



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 15, 2021

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

RE: CCN: 245083
Cycle Start Date: June 29, 2021

Dear Administrator:

On June 29, 2021, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 14, 2021.
- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 14, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 14, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is

your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by August 14, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Park Health A Villa Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 14, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Jamie Perell, Unit Supervisor
Metro A 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: jamie.perell@state.mn.us
Office: (651) 245-8094

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 29, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

**Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462**

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

Park Health A Villa Center

July 15, 2021

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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/ltr_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.

Feel free to contact me if you have questions.

Sincerely,



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

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

PRINTED: 08/11/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245083		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/29/2021	
NAME OF PROVIDER OR SUPPLIER PARK HEALTH A VILLA CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 000	INITIAL COMMENTS On 6/28/21, through 6/29/21, a standard abbreviated survey was conducted at your facility. 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 complaint was found to be SUBSTANTIATED: H5083101C (MN74094), with a deficiency cited at 760. The following complaint was found to be UNSUBSTANTIATED: H5083100C (MN72373). In addition, as a result of the investigation other deficiencies were identified at F880. 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 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant			F 760			8/3/21

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

TITLE

(X6) DATE

Electronically Signed

07/23/2021

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 760	Continued From page 1 medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure anti-seizure medication was administered as ordered by the resident's physician for 1 of 3 residents (R1) reviewed for significant medication errors. Findings include: R1's diagnoses obtained from the admission record dated 6/29/21, included alerted mental status and a seizure disorder. R1's 5-day prospective payment system (PPS) Minimum Data Set (MDS) dated 4/19/21, indicated R1 had severely impaired cognition. The MDS further indicated R1 had a seizure disorder and required extensive assistance with walking and locomotion. R1's care plan dated of 6/17/21, indicated R1 had an alteration in neurological status related to a seizure disorder. R1's goal was to have no seizures through the next review date. R1's hospital discharge paperwork dated 6/17/21, indicated R1 was prescribed and to start taking Phenytoin (medication for seizures) 125 milligrams (mg) / 5 milliliter (mL) suspension. R1 was to be administered 4 mL (100 mg) per G-tube (gastrostomy tube) every evening and take 6 mL's (150 mg) per G-tube every morning. R1's Order Summary Report dated 6/29/21, lacked an order for Phenytoin take 6 mL's (150 mg) per G-tube every morning.	F 760	R1 was assessed and no adverse effects were identified. DON immediately notified MD. No new orders. R1 no longer at the facility. All resident orders were reviewed to ensure accuracy. All licensed nurses will be educated on admission medication reconciliation to validate physician orders. Tool created to validate 1st and 2nd checks for admission order was completed in clinical start up. DON/designee will audit all new admission orders for 4 weeks. Administrator/designee will bring all audits through QAPI for review continued quality improvement.		

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F 760	Continued From page 2 R1's June 2021, medication administration record (MAR), lacked indication R1 was administered Phenytoin 6 mL's (150 mg) per G-tube every morning since arriving to the facility from the hospital on 6/17/21. During an interview on 6/28/21, at 1:38 p.m. registered nurse (RN)-C stated he did not work on the transitional care unit (TCU), where R1 resided, during the evening of 6/17/21. RN-C denied he worked with R1. During an interview on 6/28/21, at 2:11 p.m., contrary to RN-C's statement, the staffing coordinator stated RN-C was the nurse who worked on the TCU during the evening of 6/17/21. During an interview on 6/28/21, at 2:18 p.m. the director of nursing (DON) confirmed RN-C was the nurse assigned to the TCU during the evening of 6/17/21 when R1 was readmitted to the facility. The DON stated RN-C was stressed about the admission and she provided RN-C her phone number so RN-C could call her when R1 arrived to the facility. The DON stated RN-C did not call her when R1 arrived at the facility and she figured everything was fine. The DON stated when R1 arrived at the facility during the evening of 6/17/21, the hospital orders were not entered into the computer system. The DON stated it was expected the admitting nurse and overnight nurse should had caught the missed orders. During an interview on 6/29/21, at 10:14 a.m. the DON stated the order for Phenytoin 125 mg/5 mL suspension 6 mL (150 mg) per G-tube every morning "was missed" and verified R1 had not received the medication since being readmitted to	F 760			

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F 760	Continued From page 3 the facility on 6/17/21. The DON verbalized medical doctor (MD)-A would immediately be notified of the omitted medication. During an interview on 6/29/21, at 11:36 a.m. the consultant pharmacist stated seizure medications had a long half-life (time it takes for the amount of a drug's active substance in your body to reduce by half) and missing a seizure medication may or may not be significant for a resident. During an interview on 6/29/21, at 1:00 p.m. MD-A stated R1 did not have a seizure since he had missed the morning does of Phenytoin. MD-A stated a laboratory draw of R1's Phenytoin level (drug concentration in the blood) would be taken to determine if the medication was still necessary. Medication Reconciliation Upon Admission policy dated May 2017, indicated a list of discharge medications will be obtained from the patient's previous care setting and carefully compared to the prescriber verified admission orders entered into the clinical software. Any irregularities between the two lists will be identified, discussed with the prescriber, and either corrected with an order change/ additional order or documented rationale for the change will be noted. The policy further indicated a 2nd nurse will compare a complete list of a resident's hospital discharge medications to the list of the physician's orders entered into the facility's clinical software as a second check to ensure accuracy and any discrepancies discovered by the nurse should be resolved with the prescriber as quickly as possible.	F 760			
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880			8/3/21

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F 880	Continued From page 4 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to:	F 880			

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F 880	Continued From page 5 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff wore appropriate personal protective equipment (PPE) including eye protection and source control masks to prevent and/or minimize the spread of COVID-19. This had the potential to affect all 44 residents who resided at the facility. Findings include: On 6/28/21, at 11:15 a.m. upon facility entrance	F 880	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected by this practice. Address how the facility will identify other resident having the potential to be affected by the same deficient practice: All residents have the potential to be affected. There has been no recent covid in the building.		

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F 880	Continued From page 6 the front desk receptionist (R)-A was observed to be wearing a mask under her chin and was not wearing eye protection. An unidentified activities assistant was also noted to be sitting in the activities area/living room with no eye protection on. Two unidentified residents were noted to be in the activities area/living room and were listening to a woman singing. Multiple unidentified staff which included nursing assistants and nurses were observed in the transitional care unit (TCU) with no eye protection on and several unidentified residents were noted in the hallway. The administrator was observed exiting an elevator without eye protection on and proceeded to an office. The administrator had eye protection on upon exiting the office. During an interview on 6/28/21, at 11:20 a.m. the administrator stated staff needed to wear eye protection. The administrator stated the facility provided constant reminders to staff and most of the time staff would pull eye protection out from their pockets. The administrator confirmed several staff were not wearing eye protection should have had it on. During observation on 6/28/21, at 11:32 a.m. the front desk R-A was still not wearing eye protection. Several unidentified residents were at the receptionist desk speaking to her and other residents. During an interview on 6/28/21, at 11:38 a.m. the administrator indicated the facility had not conducted an Universal Eye Protection Risk assessment to determine whether staff could remove eye protection. The administrator further added that staff are expected to wear eye protection and masks under the current guideline.	F 880	The facility's QAPI Committee with assistance from the IF and Governing Body will conduct a root cause analysis to identify the problem that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence: Root cause analysis was completed on 7/22/21 by DON, NHA and IDT. The infection preventionist and Director of Nursing, shall complete the following: Review hand hygiene policies and procedures to ensure they meet CDC guidance and CMS requirements and revise as needed: Reviewed by DON and DCO on 7/21/21. The DON/designee, shall complete the following: Review policies and procedure for donning/doffing PPE during COVID -19 with current guidelines to include crisis standard of care, contingency standard of care and standard of care. Reviewed by DON and DCO on 7/21/21 Develop and implement a policy and procedure for source control masks. Current policy in place. Develop and implement a policy and procedure for proper use of gowns. Current policy in place Review policies regarding standard and transmission-based precautions and revise as needed. DON and DCO reviewed on 7/21/21. Training and Education: As part of the corrective action plan, the facility must provide training for all staff providing direct care to residents, and all staff entering residents rooms, whether to be for residents ☐ dietary needs or cleaning and		

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F 880	Continued From page 7 During observation on 6/28/21, at 11:37 a.m. the staffing coordinator (SC)-A was observed telling nursing assistant (NA)-A and NA-B to wear eye protection who were on the long-term nursing care unit. NA-B stated he did not have eye protection. NA-A was observed going behind a desk area and put on eye protection. SC-A offered to find eye protection for NA-B. During observation on 6/28/21, at 11:38 SC-A gave NA-B eye protection. During an interview on 6/28/21, at 11:56 a.m. NA-A stated staff should always wear eye protection and a surgical mask. During observation on 6/28/21, at 11:39 a.m. trained medication assistant (TMA)-A, who was on the long-term care nursing unit, was observed wearing reading glasses and had mask below her chin. During an interview on 6/28/21, at 12:00 p.m. TMA-A stated a surgical mask and eye protection needed to be worn when cares were performed or when residents were in the hallways. During observation on 6/28/21, at 11:50 a.m. registered nurse (RN)-A was observed wearing N95 mask which did not conform to RN-A's face. RN-A was noted to frequently readjust the N95 mask. RN-A stated she had a different mask, but was told to wear an N95 mask because State was at the facility. RN-A stated she was not fit tested to wear a N95 mask and confirmed it did not fit appropriately. RN-A stated she was not caring for any COVID-19 residents or residents which would require an N95 mask. RN-A stated	F 880	maintenance services. The training must cover standard infection control practices, including but not limited to, transmission-based precautions, appropriate PPE use and donning and doffing of PPE. The training will include an attestation statement of completion. The training will include competency testing of staff that is documented. Residents and their representatives will receive education on facility Infection Prevention Control Program. Letter sent out on 7/21/2021 and given to residents on 7/21/21. Monitoring/Auditing: The DON and other facility leadership will conduct audits of donning/doffing PPE with Transmission based precautions ie: droplet precautions. See attached audit. The DON and other facility leadership will conduct routine audits on all shifts 4 times a week for one week, then twice weekly for one week once compliance is met. Audits should continue until 100% compliance is met on source control masking for staff, visitors, and residents. See attached audit. The DON and other facility leadership will conduct real time audits on proper use of gowns to ensure PPE is in use. See attached audit. The DON or designee will review the results of audits and monitoring with QAPI.		

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

PRINTED: 08/11/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245083	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/29/2021
NAME OF PROVIDER OR SUPPLIER PARK HEALTH A VILLA CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416		
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F 880	Continued From page 8 appropriate PPE was a surgical mask and protective eyewear. During observation on 6/28/21, at 12:11 p.m. R-A was observed with eye protection on top of her head. R-A's face mask was under her nose. The Infection Prevention and Control Interim Guideline for Suspected or Confirmed Coronavirus (COVID-19) policy revised on 4/28/21, indicated long term care facility personnel must wear a well fitted surgical mask at all times, and use of eye protection is required in areas with moderate to substantial community transmission. Review of the Centers for Disease Control (CDC) guidance titled Strategies for Optimizing the Supply of N95 Respirators revealed, "N95 respirators are the PPE most often used to control exposures to infectious pathogens transmitted via the airborne route, though their effectiveness is highly dependent upon proper fit and use."	F 880			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 15, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: RUV811

Dear Administrator:

The above facility was surveyed on June 28, 2021 through June 29, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

Park Health A Villa Center

July 15, 2021

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"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Jamie Perell, Unit Supervisor
Metro A 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: jamie.perell@state.mn.us
Office: (651) 245-8094

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

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

Please feel free to call me with any questions.

Sincerely,



Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

Park Health A Villa Center

July 15, 2021

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Program Assurance Unit

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

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

PRINTED: 07/15/2021
FORM APPROVED
OMB NO. 0938-0391

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F 000	INITIAL COMMENTS On 6/28/21, through 6/29/21, a standard abbreviated survey was conducted at your facility. 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 complaint was found to be SUBSTANTIATED: H5083101C (MN74094), with a deficiency cited at 760. The following complaint was found to be UNSUBSTANTIATED: H5083100C (MN72373). In addition, as a result of the investigation other deficiencies were identified at F880. 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 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant	F 760			

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

TITLE

(X6) DATE

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 760	Continued From page 1 medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure anti-seizure medication was administered as ordered by the resident's physician for 1 of 3 residents (R1) reviewed for significant medication errors. Findings include: R1's diagnoses obtained from the admission record dated 6/29/21, included alerted mental status and a seizure disorder. R1's 5-day prospective payment system (PPS) Minimum Data Set (MDS) dated 4/19/21, indicated R1 had severely impaired cognition. The MDS further indicated R1 had a seizure disorder and required extensive assistance with walking and locomotion. R1's care plan dated of 6/17/21, indicated R1 had an alteration in neurological status related to a seizure disorder. R1's goal was to have no seizures through the next review date. R1's hospital discharge paperwork dated 6/17/21, indicated R1 was prescribed and to start taking Phenytoin (medication for seizures) 125 milligrams (mg) / 5 milliliter (mL) suspension. R1 was to be administered 4 mL (100 mg) per G-tube (gastrostomy tube) every evening and take 6 mL's (150 mg) per G-tube every morning. R1's Order Summary Report dated 6/29/21, lacked an order for Phenytoin take 6 mL's (150 mg) per G-tube every morning.	F 760			

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F 760	Continued From page 2 R1's June 2021, medication administration record (MAR), lacked indication R1 was administered Phenytoin 6 mL's (150 mg) per G-tube every morning since arriving to the facility from the hospital on 6/17/21. During an interview on 6/28/21, at 1:38 p.m. registered nurse (RN)-C stated he did not work on the transitional care unit (TCU), where R1 resided, during the evening of 6/17/21. RN-C denied he worked with R1. During an interview on 6/28/21, at 2:11 p.m., contrary to RN-C's statement, the staffing coordinator stated RN-C was the nurse who worked on the TCU during the evening of 6/17/21. During an interview on 6/28/21, at 2:18 p.m. the director of nursing (DON) confirmed RN-C was the nurse assigned to the TCU during the evening of 6/17/21 when R1 was readmitted to the facility. The DON stated RN-C was stressed about the admission and she provided RN-C her phone number so RN-C could call her when R1 arrived to the facility. The DON stated RN-C did not call her when R1 arrived at the facility and she figured everything was fine. The DON stated when R1 arrived at the facility during the evening of 6/17/21, the hospital orders were not entered into the computer system. The DON stated it was expected the admitting nurse and overnight nurse should had caught the missed orders. During an interview on 6/29/21, at 10:14 a.m. the DON stated the order for Phenytoin 125 mg/5 mL suspension 6 mL (150 mg) per G-tube every morning "was missed" and verified R1 had not received the medication since being readmitted to	F 760			

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F 760	Continued From page 3 the facility on 6/17/21. The DON verbalized medical doctor (MD)-A would immediately be notified of the omitted medication. During an interview on 6/29/21, at 11:36 a.m. the consultant pharmacist stated seizure medications had a long half-life (time it takes for the amount of a drug's active substance in your body to reduce by half) and missing a seizure medication may or may not be significant for a resident. During an interview on 6/29/21, at 1:00 p.m. MD-A stated R1 did not have a seizure since he had missed the morning does of Phenytoin. MD-A stated a laboratory draw of R1's Phenytoin level (drug concentration in the blood) would be taken to determine if the medication was still necessary. Medication Reconciliation Upon Admission policy dated May 2017, indicated a list of discharge medications will be obtained from the patient's previous care setting and carefully compared to the prescriber verified admission orders entered into the clinical software. Any irregularities between the two lists will be identified, discussed with the prescriber, and either corrected with an order change/ additional order or documented rationale for the change will be noted. The policy further indicated a 2nd nurse will compare a complete list of a resident's hospital discharge medications to the list of the physician's orders entered into the facility's clinical software as a second check to ensure accuracy and any discrepancies discovered by the nurse should be resolved with the prescriber as quickly as possible.	F 760			
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880			

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F 880	Continued From page 4 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to:	F 880			

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F 880	Continued From page 5 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff wore appropriate personal protective equipment (PPE) including eye protection and source control masks to prevent and/or minimize the spread of COVID-19. This had the potential to affect all 44 residents who resided at the facility. Findings include: On 6/28/21, at 11:15 a.m. upon facility entrance	F 880			

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F 880	Continued From page 6 the front desk receptionist (R)-A was observed to be wearing a mask under her chin and was not wearing eye protection. An unidentified activities assistant was also noted to be sitting in the activities area/living room with no eye protection on. Two unidentified residents were noted to be in the activities area/living room and were listening to a woman singing. Multiple unidentified staff which included nursing assistants and nurses were observed in the transitional care unit (TCU) with no eye protection on and several unidentified residents were noted in the hallway. The administrator was observed exiting an elevator without eye protection on and proceeded to an office. The administrator had eye protection on upon exiting the office. During an interview on 6/28/21, at 11:20 a.m. the administrator stated staff needed to wear eye protection. The administrator stated the facility provided constant reminders to staff and most of the time staff would pull eye protection out from their pockets. The administrator confirmed several staff were not wearing eye protected should have had it on. During observation on 6/28/21, at 11:32 a.m. the front desk R-A was still not wearing eye protection. Several unidentified residents were at the receptionist desk speaking to her and other residents. During an interview on 6/28/21, at 11:38 a.m. the administrator indicated the facility had not conducted an Universal Eye Protection Risk assessment to determine whether staff could remove eye protection. The administrator further added that staff are expected to wear eye protection and masks under the current guideline.	F 880			

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F 880	Continued From page 7 During observation on 6/28/21, at 11:37 a.m. the staffing coordinator (SC)-A was observed telling nursing assistant (NA)-A and NA-B to wear eye protection who were on the long-term nursing care unit. NA-B stated he did not have eye protection. NA-A was observed going behind a desk area and put on eye protection. SC-A offered to find eye protection for NA-B. During observation on 6/28/21, at 11:38 SC-A gave NA-B eye protection. During an interview on 6/28/21, at 11:56 a.m. NA-A stated staff should always wear eye protection and a surgical mask. During observation on 6/28/21, at 11:39 a.m. trained medication assistant (TMA)-A, who was on the long-term care nursing unit, was observed wearing reading glasses and had mask below her chin. During an interview on 6/28/21, at 12:00 p.m. TMA-A stated a surgical mask and eye protection needed to be worn when cares were performed or when residents were in the hallways. During observation on 6/28/21, at 11:50 a.m. registered nurse (RN)-A was observed wearing N95 mask which did not conform to RN-A's face. RN-A was noted to frequently readjust the N95 mask. RN-A stated she had a different mask, but was told to wear an N95 mask because State was at the facility. RN-A stated she was not fit tested to wear a N95 mask and confirmed it did not fit appropriately. RN-A stated she was not caring for any COVID-19 residents or residents which would require an N95 mask. RN-A stated	F 880			

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F 880	Continued From page 8 appropriate PPE was a surgical mask and protective eyewear. During observation on 6/28/21, at 12:11 p.m. R-A was observed with eye protection on top of her head. R-A's face mask was under her nose. The Infection Prevention and Control Interim Guideline for Suspected or Confirmed Coronavirus (COVID-19) policy revised on 4/28/21, indicated long term care facility personnel must wear a well fitted surgical mask at all times, and use of eye protection is required in areas with moderate to substantial community transmission. Review of the Centers for Disease Control (CDC) guidance titled Strategies for Optimizing the Supply of N95 Respirators revealed, "N95 respirators are the PPE most often used to control exposures to infectious pathogens transmitted via the airborne route, though their effectiveness is highly dependent upon proper fit and use."	F 880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00129	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/29/2021
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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/28/21 through 6/29/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

07/23/21

Minnesota Department of Health

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5083101C (MN74094), with a deficiency cited at 1545. The following complaint was found to be UNSUBSTANTIATED: H5083100C (MN72373). In addition, as a result of the investigation other deficiencies were identified at 1375. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for	2 000		

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2 000	Continued From page 2 State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff wore appropriate personal protective equipment (PPE) including eye protection and source control masks to prevent and/or minimize the spread of COVID-19. This had the potential to affect all 44 residents who resided at the facility. Findings include: On 6/28/21, at 11:15 a.m. upon facility entrance the front desk receptionist (R)-A was observed to	21375	Corrected	8/3/21

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21375	Continued From page 3 be wearing a mask under her chin and was not wearing eye protection. An unidentified activities assistant was also noted to be sitting in the activities area/living room with no eye protection on. Two unidentified residents were noted to be in the activities area/living room and were listening to a woman singing. Multiple unidentified staff which included nursing assistants and nurses were observed in the transitional care unit (TCU) with no eye protection on and several unidentified residents were noted in the hallway. The administrator was observed exiting an elevator without eye protection on and proceeded to an office. The administrator had eye protection on upon exiting the office. During an interview on 6/28/21, at 11:20 a.m. the administrator stated staff needed to wear eye protection. The administrator stated the facility provided constant reminders to staff and most of the time staff would pull eye protection out from their pockets. The administrator confirmed several staff were not wearing eye protected should have had it on. During observation on 6/28/21, at 11:32 a.m. the front desk R-A was still not wearing eye protection. Several unidentified residents were at the receptionist desk speaking to her and other residents. During an interview on 6/28/21, at 11:38 a.m. the administrator indicated the facility had not conducted an Universal Eye Protection Risk assessment to determine whether staff could remove eye protection. The administrator further added that staff are expected to wear eye protection and masks under the current guideline. During observation on 6/28/21, at 11:37 a.m. the	21375		

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21375	Continued From page 4 staffing coordinator (SC)-A was observed telling nursing assistant (NA)-A and NA-B to wear eye protection who were on the long-term nursing care unit. NA-B stated he did not have eye protection. NA-A was observed going behind a desk area and put on eye protection. SC-A offered to find eye protection for NA-B. During observation on 6/28/21, at 11:38 SC-A gave NA-B eye protection. During an interview on 6/28/21, at 11:56 a.m. NA-A stated staff should always wear eye protection and a surgical mask. During observation on 6/28/21, at 11:39 a.m. trained medication assistant (TMA)-A, who was on the long-term care nursing unit, was observed wearing reading glasses and had mask below her chin. During an interview on 6/28/21, at 12:00 p.m. TMA-A stated a surgical mask and eye protection needed to be worn when cares were performed or when residents were in the hallways. During observation on 6/28/21, at 11:50 a.m. registered nurse (RN)-A was observed wearing N95 mask which did not conform to RN-A's face. RN-A was noted to frequently readjust the N95 mask. RN-A stated she had a different mask, but was told to wear an N95 mask because State was at the facility. RN-A stated she was not fit tested to wear a N95 mask and confirmed it did not fit appropriately. RN-A stated she was not caring for any COVID-19 residents or residents which would require an N95 mask. RN-A stated appropriate PPE was a surgical mask and protective eyewear.	21375		

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21375	Continued From page 5 During observation on 6/28/21, at 12:11 p.m. R-A was observed with eye protection on top of her head. R-A's face mask was under her nose. The Infection Prevention and Control Interim Guideline for Suspected or Confirmed Coronavirus (COVID-19) policy revised on 4/28/21, indicated long term care facility personnel must wear a well fitted surgical mask at all times, and use of eye protection is required in areas with moderate to substantial community transmission. Review of the Centers for Disease Control (CDC) guidance titled Strategies for Optimizing the Supply of N95 Respirators revealed, "N95 respirators are the PPE most often used to control exposures to infectious pathogens transmitted via the airborne route, though their effectiveness is highly dependent upon proper fit and use." SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON), or designee, could review/revise facility policies to ensure they contain all components of an infection control program, and ensure the appropriate use of PPE. The DON, or designee, could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21375		

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21545	Continued From page 6	21545		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or	21545		8/3/21

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21545	Continued From page 7 resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure anti-seizure medication was administered as ordered by the resident's physician for 1 of 3 residents (R1) reviewed for significant medication errors. Findings include: R1's diagnoses obtained from the admission record dated 6/29/21, included alerted mental status and a seizure disorder. R1's 5-day prospective payment system (PPS) Minimum Data Set (MDS) dated 4/19/21, indicated R1 had severely impaired cognition. The MDS further indicated R1 had a seizure disorder and required extensive assistance with walking and locomotion. R1's care plan dated of 6/17/21, indicated R1 had an alteration in neurological status related to a seizure disorder. R1's goal was to have no seizures through the next review date. R1's hospital discharge paperwork dated 6/17/21, indicated R1 was prescribed and to start taking Phenytoin (medication for seizures) 125 milligrams (mg) / 5 milliliter (mL) suspension. R1 was to be administered 4 mL (100 mg) per G-tube (gastrostomy tube) every evening and	21545	Corrected.	

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21545	Continued From page 8 take 6 mL's (150 mg) per G-tube every morning. R1's Order Summary Report dated 6/29/21, lacked an order for Phenytoin take 6 mL's (150 mg) per G-tube every morning. R1's June 2021, medication administration record (MAR), lacked indication R1 was administered Phenytoin 6 mL's (150 mg) per G-tube every morning since arriving to the facility from the hospital on 6/17/21. During an interview on 6/28/21, at 1:38 p.m. registered nurse (RN)-C stated he did not work on the transitional care unit (TCU), where R1 resided, during the evening of 6/17/21. RN-C denied he worked with R1. During an interview on 6/28/21, at 2:11 p.m., contrary to RN-C's statement, the staffing coordinator stated RN-C was the nurse who worked on the TCU during the evening of 6/17/21. During an interview on 6/28/21, at 2:18 p.m. the director of nursing (DON) confirmed RN-C was the nurse assigned to the TCU during the evening of 6/17/21 when R1 was readmitted to the facility. The DON stated RN-C was stressed about the admission and she provided RN-C her phone number so RN-C could call her when R1 arrived to the facility. The DON stated RN-C did not call her when R1 arrived at the facility and she figured everything was fine. The DON stated when R1 arrived at the facility during the evening of 6/17/21, the hospital orders were not entered into the computer system. The DON stated it was expected the admitting nurse and overnight nurse should had caught the missed orders.	21545		

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21545	Continued From page 9 During an interview on 6/29/21, at 10:14 a.m. the DON stated the order for Phenytoin 125 mg/5 mL suspension 6 mL (150 mg) per G-tube every morning "was missed" and verified R1 had not received the medication since being readmitted to the facility on 6/17/21. The DON verbalized medical doctor (MD)-A would immediately be notified of the omitted medication. During an interview on 6/29/21, at 11:36 a.m. the consultant pharmacist stated seizure medications had a long half-life (time it takes for the amount of a drug's active substance in your body to reduce by half) and missing a seizure medication may or may not be significant for a resident. During an interview on 6/29/21, at 1:00 p.m. MD-A stated R1 did not have a seizure since he had missed the morning does of Phenytoin. MD-A stated a laboratory draw of R1's Phenytoin level (drug concentration in the blood) would be taken to determine if the medication was still necessary. Medication Reconciliation Upon Admission policy dated May 2017, indicated a list of discharge medications will be obtained from the patient's previous care setting and carefully compared to the prescriber verified admission orders entered into the clinical software. Any irregularities between the two lists will be identified, discussed with the prescriber, and either corrected with an order change/ additional order or documented rationale for the change will be noted. The policy further indicated a 2nd nurse will compare a complete list of a resident's hospital discharge medications to the list of the physician's orders entered into the facility's clinical software as a second check to ensure accuracy and any discrepancies discovered by the nurse should be resolved with the prescriber as quickly as	21545			

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21545	Continued From page 10 possible. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review and revise policies and procedures for medication errors and transcription. The director of nursing, or designee, could develop a system to educate staff and develop a monitoring system to ensure medications were administered as ordered. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545		

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Minnesota Department of Health

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

TITLE

(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff wore appropriate personal protective equipment (PPE) including eye protection and source control masks to prevent and/or minimize the spread of COVID-19. This had the potential to affect all 44 residents who resided at the facility. Findings include: On 6/28/21, at 11:15 a.m. upon facility entrance the front desk receptionist (R)-A was observed to	21375		

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21375	Continued From page 3 be wearing a mask under her chin and was not wearing eye protection. An unidentified activities assistant was also noted to be sitting in the activities area/living room with no eye protection on. Two unidentified residents were noted to be in the activities area/living room and were listening to a woman singing. Multiple unidentified staff which included nursing assistants and nurses were observed in the transitional care unit (TCU) with no eye protection on and several unidentified residents were noted in the hallway. The administrator was observed exiting an elevator without eye protection on and proceeded to an office. The administrator had eye protection on upon exiting the office. During an interview on 6/28/21, at 11:20 a.m. the administrator stated staff needed to wear eye protection. The administrator stated the facility provided constant reminders to staff and most of the time staff would pull eye protection out from their pockets. The administrator confirmed several staff were not wearing eye protected should have had it on. During observation on 6/28/21, at 11:32 a.m. the front desk R-A was still not wearing eye protection. Several unidentified residents were at the receptionist desk speaking to her and other residents. During an interview on 6/28/21, at 11:38 a.m. the administrator indicated the facility had not conducted an Universal Eye Protection Risk assessment to determine whether staff could remove eye protection. The administrator further added that staff are expected to wear eye protection and masks under the current guideline. During observation on 6/28/21, at 11:37 a.m. the	21375			

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21375	Continued From page 4 staffing coordinator (SC)-A was observed telling nursing assistant (NA)-A and NA-B to wear eye protection who were on the long-term nursing care unit. NA-B stated he did not have eye protection. NA-A was observed going behind a desk area and put on eye protection. SC-A offered to find eye protection for NA-B. During observation on 6/28/21, at 11:38 SC-A gave NA-B eye protection. During an interview on 6/28/21, at 11:56 a.m. NA-A stated staff should always wear eye protection and a surgical mask. During observation on 6/28/21, at 11:39 a.m. trained medication assistant (TMA)-A, who was on the long-term care nursing unit, was observed wearing reading glasses and had mask below her chin. During an interview on 6/28/21, at 12:00 p.m. TMA-A stated a surgical mask and eye protection needed to be worn when cares were performed or when residents were in the hallways. During observation on 6/28/21, at 11:50 a.m. registered nurse (RN)-A was observed wearing N95 mask which did not conform to RN-A's face. RN-A was noted to frequently readjust the N95 mask. RN-A stated she had a different mask, but was told to wear an N95 mask because State was at the facility. RN-A stated she was not fit tested to wear a N95 mask and confirmed it did not fit appropriately. RN-A stated she was not caring for any COVID-19 residents or residents which would require an N95 mask. RN-A stated appropriate PPE was a surgical mask and protective eyewear.	21375			

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21375	Continued From page 5 During observation on 6/28/21, at 12:11 p.m. R-A was observed with eye protection on top of her head. R-A's face mask was under her nose. The Infection Prevention and Control Interim Guideline for Suspected or Confirmed Coronavirus (COVID-19) policy revised on 4/28/21, indicated long term care facility personnel must wear a well fitted surgical mask at all times, and use of eye protection is required in areas with moderate to substantial community transmission. Review of the Centers for Disease Control (CDC) guidance titled Strategies for Optimizing the Supply of N95 Respirators revealed, "N95 respirators are the PPE most often used to control exposures to infectious pathogens transmitted via the airborne route, though their effectiveness is highly dependent upon proper fit and use." SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON), or designee, could review/revise facility policies to ensure they contain all components of an infection control program, and ensure the appropriate use of PPE. The DON, or designee, could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21375		

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21545	Continued From page 6	21545		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or	21545		

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21545	Continued From page 7 resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure anti-seizure medication was administered as ordered by the resident's physician for 1 of 3 residents (R1) reviewed for significant medication errors. Findings include: R1's diagnoses obtained from the admission record dated 6/29/21, included alerted mental status and a seizure disorder. R1's 5-day prospective payment system (PPS) Minimum Data Set (MDS) dated 4/19/21, indicated R1 had severely impaired cognition. The MDS further indicated R1 had a seizure disorder and required extensive assistance with walking and locomotion. R1's care plan dated of 6/17/21, indicated R1 had an alteration in neurological status related to a seizure disorder. R1's goal was to have no seizures through the next review date. R1's hospital discharge paperwork dated 6/17/21, indicated R1 was prescribed and to start taking Phenytoin (medication for seizures) 125 milligrams (mg) / 5 milliliter (mL) suspension. R1 was to be administered 4 mL (100 mg) per G-tube (gastrostomy tube) every evening and	21545		

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21545	Continued From page 8 take 6 mL's (150 mg) per G-tube every morning. R1's Order Summary Report dated 6/29/21, lacked an order for Phenytoin take 6 mL's (150 mg) per G-tube every morning. R1's June 2021, medication administration record (MAR), lacked indication R1 was administered Phenytoin 6 mL's (150 mg) per G-tube every morning since arriving to the facility from the hospital on 6/17/21. During an interview on 6/28/21, at 1:38 p.m. registered nurse (RN)-C stated he did not work on the transitional care unit (TCU), where R1 resided, during the evening of 6/17/21. RN-C denied he worked with R1. During an interview on 6/28/21, at 2:11 p.m., contrary to RN-C's statement, the staffing coordinator stated RN-C was the nurse who worked on the TCU during the evening of 6/17/21. During an interview on 6/28/21, at 2:18 p.m. the director of nursing (DON) confirmed RN-C was the nurse assigned to the TCU during the evening of 6/17/21 when R1 was readmitted to the facility. The DON stated RN-C was stressed about the admission and she provided RN-C her phone number so RN-C could call her when R1 arrived to the facility. The DON stated RN-C did not call her when R1 arrived at the facility and she figured everything was fine. The DON stated when R1 arrived at the facility during the evening of 6/17/21, the hospital orders were not entered into the computer system. The DON stated it was expected the admitting nurse and overnight nurse should had caught the missed orders.	21545		

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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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21545	Continued From page 9 During an interview on 6/29/21, at 10:14 a.m. the DON stated the order for Phenytoin 125 mg/5 mL suspension 6 mL (150 mg) per G-tube every morning "was missed" and verified R1 had not received the medication since being readmitted to the facility on 6/17/21. The DON verbalized medical doctor (MD)-A would immediately be notified of the omitted medication. During an interview on 6/29/21, at 11:36 a.m. the consultant pharmacist stated seizure medications had a long half-life (time it takes for the amount of a drug's active substance in your body to reduce by half) and missing a seizure medication may or may not be significant for a resident. During an interview on 6/29/21, at 1:00 p.m. MD-A stated R1 did not have a seizure since he had missed the morning does of Phenytoin. MD-A stated a laboratory draw of R1's Phenytoin level (drug concentration in the blood) would be taken to determine if the medication was still necessary. Medication Reconciliation Upon Admission policy dated May 2017, indicated a list of discharge medications will be obtained from the patient's previous care setting and carefully compared to the prescriber verified admission orders entered into the clinical software. Any irregularities between the two lists will be identified, discussed with the prescriber, and either corrected with an order change/ additional order or documented rationale for the change will be noted. The policy further indicated a 2nd nurse will compare a complete list of a resident's hospital discharge medications to the list of the physician's orders entered into the facility's clinical software as a second check to ensure accuracy and any discrepancies discovered by the nurse should be resolved with the prescriber as quickly as	21545		

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21545	Continued From page 10 possible. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review and revise policies and procedures for medication errors and transcription. The director of nursing, or designee, could develop a system to educate staff and develop a monitoring system to ensure medications were administered as ordered. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545		