

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2 930	Continued From page 19 stated the nurses were supposed to check placement before giving any medications or tube feeding and medications were supposed to be given via gravity. The director of nursing further stated if a resident was to get medications in a different way then what the facility policy directed, then staff would get an order for it. The facility Medication Administered Through an Enteral Tube Guideline dated 11/28/17, indicated staff should check the placement of G-tubes in accordance with facility policy. In addition the guideline directed staff to insert medication syringe in appropriate port then staff was to remix the medication and pour into the medication syringe to allow medication to flow down the syringe via gravity "Do not push medications through a tube." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to administration of medication and enteral feeding solution by a feeding tube. The DON or designee, could provide training for all nursing staff related to the administration of medications and enteral feeding solution by a feeding tube. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 930		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and	21390		9/4/18

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21390	Continued From page 20 procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to perform appropriate hand hygiene for 5 of 8 residents (R56, R29, R77, R33, R5) observed during treatment and cares. in addition facility failed to sanitize shared resident equipment after use by residents on contact precautions for C-diff before returning equipment to storage usage for use by non infected for 2 of 2 residents (R56, R49) who were on contact precautions. In addition failed to clean	21390	completion date 9/4/18	

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the urine collection bag appropriately after emptying it for 2 of 4 residents (R33, R5) reviewed for a catheter. In addition, the facility failed to develop a system wide program to identify trends for infections specifically related to Clostridium difficile (C-Diff), a specific kind of bacterial infection that causes mild to life-threatening forms of diarrhea and colitis.

Findings include:

R56's admission minimum data set (MDS) dated 6/22/18, indicated she was moderately cognitively impaired, required extensive assitance for transfers and toileting and was frequently incontinent of bowel and bladder. R56's care plan dated 6/21/18, identified a self care deficit and directed staff to assist with all activities of daily living.

A review of R56's Order Summary Report dated 7/27/18, identified the following orders:
7/20/18, Contact isolation every shift for C-diff.
7/20/18, Vancomycin solution 250 milligrams (mg) by mouth four times daily for C-diff.

During observation on 7/23/18, at 5:05 p.m. R56 was noted to have an infection precaution cart outside the door to her room. Nursing assistant (NA)-F stated R56 had C-diff and stated a resident two doors down in room 134 also had C-diff. During the observation, a cart was also observed outside the door of room 122.

During observation of the transitional care unit shower room on 7/26/18, at 5:33 a.m. a sign was posted on the wall directing staff to clean the shower room and shower chair with Virex cleanser. The sign indicated the cleanser was locked in a cabinet in the shower room. There

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was no cabinet in the shower room and no cleanser in the room. At 7:31 a.m. NA-F assisted a resident to the shower room. At 7:50 a.m. NA-F completed the shower and assisted the resident back to room. The shower room had linens on the floor next to the shower chair and no sanitizer was observed in the room. At 7:54 a.m. NA-F again entered the shower room. NA-F picked up linens from floor, placed them in bags, replaced the bags, turned off light and left room. There was still no sanitizer noted in shower room.

During observation on 7/26/18, at 8:24 a.m. NA-F entered R56's room after applying a gown, gloves and shoe protectors. NA-F removed R56's incontinent product and used wipes to clean her perineum. At 8:30 a.m. R56 requested to use the toilet. NA-F stated she would need to get another NA to assist and applied a clean brief, removed her gloves and left the room without performing any hand hygiene.
NA-F waked to the other side of the unit and retrieved a mechanical stand from the tub room and brought it to R56's room. NA-F then stated she had to look for the other NA on the unit. At 8:48 a.m. NA-F returned with NA-G. NA-F and NA-G applied gloves, gowns and shoe covers and entered R56's room with the mechanical stand. R56 was assisted to sit up on the side of the bed. The mechanical lift harness was placed around R56's waist, hooked to the machine and R56 was assisted to the toilet. At 8:53 a.m. while R56 was seated on the toilet, NA-F and NA-G removed the personal protective equipment (PPE). NA-F, without performing any hand hygiene, picked up R56's telephone and used it to call the kitchen. NA-G left the room and washed her hands. At 9:08 a.m. R56 put her call light on. NA-F and NA-G donned PPE and entered R56's room. NA-F removed R56's brief and wiped stool

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from her bottom with wet wipes. NA-G handed NA-F a tube of cream and NA-F, still wearing the same gloves, removed the cap, applied some cream to R56's bottom, replaced the cap and placed the tube on the hand rail behind the toilet. Without performing hand hygiene or changing gloves, NA-F applied a new brief. NA-F and NA-G re-applied the harness to R56's waist, hooked the harness to the lift and assisted R56 into her wheel chair. The harness was removed from around R56's waist and place on top of the mechanical stand. NA-F, still without performing hand hygiene or removing gloves, grabbed the handles of the wheel chair and pushed R56 up to the sink in her room. NA-F and NA-G then removed the PPE and left the room without performing hand hygiene. NA-G took the mechanical lift down the hallway then returned to the sink and washed her hands. At 9:29 a.m. NA-G removed the stand from the hallway and placed it in the tub room of the unit and left the room without sanitizing the stand.

During interview on 7/26/18, at 9:30 a.m. NA-F stated she had not received training related to C-diff precautions since it had been identified on the unit. NA-F stated, "I know if you get it on you, it's not good." She stated hands should have been washed prior to going into the room, after changing the resident and after leaving the room. NA-F stated she had not received education regarding sanitizing the mechanical stand and further stated she had been employed in the facility for four months and had never used sanitizer to clean the shower and did not know where to find it.

During interview on 7/26/18, at 9:35 a.m. registered nurse (RN)-F stated there were currently three residents on the unit on

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precautions related to C-diff. RN-F stated two of the residents acquired C-diff while in the facility. RN-A stated the staff needed to wear PPE, wash their hands with soap and water and should sanitize all equipment going in and out of the room with bleach wipes. RN-A observed the tub room with surveyor and verified there was no sanitizer available for use in the room. Surveyor alerted RN-A the mechanical stand had not been sanitized. RN-A further stated the shower room should have been sanitized in between residents. RN-A located a bottle of sanitizer on a shelf in a utility room on the unit.

During interview on 7/26/18, at 12:25 p.m. NA-G stated she had received a brief education related to C-diff. NA-G stated staff were to wash hands prior to entering a room, wear PPE and wash hands any time they got dirty. NA-G stated there were sanitizing wipes available to wipe down the vitals machine but stated she had never been educated to wipe down the mechanical stand.

During interview on 7/26/18, at 12:31 p.m. registered nurse (NA)-F stated the mechanical stand shared between three residents on the unit was the only stand available for use on the unit.

During interview on 7/26/18, at 12:36 p.m. licensed practical nurse (LPN)-H stated R56 was still having loose stools. LPN-H stated there was not much training in the facility related to C-diff. She stated a cart was put outside the door but staff did not receive training related to sanitizing equipment that went in and out of the room. LPN-H stated she thought there should be a refresher training when there were new cases of C-diff. LPN -H further stated the two most recent cases were contracted while in the facility and stated one resident had been on antibiotics but

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

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21390	Continued From page 25 R56 had not. A review of facility documents titled Infections and Antibiotics dated January 2018 through July 2018 identified the following cases of C-Diff. 1/9/18 - R47, room 232 1/29/18 - R192, room 125 2/14/18 - R192, room 134 (readmitted) 3/18/18 - R11, room 222 3/24/18 - R49, room 135 4/9/18 - R195, room 138 4/10/18 - R194, room 123 4/19/18 - R196, room 124 4/23/18 - R193, room 138 5/4/18 - R194, room 123 5/22/18 - R197, room 128 7/11/18 - R1, room 124 7/19/18 - R48, room 134 7/19/18 - R56, room 138 During an interview on 7/25/18, at 7:26 a.m. RN-F stated infections were tracked by RN-A and the director of nursing (DON). RN-F stated he did not track ongoing on the unit and stated, "as they happen I keep a mental note." During and interview on 7/26/18, at 12:04 p.m. RN-A stated infections were tracked on a monthly basis. RN-A stated she tracked who was started on and antibiotic, how long they were on the antibiotic and reviewed the infections monthly with the interdisciplinary team (IDT). RN-A stated the pharmacy sent out a monthly report of the antibiotics. RN-A stated she used a facility map to track the locations of the residents with infections and try to contain the infections. RN-A stated in the past year she had not identified any trends and stated in relation the to C-diff, some of the	21390		

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residents admitted to the facility and some acquired it while residing tin the facility. She stated the procedure followed after identifying a new infection was to place a cart outside the residents door with PPE and make sure everyone was aware of the precautions. RN-A stated she was unsure if there had been any recent training related to infection control precautions for C-diff.

During interview on 7/26/18, at 12:47 p.m. the director of nursing (DON) stated the IDT reviewed new antibiotics and new infections daily. The DON stated resident identified with C-diff were placed on precautions and stated the infections were tracked on a spread sheet. She stated the infections were reviewed in the quality assurance meetings and were reviewed with the medical director. The DON stated the facility mapped the locations of the infections and stated C-Diff was something the facility had a long standing issue with. She stated she did not recall a trend with facility acquired C-Diff but did identify the two most recent cases were acquired in house. The DON stated the facility had not looked at staff breaks in infection control and stated she expected staff to follow the appropriate precautions. During a subsequent interview on 7/27/18, at 3:01 p.m. the DON stated the IDT looked at the mapping and where the outbreaks were located and if they were in the same vicinity or same floor. She stated "looking back at the C-diff prior to this month, we haven't noticed any location trends as far as mapping," even though, 10 of 12 cases originated on the transitional care unit, station two.

A facility policy titled Villa, Infection Prevention and Control Guidance dated 11/28/17,was reviewed. The policy indicated the facility practiced infection prevention and control based

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21390	Continued From page 27 upon information from the facility assessment and following national standards to prevent, recognize and control the onset and spread of infections. The policy identified the use of surveillance, reporting and the use of standard and transmission based precautions and directed staff to perform hand hygiene when providing direct care, handling resident care equipment and the environment. R49's admission record dated 3/15/18, indicated diagnoses complete paraplegia. R49's quarterly Minimum Data Set (MDS) dated 6/18/18, indicated had the ability to understand others and make self understood, was cognitively intact. During morning cares observation on 7/25/18, the following was observed, R49 was on contact precaution for Extended-Spectrum Beta-lactamase (ESBL)- a superbug resistant to antibiotic treatments: -8:15 a.m. nursing assistant (NA)-I and NA-J entered R49's room to assist resident in morning cares. -8:45 a.m. NA-I was observed to bring mechanical lift into R49's contact precaution room. NA-I placed the lift under R49's bed. NA-I and NA-J attached sling loops to the lift and R49 was lifted off the bed and lowered into wheelchair. -9:15 a.m. NA-I removed the mechanical lift out of the room, placed it outside of R49's room, paralled to the wall next to R49's door. NA-I and NA-J proceeded to finish morning cares including chaning bed linens. -9:26 a.m. mechaninal lift hallway. -9:34 a.m. NA-J was observed to take mechanical lift to use for another resident. Surveyor stopped NA-J.	21390		

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21390	Continued From page 28 During an interview on 7/25/18, at 9:40 a.m. NA-I confirmed mechanical lift was not wiped down before taking out of R49's contact precaution room. NA-I further indicated the overnight shift cleaned it and was not aware of anything specific regarding the cleaning of equipment from a contact precaution room. NA-I proceeded to move the mechanincal lift back into R49's room and clean it with disinfecting wipes which was already in resident's room. During an interview on 7/26/18, at 10:51 a.m. assistant director of nursing (ADON) verified that equipment should be cleaned after use in a contact precaution room. On 7/25/18, at 7:24 a.m. NA-E was observed to provide R29 pericare to his bottom as R29 laid on his left side. During the observation, NA-E used several wipes to wipe off bowel movement from R29's bottom, then reached for a tube of skin barrier cream, took the cap off, and applied the cream to R29's bottom with the same gloves used to clean the bowel movement. NA-E with the same gloves applied a clean pad under R29's bottom and then removed the gloves. NA-E then applied another pair of gloves without washing hands, laid R29 on his back and provided pericare in the front using wipes. The used wipes were observed to have smears of stool. NA-E then fastened R29's pad. -At 7:26 a.m. as NA-B came into the room, NA-E reached out and pulled the privacy curtain with the same gloves used to provide pericare. NA-E then turned resident to the right and left sides, adjusted the pants and applied the shoes still with the same gloves. -At 7:31 a.m. as NA-E was going to assist R29 to sit on the edge of bed, surveyor intervened and requested NA-E to remove the gloves and wash	21390		

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21390	Continued From page 29 his hands. -At 7:33 a.m. NA-B and NA-E transferred R29 to the wheelchair using a transfer belt and then repositioned R29 on the wheelchair. -At 7:38 a.m. applied gloves prior to combing R29's hair. -At 7:41 a.m. NA-E removed gloves stated he was going to get more towels left the room without washing hands. -At 7:43 a.m. NA-E came back to room, applied a pair of gloves shaved R29 and washed his face. -At 7:58 a.m. NA-E was observed to brush R29's teeth and then had R29 rinse his mouth and spit on to a small basin. When R29 had completed rinsing his mouth NA-E was observed to dump the secretions in the sink, rinsed the basin and tooth brush then came back wiped R29's mouth and went over to the sink area gathered all the soiled linen and then removed the gloves the gloves. -At 8:03 a.m. without washing his hands, NA-E was observed to go over to R29's roommate to assist with a transfer. At this point surveyor intervened and asked NA-E to wash his hands. Cleaning catheter drainage bag tube: On 7/23/18, at 2:16 p.m. a urine collection bag was observed to be hanging on the right side of the bed frame and a strong odor of urine was noted in the room. On 7/24/18, at 1:47 p.m. NA-H applied gloves and went into the bathroom to obtain a graduate to drain the urine into. NA-H set the urinal on the floor, without barrier, drained the urine from the collection bag, clamped the tube and inserted the tip of the tube into the holder on the bag. NA-H took the urinal to the bathroom, poured the urine into the toilet, rinsed the urinal with water from the	21390		

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sink, poured the water into the toilet and set the urinal on the back of the toilet tank. NA-H removed gloves and washed her hands.
-At 2:03 p.m. NA-H acknowledged she had not used a barrier under the urinal when emptying the urine and she had not cleaned the tubing tip of the collection bag after emptying it. NA-H stated the bags were changed every so often and did not think she was supposed to wipe the tubing tip. When asked what the facility was, NA-H stated she was going to find out and would get back.
-At 2:06 p.m. NA-H approached stated the director of nursing was going to provide the policy.

On 7/24/18, at 2:51 p.m. the director of nursing stated she would expect the staff to clean the spout with an alcohol wipe before re-inserting it back into the holder on the bag.

The undated Emptying a Urinary Drainage Bag procedure directed staff, "5. After the urine has drained into the graduate, wipe the emptying spout with a alcohol wipe, re-clamp the emptying spout and return it to the holder."

Catheter Cares and Cleaning Catheter Bag Drainage Tube:
On 7/23/18, at 12:10 p.m. R5 was seated in a Broda wheelchair. R5 was asleep and the Foley catheter bag was observed lying on the floor. The urine was clear amber and urine was along the entire length of the tube.

On 7/23/18, at 6:47 p.m., R5 was observed in bed with Foley catheter bag lying on the floor. The urine was clear amber and urine was along the entire length of the tube. There was a privacy bag attached to the bed above the catheter bag.

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21390	Continued From page 31 During observation of morning cares on 7/25/18, at 10:26 a.m. nursing assistant (NA)-D put on gloves and went to the bathroom to get a urinal to empty R5's catheter bag. NA-D drained the urine from the Foley catheter bag into the urinal, clamped the tube and inserted the tip of the tube into the holder on the bag. NA-D took the urinal to the bathroom, poured the urine into the toilet, brought the urinal back into R5's room and rinsed the urinal with water from the sink. NA-D took the urinal to the bathroom, poured the water into the toilet, and set the urinal on the back of the toilet tank. NA-D removed gloves and washed her hands. NA-D washed R5's abdomen, peri-area and groin. NA-D moved R5's suprapubic catheter tubing but did not wipe it down. During interview on 7/25/18, at 11:45 a.m. NA-E stated nursing assistants were supposed to clean the catheter tubing during morning and evening cares. NA-E stated he thought NA-D had done so when she washed R5's abdomen. During interview on 7/25/18, at 12:38 a.m. NA-D verified she did not wipe the catheter tubing. NA-D verified she had not cleaned the tubing tip of the collection bag after emptying it. During interview on 7/26/18, at 12:42 p.m. registered nurse (RN)-A stated staff were to do catheter cares with morning and evening cares. RN-A stated for a suprapubic catheter, staff were to wipe the catheter from the dressing to the connection to the urinary collection bag. RN-S stated nurses were to do the suprapubic dressing changes. RN-A stated staff were to clean the end of the drainage spout, drain the urine from the catheter bag, clean the end of the drainage spout and then reinsert it into the side of the catheter bag.	21390		

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21390	Continued From page 32 Hand hygiene with Colostomy care and Pericare On 7/26/18, at 7:30 a.m. R77 said to licensed practical nurse (LPN)-A, "I need to have them change my colostomy bag" LPN-A checked R77's colostomy bag and told R77 that the bag was intact and that NA-K would empty the bag and get R77 dressed for the morning. NA-K entered the room, washed his hands and put gloves on. NA-K helped R77 get untangled from the blankets and put a transfer belt about her waist. NA-K assisted R77 to stand and transfer to a wheel chair. NA-K took R77 to the bathroom , assisted her to stand and removed a wet incontinence brief. R77 sat on the toilet and voided a small amount of urine into the toilet. NA-K unclipped the end of the colostomy bag and emptied the stool into the toilet. NA-K got a small drop of stool on R77's left thigh. NA-K wiped the stool off R77 thigh. NA-K removed his gloves, then without washing or using an alcohol based hand sanitizer put a clean pair of gloves on. NA-K got clothing out of the closet and had R77 choose a shirt and pair of pants to wear. NA-K put the shirt on R77 and put the pants on, and pulled them up to her knees, and put her shoes and socks on. R77 stood up and held on to the safety rail while NA-K performed pericare and wiped R77's bottom. NA-K put an incontinence brief on R77 and pulled her pants up. NA-K assisted R77 to the wheel chair and brought resident out to the sink. NA-K removed gloves and washed hands. During interview on 7/26/18, at 8:18 a.m. registered nurse (RN)-F stated NA-K should have washed his hands between glove changes and should have changed his gloves after washing R77's peri area, before doing anything else. During interview on 7/26/18, at 1:15 p.m. the	21390		

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21390	Continued From page 33 director of nurses (DON) stated catheter bags belong in privacy bags, not on the floor. The DON stated staff should do catheter care on residents during morning and evening cares. The DON stated were wash hands after changing their gloves. The DON stated staff should change gloves after performing peri-care. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could assure that a system wide infection control program is developed, implemneted, monitored, staff trained, and precautions taken to assure appropriate infection control techniques are performed to prevent and/or minimize the spread of infections. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to determine if the practice of self-administration of medications (SAM) was safe for 1 of 1 resident (R142) observed to self-administer a nebulizer. Findings include:	21565	completion 9/4/18	9/4/18

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21565	Continued From page 34 R142's diagnoses included chronic obstructive pulmonary disease (COPD), malignant neoplasm of unspecified part of right bronchus or lung and generalized muscle weakness obtained from Admission Record dated 7/26/18. R142's Physician Orders dated 7/11/17, directed to administer ipratropium/albuterol nebulizer (Duoneb, a respiratory medication) via nebulizer every six hours for shortness of breath and wheezing while awake. The Physician's Orders did not identify R142 could self-administer medications, including the nebulizer treatment. On 7/25/18, at 8:18 a.m. an audible noise of a nebulizer machine was heard when standing at the door of R142's shared room. Upon entering the room a hand held nebulizer chamber (a inhalation treatment device) was observed lying on top of the bedding to the left side in front of R142. R142 stated her roommate had just turned it off for her. -At 8:22 a.m. R142's roommate R9 stated she had turned the nebulizer off because "it is chaos here in the morning". R9 explained that if there is something that she can help with she does and said she turned the machine off so that the nurse wouldn't have to come back to do it. On 7/25/18, at 8:26 a.m. registered nurse (RN)-D acknowledged that she set up the nebulizer, stating, "the nebulizer was running on it's own and I am the one who goes and turns it off after 15 minutes. I did not go to turn it off. When I just went to the room with you, that was when I found it was not running." RN-D stated because R142 was alert and was able to inhale the mist after set up he did not need to stay with R142 the entire time." RN-D verified R142 did not have an order	21565		

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21565	Continued From page 35 to self administer the nebulizer and did not have an assessment for it. R142's care plan dated 7/23/18, indicated R142 had altered respiratory status/difficulty breathing related to lung cancer/COPD/ history of smoking. The care plan directed staff to administer medication/puffers as ordered and to monitor for effectiveness and side effects. On 7/26/18, at 8:37 a.m. the director of nursing stated she would expect the nurse to make sure the resident had been assessed to self-administer medication and had an order for it. In addition, she stated if a resident was capable of self medication administration it would be addressed in the care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to self administration of medication. The DON or designee, could provide training for all nursing staff related to the self administration of medications based on the assessment. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit	21610		9/4/18

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21610	Continued From page 36 only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure unauthorized staff did not have access to 1 of 4 medication rooms. Findings include: On 7/23/18, at 5:51 p.m. nursing assistant (NA)-A was observed approached registered nurse (RN)-C who was seated at the nursing station and requested access to the medication room. RN-C stood up grabbed a single key on a lanyard which was hanging on the wall next to the chart rack and opened the door to the medication room. NA-A then was observed go into the medication room and shut the door behind as RN-C hang the key back on the hook and came back sat at the nursing station. After about 20 seconds NA-A came out of the medication room carrying hygiene supplies. -At 5:54 p.m. when asked if the NA-A was a trained medication aide (TMA), RN-C stated most NA's were TMA's and he thought NA-A was a TMA "I have not worked here for a long time and thought he was a TMA." -At 5:55 p.m. RN-A stated RN-C was supposed to be in the medication room with the NA-A or get the supplied for him. During a brief tour to the medication room with RN-A, multiple stock over the counter medications in the cabinets and prescription refrigerated medications in containers were observed stored in the medication room. RN-A further stated "We just moved the medication refrigerator in there and will have to do education."	21610	completion date 9/4/18.	

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	00278	A. BUILDING: _____ B. WING _____	C 07/27/2018

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21610	Continued From page 37 -At 5:59 p.m. to 6:03 p.m. the single key in the lanyard for the medication room remained hanging on the hook and RN-C was not in the area. -At 6:04 p.m. RN-A was observed grab the medication key off the hook. When asked about the observation, RN-A stated where the key was stored was not an appropriate and she was going to put the single key with the rest of the medication cart keys. On 7/26/18, at 7:24 a.m. the director of nursing stated nurses were supposed to have medication room keys on them and only authorized staff was supposed to have access to the medication rooms. The facility 5.3 Storage and Expiration of Medications, Biological, syringes and Needles policy revised 10/31/16, directed only authorized facility staff as determined by the facility was to have possession of the keys which opened medication storage areas. On 7/23/18, at 6:43 p.m., outside the second floor dining room, a medication room door was observed to be propped open with an empty medication container. There were no staff members present in the area and several residents were eating the evening meal in the dining room. The room contained multiple cards of expired medications laying on top of a counter. The medications included but were not limited to Levothyroxine, Metformin, Atenolol Senna, Clopidogrel, Keppra, Digoxin, Trazadone, Lisinopril, Zofran, phoslo, Atorvastatin, Coumadin, Amoxicillin, Cyclobenzaprine and Gabapentin, metoprolol. Inside a cabinet in the room was a box labeled E-kit (emergency kit) which contained Haldol, naloxone and Clonidine	21610		

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21610	Continued From page 38 along with various other medications. During an interview on 7/23/18, at 6:43 p.m. RN-A stated the room was not currently in use and stated it was used when they had another nurses station open. She stated she did not know who opened the door and would investigate. During interview on 7/23/18, at 7:01 p.m. the director of nursing stated the construction crew had left the door open. She stated the maintenance employee told her had unlocked the door for them and stated the station was no longer in use. The DON further stated the maintenance department should not have a key to access a room where medications were stored. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to staff who may have access to medication storage areas. The DON or designee, could provide training for all nursing staff related to staff who may have access to medication storage areas. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21610		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their	21810		9/4/18

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21810	Continued From page 39 highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to have call light within reach for 1 of 18 residents (R11) reviewed in the initial survey sample for call lights. Findings include: R11's admission record dated 7/12/18, indicated diagnoses of multiple myeloma (cancer) and pathological fracture of left shoulder (bone fracture caused by disease). R11's quarterly Minimum Data Set (MDS) date 4/23/18, indicated R11 was able to make self understood and able to understand others, had intact cognition, required supervision with one person physical assist for bed mobility and transfers and extensive assistance of one person for dressing. R11's care area assessment (CAA) dated 7/24/18, for urinary incontinence and indwelling catheter due to requiring extensive assistance for toileting. R11's care plan dated 4/21/18, indicated activities of daily living (ADL) self-care performance deficit related to weakness, immobility from disease process. Care plan directed facility staff to encourage participation from resident in regards to bed mobility and toileting with one person physical assist. R49 was to be encouraged to use the call light for assistance. During a random observation on 7/23/18, at 1:49 p.m. R11's call light was observed to be on the	21810	completion date 9/4/18.	

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21810	Continued From page 40 floor while resident was laying in bed. R11 attempted to use resident's own long handled grabber stick to try to grab the call light but was unable to. Surveyor offered to get assistance for resident since call light was not within reach. On 7/23/18, at 1:51 p.m. nursing assistant (NA)-I indicated R11 was able to use the call light. NA-I was observed to pick up the call light on the floor and place it over R11's head of bed under resident's pillow. NA-I further indicated R11's call light did not have a clip and probably fell off the bed. During an interview with the director of nursing (DON) on 7/26/18, at 12:30 p.m. confirmed residents capable of using the call lights should have their call light within reach. Facility policy for call light was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to the call lights. The DON or designee, could provide training for all nursing staff related to call lights. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		
21840	MN St. Statute 144.651 Subd. 12 Patients & Residents of HC Fac.Bill of Rights Subd. 12. Right to refuse care. Competent residents shall have the right to refuse treatment based on the information required in subdivision	21840		9/4/18

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21840	Continued From page 41 9. Residents who refuse treatment, medication, or dietary restrictions shall be informed of the likely medical or major psychological results of the refusal, with documentation in the individual medical record. In cases where a resident is incapable of understanding the circumstances but has not been adjudicated incompetent, or when legal requirements limit the right to refuse treatment, the conditions and circumstances shall be fully documented by the attending physician in the resident's medical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to have the correct advanced directive available for staff reference in case of an emergency for 1 of 18 residents (R11) reviewed for advance directives. Findings include: R11's admission record dated 7/12/18, indicated diagnoses of multiple myeloma (cancer) and pathological fracture of left shoulder (bone fracture caused by disease). R11's quarterly Minimum Data Set (MDS) date 4/23/18, indicated R11 was able to make self understood and able to understand others, had intact cognition, required supervision with one person physical assist for bed mobility and transfers and extensive assistance of one person for dressing. R11's care area assessment (CAA) dated 7/24/18, for urinary incontinence and indwelling catheter due to requiring extensive assistance for toileting. R11's care plan dated 4/21/18, indicated activities of daily living (ADL) self-care performance deficit related to weakness, immobility from disease process. Care plan	21840	completion date 9/4/18.	

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21840	Continued From page 42 directed facility staff to encourage participation from resident in regards to bed mobility and toileting with one person physical assist. R49 was to be encouraged to use the call light for assistance. During document review R11 had two code status order in the electronic medical record, one for "Do Not Resuscitate (DNR)DNAR [Do not Attempt Resuscitation]" and the other "Full Code" both dated 7/12/18. During an interview on 7/26/18, at 1:23 p.m. registered nurse (RN)-B confirmed R11's conflicting code status in the electronic medical record and verified R11's Physician Orders for Life-Sustaining Treatment (POLST) was "Full Code" and was not signed by the physician. RN-B indicated would confirm with resident about code status. During an interview on 7/26/18, at 1:29 p.m. assistant director of nursing (ADON) indicated R11 "Had left the facility and came back, someone just didn't discontinue one." ADON verified R11 had two code status in the electronic medical record and confirmed should not have two conflicting orders. ADON further indicated POLST should be signed by the physician by the next visit. Facility policy CPR-Cardiopulmonary Resuscitation with revised date of 5/11/18, indicated "The facility shall provide CPR to a resident who requires such emergency care prior to the arrival of emergency medical services, consistent with the resident's advance directives and physician orders."	21840		

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21840	Continued From page 43 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to advance directives. The DON or designee, could provide training for all nursing staff related to advance directives. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21840		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be	21880		9/4/18

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21880	Continued From page 44 followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dignified treatment for 1 of 4 residents (R24) reviewed during the survey who had reported concerns related to staff treatment. Findings include: R24's admission minimum data set dated 5/6/18, indicated he was cognitively intact, required extensive assistance for bed mobility, transfers and toileting, and was frequently incontinent of bowel. R24's care plan dated 5/2/18, identified a self care performance deficit related to activity intolerance and directed staff to assist with toileting and personal hygiene needs. During an interview on 7/23/18, at 4:21 p.m. R24 was observed lying in bed. R24 stated he did not	21880	completion date 9/4/18.	

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21880	Continued From page 45	21880		

feel all of the staff treated him with respect. R24 stated he did not appreciate the way staff spoke to him and explained that the other night, R24 had a bowel movement and had to be changed. He stated, the nursing assistant (NA) just put the incontinent product on the chair and he had to ask her for help. He stated the NA did finally help him and stated, "I don't' want to be here and it feels like I'm bothering them to do their job." R24 stated another night he had a bowel movement around 4:00 a.m. and turned on his call light for assistance. He stated he laid in his stool for an hour and 45 minutes before he was assisted. R24 stated a woman had come around with a questionnaire and he told her about it. He said she wrote it down and said she would pass it on. R24 stated no one had followed up with him regarding his concerns

Review of a Resident Interview and Resdient Observation form dated 7/15/18, indicated R24 was interviewed by an intern in the facility. The interview form indicated R24 was asked if he was treated with dignity. The form had a check box indicating R24 said no. The form further indicated he reported to the intern he had to lay in his stool for and hour and a half around 4:00 a.m.

During an interview on 7/27/18, at 11:55 a.m. the administrator stated an intern went around the facility with the questionnaire in preparation for the upcoming survey. She stated she was not aware of any concerns voiced by R24. At 3:39 a.m. the administrator stated she located a copy of the questionnaire filled out by the intern. She stated she had not been informed of R24's concerns related to the staff and stated the intern should have given her the information right away.

A facility policy titled Villa Resident Rights, dated

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21880	Continued From page 46 11/28/17, indicated residents have the right to be treated with respect and dignity. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to treating residents with dignity. The DON or designee, could provide training for all nursing staff related to the dignified treatment of residents. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		