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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: HSBL

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** (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 **07/18/2017** (L34)

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

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

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

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

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

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

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

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

Continuing waiver involving F521 has been forwarded to CMS.

17. SURVEYOR SIGNATURE — Date :
Gloria Derfus, Unit Supervisor — 08/18/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kamala Fiske-Downing, Enforcement Specialist 08/18/2017 (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) **00**
VOLUNTARY
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 **08/03/2017** (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245182

August 14, 2017

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

Dear Ms. McCurdy:

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

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

Effective the above facility is certified for:

105 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered August 14, 2017

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

RE: Project Number S5182027

Dear Ms. McCurdy:

On June 26, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 8, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On July 18, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 8, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 13, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 8, 2017, effective July 13, 2017 and therefore remedies outlined in our letter to you dated June 26, 2017, will not be imposed.

Your request for a continuing waiver involving the deficiency(ies) cited under K521 at the time of the June 8, 2017 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@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: HSBL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00278

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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 **06/08/2017** (L34)

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

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

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

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

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

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

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

CCN 24 5182
Documentation supporting the facility's request for a continuing waiver involving F521 has been forwarded to CMS.

17. SURVEYOR SIGNATURE — Date : 07/10/2017 (L19)

Barbara White, HFE NE II

18. STATE SURVEY AGENCY APPROVAL — Date: 08/04/2017 (L20)

Kamala Fiske-Downing, Enforcement Specialist

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) **00**

VOLUNTARY
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 **08/03/2017** (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7013 3020 0001 8869 1944

June 226, 2017

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

RE: Project Number S5182027 and H5182064

Dear Ms. McCurdy:

On June 8, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the June 8, 2017 standard survey the Minnesota Department of Health completed an investigation of complaint number H5182064 that was found to be unsubstantiated.

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

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

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

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

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the

Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

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 July 18, 2017, 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 July 18, 2017 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

imposition of these remedies.

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

If substantial compliance with the regulations is not verified by September 8, 2017 (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 December 8, 2017 (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 a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Enclosure

cc: Licensing and Certification File

RECEIVED
JUL - 5 2017
MN Dept of Health
Duluth

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 _____	06/08/2017

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 000	INITIAL COMMENTS A recertification survey was conducted June 5, 6, 7, and 8, 2017, and a complaint investigation was also completed at the time of the standard survey. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An investigation of complaint #H5182064 was completed and found not to be substantiated.	F 000	The Villa of St. Louis Park submits this plan of correction Because it is required by State and Federal Regulation And is not a legal admission that this statement of deficiencies Is correctly cited, and is not to be construed as an admission Against the interest by the Center, the Administrator or any Employees, agents or other individuals who draft or may be Discussed in the response and plan of correction. The Villa Of St. Louis Park respectfully submits this plan of correction And our allegation of compliance as of July 13th, 2017.	
F 176 SS=D	483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE (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 assess self-administration of medications (SAM) for 2 of 2 residents (R85, R69) observed to self-administer a nebulizer treatment. Findings include: R85's admission Minimum Data Set (MDS) dated	F 176	dc TN 7/10/17	

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

Kristin McCluney | NHA | 6/30/17

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 _____	06/08/2017

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 176	Continued From page 1 3/17/17, indicated R85 had modified independence with decision making, and had a diagnosis of dementia. R85's Order Summary Report dated 6/8/17, directed Albuterol Sulfate (medication that dilates the airways in the lungs) nebulization solution 2.5 milligrams (mg) /3 milliliters (ml) four times a day for shortness of breath. The Order Summary Report lacked an order for self-administration of medications. R85's Self-Administration of Medication Assessment (SAM) indicated self-administration of medication was not applicable for R85; staff gave him medication and treatments. The form was signed 3/13/17. On 6/5/17, at 4:06 p.m. registered nurse (RN)-G was observed to prepare a dose of Albuterol Sulfate nebulization solution for R85. RN-G set up the nebulizer for R85, and left the room. RN-G stated normally when family is present he would leave the nebulizer set up with R85, and would check back later. On 6/6/17, at 1:26 p.m. RN-D verified R85 did not have an order to self-administer any medications. R69's admission MDS dated 5/5/17, indicated R69 had severe cognitive impairment, and had a diagnosis of dementia. R69's Order Summary Report dated 6/8/17, directed budesonide suspension (also known as Pulmicort, a medication that dilates the airways in the lungs) nebulization solution 0.25 mg /2 ml every day for chronic obstructive lung disease. The Order Summary Report lacked an order for	F 176	F176 1. a.) R69 and R85 were assessed and no adverse Effects were noted. Both have self-medication Assessments completed. Completed by ADON On 6/6/17(R69) and 6/20/17(R85). 2. All residents will be reviewed to ensure a self-Medication assessment is completed if appropriate. Will be completed by ADON and TCU Manager By July 13th. 3. Licensed Nursing staff will be educated on the self-medication policy and procedure. Completed by DON on 6/23/17 and 6/25/17. 4. Five random SAM audits will be conducted weekly on Patients to ensure self- med assessments are completed, Order is received, care plan is updated and Staff are following policy. Audits will continue until No deficient practice is determined by QAPI review. 5. Audits will be brought to QAPI monthly for review. Completed by NHA or designee.	

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	245182	A. BUILDING _____ B. WING _____	06/08/2017

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 176	Continued From page 2 self-administration of medications. R69's SAM Assessment dated 4/2/17, indicated R69 did not wish to self-medicate, R69 was not oriented to time and place, and R69 had a cognitive disability. The SAM assessment indicated R69 could not demonstrate he was capable of SAM safely. On 6/6/17, at 10:42 a.m. R69 was observed sitting on edge of his bed with nebulizer mouthpiece part way in mouth. R69 removed the mouthpiece, and asked for the nebulizer machine to be turned off. There were no staff in room. At 10:47 a.m. RN-H entered the room. RN-H verified the medication in the nebulizer machine was Pulmicort. RN-H verified R69 did not have an order to self-administer nebulizer. On 6/6/17, at 11:28 a.m. RN-E was interviewed and verified R69 had an assessment for SAM that indicated R69 was not capable of SAM. RN-E verified R69 did not have an order for SAM. On 6/8/17, at 8:49 a.m. the director of nursing (DON) stated prior to a resident self-administering any medication, they must have an assessment that indicates it would be safe for them to do so, a physicians order to self administer medications, and a care plan. The DON stated a resident without a SAM order must have a nurse present at all times while the nebulizer was running. The facility Self-Administration of Drugs policy revised 2011, directed staff residents in the facility who wish to self-administer their medications may do so, if it is determined they are capable of doing so.	F 176		

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F 176	Continued From page 3 1. As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities, to determine whether a resident is capable of self-administering medications. 2. In addition to general evaluation of decision-making capacity, the staff and practitioner will perform a more specific skill assessment, including (but not limited to) the resident's ability to read and understand medication labels, comprehension of the purpose and proper dosage and administration time for his or her medications, and have the ability to remove medications from a container and to ingest and swallow (or otherwise administer) them. The policy further directed the resident must have the ability to recognize risks and major adverse consequences of his or her medications. The policy also directed if the staff determine that a resident cannot safely self-administer medications, the nursing staff will administer the resident's medications. The facility Administering Medications Through a Small Volume (Handheld) Nebulizer policy revised 10/10, directed staff to ask the resident to hold the mouthpiece gently between his/her lips (or apply face mask), instruct resident to take a deep breath, pause briefly and then exhale normally. The policy further directed to encourage the resident to repeat the above breathing pattern until the medication is completely nebulized, or until the designated time of the treatment has been reached. Remain with the resident for the treatment.	F 176		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		

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F 241	Continued From page 4 (a)(1) A facility must treat 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure privacy and dignity was maintained for 2 of 3 residents (R21, R96) reviewed for dignity. Findings include: R21's significant change Minimum Data Set (MDS) dated 3/13/17, indicated R21 was severely cognitively impaired, required assistance with all activities of daily living, and had a diagnosis of dementia. On 6/7/17, at 10:43 a.m. during observation of R21's morning cares, an unknown housekeeper opened R21's door wide and said, "I will come back later." R21 was lying on his bed, with the right side of his body exposed while nursing assistant (NA)-A and NA-B were completing personal cares. On 6/7/17, at 11:03 a.m. R21 stated, "They never knock. They are doing their job I guess." On 6/7/17, at 11:15 a.m. NA-B verified the housekeeper did not knock prior to opening the door. On 6/08/17, at 12:08 p.m. the director of housekeeping (DH)-A stated housekeeping staff had no formal training on dignity, or knocking and	F 241	F241 1. R21 and R96 were assessed and no adverse Effects were noted. Completed by IDT on 6/28/17. 2. Staff education will be completed on Dignity/ knocking and asking permission before Entering a resident's room. Completed by DON on 6/23/17 And 6/25/17. 3. Residents to be interviewed about knocking/Dignity by SW or designee by July 13th. 4. Five audits of Dignity/Knocking will be completed weekly to ensure Staff are knocking and providing cares in a Dignified manner. Audits will be completed by SS or designee, audits to continue until no residents Report dignity concerns or staff entering without knocking. 5. Audits will be brought to QAPI by NHA or designee Monthly to identify a pattern of reduction in complaints or Violations with the ultimate elimination in dignity concerns.	

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F 241	Continued From page 5 waiting prior to entering a resident's room, except during initial orientation. R96's annual MDS dated 3/6/17, indicated R96 was cognitively intact, required assistance with all activities of daily living except eating, and had a diagnosis of depression. On 06/7/17, at 3:10 p.m. NA-F entered R96's room without knocking. NA-F was holding towels and incontinence products. R96 was sitting in his wheelchair in front of the television reading. NA-F opened R96's dresser drawers and moved things around. NA-F did not speak to R96 while in room. NA-F verified she did not knock, and that R96 was in the room. NA-F stated, "I did not want to disturb him, so I just took his linens in, and incontinence products. I needed to check his drawers to know what he needed." On 6/8/17, at 9:55 a.m. R96 stated, "I was not happy for her to come in without knocking. I hate it when they go into my drawers without asking. I have lost money and lotion and deodorant. The staff are mostly good, but these are my things. I keep the things they need on top of the counter." R96 pointed at a container with towels and incontinence briefs on top of dresser. On 6/8/17, at 8:49 a.m. the director of nursing (DON) stated staff should knock prior to entering a room, let the resident know what they are doing, and get permission to look in resident's drawers. The DON further stated it would be wrong to just walk in and open someone's drawers, and the rooms are the resident's home. The facility Quality of Life-Dignity policy revised 10/09, directed residents' private space and	F 241		

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F 241	Continued From page 6 property shall be respected at all times, staff will knock and request permission before entering residents' rooms and staff will not handle or move a resident's personal belongings including radios and televisions) without the resident's permission.	F 241		
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (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 identify resident preferences for waking times for 1 of 3 residents (R126) reviewed for choices. In addition, the facility failed to ensure a call light was in reach for 2 of 2 residents observed for access to call system.(R85, R26). Findings include: R126's Admission Record indicated diagnoses that included major depressive disorder and generalized muscle weakness. R126's significant change Minimum Data Set (MDS) dated 6/2/17, indicated R126 was cognitively intact. R126's care plan dated 2/16/17, directed staff to	F 246	F 246 1. Resident R126 was interviewed about his Bedtime preferences. Completed by IDT on 6/28/17. No adverse effects were noted. Care plan was updated. And R26 and R85 were assessed and no adverse Effects were noted completed by NHA on 6/19/17. 2. Residents were interviewed on their Preferences on 6/7/17- 6/28/17 by LE and SS. Care plans and group sheets were Updated. All residents were reviewed on 6/26/17 to Ensure call lights were within reach. Completed by LE and SS. Audits of call lights will continue until sustained Deficient practice identified. 3. Staff will be educated on ensuring call lights Are within reach before leaving patient room. Staff will be educated on resident's rights to have Choices and to have their voices reflected in plan Of care. Completed by Don on 6/23 and 6/25. 4. Five audits will be completed weekly to ensure Call lights are within resident reach. Completed by SS or Designee. Five audits will be completed weekly on Resident bed times and preferences' Audits will Be completed by Life Enrichment or designee. 5. Audits will be brought to QAPI monthly for review By NHA or designee.	

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F 246	Continued From page 7 allow R126 to make decisions about treatment regime, to provide sense of control. On 6/5/17, at 2:36 p.m. R126 stated, "They [staff] come in and wake us up early sometimes. Like today, I would have liked to stay in [bed]. At one point they knew, and then all changed." On 6/7/17, at 7:10 a.m. resident was observed sleeping in bed. At 7:20 a.m. nursing assistant (NA)-B was observed go into R126's room. NA-B stated he was locking the closet, and would get R126 up later, as she was going to get NA-A to assist with cares. NA-B left the room. At 7:22 a.m. NA-B came back to room stated she was not going to get resident up at the time because she had to wait for her co-worker to help her as resident required two assist with cares. At 7:34 a.m. NA-B and NA-A entered R126's room. NA-A approached R126, and asked how he had slept. R126 was trying to open his eyes, and asked for a drink of water. NA-A put the light on right above R126's bed. NA-B gathered supplies and filled a water basin. At 7:36 p.m. both NA-B and NA-A left the room briefly. The surveyor asked R126 if staff had asked him if he wanted to get up. R126 stated, "No, I want to sleep in a little bit. I have told them and am just tired of it." R126 appeared tired and his eyes were barely open. The NAs returned to the room. At 7:38 a.m. NA-B went and got two shirts from the closet, and asked R126 to choose the one he wanted to wear. R126 responded by saying he wanted to sleep in. NA-B continued to talk over R126 asking what shirt and clothing he wanted to wear. NA-A stated, "We are going to get you up now." The surveyor intervened, walked with both NAs to the other side of the room, and asked them if R126 had been asked if he wanted to get up. NA-B stated	F 246		

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F 246	Continued From page 8 she had asked him. NA-B then asked R126 if he was wanted to get up, and R126 replied, "I would like to sleep in until after 8:00 a.m." NA-B kept walking around the room, applied gloves and then took them off and left the room. As NA-B was leaving the room, maintenance worker (M)-A came into the room and stated he wanted to take the grab bars off R126's bed. Both NA-B and M-A stood in the doorway, talking loudly. NA-A stated all staff were supposed to ask residents if they wanted to get up. When asked what R126's waking up preferences were, NA-A was not sure. NA-A stated R126 was soft spoken, and that was why NA-B had not heard him when he had asked to sleep in however, staff was supposed to face the resident and listen to the resident. On 6/7/17, at 7:54 a.m. registered nurse (RN)-B was interviewed and stated residents were assessed their preferences on admission, and should be asked on an on-going basis however, R126's waking preferences had not been assessed or addressed. RN-B stated staff were supposed to give residents a choice on waking preferences. On 6/7/17, at 8:45 a.m. to 9:24 a.m. staff was observed providing R126 cares. NA-A asked R126 how he had slept and R126 stated, "Good." On 6/7/17, at 9:29 a.m. NA-B stated she was not sure of R126's wake time preference, and verified the care assignment sheet did not address R126's wake time preference. On 6/7/17, at 10:08 a.m. R126 stated it felt really good to sleep in. R126 continued, "Most of the time when I tell them I want to sleep in they just talk over me, and tell me I have to get up for	F 246		

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F 246	Continued From page 9 breakfast. They were very nice and kind and took all the time with me this morning and usually would hurry." On 6/8/17, at 2:56 p.m. the director of nursing (DON) stated she would expect residents to be given choice on when to wake up, and if a resident had voiced a preferred time to wake up, it would be put on the group sheet and care plan. The DON stated R126 should have been asked if he was ready to get up before getting him up, his preference should be honored, and the information should have been communicated to management to make the changes. R85's care plan dated 3/16/17, identified diagnoses that included dementia and anxiety. The care plan also indicated R85 had limited physical mobility, directed staff to ensure the call light was within reach, and to encourage R85 to use it for assistance as needed. R85's admission Minimum Data Set (MDS) dated 3/17/17, indicated R85 was not steady when moving from seated position, and could only stabilize with human assistance. R85 was observed resting in recliner in his room on 6/6/17, at 9:31 a.m. The call light was observed to be attached to a bed sheet approximately six feet from R85. R85 stated he could use the call light, and thought he could get out of his chair if he needed to use the call light. R26's care plan dated 4/21/17, identified diagnoses that included paraplegia. The care plan directed facility staff to ensure R26's call light was within reach, and to encourage R26 to use it	F 246		

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F 246	Continued From page 10 for assistance as needed. R26's quarterly MDS dated 4/24/17, indicated R26's upper extremities were impaired. On 6/5/17, 3:31 p.m. R26 was observed seated in a wheelchair in her room. The call light was lying on the bed, approximately five feet from R26. On 6/5/17, at approximately 6:30 p.m. R26 was observed to use her call light appropriately. On 6/08/17, at 12:57 p.m. the director of nursing (DON) stated that she would expect the call light to always be within the resident's reach. A policy on call lights was requested, but not provided.	F 246		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.	F 280	F280 1. R33 skin has been assessed and Care plan was updated on 6/6/17 to reflect Skin area on bilateral buttocks and heel. Completed by RDCS on 6/6/17. Resident discharged on 6/30/17. 2. All residents with wound care have been Assessed for adverse effects and to ensure Care plans are accurate. Completed by DON And ADON by 7/13/17. 3. MDS nurse will validate all resident skin areas are Appropriately coded. 4. Licensed staff and IDT will be educated on care plan Policy and procedure by DON or designee By 7/13/17. 5. Five audits of identified skin areas will be Completed weekly by DON or designee. 6. Audits will be brought to monthly QAPI For review by NHA or designee.	

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F 280	Continued From page 11 (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the	F 280		

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F 280	Continued From page 12 resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to revise the care plan to include open wounds for 1 of 1 residents (R33) reviewed for non-pressure related skin conditions. Findings include: R33's Admission Record indicated diagnoses that included type 1 diabetes, and multiple sclerosis. R33's admission Minimum Data Set (MDS) dated 3/7/17, indicated R33 was cognitively intact. The MDS further indicated R33 had surgical dressing changes, and application of ointments to areas other than feet. R33's Care Area Assessment (CAA) dated	F 280		

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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 280	Continued From page 13 3/9/17, indicated R33 was wheelchair bound, and required assistance with activities of daily living (ADLs). R33's care plan dated 3/20/17, lacked information on skin issues or current open areas. A care plan for skin issues was added 6/6/17, after the surveyor asked questions about R33's open wounds. On 4/27/17, a Physician's Order directed Silverstat gel to open area on left buttock daily. Use a foam dressing to cover for moisture. On 5/18/17, a Physician's Order directed Silverstat gel to right heel after cleansing. Cover with foam dressing and change every 3 days in the evening. On 6/7/17, at 8:20 a.m. R33's wound care was observed with registered nurse (RN)-C. R33 had a wound on the left buttock, and a wound on the right buttock. The wound on left buttock was irregularly shaped with irregular edges. The wound on the right buttock had two rectangular wounds that were larger at the top and smaller at the bottom. R33 also had a wound on the right heel, and the wound was observed with RN-C. On 6/6/17, at 9:21 a.m. RN-E was interviewed and verified R33's care plan did not address open areas on bilateral buttocks or heel. On 6/8/17, at 3:36 p.m. the director of nursing (DON) was interviewed and stated any alteration in the skin should be on the care plan. The facility Care Planning- Interdisciplinary Team (IDT) policy revised 12/08, directed it was the	F 280		

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F 280	Continued From page 14 facility care planning and IDT's responsibility to develop an individualized comprehensive care plan for each resident. The policy also directed the resident and/or family or legal representative were encouraged to participate in the development of and revisions of the resident's care plan.	F 280	F309 1. R126 was assessed and no adverse effects Were noted. New orders were received. Pain was assessed by ADON on 6/14/17. Both the MDS and the Plan of care have been Reviewed and followed up on. Completed by MDS on 6/13/17. R33's skin was assessed and no adverse Effects were noted on 6/22/17 by DON. Care plan was updated On 6/6/17 to reflect skin area on Bilateral buttocks and heel. Completed by RDCS on 6/6/17. 2. Residents will be reviewed to Ensure pain management plan Is appropriate by 7/13/17. All residents with Wounds will be reviewed to ensure Measurements are in place and Current by 7/13/17. MDS nurse will validate coding of all skin areas and pain triggers. 3. Licensed staff will be educated on the policy And procedure related to processing new Orders and policy and procedure for Discontinuing medications. Licensed staff will also be educated on Policy and procedure For skin care and pain. Will be completed by 7/13/17. 4. Five audits will be conducted weekly On skin areas triggered in the progress notes by DON or designee. Five audits on new medication orders to be reviewed weekly. To be completed by Medical Records or designee. Five audits will be completed weekly for pain assessment by DON or designee. 5. Audits will be brought to QAPI by NHA	
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 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, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 309		

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F 309	Continued From page 15 (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and document review, the facility failed to ensure pain medication was ordered for 1 of 3 residents (R126) reviewed for pain. In addition, the facility failed to ensure monitoring of open wounds for 1 of 1 residents (R33) reviewed for non-pressure related skin conditions. Finding included: R126's Face Sheet indicated diagnoses that included spondylosis (deterioration of the spine), and muscle weakness. R126's significant change Minimum Data Set (MDS) dated 6/2/17, indicated R126 was cognitively intact. The MDS also indicated R126 was not on a scheduled pain medication regimen, and did not currently have any pain. R126's care plan dated 8/19/16, directed staff to anticipate R126's need for pain relief, and respond immediately to any complaint of pain. The care plan also directed staff to identify previous response to analgesia, including pain relief. In addition, the care plan also directed staff to administer medications as ordered, and monitor for effectiveness and side effects. On 6/5/17, at 2:43 p.m. R126 was interviewed and stated his shoulders hurt. R126 stated the	F 309		

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F 309	Continued From page 16	F 309		

facility had stopped giving him a Lidocaine patch (used to treat pain), and his shoulders had been hurting. R126 was observed moving and rubbing his shoulders against the back of his wheelchair. R126 stated his "bottom" was hurting also.

On 6/6/17, R126's Physician Orders directed Lidoderm 4% patches (used for pain relief) one to each anterior shoulder area of pain. On 12 hours off 12 hours. Place every morning.

On 6/7/17, at 10:08 a.m. R126 stated he continued to have pain his shoulders. R126 stated he had previously used a Lidocaine patch to his shoulders, but had been admitted to the hospital, and it was not reordered when he returned from the hospital. R126 rated the pain in his shoulders at a five (on a scale of zero no pain and 10 the most pain).

On 6/8/17, at 10:12 a.m. the facility's pharmacy was called. The pharmacy staff stated they had not received an order for R126's Lidocaine patch.

On 6/8/17, at 10:14 a.m. registered nurse (RN)-B was interviewed and stated a new order should be faxed to the pharmacy to get the medication delivered.

On 6/8/17, at 10:17 a.m. RN-D stated he was going to give R126 the Lidocaine patch,and there was none. RN-D stated he had reported this to RN-F, who told him to discontinue the Lidocaine patch because there was no order per pharmacy. RN-D stated he had called the pharmacy on 6/7/17, and had been told the pharmacy did not have an order.

On 6/8/17, at 10:22 a.m. RN-B stated the nurses

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F 309	Continued From page 17 were not supposed to discontinue medications without letting the physician know. On 6/8/17, at 10:32 a.m. R126 was observed seated in his wheelchair in his room. R126 rated his pain at a 6, and stated he had told the staff daily about the pain in his shoulders. R126 stated he has asked staff about the Lidocaine patch. R126 stated he had used the Lidocaine patch for a while, and it did give him pain relief as sitting in wheelchair was uncomfortable at times. On 6/8/17, at 3:01 p.m. the director of nursing (DON) stated when physician orders were written, the nurses were supposed to put the order in the computer, and fax the order to pharmacy. The DON stated when a nurse was going to discontinue an order, the nurse was supposed to call a doctor to get the orders to discontinue the medication. Nurses were not to discontinue orders without a physician order. The DON further stated she would expect the nurse(s) to have faxed the physician's order for the Lidoderm patch as written to the pharmacy, so the pharmacy would supply the medication. The facility Physician Medication Orders policy revised 4/10, directed the Charge Nurse or the Director of Nursing Services shall call-in the order for all prescribed medications. Drugs and biologicals that are required to be refilled mush be reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to ensure that refills are readily available. A policy for discontinuing orders was requested but was not provided.	F 309		

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F 309	Continued From page 18	F 309		

R33's Admission Record indicated diagnoses that included type 1 diabetes, and multiple sclerosis.

R33's admission Minimum Data Set (MDS) dated 3/7/17, indicated R33 was cognitively intact. The MDS further indicated R33 had surgical dressing changes, and application of ointments to areas other than feet. The MDS also identified R33 was at risk for development of pressure ulcers, and had surgical wounds. The MDS lacked information if R33 had pressure ulcers, venous or arterial ulcers, or moisture associated skin damage.

R33's Care Area Assessment (CAA) dated 3/9/17, indicated R33 was wheelchair bound, and required assistance with activities of daily living (ADLs). The CAA also indicated R33 had a Foley (urinary) catheter, and was at risk for pressure ulcer development.

R33's care plan dated 3/20/17, lacked information on skin issues or current open areas. A care plan for skin issues was added 6/6/17, after the surveyor asked questions about R33's open wounds.

Progress notes indicated the following:
-3/20/17. Noted the following skin issues; dry, peeling skin on soles of feet, open sores on buttocks, and redness on buttocks.
-3/24/17. A skin check identified R33 had open sores and her bottom and the skin was very red.
-3/27/17. The following was noted: shearing on

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F 309	Continued From page 19 buttocks, some bleeding present. Barrier cream placed and will need to monitor continuously. -4/5/17. Skin check performed and noted peri area was bright red. Redness to buttock, and open areas to both sides of buttocks. -4/14/17. Buttock, skin light purple/red and slightly raised. Three open areas were present. -4/19/17. Skin clear and intact at this time. -4/24/17. Buttocks look raw and bleeding. Resident advised to be off the buttocks to prevent pressure to buttocks. -4/27/17. Open ulcer on the left buttock measuring 100 by 50 centimeters (cm). (This was incorrect as 100 cm is approximately 39.5 inches, and 50 cm is approximately 19.6 inches). -5/1/17. Left buttocks ulcer raw and bloody. Foul odor to buttocks noted when cleaning the buttocks. Ulcer to right buttocks reddish. -5/5/17. Buttocks redness remains. Resident and family advised about being off the buttocks. -5/9/17. Buttock redness present. -5/12/17. Left buttock continues to be open. Foam dressing applied. Right buttock red non-blanchable. -5/16/17. Buttock continues to be open and weeping of serosanguinous fluid. -5/23/17. Right heel blister open and shows scant bleeding. Buttocks areas remains excoriated with open areas. -5/24/17. Buttocks remain excoriated and foul odors noted while doing treatments. Right heel bleeding while doing treatments. Buttocks:bend of wound drying up. The size of the wound is shrinking and dark tissue is in the wound. Resident denies pain to the wound. -6/2/17. Body audit performed on shower day. Buttocks show improvement with less redness. Open area left inner upper buttocks remains. Right heel scab smaller in size.	F 309		-

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F 309	Continued From page 20 The progress notes lacked consistent documentation of the wounds including measurements, drainage, observation of wound bed, cause of wound, and progress toward healing. On 6/6/17, at 9:39 a.m. the director of nursing (DON) and RN-B assessed R33's wounds. The right heel wound was documented in the progress notes as: "Area is superficial measuring 0.8 x 0.9 cm with irregular edges. Wound bed red with scant sanguineous drainage. Periwound dry. No odor. Area appears to be from AFO/boot that resident wears when out of bed. AFO is very hard on heel area and provides no pressure relief. Resident leaves for long periods of time during daytime to go home with husband. Advised resident to let area heal before resuming boot. Will update MD. Area cleansed and comfort foam border dressing applied. Resident also has diffuse maceration to bottom. Area very moist. Barrier cream applied. Educated resident on importance of offloading during the day in order to keep area drier. Resident is non compliant with this. Resident reeducated on not wearing brief at night and offloading onto her side. Will continue to encourage compliance." On 6/7/17, at 8:20 a.m. R33's wound care was observed with registered nurse (RN)-C. RN-C washed hands, put on gloves and assisted R33 to lie on right side. RN-C removed a foam dressing. R33 had a wound on the left buttock, and a wound on the right buttock. The wound on left buttock was irregularly shaped with irregular edges. The wound on the right buttock had two rectangular wounds that were larger at the top	F 309		

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F 309	Continued From page 21 and smaller at the bottom. RN-C did not measure the wounds. The surrounding tissue on both buttocks was a purple-red color, and did not blanch when RN-C pressed on it. RN-C continued with the wound care, and sprayed a gauze pad with wound cleanser. RN-C cleansed the left wound, and then using the same gauze cleansed the right wound. RN-C used dry gauze and patted the left wound then the right wound dry. RN-C applied Silverstat gel (an antibacterial wound dressing gel) to the index finger of his gloved right hand, and applied the gel to R33's left wound, then the right wound. RN-C applied new foam dressing to R33's wounds, then removed his soiled gloves and washed his hands. RN-C then left the room. On 6/7/17, at 8:47 a.m. RN-C returned to R33's room to do a dressing change on R33's right heel wound. R33's heels were flat on the bed, and R33 was wearing anti-slip socks. R33 stated, "I have blue boots [heel protectors], but did not have them last night because the nursing assistants left them in the shower. I only wear the boots at night." R33's dressing was on the ankle, not covering the right heel wound. RN-C washed his hands and put on gloves. RN-C removed the soiled dressing that had drainage on it. RN-C placed a clean towel under R33's heel and then removed his soiled gloves and washed his hands. RN-C put on clean gloves, sprayed a gauze with wound cleanser and scrubbed R33's right heel wound. RN-C used clean gauze to pat the wound dry. Without changing gloves and completing had hygiene, RN-C applied Silverstat gel to index finger of his gloved right hand, and applied the gel to R33's right heel. RN-C covered the heel with a foam dressing, then removed his soiled gloves and washed his hands.	F 309		

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F 309	Continued From page 22 A Skin Issues Details Report dated 5/18/17, indicated R33 had an abrasion measuring 0.8 x 0.9 cm with irregular edges. The wound bed was described as red with scant sanguineous drainage. The location of the abrasion was not indicated. On 3/9/17, a Physician's Order directed may apply barrier cream to perineal and buttocks every shift for redness to the perineal areas. Monitor the areas and report any adverse changes to the MD as needed. On 4/27/17, a Physician's Order directed Silverstat gel to open area on left buttock daily. Use a foam dressing to cover for moisture. On 5/18/17, a Physician's Order directed Silverstat gel to right heel after cleansing. Cover with foam dressing and change every 3 days in the evening. On 6/6/17, at 11:33 a.m. RN-B was interviewed. RN-B stated R33 had maceration (softening and breaking down of skin resulting from prolonged exposure to moisture) on her buttocks due to sitting in her chair a long time. RN-B stated R33's heel wound was caused by the hard leather boot (the AFO), and they had not defined the open area as a pressure ulcer. RN-B stated R33 was no longer wearing the boot. On 6/7/17, at 8:17 a.m. RN-C stated R33's skin was open on both buttocks. RN-C further stated it looked like R33 had developed a pressure ulcer on her buttocks, and she would classify it as a Stage 2 pressure ulcer (Partial Thickness Skin Loss: Partial thickness loss of dermis presenting	F 309		

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F 309	Continued From page 23 as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising). RN-C stated she believed the open area on the buttocks got worse because R33 went home for visits many days. RN-C continued to state R33's left buttock was the only open area, but R33 had developed an open area on the right buttock also. On 6/8/17, at 3:36 p.m. The DON stated R33 had a hard molded brace (ACO) that she had been told to wear every day. The DON stated R33's husband brought the brace in from home. The DON stated R33 was not standing any more, and the brace was rubbing on her heel, it was ill fitting. The DON stated she didn't believe the heel wound was caused by pressure because R33 did not bear any weight. The DON stated, "They [facility staff] should have floated her heels until her boots were found." The DON further stated, "I became aware of the heel issue on Monday, and looked at it Tuesday." The DON stated she would expect staff to do weekly charting on that type skin alteration. The DON stated, "I could not tell on 6/6/17, whether the wounds were better or worse." The DON stated any skin alteration should have gone on the care plan. The DON stated R33's skin was peeling and she felt it was moisture associated skin damage, not from pressure. The DON stated she believed the source of moisture was the length of time R33 was sitting in her chair. The facility policy Skin Tears-Abrasions and Minor Breaks, Care of, revised 10/10, directed staff to document all assessment data, i.e. bleeding, size of wound, tissue loss, etc. when a wound was	F 309		

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F 309	Continued From page 24 first found.	F 309		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain safe and secure side rails for 1 of 3 residents (R26) reviewed for accidents. Findings include:	F 323	F323 1. R26 was assessed and no adverse effects Were noted. Side rails were discontinued and Taken off bed on 6/5/17. Completed by Maintenance Director. Care plan updated and order discontinued. 2. All side rails were reviewed by maintenance For safety of the beds on 6/9/17. Nursing will review residents Who have side rails for appropriateness by 7/13/17. Care plans and assessments were updated by IDT team. 3. Education was completed with Maintenance to Ensure bed safety policy is being followed. Completed by NHA on 6/20/17. Education with staff on bed safety policy and the safety requirements associated with side rails. Will be completed by DON by 7/13/17. 4. Five audits will be completed weekly by NHA or Designee to ensure side rails are safe, in good Working order and care plan, assessment and Order is received. Maintenance to audit 5 resident rooms each week for bed and room safety. 5. Audits will be brought to QAPI by NHA or Designee for review.	

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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 323	Continued From page 25 R26's care plan dated 4/21/17, indicated diagnoses including early-onset Friedrich's ataxia (disease that causes nervous system damage and movement problems), and paraplegia. R26's quarterly Minimum Data Set (MDS) dated 4/24/17, indicated R26 was totally dependent on staff for cares, and had impairment in both upper extremities. On 6/5/17, at 6:41 p.m. half side rails were observed on R26's bed. The left side rail was loose, moving approximately 10 inches side to side. On 6/6/17, at 8:12 a.m. the left side rail remained loose. On 6/7/17, at 10:34 a.m. the director of maintenance (DM) stated that he checks side rails monthly. The DM stated he last checked the side rail on R26's bed on 5/24/17, and that it was broken. DM stated the bed and side rails were not facility property, so he asked a facility staff member to call the hospice provider and have the side rails removed. The DM stated he believed phone contact had been made with the hospice provider. On 6/7/17, at 11:56 a.m. the hospice registered nurse (RN)-I stated R26 was been receiving hospice services, and R26's bed was provided by the hospice provider. RN-I stated he was not aware the left siderail rail was loose, and denied the hospice provider had been contacted about the loose siderail. RN-I stated that he is in the facility approximately three times per week, and that staff could have contacted him if needed.	F 323		

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	245182	A. BUILDING _____ B. WING _____	06/08/2017

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F 323	Continued From page 26 On 6/8/17, at 8:22 a.m. the administrator stated a member of the maintenance department checks all rails and grab bars monthly. The facility policy Bed Safety Policy, revised 12/07, directed the facility shall strive to provide a safe sleeping environment for the resident. The policy further directed the facility shall promote the following approaches: Inspection by maintenance staff of all beds and related equipment as part of the regular bed safety program to identify risks and problems including potential entrapment risks. The policy further directed staff to review the gaps within the bed system and ensure they are within the dimensions established by the Federal Drug Administration (FDA). The FDA Seven Zones of Bed Entrapment guide directs the area between the inside of the rail and the mattress not exceed 4 3/4 inches.	F 323		
F 333 SS=D	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medication was administrated as ordered to prevent a significant medication error for 1 of 1 residents (R259) reviewed for medication administration.	F 333		

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F 333	Continued From page 27 Findings include: R259's care plan dated 5/25/17, indicated R259 had a diagnosis of Parkinson's disease. The care plan also directed R259 required physical assist of 1 staff for ambulation R259's Hospital Discharge orders signed 5/25/17, directed R259 was to receive carbidopa-levodopa (also known as Sinemet, a combination of medications used to treat the symptoms of Parkinson's disease) 25-250 milligrams (mg), take 1 tablet five times a day for Parkinson's disease. The orders included, "Another medication with the same name was changed. Make sure you understand how and when to take each." The orders also included carbidopa-levodopa 25-100 mg, take 1 tablet two time daily as needed for Parkinsonian tremors. R259's Admission Nursing Evaluation dated 5/25/17, indicated R259 was oriented only to person and situation, and was experiencing a delirium or an acute confusion episode. The evaluation also indicated R259 required physical assist of one staff member to walk. On 6/8/17, at 8:08 a.m. registered nurse (RN)-A was observed to give R259 1 tablet of Sinemet 25 mg-250 mg. R259 was in room walking from bathroom with a jerking gait without an assistive device. R259 had tremors of right arm and hand. R259's Medication Administration Record (MAR) for 5/25-5/31/17, indicated R259 received carbidopa-levodopa 25-250 mg 7 out of 32 doses (missing 25 scheduled doses). R259's MAR for 6/1-6/8/17, indicated R259 missed 36 of 36 doses of carbidopa-levodopa 25-250 mg at the time	F 333	F333 1. R259 was assessed for any adverse Side effects and the facility policy And procedure for medication errors was followed With the entry into Risk watch and MD notification Along with Pharmacist review. It was Determined by the facility to not have been a significant error. Resident R259 has since discharged home safely. 2. Residents will have their medication profile audited And reviewed to check for errors of transcription. The staff will use the monthly order set for review. To be completed by the Nursing staff and medical records by 7/13/17 3. Licensed staff will be educated on the correct procedures For order entry and transcription. Licensed staff will be Educated on how to double check admission orders, discontinued orders and to have a dual note and transcription Process for admission and discontinued orders. Completed by DON or designee by July 13th. 4. Five audits will be conducted weekly On new patient orders and discontinued orders to ensure there are no Transcription errors. Audits will be completed By DON or designee. 5. Audits will be brought to QAPI by NHA or designee.	

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F 333	Continued From page 28 significant medication error was identified. During interview on 6/8/17, at 8:49 a.m. the director of nursing (DON) was interviewed and stated when a resident was admitted, the health unit coordinator inputs the orders into the computer, and a nurse checks the orders to ensure they are entered correctly. The DON stated, "There is an order here dated 5/27, that discontinues the five times a day and says duplicate." The DON verified the order for five times a day was not a duplicate order. The DON verified there was no order from the nurse practitioner or physician to discontinue carbidopa-levodopa 25-250 five times a day. The DON stated, "From what I am seeing, the medication error was due to someone thinking it was a duplicate. [R259's] medications were not entered correctly. [R259] is at risk for increased Parkinson's symptoms, tremors and freezing. Depending on the severity, [R259] would be at risk for falls." On 6/8/17, at 8:55 a.m. RN-A verified there was no order change for the carbidopa-levodopa 25-250 five times a day since R259's admission. On 6/8/17, at 12:32 p.m. nurse practitioner (NP)-A stated, "We did not discontinue the order. It was a mistake, I restarted the original order. I met with the patient and discussed the problem. He feels his tremors are about the same. I have never seen the patient before." NP-A stated there was a call out to R259's neurologist, to ask if he wanted to see R259. NP-A said the medication error should not have happened. The facility policy on Reconciliation of Medications on Admission revised 10/10, directed	F 333		

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F 333	Continued From page 29 staff to ensure medication safety by accurately accounting for the resident's medications, routes and dosages upon admission or readmission to the facility. The policy also directed medication reconciliation reduces medication errors and enhances resident safety by ensuring that the medications the resident needs, and has been taking continue to be administered without interruption, in the correct dosages and routes, during the admission/transfer process.	F 333		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (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 (facility assessment implementation is Phase 2); (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;	F 441	F441 1. Residents R1 and R33 were reviewed. No Adverse effects were noted. Completed by IDT (R33) On 6/28/27. R1 IDT reviewed on 6/28/17. 2. Facility will review other residents in the building For any adverse effects possibly from similar Related practices. Facility will review the current list of residents with their lab reports and antibiotic use to identify any noscicomial infections. 3. Staff will be educated on handwashing/hand hygiene Policy to ensure proper technique to avoid infection. Staff education on providing cares and Clean vs dirty techniques will be completed by July 13th. 4. Five care observation audits will be completed weekly By DON or designee. 5. Audits will be brought to monthly QAPI by NHA or Designee.	

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F 441	Continued From page 30 (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 by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (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:	F 441		

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F 441	Continued From page 31 Based on observation, interview, and document review, the facility failed to provide proper hand hygiene and glove usage for 1 of 3 residents (R1) reviewed for personal cares, and 1 of 3 residents (R33) observed for wound care. Findings include: R1's annual Minimum Data Set (MDS) dated 3/20/17, indicated diagnoses of dementia and anxiety disorder. The MDS also indicated R1 required extensive assistance of two staff with toileting and personal hygiene. On 6/8/17, at 7:32 a.m. nursing assistant (NA)-C and trained medication aide (TMA)-A entered R1's room to provide personal cares. R1 stated she wanted to sleep in and get up later however, NA-C stated to R 1 she was going to change R1's incontinence brief, and then would leave her alone. NA-C provided pericare to R1's front, asked R1 to turn, and provided pericare in the back. As NA-C wiped R1's bottom, smears of bowel movement were observed. R1's incontinent brief was saturated with urine. TMA-A handed NA-C a clean incontinent brief, and NA-C tucked the brief under R1. NA-C cued R1 to turn over. NA-C proceeded to fasten the incontinent brief, and with soiled gloves, assisted R1 to put a shirt over her head. With the same soiled gloves, NA-C adjusted the pillow under R1's head, touched the linen, and covered R1. NA-C removed her right glove and positioned R1's bed to a low position. NA-C removed the left glove, but did not perform hand hygiene. R1 requested her blinds be opened, and NA-C opened them. NA-C then washed her hands, and left the room. At 7:45 a.m. NA-C acknowledged she had not changed or washed her hands after providing	F 441		

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F 441	Continued From page 32 pericare. NA-C acknowledged she continued to provide cares and had touched several items with her soiled gloves. NA-C stated she was supposed to change the gloves and wash hands after pericare, and before continuing to provide care. On 6/8/17, at 2:46 p.m. registered nurse (RN)-B stated stated the staff were expected to change soiled gloves after providing pericare, wash their hands and apply clean gloves. On 6/8/17, at 2:55 p.m. the director of nursing (DON) stated staff was expected to remove soiled gloves, wash their hands, and apply clean gloves to continue with cares. R33's Admission Record indicated diagnoses that included type 1 diabetes, and multiple sclerosis. R33's admission Minimum Data Set (MDS) dated 3/7/17, indicated R33 was cognitively intact. The MDS further indicated R33 had surgical dressing changes, and application of ointments to areas other than feet. The MDS also identified R33 was at risk for development of pressure ulcers, and had surgical wounds. The MDS lacked information if R33 had pressure ulcers, venous or arterial ulcers, or moisture associated skin damage. On 4/27/17, a Physician's Order directed Silverstat gel to open area on left buttock daily. Use a foam dressing to cover for moisture. On 5/18/17, a Physician's Order directed Silverstat gel to right heel after cleansing. Cover with foam dressing and change every 3 days in	F 441		

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F 441	Continued From page 33 the evening. On 6/7/17, at 8:20 a.m. R33's wound care was observed with registered nurse (RN)-C. RN-C washed hands, put on gloves and assisted R33 to lie on right side. RN-C removed a foam dressing. R33 had a wound on the left buttock, and a wound on the right buttock. The wound on left buttock was irregularly shaped with irregular edges. The wound on the right buttock had two rectangular wounds that were larger at the top and smaller at the bottom. RN-C did not measure the wounds. The surrounding tissue on both buttocks was a purple-red color, and did not blanch when RN-C pressed on it. RN-C continued with the wound care, and sprayed a gauze pad with wound cleanser. RN-C cleansed the left wound, and then using the same gauze cleansed the right wound. RN-C used dry gauze and patted the left wound then the right wound dry. RN-C applied Silverstat gel (an antibacterial wound dressing gel) to the index finger of his gloved right hand, and applied the gel to R33's left wound, then the right wound. RN-C applied new foam dressing to R33's wounds, then removed his soiled gloves and washed his hands. RN-C then left the room. On 6/7/17, at 8:47 a.m. RN-C returned to R33's room to do a dressing change on R33's right heel wound. R33's heels were flat on the bed, and R33 was wearing anti-slip socks. R33 stated, "I have blue boots [heel protectors], but did not have them last night because the nursing assistants left them in the shower. I only wear the boots at night." R33's dressing was on the ankle, not covering the right heel wound. RN-C washed his hands and put on gloves. RN-C removed the soiled dressing that had drainage on it. RN-C	F 441		

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F 441	Continued From page 34 placed a clean towel under R33's heel and then removed his soiled gloves and washed his hands. RN-C put on clean gloves, sprayed a gauze with wound cleanser and scrubbed R33's right heel wound. RN-C used clean gauze to pat the wound dry. Without changing gloves and completing had hygiene, RN-C applied Silverstat gel to index finger of his gloved right hand, and applied the gel to R33's right heel. RN-C covered the heel with a foam dressing, then removed his soiled gloves and washed his hands. At 9:00 a.m. RN-C stated, "I should have washed my hands more often and used new gauze for each wound. I did not have a q-tip so I used my finger to spread the gel." On 6/8/17, at 8:49 a.m. the director of nursing (DON) was interviewed and stated it was not acceptable to use the same gauze to cleanse or dry two separate wounds. The DON stated gels or ointments were to be applied with a swab, not a glove, and staff are to use a new swab on each wound. The DON stated that after cleaning a wound, staff are expected to change their gloves and wash hands before putting a new dressing on. The facility policy Skin Tears-Abrasions and Minor Breaks, Care of revised 10/10, directed staff to wash and dry hands thoroughly. Put on gloves. Pour cleansers directly on gauze sponges while the sponges are still in opened package. Cleanse the wound with normal saline or wound cleanser to remove dirt or debris. If the wound is dirty, use gauze along with the cleansing solution to gently clean the area. Remove disposable gloves. Wash hands and don new pair of clean disposable gloves. Apply topical antibiotics if ordered. Apply dressings as indicated. Discard all soiled laundry,	F 441		

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F 441	Continued From page 35 linen, towels, and washcloths into the soiled laundry container. Remove disposable gloves and discard into designated container. Wash and dry your hands thoroughly. The facility Handwashing/Hand Hygiene policy revised 4/12 directed all staff were to follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other staff, residents and visitors. The policy directed staff to wash perform hand hygiene before and after assisting a resident with personal care (e.g., oral care, bathing), after contact with the resident's mucous membranes and body fluids or excretions, and after handling soiled or used linens, dressings, bedpans, catheters and urinals.	F 441		
F 465 SS=C	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, that facility failed to ensure clean vents in the food preparation area of the kitchen. This had the potential to affect all 76 residents residing in the facility.	F 465	F 465 1. Vent identified on MDH survey was cleaned On 6/5/17 by Maintenance Director. 2. Other fans will be cleaned by 7/13/17. 3. Maintenance staff will be educated on Cleaning vents monthly. Kitchen staff Will be educated to make maintenance Aware if they notice vents or fans are Dirty to ensure more frequent cleaning If needed. 4. Audits will be conducted weekly by NHA or designee to ensure vents and environment are cleaned. 5. Audits will be brought to monthly to QAPI For review by NHA or designee.	

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F 465	Continued From page 36 Findings include: On 6/5/17, at approximately 12:00 p.m. an initial tour of the kitchen was done with the dietary consultant (DC)-A. Gray debris was observed covering the vent in the wall directly above the cold food preparation area. On the lower left corner of the vent, a dark green/black substance was observed. The DC-A verified the gray debris and the dark-green/black substance. The DC-A stated maintenance is responsible to clean the vents. The DC-A stated there was a cleaning schedule, but was unable to state when the vents were last cleaned. The maintenance logbook documentation indicated the vents had been cleaned on 5/19/17, and indicated the vents were to be cleaned monthly. A policy was requested, but not provided.	F 465		

The Villa at St. Louis Park

Plan of correction tag responsibilities:

F176 Director of Nursing

F241 Director of Nursing

F246 Director of Nursing

F280 Director of Nursing

F309 Director of Nursing

F323 Director of Nursing

F333 Director of Nursing

F441 Director of Nursing

F465 Director of Maintenance

Please call with any questions!

Jessica Roisum, RN, DON

7/10/17

Rec'd 7/10/17 2:40 pm TA

FS182027

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

PRINTED: 06/26/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245182	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**06/07/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	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 June 07, 2017. 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: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	APPROVED 7-5-17 RECEIVED JUL - 3 2017 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Director of Nursing | (X6) DATE: 7-7-17

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245182	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/07/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 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 that 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 74 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 521 SS=F	NFPA 101 HVAC HVAC	K 521		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 521	Continued From page 2 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 STANDARD 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 effect all 74 residents. Findings include: On a facility tour between the hours of 1000 and 1400 on June 07, 2017, observation revealed that the ventilation system has supply ducts serving the resident corridors without return ducts in the corridors. It appears that the only return is through the continuous operation of the resident room bathroom fans. Date of building construction is 1971. This deficient practice was verified by the Director of Maintenance at the time of inspection.	K 521		

Name of Facility

The Villa at St. Louis Park

2012 LIFE SAFETY CODE

PART III – RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

PROVISION NUMBER(S)	JUSTIFICATION
K 521	

An annul/continuing waiver is being requested for K-400.
A. Compliance with this provision will cause an unreasonable hardship in accordance with CMS SOM 2480C because of the following:
1. The most recent cost estimate for complying HVAC dated 6/7/17 is $505,000 and will include the upgrade of the following systems; install 3 new rooftop units and reconfigure one existing unit. Duct work to run on roof and penetrate above resident rooms. Plus an additional $26,000 to install sheet rock enclosures and 23 verticle ducts in resident rooms.
2. Installing a complying HVAC system will force disruption to the facility residents by displacing during the period of installation in specific rooms and add to noise and dust levels for an extended period. In 23 resident rooms, spaces available to residents wil be negatively reduced.
3. Under current CMS reimbursement rates, it is estimated to take 20 or more years to recoup the cost. This facility has had operating losses during each of the past five years.
4. Given the facilities financial condition, it would be difficult to acquire a loan in the amount of the estimate. However, a bank load at 5% over 20 years would add $261,548 in interest to the cost of the project. The annual cash burden for the loan would be $35,479.
5. The building is 44 years old and is not slated for replacement.

B. There will no adverse effect on the building occupant's safety in accordance with SOM2480B.
1. The building is Type II(2222) constructions with an interior finish ration Class A.
2. The walls, floors, ceiling and vertical openings resist the passage of smoke.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date
	Fire Safety Supervisor	State Fire Marshal	07-05-2017

Name of Facility

The Villa at St. Louis Park

2012 LIFE SAFETY CODE

PART III – RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

PROVISION NUMBER(S)	JUSTIFICATION
K521	

Continued...

3. The following life safety features are installed; Notifier fire alarms throughout; Reliable and Tyco brand sprinkler system throughout, automatic dialer to fire department monitored by Trans-alarm, UL300 rated kitchen hood suppression system.
4. The facility has a fire watch policy and procedure in place.
5. There are 4 smoke compartments per floor of the facility.
6. Current facility staff to resident ratio is 3.16.
7. The facility is of two floor concrete, spancrete, and brick construction.
8. Our building is two floors with about 27 patients on our 1st floor and 53 residents on the 2nd floor. We do have a TCU unit on the first floor and long term care is on the 2nd floor.
9. The closest fire department is 1 mile away and has an average response time of five minutes of less.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title Fire Safety Supervisor	Office State Fire Marshal	Date 07-05-2017

GILBERT

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

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

Company:	The Villa at Saint Louis Park	Date:	06/07/17 (revised from 05/20/16)
Street:	7500 West 22nd Street	Project:	Westwood Health Care – Ducted
City/State:	Saint Louis Park, MN 55426		Fresh Air to Resident Rooms
ATTN:	Kent Netzer	Pages	2

Proposal

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

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

Amount: $505,000.00 (budget price)

Add: $680.00 to $1,790.00 for structural engineering. This should not be necessary but the city may require it.

Add: $26,000.00 (rough approximate price) to have a general contractor install sheet rock enclosures around each of approximately 23 vertical ducts in the resident rooms as a result of this project. You may also want to have a contingency fund for patching and painting at penetrations (approximately $8,000.00?)

Exclusions:
Work to be performed during normal working hours.
We have not included any asbestos abatement.
Pricing is based on 2017 installation costs.

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

Proposed By:
Gilbert Mechanical Contractors, Inc.

Date: 6/7/17

Ed Dahlgren
Vice President, PE

Accepted By:

Date:

Print Name:

RO V LSC Annual Waiver Checklist

Facility: The Villa at St. Louis Park CCN: 245182

Date of Survey: 06/07/17 K Tag: 521

Summary of Deficiency:

1. Corridors used as a plenum.

Was this deficiency previously waived? Yes Date: 10/27/2016

SA Recommendation: Approve

Evidence that lack of correction will not adversely affect resident health and safety:

Facility is documented to be fully sprinklered.

Evidence that corrective action would pose an unreasonable hardship on the facility:

Per recent CO guidance, waivers related to corridor plenums can be approved without evidence of hardship.

RO Decision: Approve Date: 07/11/2017

Comments:

K67 previously approved. K521 is the new equivalent K tag.

DEPARTMENT OF HEALTH

July 27, 2017

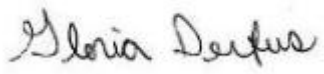
Ms. Kristie McCurdy,
The Villa at St Louis Park
7500 West 22nd Street
Saint Louis Park, MN 55426

RE: Project Number S5182027

Dear Ms. McCurdy:

On June 8, 2017, a survey was completed at your facility. You have alleged that the deficiencies cited on that survey by the Minnesota Department of Health, Licensing and Certification Program staff have been corrected. We are accepting your plan of correction and presume that your facility will achieve substantial compliance.

Sincerely,



Gloria Derfus, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: 651-201-3792
Fax: 651-215-9697

cc: Licensing and Certification File
POCA HEALTH SURVEY.ORC