Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 22, 2023

Administrator
Park Health A Villa Center
4415 West 36 1/2 Street
Saint Louis Park, MN 55416

RE: CCN: 245083
Cycle Start Date: January 26, 2023

Dear Administrator:

On January 26, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Nathan Schreier, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: nate.schreier@state.mn.us
Office: Mobile (651)392-2726

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by April 26, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 26, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245083	A. BUILDING _____ B. WING _____	C 01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK HEALTH A VILLA CENTER	4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416

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E 000	Initial Comments On 1/23/23-1/26/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was not in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
F 000	INITIAL COMMENTS On 1/23/23-1/26/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H50837711C (MN88118) and (MN88147) with a deficiency cited at F755 H50837820C (MN90333), with a deficiency cited at F755. The following complaints were found to be UNSUBSTANTIATED, however related deficiencies were cited. H50867710C (MN86164),	F 000		

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

Electronically Signed | 03/01/2023

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

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F 000	Continued From page 1 with a deficiency cited at F755. The following complaints were found to be UNSUBSTANTIATED: H50837707C (MN86411) H50837708C (MN86882) H50837709C (MN90133) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to monitor blood pressures as ordered for 1 of 1 residents (R2) reviewed for resident monitoring and failed to	F 684	R2 and R 20 plan of care reviewed, and blood pressure and weights completed per physician orders.	3/21/23

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F 684	Continued From page 2 monitor weights for 1 of 1 residents (R20) reviewed for edema and received a diuretic (water pill). Findings include: Blood Pressure Monitoring R2 R2's quarterly Minimum Data Set (MDS) dated 12/7/22, indicated she was cognitively intact, require assistance of two staff for bed mobility, transfers, and toileting, and diagnoses of hypertension (high blood pressure), partial paralysis, seizure disorder, and depression. R2's care plan dated 9/12/22, directed staff to monitor for significant changes in vital signs and other signs and symptoms of bleeding because she was on an anticoagulant. A progress note dated 1/16/23, at 4:30 a.m. indicated R2 went to the hospital at 3:30 a.m. on 1/15/23, due to frequent headaches and nystagmus (uncontrolled repetitive movements of the eyes). A progress note dated 1/17/23, at 8:55 a.m. indicated R2 was still in the hospital to lower her blood pressure (BP). R2's hospital Interagency Assessment and Orders dated 1/19/23, indicated she was hospitalized for hypertensive urgency (a BP of more than 180/120 millimeters of mercury [mm Hg] without progressive organ dysfunction) from 1/16/23 through 1/19/23. The orders included a new prescription for Lisinopril 20 milligram (mg)	F 684	All residents who have daily blood pressures, weight more frequent than monthly have the potential to be affected by the deficient practice and plan of care will be reviewed. Education will be provided to nursing staff related to ensuring blood pressure and weights are completed per physician orders. Audits will be completed by the DON and/or designee for residents with daily blood pressure along with resident who have more frequent than monthly weights: weekly for 4 weeks and then twice a month for 1 month and then 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule is needed.	

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F 684	Continued From page 3 tablet - take one tablet by mouth daily for high blood pressure. A progress noted dated 1/19/22, at 10:22 p.m. indicated R2 was readmitted to the facility with a diagnosis of hypertensive urgency. R2's Order Listing report printed 1/26/23, included and order check blood pressure every evening following diagnosis of hypertension and to document BP in progress notes starting 1/20/23. R2's progress notes lacked evidence of BP results on 1/20/23, 1/21/23, and 1/22/23. During interview on 1/23/23, at 1:13 p.m. R2 asked staff to check her blood pressure and the nurse said she would check it later. R2 stated she had recently been hospitalized for blood pressure concerns. During interview on 1/25/23, at 2:16 p.m. registered nurse (RN)-A stated all residents had vital signs taken on shower day, and it was evident in the medication administration record (MAR) when they were due. He stated R2 went to the hospital recently for high blood pressure and was not sure if she needed monitoring, but it would be in the orders if she did. During interview on 1/25/23, at 2:18 p.m. RN-D stated the nurses were responsible to taking resident blood pressure and knew who needed one taken by looking at the MAR and it was based on the resident's medications and history. She reviewed R2's electronic medical record and confirmed R2's record lacked documentation of blood pressure on 1/20/23, 1/21/23, and 1/22/23. She stated it was important to monitor how R2	F 684		

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F 684	Continued From page 4 was doing, as R2 may have needed medication changes if readings were not stable and within normal limits. During interview on 1/25/23, at 2:25 p.m. director of nursing (DON) stated she expected R2's blood pressures to be taken and documented per provider orders, and R2 should have had consistent blood pressure monitoring to determine if there was a concern and to keep the provider informed. A facility policy regarding vitals sign monitoring was requested but not provided. R20's quarterly Minimum Data Set (MDS) dated 12/1/22, indicated she was cognitively intact and required assist of two staff for bed mobility and transfers, and assist of one staff for dressing, toileting, and personal hygiene. The MDS indicated she did not reject cares. R20's had diagnoses list dated 1/25/23, indicated she had localized edema, morbid obesity, diabetes, and history of traumatic brain injury. R20's care plan dated 12/21/22, indicated she was morbidly obese and had a goal of weight will remain stable at 275 pounds +/- 3 pounds or would benefit from 1-2 pounds weight loss toward BMI less than 40 if desired. The care plan instructed staff to monitor weight per policy initiated 2/21/22. There was no indication of monitoring for edema in the care plan even though R20 had a diagnosis of edema and was receiving medication to relieve this problem. During interview on 1/23/23, at 5:15 p.m. R20 stated she had gained some weight recently.	F 684		

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F 684	Continued From page 5 R20 was observed lying in bed wearing a hospital gown with her right leg above the blankets, her right leg has visible edema. R20's order report dated 1/25/23, included an order for furosemide (a water pill) 20 milligrams (MG) by mouth once per day for edema, and weekly weights every Friday day shift starting 10/28/22. R20's Weights documentation included the following: 10/21/22 - 262.8 pounds 11/4/22 - 295.5 pounds, which is a 12.4 percent (%) gain in two weeks. 12/21/22 - 276.4 pounds, which is a 6.5% loss in approximately 6.5 weeks. 1/20/23 - 296.0 pounds, which is a 7.1% gain in one month. There was no indication weekly weights were completed to consistently identify fluid loss or gain or if the resident refused weights. During interview on 1/25/23, at 6:31 p.m. family member (FM)-A stated R20's weight was being monitored since she had right leg edema from a previous surgery and was taking a water pill. During interview on 1/26/23, at 8:25 am nursing assistant (NA)-F stated she either received a paper list of residents needing weights from the nurses or was verbally told who needed them. She reported the results back to the nurse. She stated if a resident refused, she reapproached and if still unsuccessful she told the nurse, but she did think R20 refused weights. During interview on 1/26/23, at 8:29 a.m.	F 684		

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F 684	Continued From page 6 registered nurse (RN)-B stated nurse identified resident who needed weights completed by viewing the electronic health record (EHR) and gave a list of residents to the NAs to complete each shift, but the NAs could also see the information in the EHR. She stated the nurses documented the weight and compared it to the previous weight, but sometimes the EHR notified the nurse of a significant change. She stated if there was a four pound or more change, she tried to figure out why. She verified R20 had an approximate 20-pound change and stated the weight should have been checked again and the provider notified, especially since she had edema and took furosemide, and confirmed the record did not have evidence of reweigh or provider notification. During interview on 1/26/23, at 9:22 a.m. NA-G stated nurses gave the NAs a list of residents who needed weights and once completed, the NA returned the list and results to the nurse for documentation. She stated if a resident refused, she told the nurse. During interview on 1/26/23, at 9:55 a.m. director of nursing (DON) stated resident weights should be done per provider orders, and any the resident who refused should be educated regarding the importance of weight monitoring. She stated the nurse compared weights to the previous value and reported gains or losses of two pounds or more in a day and/or five or more pounds in a week to the provider unless the resident had more specific orders. She stated staff should identified R20's significant change, re-weighed her, and reported any significant change to the provider to allow for follow up as needed.	F 684		

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F 684	Continued From page 7 During interview on 1/26/23, at 10:37 a.m. dietary manager stated she reviewed the weight report in the electronic documentation system at least weekly, which identified residents who had a 3, 7, or 10 percent weight change. She reviewed R20's medical record and confirmed R20 had triggered for a significant weight gain and should have had follow-up but did not and stated weight monitoring was especially important for residents with a history of edema, heart failure, or if on a diuretic to make sure they do not go into fluid overload. The facility policy Resident Weight Evaluation dated 9/12, indicated weights should be done for each resident monthly or more often according to the physician's order, or a consensus between the interdisciplinary team to ensure that resident weight gains and losses are assessed regularly based on a comprehensive resident assessment and that follow-up interventions are implemented to ensure the resident reaches their highest potential. Should the nurse note a five-pound weight increase or decrease, he/she must weigh that individual again.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives	F 686		3/21/23

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F 686	Continued From page 8 necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: During observation, interview, and document review, the facility failed to ensure repositioning was completed for 1 of 1 residents (R4) reviewed for pressure ulcers. Findings include: R4 R4's annual Minimum Data Set dated 11/3/22, indicated she was cognitively intact, required assist of two staff for bed mobility, transfers, dressing, and toilet use. R4 had diagnoses of multiple sclerosis (a disease that impacts the brain, spinal cord, and optic nerves, and causes symptoms such as numbness, tingling, mood changes, memory problems, pain, fatigue, blindness and/or paralysis), anxiety disorder, and depression. The MDS indicated she was at risk for pressure ulcers. R4's care plan dated 6/17/22, identified R4 had potential for a pressure ulcer of heels, coccyx, and right hip. The care plan included R4 preferred to be on her right side and directed staff to encourage repositioning every two to three hours. R4's Order Listing printed 1/26/23, included an order dated 1/20/23 to clean wound on left buttock moisture-associated skin damage (MASD) with wound cleanser and gauze and to apply peri-protectant lightly over area.	F 686	R4 plan of care reviewed and current. All residents who are on repositioning schedule have the potential to be affected by the deficient practice and plan of care will be reviewed and updated as needed. Education will be provided to nursing staff related to following resident plan of care, importance repositioning schedule and skin policy. Skin policy reviewed and remained current Audits will be completed by the DON and/or designee related to resident repositioning per schedule: weekly for 4 weeks and then twice a month for 1 month and then 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule is needed.	

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F 686	Continued From page 9 During interview on 1/23/23, at 2:43 p.m. R4 stated she had pressure ulcers on her bottom and did not get repositioned every two hours during the day or night. She stated she could not do it herself, and it was important to shift to a different position to help eliminate her "bed sores." During continuous observation on 1/24/23, the following was observed: " At 8:20 a.m. R4 was dressed and seated in her wheelchair in her room, legs slightly tipped to her right side. " From 8:40 a.m. until 9:24 a.m. NA-D assisted R4 to eat breakfast with the door open. " At 9:24 a.m. NA-D left the room. " At 9:42 a.m. R4 left room in her power wheelchair and went to the nurse at the medication cart and returned to her room at 9:47 a.m. " At 9:55 a.m. RN-D entered R4's room and gave her medications. " At 10:10 a.m. R4 put her call light on. Two staff responded within one minute, one left immediately, and the other assisted R4 with her purse. No other cares were provided. " At 10:30 a.m. R4 put her call light on. Two staff entered at 10:33 a.m. and spoke with R4. R4 was not repositioned. " At 11:02 a.m. NA-D entered R4's room, handed her the television remote, and left. " At 11:52 a.m. NA-D entered R4's room, spoke with R4, and left. During interview on 1/24/23, at 11:56 a.m. R4 stated staff never asked her if she wanted to be repositioned, and she had to initiate it, or it did not happen.	F 686		

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F 686	Continued From page 10 During interview on 1/24/23, at 11:57, nursing assistant (NA)-B stated she looked at the care plan or asked the nurses to learn what type of assistance each resident needed. She stated R4 had a sore on her bottom, was totally dependent on staff, and required a brief check and repositioning every two hours and when R4 requested it. She stated R4 got up into her wheelchair about 8:00 a.m. that morning and R4 had not been repositioned since that time. She stated sometimes staff waited for R4 to let them know she was uncomfortable before repositioning her, and NA-D confirmed she had not offered to turn and reposition R4 that morning. On 1/24/23, at 11:58 a.m. NA-A and NA-D entered R4's room and shifted her body position within her wheelchair to change pressure points on her body. During interview on 01/24/23, at 11:59 a.m. NA-A stated R4 had two small red spots on her buttocks and one on her left hip and needed to be turned and repositioned regularly. During interview on 1/24/23, at 3:03 p.m. registered nurse (RN)-A stated R4 had a wound on her hip, needed to be repositioned every two hours and could not do it herself. He stated she generally accepted when offered, and sometimes asked to be repositioned. He stated it was important to prevent skin breakdown and promote functional ability. During interview on 1/25/23, at 2:25 p.m., director of nursing (DON) stated staff needed to follow what the care plan outlined and turning, and repositioning was important to reduce the risk of	F 686		

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F 686	Continued From page 11 skin breakdown. She stated if a resident refused it should be documented and the nurse informed so the resident could be education and risks explained. The facility policy Skin Management Guideline dated 11/28/17, indicated interventions for prevention, removing and reducing predicting factors and treatment for skin many include specified turning and repositioning. An effective turning and repositioning schedule can help reduce the risk of developing a pressure ulcer, and it is important to individualize each resident's turning and repositioning schedule	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 688	R4 plan of care reviewed, reassessed for	3/21/23

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F 688	Continued From page 12 review, the facility failed to ensure an ordered hand brace was care planned and consistently implemented to maintain range of motion and reduce the risk of contractures for 1 of 1 resident (R4) reviewed for a brace. Findings include: R4's annual Minimum Data Set (MDS) dated 11/3/22, indicated she was cognitively intact, required assist of two staff for bed mobility, transfers, dressing, and toilet use. The MDS indicated R4 did not exhibit any behaviors including rejecting of cares, identified she had one day of occupational therapy in the previous seven days, and indicated she had functional limited range of motion of her upper and lower extremities bilaterally. R4's diagnosis list printed 1/25/23 included R4 had multiple sclerosis (a disorder of the central nervous system causing weakness, numbness, a loss of muscle coordination) (MS), muscle weakness, and muscle wasting atrophy R4's care plan updated 11/19/22, included R4 was at risk for developing impairment in functional joint mobility related to MS and generalized weakness, with a goal of resident will receive passive range of motion twice per day or to tolerance to prevent contracture development and allow participation in eating. The care plan lacked indication of R4's brace and application parameters. R4's medical record included a Consultation order dated 11/3/22, by physician assistant (PA)-A to continue hand bracing as ordered. There was no indication of initial order or time parameters for	F 688	use of splint, and resident is currently refusing to wear splint when offered. Education provided on risks of not wearing splint. All residents who have splints have the potential to be affected by the deficient practice and plan of care will be reviewed and updated as needed. Education will be provided to nursing staff related use of adaptive equipment. Audits will be completed by the DON and/or designee related to resident who have splints are used per order. Audits completed weekly for 4 weeks and then twice a month for 1 month and then 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule is needed.	

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F 688	Continued From page 13 when the brace was to be worn. During interview on 1/23/23, at 2:43 p.m. R4 stated she got a brace for her right hand from her orthopedic provider and staff would not put it on her. She stated she was supposed to wear it at night but could also wear it for an hour in the morning and an hour in the afternoon. A blue and white hand splint/brace was observed sitting on top of the dresser and tucked slightly under the television in her room. On 1/24/23, at 8:20 a.m. R4's right hand brace was observed in the same position under the television as previously noted. R4 stated staff did not put her splint on the previous night. During interview on 1/24/23, at 3:03 p.m. registered nurse (RN)-A stated he did not know if R4 had a hand brace. On 1/25/23, at 7:52 a.m. nursing assistant (NA)-B knocked on R4's door to awaken her for the day. R4 was not wearing her hand brace while asleep in bed. The brace was observed in the same position under the television as previously noted. NA-B stated she did not know about any brace for R4's hand and had not seen her wear it. On 1/26/23, at 8:19 a.m. R4 was observed sleeping in bed and not wearing her brace on her right hand. The brace was observed in the same position under the television as previously noted. During interview on 1/26/23, at 8:25 a.m. NA-F stated she did not think R4 had a brace at that time but might have had one a long time ago. During interview on 1/26/23, at 8:29 a.m. RN-B	F 688		

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F 688	Continued From page 14 confirmed R4 had a brace sitting on her dresser under the television and stated R4 was able to tell staff what she wanted so staff waited for her to ask for it. During interview on 1/26/23, at 8:43 a.m. occupational therapist (OT) stated R4 only had control of one arm because of the severity of her MS but was not aware of any splint or brace and had not been approached by staff about it. OT stated not wearing the prescribed brace could have a significant increase in tone where she was contracted, leading to pain and decreased use, and if it got too contacted, any movement she had could be lost. During interview on 1/26/23, at 9:55 a.m. director of nursing (DON) stated R4's brace should be applied per orders and therapy recommendations to ensure R4's comfort and should be documented if refused. A policy pertaining to the application of therapeutic positioning devices was requested but not provided.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		3/21/23

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F 689	Continued From page 15 Based on interview and document review, the facility failed to implement fall interventions to reduce the risk of falls for 1 of 1 resident (R32) reviewed for falls. Findings include: R32's admission Minimum Data Set (MDS) dated 12/7/22, indicated R32 had severely impaired cognition, was incontinent of bowel and bladder, had no toileting program initiated, and required extensive assistance of two with bed mobility, transfers, and toileting. R32's medical diagnosis list retrieved on 1/26/23, indicated that R32 had hepatic encephalopathy (loss of brain function when the liver fails to remove toxins from the blood), communication deficits, muscle weakness, difficulty in walking, and liver disease. R32's care plan last revised on 1/17/23, indicated that R32 was a risk for falls related to a history of falls, impaired mobility, safety awareness, unsteady gait, and weakness, and included an intervention of anticipate resident needs. The care plan also indicated that R32 had bowel incontinence related to the use of a laxative, and interventions included checking the resident every two hours and assist with toileting as needed, providing incontinent care after each incontinent episode, and toileting the resident after eating. Additionally, the care plan indicated that R32 had a communication problem related to Spanish being R32's primary language, and R32 speaking limited English. The interventions listed under this focus indicated that R32 required a translator for detailed conversations and directed staff to provide a translator as necessary to	F 689	R32 no longer residents at facility. All residents have the potential to be affected by the deficient practice and plan of care reviewed for interventions and updated. Residents at risk for falls will have their assessment reviewed to ensure appropriate interventions are implemented and reassess falls if needed. Education will be provided to nursing staff on Fall Prevention and Management policy. Fall Prevention and Management policy reviewed and current. Audits will be completed by the DON and/or designee related to residents with falls ensuring interventions are in place along with care plan being updated. Audits completed weekly for 4 weeks and then twice a month for 1 month and then 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule is needed.	

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F 689	Continued From page 16 communicate with the resident. A section intended on naming a translator for R32 was blank. R32's progress note dated 12/23/22, at 4:56 p.m. indicated that R32 had a witnessed fall where R32 slid from the chair. R32 stated that he was trying to go to the bathroom. The progress note further indicated that R32 was soiled with stool and was taken to the bathroom. The progress note did not indicate education being provided to the resident regarding self-transfers. A post fall evaluation dated 12/23/22, indicated that R32 was at high risk for falls, was receiving a laxative medication, and indicated that the intervention for the fall was asking that R32's mother take away "those open toe sylibus [sic]." R32's progress note dated 1/16/23, at 2:30 p.m. indicated that R32 was observed on the floor at 1:00 p.m. The progress note indicated that R32 stated that he was transferring to the bed so he could use his urinal when he lost his balance and fell and that he hit his head upon falling. R32's progress note dated 1/17/223, at 9:34 a.m. indicated that the interdisciplinary team (IDT) met to review R32's fall from 1/16/23. The progress note indicated that R32 had a history of falls, was forgetful, did not follow interventions to help decrease falls, and that an extra urinal would be brought to the resident's room and left on the nightstand where the resident could access the urinal while in a chair. During interview on 1/26/23, at 10:08 a.m. the assistant director of nursing (ADON) was asked what interventions were in place for R32's falls.	F 689		

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F 689	Continued From page 17 ADON stated that the extra urinal was one of them. ADON confirmed there was only one urinal in R32's room. ADON confirmed there was no sign in R32's room to remind R32 to call for assistance ADON stated the care staff were expected to use the interventions listed on care plans. Although the ADON identified interventions, there were no updates to the care plan nor were staff aware of the interventions or if they were effective to decrease R32's fall risk. During interview on 1/26/23, at 12:06 p.m. NA-B stated that R32's fall interventions included having the resident in a wheelchair and using a gait belt with transfers. NA-B stated that the resident's fall risk and interventions were in the resident care plan and that the interventions could also be found on a paper in the resident room. During interview on 1/26/23, at 12:06 p.m. RN-B stated that fall risk residents could be identified by having a poster in their room, by a wrist band from the hospital and that sometimes the resident fall risk status would be in the physician orders. RN-B further stated the facility generally used interventions such as keeping things in reach, lowering beds, frequent checks and keeping the doors open for residents to prevent falls. RN-B identified R32 was not a high fall risk. During interview on 1/26/23, at 2:25 p.m. the director of nursing (DON) stated her expectation was that care plans would be individualized, and all interventions would be included on the resident's care plan. The facility policy Fall Evaluation Safety Guideline dated 11/28/17, indicated staff would evaluate the	F 689		

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F 689	Continued From page 18 resident's fall risk and implement interventions to help prevent falls and monitor the effectiveness of the implemented individualized interventions.	F 689		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on document review and interview the facility failed to identify triggers to avoid potential re-traumatization and failed to develop the care plan to include individualized trauma-informed approaches for 2 of 2 residents (R35 and R30) who had a history of trauma. Findings include: R35's quarterly minimum date set (MDS) dated 1/5/23, identified intact cognition, moderate depressive symptoms, and was independent with activities of daily living (ADLs). R35's diagnoses included post-traumatic stress disorder (PTSD), acute stress reaction, major depressive disorder, and generalized anxiety disorder. R35's care plan reviewed 1/23/23, lacked individualized trauma-informed approaches or interventions and lacked identification of triggers to avoid potential re-traumatization related to the PTSD diagnosis.	F 699	R30 and R35 plan of care reviewed, and triggers for residents were updated on care plan. All residents with PTSD have the potential to be affected by the deficient practice and plan of care will be reviewed and updated as needed. Education will be provided to all staff related to Trauma informed Care policy and IDT will get additional training on completion of trauma questionnaire on admission. Audits will be completed by the social service director and/or designee related to the trauma questionaire, intervention is being placed on care plan, and PTSD diagnosis of resident. Audits completed weekly for 4 weeks and then twice a month for 1 month and then 1x for 1	3/21/23

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F 699	Continued From page 19 R35's psychiatric consult progress note dated 3/24/22, identified posttraumatic stress disorder resulting from childhood trauma. Additionally, the progress note included, "Prior traumatic experiences she has been through (childhood physical abuse, abusive relationships with prior ex's)." R35's Social Service Admission/Discharge Evaluation dated 3/29/22, identified R35 had been feeling more sad and depressed after amputation surgery. Reports feeling depressed "for years" due to being homeless." However, the Trauma Informed Care section of the evaluation was left blank and lacked identification of prior trauma or PTSD. R35's psychology progress note dated 5/3/22, identified, "Hx [history] of PTSD, patient would not elaborate present symptoms." The progress note identified the following recommendations: "Client may benefit from increased engagement in meaningful activities; ongoing engagement with her ability to expand her artistic grifts and abilities; Client may benefit from engaging in guided imagery with visualization of a calm environment, such as a lake, flower garden forest or [sic] other safe place; Client may benefit from ancillary support, if available, that is sensory based, if available such as music or aromatherapy; If client does not self-initiate, it is recommended that staff encourage use of relaxation music or naturescape sounds for calming effect." These recommendations were not found on R35's care plan. R35's psychology progress note dated 5/17/22, included, "Encourage [R35] to draw; she is open	F 699	month. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule is needed.	

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F 699	Continued From page 20 to considering drawing out emotions to hang on wall to express self, engage with staff, and make other residents laugh; Encourage her to draw out her current feelings, thoughts, fears, etc. She describes self as an artist; she may respond to "talking up" her artistic abilities as rare - and that the non-artistic staff and residents would appreciate seeing her gift since not many people can express themselves through drawing." These interventions were not found on R35's care plan. R35's psychiatric progress note dated 12/20/22, included, "Increasing PTSD related nightmares" and "She feels that she is more triggered amid the winter months r/t [related to] her PTSD. [Her past history includes losing her lower limbs due to frostbite after being kicked out of a friend's home]". R30's quarterly MDS dated 12/1/22, included intact cognition, moderate depressive symptoms, extensive assistance with ADLs. R30's diagnoses included post-traumatic stress disorder and adjustment disorder with anxiety. R35's Social Service Admission/Discharge Evaluation dated 4/4/22, identified R30 "has been declining in mood in recent months." However, the Trauma Informed Care section of the evaluation was left blank and lacked identification of prior trauma or PTSD. During an interview on 1/23/23, at 5:17 p.m. R35 stated she was aware she was diagnosed with PTSD, however, no one had talked to her about this diagnosis or related triggers since she admitted to the facility. R35 identified she has PTSD related to childhood trauma and additionally a more recent traumatic event in	F 699		

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F 699	Continued From page 21 which she suffered severe frostbite which resulted in both legs being amputated below the knee. R35 stated people in her "personal space" is a significant trigger along with very cold temperatures outside or generally feeling cold. R35 stated when she encounters something that triggers her PTSD symptoms, she can feel very anxious or shuts down, stops talking and isolates in her room. During an interview on 1/25/23, at 10:00 a.m. nursing assistant (NA)-C stated staff are informed of resident specific behaviors and corresponding interventions by the care plan. NA-C stated she has not received any specific training or education on trauma informed care or PTSD. NA-C stated she regularly worked with R35 and R30 but was not aware of any resident-specific behavior interventions. During an interview on 1/25/23, at 10:08 a.m. registered nurse (RN)-C staff are informed of resident specific behaviors and corresponding interventions by the care plan. RN-C stated she had not received any training or education at the facility related to PTSD, however, in nursing school she learned that PTSD presents differently for each person with unique causes and triggers. RN-C stated she learned R35 has a diagnosis of PTSD due to a traumatic amputation of both of her legs from reading the paperwork from the hospital when she admitted to the facility. During an interview on 1/25/23, at 10:18 a.m. NA-E stated he learns about resident specific behaviors and interventions on the care plan or the nursing assistant care sheets. NA-E stated he is aware PTSD is caused by trauma but does not think any residents at the facility have a diagnosis	F 699		

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F 699	Continued From page 22 of PTSD. NA-E is not aware of any resident specific behavior interventions for R35 or R30. Additionally, NA-E reviewed his care sheet which did not include any resident specific interventions or information about PTSD triggers or interventions. During an interview on 1/25/23, at 10:32 a.m. the social services director (SSD) stated resident specific behaviors are reviewed during a clinical interdisciplinary team meeting and corresponding interventions or approaches are developed during the meeting. The SSD then updates the resident's care plan and verbally informs the staff. SSD stated he has not received specific training or education at the facility related to PTSD, however, due to previous education he is aware PTSD is caused by a specific traumatic event or series of events. PTSD symptoms can be triggered by "everything in the environment" including odors or tone of voice. SSD stated he completed a trauma assessment on every resident upon admission to learn if there is a trauma history, and if so, any triggers. This information is then added to the resident's care plan. Additionally, this information would be added to the care sheets for the nursing assistants. SSD stated he reviews each resident's behavioral health progress notes and updates resident's care plan with recommendations and suggested interventions. The SSD stated he would need to check if any current residents had a diagnosis of PTSD or trauma specific care plan. No follow up information was provided. During an interview on 1/26/23, at 12:39 p.m. the director of nursing (DON) stated the social worker is to complete an assessment for every new	F 699		

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F 699	Continued From page 23 admission to determine if a resident has a history of trauma and anything that could re-trigger PTSD symptoms. Any known triggers and interventions should be added to the resident's care plan and the nursing assistant's care sheets. The DON added, "It is important to help and be mindful of a resident's potential triggers." During an interview on 1/26/23, at 2:29 p.m. the psychotherapist (PST)-A stated she is seeing R35 to "work on trauma and history of homelessness." PST-A stated she is seeing R30 "for years," however, she was unaware R30 had a diagnosis of PTSD. PST-A stated she provides recommendations for staff after each visit with a resident and she expects the facility attempt to implement the provided recommendations. Additionally, the PST-A stated for any resident with a diagnosis of PTSD or trauma history the facility should attempt to figure out the resident's specific triggers and corresponding interventions. PST-A added it is important to establish the resident specific triggers to proactively prevent additional distress by a caregiver who could unknowingly trigger a resident's PTSD symptoms. During an interview on 1/27/23, at 10:08 a.m. the psychiatric nurse practitioner (PNP) stated she prescribed medication to help manage R35's nightmares related to her PTSD diagnosis. PNP added, for any resident diagnoses with PTSD or with a known trauma history she would expect the facility to make appropriate referrals, check in about symptoms, and establish triggers so they could be avoided. The PNP explained PTSD is unique and symptoms are not the same for every person, therefore the facility needs assess each individual so interventions can be personalized.	F 699		

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F 699	Continued From page 24 The facility policy, "Trauma Informed Care Guidelines" (11/28/19), included, "Ensure trauma survivors receive culturally competent trauma-informed care in accordance with professional standards of practice and preferences in order to eliminate or mitigate triggers that may cause re-traumatization."	F 699		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(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. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure grab bars were assessed to determine appropriate and safety use for 1 of 2 residents (R26) who were observed	F 700	R26 plan of care reviewed, and bed mobility device evaluation completed which included consent, risk, and benefits.	3/21/23

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F 700	Continued From page 25 to have a grab bar affixed to their bed. Findings include: R26's quarterly Minimum Data Set (MDS) dated 12/9/22, identified R26 had moderately impaired cognition and required extensive assistance with bed mobility and total assistance with transfers. R26's diagnoses included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body) following cerebral infarction (disrupted blood flow to the brain) affecting left non-dominant side. R26's care plan dated 12/9/21, included, "Bedfast all or most of the time." Additionally, the care plan included "Requires a [assist] x 1-2 to reposition and turn in bed." During observation on 1/23/23, at 3:39 p.m. R26 was resting in bed had a grab bar affixed to the right side of the bed. R26's doctor's order dated 11/2/22, included "Grab bar on right side of bed to help with bed mobility." However, R26's medical record lacked evidence an assessment had been completed to determine necessity and whether R26 could safely use the bar. Additionally, R26's medical record lacked evidence alternatives were tried prior to intalling the grab bar, the resident or representative were educated on the risk of having a grab bar on her bed, or a consent form completed. During an interview on 1/24/23, at 10:14 a.m. registered nurse (RN) supervisor stated there should be a device evaluation completed and a doctor's order obtained prior to a grab bar being	F 700	All residents who use grab bars have the potential to be affected by the deficient practice and plan of care and bed mobility device evaluation completed which includes consent, risk, and benefits. Education will be provided to nursing staff and IDT related to process for Grab Bars. Audits will be completed by the DON and/or designee related to resident who have grab bars are used per order and bed mobility device evaluation which includes consent, risk, and benefits. Audits completed weekly for 4 weeks and then twice a month for 1 month and then 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule is needed.	

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F 700	Continued From page 26 added to a resident's bed. The bar needs to be assessed to ensure it is safe for the resident to use and is not a restraint. RN supervisor added grab bars needed to be reassessed if the resident experiences a significant change in condition. RN supervisor observed the grab bar affixed to the right side of R26's bed but was unable to find a device assessment, education on risks or a consent form in R26's medical record. RN supervisor stated there should have been a device assessment completed prior to the grab bar being added to R26's bed. During an interview on 1/24/22, at 10:59 a.m. the director of nursing (DON) stated a device assessment should be completed before grab bars are added to a resident's bed to ensure the bars are safe and necessary. The DON added grab bars should be reassessed quarterly or with a significant change in a resident's mobility or general condition. The DON stated a device assessment should have been completed before the grab bar was affixed to R26's bed, however the DON was unable to find a device assessment in R26's medical record. The facility policy, "Bed Rail Device Guideline" (revised 7/19/17) included, "The facility will also ensure individual resident bed rail evaluations are performed on a regular basis. Individual bed rail evaluations will include data collection analysis and determination of potential alternatives to bed rail use. When bed rail(s) are deemed necessary and appropriate, the facility will provide education to resident or resident's representative pertaining to the risk and benefits of bed rail use. The facility's priority is to ensure safe and appropriate bed rail use."	F 700		

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F 740	Continued From page 27	F 740		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to review and revise behavioral health care plans and interventions that have not been effective and adequately monitor resident behaviors for 1 of 1 resident (R25) reviewed for dementia care. Findings include: R25's quarterly Minimum Data Set (MDS) dated 11/10/22, indicated that R25 was severely cognitively impaired with hallucinations and delusions, was occasionally incontinent of bowel and bladder and was not on a bowel or urinary toileting program. The MDS indicated that R25 exhibited rejection of care behaviors and was not receiving physical or psychosocial therapies. R25's medical diagnosis list accessed 1/24/23 reflected diagnoses of aphasia (the loss of ability to comprehend and express speech), dementia and recurrent major depressive disorder.	F 740	R25 plan care reviewed, and updates made as necessary. All residents who have behaviors have the potential to be affected by the deficient practice and plan of care will be reviewed and updated as needed. Education will be provided to IDT and nursing, dietary, housekeeping staff. Related to behavioral health policy. Monitoring behavior and updating plan of care Audits will be completed by the social service and/or designee for residents with behavior for proper care plan of behaviors and interventions, effective of interventions and changes to care plan if needed weekly for 4 weeks and then twice a month for 1 month and then 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI)	3/21/23

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F 740	Continued From page 28 R25's care plan dated 7/28/22, indicated that R25 often urinated on the floor rather than using the bathroom, commode, or urinal, believed previous roommates were out to get him, yelled at staff, refused room to be cleaned, and defecated in the hallway. Interventions for these behaviors included positive interaction, document and monitor behavior episodes and attempt to determine cause while documenting responses to interventions, increased housekeeping visits, psych consult as needed, analysis of behavior circumstances, provide positive feedback, provision of an incentive program involving providing the resident snacks when resident does not urinate on the floor. R25's physician orders indicated targeted behavior monitoring directing staff to document behavior episodes, interventions, and outcomes for physical aggression, verbal aggression, voiding on the floor and defecating on the floor. R25's treatment administration record (TAR) from 1/5/23 to 1/25/23, indicated staff documented no episodes, interventions, or outcomes for the targeted behavior monitoring ordered with evidence of documentation that included "0", NA, or a blank entry. R25's progress notes from 1/1/23 to 1/24/23 did not indicate the resident exhibited any behaviors including urinating or defecating on the floor. During observation on 1/23/23, at 5:39 p.m. the floor of R25's bathroom is sticky to touch. Bedroom smells of urine. R25 was dressed and sitting in a chair outside of bedroom. R25 smelled of urine at this time. Resident did not respond to verbal interaction.	F 740	monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule is needed.	

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F 740	Continued From page 29 During observation on 1/24/23, at 8:23 a.m. the floor of the R25's room was sticky to touch, and the room smelled of urine. Toilet bowl with a blue sediment and blue colored water. The floor of the bathroom was sticky to touch and the bathroom smells of urine. A light brownish yellow liquid was noted under the resident's bedside table next to his bed, partially dried around the edges. A light brownish yellow liquid was partially dried in an area in front of resident's television. At 9:40 AM, NA-A brought a bucket of liquid into resident's room and together with MDS Coordinator-A cleaned up the brownish yellow liquid on the floor of R25's room. During interview on 1/24/23, at 10:11 a.m. NA-A stated that the substance on R25's floor was urine. NA-A responded that the liquid was urine. NA-A states that urinating on the floor was a behavior R25 had developed and if no staff were present to prompt R25 to use the toilet, R25 would void on the floor. During interview on 1/24/23, at 10:16 a.m. RN-A stated that the process for handling a resident who urinates on the floor is to redirect them, check them frequently and toilet the resident as frequently as possible. RN-A states R25's room needs the urine cleaned from the floor at least daily. During observation on 1/26/23, at 8:56 a.m. a brownish yellow liquid was noted on the floor of R25's room near the foot of the bed. Staffing coordinator (SC)-A and housekeeping manager begin cleaning R25's floor.	F 740		

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F 740	Continued From page 30 During interview on 1/26/23, at 9:02 a.m. SC-A stated that R25 urinated on the floor daily and the nurse was made aware of the behavior occurrence. When asked about interventions in place for R25's behavior, SC-A stated that R25 was toileted frequently but often refused. During interview on 1/26/23, at 2:18 a.m. the director of nursing (DON) stated that staff should be monitoring residents for behaviors and documenting the occurrences and interventions. DON confirmed R25's behaviors was a daily occurrence, and that staff should be documenting them appropriately and implementing interventions.	F 740		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all	F 755		3/21/23

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F 755	Continued From page 31 aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure pharmaceutical services were available and dispensed medication timely for 3 of 3 residents (R20, R45, R201) reviewed that were newly admitted to the facility. R20 R20's quarterly Minimum Data Set dated 12/1/22, indicated she was cognitively intact. R20's diagnosis list printed 1/25/23, included she had previous abdominal surgery, diabetes, chronic pain syndrome, anxiety, depression, high blood pressure, and history of traumatic brain injury. R20's care plan dated 10/9/22, instructed staff to administer medications as ordered by physician. R20's hospital After Visit Summary dated 10/6/22, indicated R20 was admitted to the hospital on 9/20/22, had a gallbladder removal surgery, and was diagnosed with sepsis (infection in the blood) and liver failure.	F 755	R45 no longer resides at facility R 20 and R 201 medication are available and medication observation was compelted which concluded medications were administered timely. All new admissions have the potential to be affected by the deficient practice and will be reviewed upon admission All new admission's medications orders are to be STAT to pharmacy to ensure medications are made available timely. Education will be provided to IDT, Nurses and TMAs related to pharmacy services and process for receiving medications. Audits will be completed by the DON and/or designee related to new admission receiving of medications timely within 4 hours and medication observation to ensure medications are being administered timely. Audits completed weekly for 4 weeks and then twice a month for 1 month and then 1x for 1 month. Audit results will be reviewed at	

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F 755	Continued From page 32 A progress notes dated 10/6/22, at 11:22 p.m. identified R20 was re-admitted to the facility at 6:20 p.m. and indicated orders were faxed to pharmacy and all medications were activated. During interview on 1/23/23, at 5:15 p.m., R20 stated she went to the hospital recently and had surgery she came back in a lot of pain, but the facility did not have any pain medications for her. During interview on 1/25/23, at 6:31 p.m. family member (FM)-A stated R20 had surgery a few months ago and it took the facility several days to get all R20's medications, including her seizure and pain medication. R20's orders dated 10/6/22, included Enoxaparin Sodium Solution Prefilled Syringe 40 mg/ 0.4 ml - Inject 0.4 ml subcutaneously (under the skin) every 12 hours for DVT prophylaxis (blood clot prevention) 10/6/22, starting at 9:00 p.m. R20's Medication Administration Record (MAR) dated 10/22, indicated she did not receive her first two doses on 10/6/22, at 9 p.m. and 10/7/22, at 9:00 a.m. R20's orders dated 10/6/22, included the following medications due to start at 8:00 a.m. on 10/7/22: " Atenolol Tablet 25 mg - Give 12.5 mg by mouth one time a day for high blood pressure " B Complex Capsule - Give one capsule by mouth one time a day for nutrition " Furosemide Tablet 20 mg - Give one tablet by mouth one time a day for edema " Quetiapine Fumarate Tablet 200 mg - Give 200 mg by mouth at bedtime for manic-depression. " Levetiracetam Tablet 750 mg - Give one	F 755	Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule is needed.	

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F 755	Continued From page 33 tablet by mouth two time a day for seizures " Celecoxib Capsule 200 mg - Give one capsule by mouth two times a day for pain for five days starting 10/7/22 at 8:00. R20's MAR dated 10/22, indicated she did not receive any of the above medications scheduled to start on 10/7/22, at 8:00 a.m. In addition, the MAR indicated she did not receive her Celecoxib on 10/7/22 at 4:00 p.m. A progress note dated 10/7/22, at 4:17 p.m. identified medication [Celecoxib Capsule 200 mg - Give one capsule by mouth two times a day for pain for five days] had not arrived from pharmacy yet, 22 hours after admission. R45 R45's admission Minimum Data Set had not been initiated. R45's care plan had not been initiated. R45's hospital discharge documentation faxed from the hospital on 10/27/22, at 10:43 a.m. she had a 4-level anterior cervical fusion and included a provider recommendation for R45 to transfer to a transitional care unit (TCU) as she required assist of 1 staff for bed mobility, was unable to ambulate "household distances", and was at very high falls risk. The documentation also included R45 had new left upper extremity weakness possibly from the surgical procedure and was taking acetaminophen tablets 650 milligrams scheduled every four hours, and oxycodone tablet 15 mg every four hours as needed for pain.	F 755		

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F 755	Continued From page 34	F 755		

A progress note dated 10/28/2022, at 1:08 p.m. indicated R45 was admitted to facility around 5:45 pm on 10/27/22. R45 left facility around 12:00 a.m. AMA and went to a hotel.

R45's census tab indicated she was electronically admitted to the facility on 10/27/22, at 10:17 p.m.

R45's medical record lacked documentation of any diagnoses, medication administration, admission assessment, or vital signs, and included entry of two medications, Fluticasone-Salmeterol Inhaler and Ondansetron HCl 4 milligram tablet which were identified as "pending confirmation". No other orders were entered into the system.

A progress note dated 10/28/2022, at 12:35 a.m. identified R45 was complaining about pain medication oxycodone but it had not been delivered by pharmacy. The note indicated staff called the pharmacy to find out the status of the medication and was told it was ready to be delivered. The resident was informed but she could not wait she left against medical advice (AMA) at around 12:05 a.m. in an Uber. The note indicated R45 refused to sign the AMA form, her transportation came, and she left with all her belonging. The note indicated her medications were delivered at around 1:00 am. R45 did not return to the facility.

During interview on 1/24/23, at 2:22 p.m. R45 stated she was discharged from the hospital after having had 16 screws placed in her neck during an 11-hour surgery and arrived at the facility in a wheelchair and wearing a cervical collar at 6:30 p.m. on 10/27/22. She stated there was no staff to greet her and nobody at the nurse's desk. She

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F 755	Continued From page 35 went to her room and sat there until a man walked in and told her she had to get into bed because he needed the wheelchair back. She needed to use the bathroom but had orders to use a walker but did not have one and had to wait 90 minutes to get one and use the bathroom. She stated someone came in at about 7:45 p.m. and took her blood pressure and R45 asked about her 8:00 p.m. medications and was told the nurse was doing paperwork and the medications needed to be filled and delivered. R45 stated she asked about medications again at 9:30 p.m. and was told they did not yet have her pain medication. She stated she put her call light on at 10:30 p.m., and when nobody came by 11:30 p.m. she got up with the walker and started yelling as loud as she could looking for staff as she walked toward the end of the hallway. Upon finding two staff she asked again about pain medications, and they said they had not yet arrived, and were not coming until the next day. R45 stated at that time she "lost it" and decided to leave the facility. She stated somehow, she got down to the ground to get her suitcase, put a sweater on over her hospital gown, called a hotel, ordered an uber, and walked to the front door which was locked. She stated staff wanted her to sign a paper before leaving but R45 stated she would not, since the facility gave her "no care". She stated it was as if they did not know she was coming. She stated nobody called her the next day to check on her, and stated "it was easily the most frightening, horrible, demoralizing experience in my adult life". R201 R201's admission MDS was not completed at the time of the survey.	F 755		

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F 755	Continued From page 36 R201's care plan and diagnoses reviewed 1/26/23, at 1:55 p.m. had not been addressed. R201's MHM Admission/Initial Data Collection dated 1/25/23, indicated she was admitted on 1/25/23, at 4:45 p.m. from the hospital. R201's electronic census data indicated she was marked as admitted on 1/25/23, at 5:39 p.m. R201's Admission Note dated 1/25/23, at 9:29 p.m. included R201 was admitted to the facility with a left upper arm fracture and right hip fracture without surgical intervention. R201's hospital orders included: " Aricept Oral Tablet 5 mg - Give 5 mg by mouth at bedtime for dementia " Seroquel Oral Tablet 25 mg - Give 25 mg by mouth at bedtime for dementia " Oxycodone HCl 5 mg oral tablet - Give 2.5-mg by mouth every six hours as needed for pain. R201's progress note dated 1/25/23, at 9:57 p.m. indicated R201's Aricept was pending delivery. R201's progress note dated 1/25/23, at 9:58 p.m. indicated R201's Seroquel was pending delivery. During interview on 1/26/22, at 1:44 p.m. R201 stated she was having pain and wanted medication. She stated she was admitted the previous day and did not recall which medications she may have received the previous night. During interview on 1/24/23, at 3:03 p.m. registered nurse (RN)-A stated when the facility received a newly admitted resident the nurse	F 755		

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F 755	Continued From page 37 manager compared the hospital orders to the ones they received earlier, entered the orders into the computer, and faxed them to pharmacy. He stated the medications usually arrived within an hour or two, and if not, they could call the pharmacy and get a code for the e-kit (emergency kit - a secured stock of back-up medication). He stated a resident should not go without medications if they were available in the e-kit. In addition, staff can call pharmacy 24 hours a day, including evenings and weekends, to let them know they need stat medications right away. During interview on 1/25/23, at 7:13 a.m. registered nurse (RN)-B stated when there was a new admission it was usually written on the admission board with a projected arrival time but sometimes the time was not accurate. She stated the nurse manager put the orders into the computer and the admitting nurse verified them, faxed the orders to pharmacy, and ask them to send the medications in the next delivery or as soon as possible. She stated there was usually a medication delivery between 6:00 p.m. and 8:00 p.m. She stated house stock medications could be just given, ask for a stat (right away) delivery which arrived within one or two hours, or use the e-kit if needed. During interview on 1/25/23, at 1:58 p.m. admissions staff (ADM) stated the facility received any recent notes and discharge orders from the hospital which were brought to the nursing station or the director of nursing (DON). The facility also received a notification of pending arrival within a day or several hours before the resident arrived. She stated they always knew when someone was coming, but sometimes the timing was not as planned, and they arrived when	F 755		

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F 755	Continued From page 38 ADM was not here. ADM reviewed her email and confirmed she received notification on 10/27/22 at 12:07 p.m. R45 was scheduled to arrive on 10/27/22, at 5:45 p.m. She stated the information was passed on to the nursing staff via an admission board which contains the resident's name and an arrival time. She stated the nurses transcribed any orders into the electronic health record a few hours ahead of arrival and they were verified when the resident arrived on site. She did not recall R45 leaving, but upon review of her text messages stated, "something happened with the meds". During interview on 1/26/23, at 8:29 a.m. registered nurse (RN)-B stated when a new admit or readmission arrived, she faxed the orders to pharmacy, and if medications did not arrive before they were needed, she used the house supply or called the pharmacy to get a code to use the e-kit. She stated if needed she also called the pharmacy to request a stat delivery which arrive in one to four hours, but usually came within an hour. RN-B reviewed R20's medical record and confirmed R20 did not get pain medication as expected and stated a resident should not have to go without medications. During interview on 1/26/23, at 4:43 p.m. director of nursing (DON) stated when they received new admissions, facility staff informed the hospital bedtime medications would not be available if the resident arrived later in the day and asked the hospital to make sure they can give them what they can before discharge. She stated if a resident arrived at 6:00 p.m. they would not receive their medications by 8:00 p.m., and even if they were ordered stat it took four hours for them to arrive. She stated they had a small e-kit	F 755		

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F 755	Continued From page 39 and did not have much in it, however pain medications were there depending upon what the hospital ordered. She stated if the order did not exactly match what they had available they could not use it, but they could possibly adjust the e-kit in the future. She stated medication deliveries were generally between 5:00 p.m. and 8:00 p.m. and after midnight. DON stated the pharmacy received admission paperwork so they knew who was coming but could not prepare anything until the resident was documented in the electronic record as being in the building. DON stated she expected there would have been some sort of documentation in the medical record for R45 while she was here. DON stated narcotic orders needed to be on an actual prescription which could be hard to get from the hospital. She stated eventually if they could not get them, they could ask the medical director to write it but prefer to receive it from the hospital since the medical director had not yet seen the resident. She stated they also often came with an order to give every four hours, but the order is only for a few tablets which could be a barrier, especially on a weekend admission. During interview on 1/26/23, at 2:32 p.m. pharmacist stated new admission/readmission paperwork was faxed to the pharmacy ahead of admission, and once the resident arrived at the facility the nurse electronically admitted the resident and faxed the signed orders, and the pharmacy prepared the medications and sent them out the same day. He stated they usually arrived at the facility on the first delivery which was about 12:00 p.m., or the second which arrived between 4:30 p.m. and 6:00 p.m. He stated if they needed anything sooner, they could call for a code to use the e-kit. He stated the e-kit	F 755		

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F 755	Continued From page 40 was changed out weekly, and the facility had run out of needed medications within it before, but if they needed anything sent out stat all they had to do was call to let them know and they got a personal driver to bring it over. Pharmacist stated R45 was admitted 10/27/22 and they received paperwork earlier in the day from the unit manager, however the staff did not electronically admit her until 10:39 p.m., and they could not prepare the medications until the resident was electronically admitted. He stated the pharmacist reviewed the orders at 11:00 p.m. and they were ready to go at 12:00 a.m. for a 1:00 a.m. arrival time. He stated there was a prescription the pharmacy had reduced in quantity so they could pull the medication from the e-kit, but there was no record of a nursing request for a code for the e-kit, and no code given. Pharmacist reviewed R20's records and identified the pharmacy received a prescription for ten pain pills on 10/6/22 with admission paperwork. He stated they gave the nurses two e-kit codes for two pills and the other eight were delivered, and then there was no additional order until 10/10/22. Pharmacist stated R201's paperwork was sent to pharmacy on 1/25/23, at 6:36 p.m. and her medications arrived at the facility near 12:00 a.m. on 1/26/23. He had no record of a request to deliver them earlier. The facility policy Medication Administration - General Guidelines dated 5/2022, indicated the facility had sufficient staff and a medication distributions system to ensure safe administration of medication without unnecessary interruptions.	F 755		

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F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended	F 758		3/21/23

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F 758	Continued From page 42 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure orders for an as needed (PRN) psychotropic medication (medication that affects behavior, mood, thoughts, or perception, including hydroxyzine pamoate) were either discontinued after 14 days or indications for extending the medication for use greater than 14 days was provided, for 1 of 5 residents (R10) reviewed for unnecessary medications. Findings include: R20's quarterly Minimum Data Set (MDS) dated 12/1/22, indicated she was cognitively intact and took antipsychotics on a routine basis and an antidepressant medication seven of the previous seven days. R20's Diagnoses dated 1/25/23, indicated she had anxiety disorder, depression, history of alcohol abuse, and history of traumatic brain injury. R20's care plan dated 11/23/22, identified R20 used antianxiety medication related to adjustment issues and anxiety disorder and included an intervention of administer antianxiety medications as ordered by physician.	F 758	R20 medications reviewed, and physician order received related to PRN medication and orders updated to reflect these changes with rationalle for continued use. All Residents who have PRN psychoactive medications have the potential to be affected by the deficient practice and review of prn medications completed. All future residents will be reviewed for PRN psychotropic medication and their clinical indication for use. Education will be provided to IDT, Nurses and TMAs related PRN medications and use of stop date or updating physician for rationale for medication to continue beyond 14 days. Audits will be completed by the DON and/or designee related to all PRN psychoactive medication and clinical indication for continued use. Audits completed weekly for 4 weeks and then twice a month for 1 month and then 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI)	

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F 758	Continued From page 43 R20's order report printed 1/25/23, included an order for hydroxyzine pamoate capsule (an antianxiety medication) 50 milligrams (MG), one capsule by mouth PRN (as needed) for anxiety TID (three times per day) starting 12/20/22. The order lacked an end date. R20's Consultant Pharmacist's Medication Regimen Review dated 11/21/22, included a request to the provider to ensure a 14-day limit on PRN hydroxyzine orders unless evaluated for continued need with rationale and specific stop date and lacked provider response. R20's Consultant Pharmacist's Medication Regimen Review dated 12/19/22, identified CMS (Centers for Medicare and Medicaid Services) regulations call for a 14-day limit for PRN psychotropic medications unless a statement of ongoing need is obtained from a provider with appropriate indication and duration of therapy, and requested the provider to identify a specific indication for use, rationale, and duration for hydroxyzine 50 MG TID PRN and lacked provider response. R20's Consultant Pharmacist's Medication Regimen Review dated 1/16/23, requested indication for use, rationale for extended duration, and specific duration of hydroxyzine PRN order and lacked provider response. During interview on 1/26/23, at 3:31 p.m. pharmacist stated he completed recommendations monthly, and once order-related pharmacy recommendations were written the nursing staff took them to the provider to address and he expected the provider to	F 758	monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule is needed.	

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F 758	Continued From page 44 respond the next time they saw the resident. He stated if they were not addressed by his next pharmacy review, he wrote the recommendation again, and once addressed by the provider the recommendation forms were included in the resident's electronic medical record. During interview on 1/26/23, at 4:18 p.m. director of nursing (DON) stated all PRN psychotropic medications should have a limit of 14 days unless there was a physician note identifying why they should be continued. She was unsure why R20's recommendations were not addressed, but stated it was important to ensure residents truly needed the medications and were not taking them unnecessarily The facility policy Drug Regimen Review dated 1/28/2017, indicated the pharmacist reviewed the resident drug regimen monthly, reported in writing any irregularities to the attending physician, and they would be acted upon by the facility medical director and DON to be acted upon to minimize or prevent adverse consequences or to prevent residents from receiving unnecessary drugs.	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were administered in accordance with physician	F 759	R149 no longer resides at the facility. All residents have the potential to be	3/21/23

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F 759	Continued From page 45 orders without errors for 1 of 3 residents (R149) observed to receive medications during the survey. This resulted in a facility medication error rate of 7.7% (percent). Findings include: R149's admission Minimum Data Set (MDS), had not been started at the time of survey. R149's diagnosis list printed 1/26/23, included heart failure, iron deficiency, high blood pressure, encephalopathy (a disease that affects brain structure or function and causes altered mental state and confusion), and recent bowel surgery, R149's care plan dated 1/21/23, included only a dietary focus and lacked any nursing-initiated interventions. R149's orders printed 1/25/23, included: - Carvedilol Oral Tablet 6.25 milligrams (MG) (used to treat high blood pressure and heart failure), give one tablet by mouth two times per day for heart with meals starting 1/19/23, used to treat high blood pressure and heart failure. - Ferrous Sulfate Oral Tablet 325 (65 Fe [iron]) MG (an iron supplement used to treat or prevent low blood levels of iron which can cause stomach pain if given on an empty stomach), give 325 MG by mouth one time per day for supplement with breakfast starting 1/20/23. - Carbamazepine Oral Tablet 200 mg - Give 200 mg by mouth three times a day for seizure - Cholecalciferol Oral Tablet 10 mcg (400 UNIT) - Give 1 tablet by mouth three times a day for supplement, On 1/25/23, at 8:13 a.m. R149 was observed	F 759	affected by the deficient practice of medication administration. Education will be provided to Nurses and TMAs related to medication administration if required to be given with food. Audit and review of all residents who have medication to be given with meals. Audits will be completed by the DON and/or designee related to medication administration if required to be given with food. Audits completed weekly on 2 nurses/tma for 4 weeks and then twice a month for 1 month and then 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly and Resident Council Meeting for feedback to determine if any trends are identified, and recommendations for adjustments to the audit schedule is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245083	A. BUILDING _____ B. WING _____	C 01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK HEALTH A VILLA CENTER	4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416

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F 759	Continued From page 46 eating breakfast in her room. During observation on 1/25/23, at 10:00 a.m. registered nurse (RN)-D prepared R149's medications scheduled at 8:00 a.m., including the following: - Carvedilol Oral Tablet 6.25 MG, give one tablet by mouth two times per day for heart with meal. - Ferrous Sulfate Oral Tablet 325 (65 Fe) MG, give 325 MG by mouth one time per day for supplement with breakfast. - Carbamazepine Oral Tablet 200 mg - Give 200 mg by mouth three times a day for seizure - Cholecalciferol Oral Tablet 10 mcg (400 UNIT) - Give 1 tablet by mouth three times a day for supplement, During observation 1/25/23, at 10:28 a.m. RN-D carried R149's medications in a plastic medication cup to R149's room where R149 was lying in bed talking with a guest. R149 took her medications and confirmed she had finished breakfast two hours prior. During interview on 1/25/23, at 10:37 a.m. RN-D stated if medications were due at 8:00 a.m. they could be given any time between 7:00 a.m. and 9:00 a.m. but there were too many medications to give the residents at the facility to give them all on time. She confirmed R149's pills were not given with breakfast, and stated some residents had 15-20 at once in addition to wound treatments, and she could not complete everything as scheduled. R149's Medication Admin Audit Report dated 1/26/23, indicated RN-D prepared R149's scheduled 8:00 a.m. medications on 1/25/23, starting at 9:58 a.m. and documented them as	F 759		

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F 759	Continued From page 47 given at 10:33 a.m. Further, R149 received her 12:00 p.m. scheduled doses of Carbamazepine and Cholecalciferol at approximately 1:00 p.m. instead of 2:00 p.m., which was only 2 hours and 30 minutes after the first doses were given. During interview on 1/24/23, at 3:03 p.m. RN-A stated if a medication was ordered to be given with food it needed to be given with meals. During interview on 1/26/23, at 8:29 a.m. RN-B stated medications could be given one hour before or one hour after their scheduled administration time, but some needed to be given with meals and were ordered as such. She stated if a medication was supposed to be given with food but was given 2 ½ hours after eating she considered it a medication error. During interview on 1/26/23 in the afternoon, the director of nursing (DON) stated medications not given as ordered, including meal instructions, should be considered errors as many medications were ordered to be given with food to improve absorption or prevent stomach upset. The (DON) was unsure why medications for R149 were not given on time but stated they should have been given within one hour of their scheduled time unless approved by the provider. This was especially important if scheduled multiple times per day to ensure they were not given too close together. During interview on 1/26/23, at 2:32 p.m. pharmacist stated some medications, such as carvedilol should be given with meals to prevent side effects and to improve the efficacy of the medication, and others were given with food to decrease side effects, including iron	F 759		

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F 759	Continued From page 48 supplements. He stated while these were not significant medication errors, he expected medications to be given as ordered. The pharmacist stated medication doses should be spaced appropriately to ensure the effects do not compound. In addition, if given late the resident may not receive the desired effect. Some medications, such as carbamazepine when given for seizures, really need to be given timely. He stated while he did not consider these "significant" medication errors, he expected medications to be given as ordered. Review of the manufacturer's instructions located at https://www.drugs.com/pro/carvedilol.html on 1/25/23, identified Carvedilol should be taken with food to slow the rate of absorption and reduce the incidence of orthostatic (blood pressure changes upon change in position) effects. The facility policy Medication Administration - General Guidelines dated 5/22, included medications are administered in accordance with written orders of the prescriber. Medications are administered within 60 minutes of scheduled time, except before, with or after meal orders, which are administered based on mealtimes.	F 759		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State	F 812		3/21/23

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F 812	Continued From page 49 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to maintain appropriate temperature in a refrigerator used for cold food storage to prevent potential food borne illness for all residents who received food from the kitchen. Findings included: On 1/23/23, at 11:56 a.m. a kitchen tour was conducted with registered dietitian (RD) and cook (C) -A. The following was observed during the kitchen tour: Upright coolers: 80 oz (ounce) partial container of low-fat cottage cheese. Expiration date 1/16/23. 80 oz partial container of low-fat sour cream. Open date 1/8/23. Observed 4 orange-colored spots of discoloration inside the container. During an interview on 1/23/23 at 12:09 p.m. C-B stated when a food item has been opened or prepared staff should clearly label with the date and the initials of the staff who opened it. During an interivew on 1/23/23, at 12:09 p.m.	F 812	Refrigerator has been placed out of order until repaired. Another refrigerator was used for food storage while one was out of order. Commercial kitchen is working on replacing parts. All residents have the potential to be affected by the deficient practice of food storage/labeling/dating. Education provided to dietary staff related to correct temperature of refrigerator and freezers along with proper storage of food/labeling/dating. Food without dates were discarded. Audits will be completed by the Dietary Manager and/or designee related to temperature of refrigerator/ freezer and proper storage of food/labeling/dating. Audits completed weekly in dietary kitchen for 4 weeks and then twice a month for 1 month and then 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and	

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F 812	Continued From page 50 surveyor observed refrigerator #1's internal thermometer read 45 degrees Fahrenheit. C-B stated the internal thermometer read 61 degrees Fahrenheit. C-B stated refrigerator temperatures should remain between 35-40 degrees Fahrenheit. During an interview of 1/23/23, at 12:15 p.m. RD stated all open food items need to be labeled with open dates and refrigerated food items, including cottage cheese and sour cream should be discarded 30 days after it is opened. RD observed the partial container of cottage cheese with the expiration date of 1/16/23 and stated it should be discarded. RD observed the orange-colored spots in the partial container of sour cream with an open date of 1/8/23 and stated the discoloration was likely the result of someone using a dirty spoon but did not feel this it was mold. RD was unsure if the sour cream should be discarded. On 1/25/23, at 7:56 p.m. C-A stated refrigerator #1's internal thermometer read 49 degrees. C-A stated refrigerator temperatures should be at or below 51 degrees. C-A checked a 2nd internal thermometer for refrigerator #1 which read 52 degrees. On 1/25/23, at 8:46 a.m. RD observed the internal thermometer in refrigerator #1 read 48 degrees. RD stated, "That is a little high." RD stated refrigerator #1 is used to hold leftovers and high use items and the temperature was likely elevated due to the frequency of staff opening the refrigerator during breakfast service and suggested doing a follow-up temperature check in one hour. Refrigerator #1 was observed to contain a partial box of individually packed yogurt,	F 812	recommendations for adjustments to the audit schedule is needed.	

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F 812	Continued From page 51 pasteurized eggs, 2 partial 80 oz containers of cottage cheese, 1 partial gallon of 2 percent milk, 1 partial 80 oz container of sour cream, a box of individual sour cream packets, a partial pan of Jell-o cubes, 2 cooked meat patties, and multiple pitchers of pre-made lemonade and juice. On 1/25/23, at 9:32 a.m. RD observed the internal thermometer of refrigerator #1 read 52 degrees. RD temped a partial 80 oz container of mayonnaise which was removed from refrigerator #1 which read 49 degrees. RD temped a pre-cooked meat patty which was removed from refrigerator #1 which read 54 degrees. RD temped an individual yogurt cup which was pulled from refrigerator #1 which read 48 degrees. RD stated both food items should be at or below 40 degrees Fahrenheit. RD stated all food needed to be discarded. "I am playing it safe. I want to be sure food is at the right temp. I don't know how long it was at the elevated temp." RD explained, dairy, meat and mayo are high risk items for food borne illness. When foods are kept at temperature between 50-70 degrees they are in the "danger zone" for growing bacteria that can cause food borne illness. During an interview 1/26/23, 8:45 a.m. C-A verified refrigerator #1 was empty and no longer in use. The policy, Food Receiving and Storage (revised 2017), included, "Foods shall be received and stored in a manner that companies with safe food handling practices." "All food stored in the refrigerator or freezer will be covered, labeled and dated ("use by" date)." "Refrigerated food must be stored below 41 F unless otherwise specified by law."	F 812		

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F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain a sanitary environment for 1 of 1 (R33) residents reviewed for environmental cleanliness. Finding include: R33's quarterly MDS dated 12/20/22, indicated moderately impaired cognition and extensive assist with activities of daily living (ADLs). During an interview on 1/23/23, at 1:30 p.m. R33 stated the privacy curtain hanging in his room had been dirty since he arrived at the facility about 1 year ago. Writer observed the privacy curtain soiled with 2 finger-print sized, crusty spots of dark brown matter. The curtain also had light brown streaking covering most of the lower half of the curtain. On 1/24/22, at 9:06 a.m. writer observed the privacy curtain in R33's room which remained soiled and appeared to be unchanged since the previous day. Additionally, writer observed a scuffed area approximately 1 ½ ft x 2 ft with 6 approximately 1-2-inch size spots of missing paint on the lower portion of R33's wall near the door and 1 deep scratch approximately 18 inches long on another portion of the same wall. On 1/25/22, at 10:51 a.m. observed the privacy	F 921	R33 curtains and walls needing repair have been resolved. All residents have the potential to be affected by the deficient practice of room cleanliness. All resident rooms were reviewed to identify any damaged walls and/or privacy curtain and were repaired and/or cleaned. Education will be provided to IDT, nursing staff and housekeeping on notification to housekeeping or maintenance related to cleanliness and repairs. Education to housekeeping staff on ensuring cleanliness of rooms and maintenance related to repairs. Audits will be completed by the housekeeping and/or designee related cleanliness of curtains and repairs of walls. Audits completed weekly for 4 weeks and then twice a month for 1 month and then 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule is needed.	3/21/23

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F 921	Continued From page 53 curtain and walls in R33's room which both appeared unchanged since the previous day. During an interview on 1/25/22, at 10:54 a.m. registered nurse (RN)-C stated all staff are responsible for ensuring residents' rooms are clean which included notifying housekeeping if a privacy curtain is dirty or notifying maintenance if there is damage to the walls that needed repair. During an interview on 1/25/22, at 11:11 a.m. housekeeping manager (HSK) stated privacy curtains should be changed when visibly dirty or when a room is deep cleaned after a resident discharged from the facility. HSK stated she had been doing weekly audits to ensure all privacy curtains were clean, however, due to staffing issues she had not been able to complete the audits recently and could not remember when the last audit had been completed. HSK stated it is the responsibility of the housekeeper to observe if the privacy curtain is soiled during the daily cleaning of the resident rooms. HSK observed R33's privacy curtain and stated, "This needs to be changed. It is dirty." HSK added, "it appears to be body fluids." During an interview on 1/26/23, at 8:55 a.m. the director of maintenance (DM) stated all 4 walls in R33's room needed to be repaired and re-painted. DM stated it is important to keep all resident rooms in good repair to support the resident's quality of life and to show [staff] care about the building and the residents. During an interview on 1/26/23, at 2:09 p.m. the administrator stated maintaining a homelike environment is important, so each resident feels like they are at home and are comfortable in their	F 921		

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F 921	Continued From page 54 home. A facility policy on homelike environment was requested but not provided.	F 921		

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	245083	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/24/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/24/2023. At the time of this survey, PARK HEALTH A VILLA CENTER was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 03/01/2023

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. PARK HEALTH A VILLA CENTER is a 2 story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1960 and was determined to be of Type II (111) construction. In 1970, an addition was constructed and was determined to be of Type II (000) construction. In 1998 an addition was constructed and was determined to be of Type II	K 000		

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K 000	Continued From page 2 (111) construction. Because the original building and the 2 additions are of the same type of construction allowed for existing buildings, the facility was surveyed as one building, Type II (000). The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 70 beds and had a census of 44 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler	K 353		3/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245083	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/24/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK HEALTH A VILLA CENTER	**4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416**

(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 353	Continued From page 3 system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2.1.1.2, 5.2.2.2 These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 01/24/2023 between 0900 AM and 0200 PM, it was revealed during the tour of the facility, that in the Kitchen Dry Goods Storage Room, cabling was attached to the Fire Sprinkler Piping. 2. On 01/24/2023 between 0900 AM and 0200 PM, it was revealed during the tour of the facility, that in the Kitchen Storage Room, uniforms were found hanging from the Fire Sprinkler Piping. Staff relocated the uniforms upon discovery. 3. On 01/24/2023 between 0900 AM and 0200 PM, it was revealed during the tour of the facility, that in the Kitchen / Dishwashing Area, sprinkler heads exhibited loading of foreign debris and potential oxidation 4. On 01/24/2023 between 0900 AM and 0200 PM, it was revealed during the tour of the facility that in the Laundry Dryer Room, sprinkler heads exhibited loading of foreign debris 5. On 01/24/2023 between 0900 AM and 0200	K 353	Cabling will be detached from Fire Sprinkler Piping. Sprinkler heads were cleaned from foreign debris. Uniforms being hung from Fire Sprinkler Piping were resolved. All residents have the potential to be affected by the deficient practice. Education will be provided to all staff related to not hanging items from Fire Sprinkler or Piping. Audits will be completed by the Maintenance Director and/or designee related to cabling and cleanliness of sprinklers. Audits completed weekly for 4 weeks and then twice a month for 1 month and then 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245083	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/24/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK HEALTH A VILLA CENTER	**4415 WEST 36 1/2 STREET** **SAINT LOUIS PARK, MN 55416**

(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 353	Continued From page 4 PM, it was revealed during the tour of the facility that on the Garden Level, in the corridor, cabling was attached to the Fire Sprinkler Piping. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to manage usage of an electrical	K 920	The power strip has been removed from office.	3/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245083	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/24/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK HEALTH A VILLA CENTER	**4415 WEST 36 1/2 STREET** **SAINT LOUIS PARK, MN 55416**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 920	Continued From page 5 adaptive device in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6 and NFPA 70, (2011 edition), National Electrical Code, section 400-8(1), and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 01/24/2023 between 0900 AM and 0200 PM, it was revealed during the tour of the facility that in Room ULW4 a refrigerator was connected to a power strip. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 920	All residents and staff have the potential to be affected by the deficient practice. Education will be provided to all staff regarding the use of appropriate power strips. Audits will be completed by the Maintenance Director and/or designee related cleanliness of curtains and repairs of walls. Audits completed weekly for 4 weeks and then twice a month for 1 month and then 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule is needed.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 27, 2023

Administrator
Park Health A Villa Center
4415 West 36 1/2 Street
Saint Louis Park, MN 55416

RE: CCN: 245083
Cycle Start Date: January 26, 2023

Dear Administrator:

On March 24, 2023, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us