



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 13, 2024

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

RE: CCN: 245182
Cycle Start Date: July 11, 2024

Dear Administrator:

On August 23, 2024, we notified you a remedy was imposed. On September 9, 2024 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 4, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 11, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 23, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 11, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on September 4, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

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



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September 13, 2024

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

Re: Reinspection Results
Event ID: V58212

Dear Administrator:

On September 9, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 7, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
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August 23, 2024

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

RE: CCN: 245182
Cycle Start Date: July 11, 2024

Dear Administrator:

On July 24, 2024, we informed you that we may impose enforcement remedies.

On August 7, 2024, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby 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 location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 11, 2024

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 11, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 11, 2024.

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.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

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 \$12,924, 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 October 11, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Villas At St Louis Park will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 11, 2024. 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

The Villas At St Louis Park

August 23, 2024

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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 January 11, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 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:

Steven.Delich@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
202-795-7490

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

The Villas At St Louis Park

August 23, 2024

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St. Paul, Minnesota 55164-0900

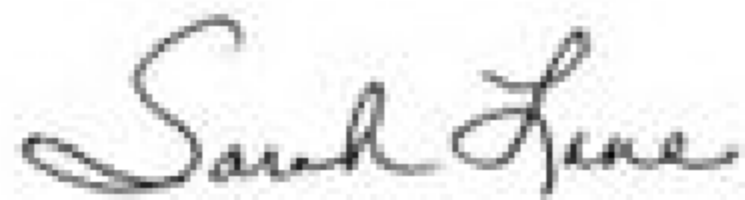
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

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,



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



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Electronically delivered
August 23, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: V58211

Dear Administrator:

The above facility was surveyed on August 5, 2024 through August 7, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

The Villas At St Louis Park

August 23, 2024

Page 2

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.

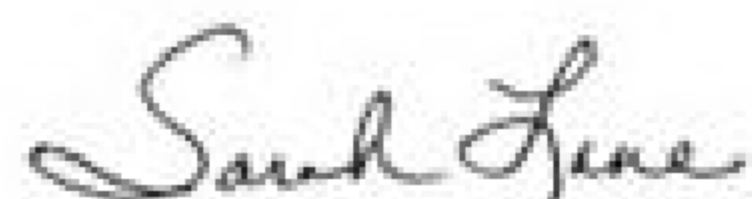
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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:

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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

Please feel free to call me with any questions.

Sincerely,



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

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

PRINTED: 08/28/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/07/2024
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NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>On 8/5/24 to 8/7/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaints were reviewed.</p> <p>H51823751C (MN00103267). H51826429C (MN00095439). H51826430C (MN00086856). H51826431C (MN00085857). H5182163C (MN00080317). H5182162C (MN00077505). H5182164C (MN00076394). H5182175C (MN00075687). H5182166C (MN00074640). H5182173C (MN00073826). H5182171C (MN00072803). H5182169C (MN00067208). H5182165C (MN00066849). H5182168C (MN00065532). H5182170C (MN00058316). H5182172C (MN00058554). H5182174C (MN00058281). H5182167C (MN00053794). H5182176C (MN00051724). H5182164C (MN00051223).</p> <p>AND</p> <p>The following complaints were reviewed. H51824735C (MN00104246) with at (F623 & F625). H51824562C (MN00104061) with a licensing order issue at (F880).</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 08/27/2024
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
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F 000	Continued From page 1 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 that substantial compliance with the regulations has been attained.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.	F 623		9/4/24

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

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F 623	<p>Continued From page 2</p> <p>(ii) Notice must be made as soon as practicable before transfer or discharge when-</p> <p>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;</p> <p>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or</p> <p>(E) A resident has not resided in the facility for 30 days.</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:</p> <p>(i) The reason for transfer or discharge;</p> <p>(ii) The effective date of transfer or discharge;</p> <p>(iii) The location to which the resident is transferred or discharged;</p> <p>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;</p> <p>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;</p> <p>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for</p>	F 623		

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F 623	<p>Continued From page 3</p> <p>the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that written notifications required for transfers were given to the resident and/or resident representative for 1 of 5 residents (R1) reviewed for admission, discharge and transfers.</p>	F 623	<p>R1 is no longer at the facility. No further action can be taken All residents, who are having a facility initiated DC were reviewed on 8/28/2024 to ensure they received written notification of facility initiated DC Facility Administrator, who is the only staff</p>	

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NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426		
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F 623	<p>Continued From page 4</p> <p>Findings include:</p> <p>R1's quarterly Minimal Data Set (MDS) dated 8/1/24, indicated R1 was cognitively intact and had diagnoses which included seizures, anxiety and depression. Identified R1 was independent for transfers and activities of daily living (ADLs).</p> <p>R1's care plan dated 6/7/24, stated R1 had a history and diagnosis of substance use. Staff were to monitor and check vitals if R1 was under the influence of a substance. Identified R1 would have an appropriate discharge plan. R1 would make a safe and appropriate decision regarding discharge.</p> <p>Review of R1's progress notes from 4/12/24 to 6/7/24, identified the following:</p> <p>-On 6/6/24 at 8:45 a.m., "resident returned to facility this AM around 8 am intoxicated. Resident stated he drank 4 beers from 10 PM to 2 am. Resident was stumbling and had difficulty focusing. Resident became upset when asked about his alcohol use. The smell of alcohol was noted in room. Resident became upset when asked if he would be willing to be seen in the ED stating he would just go home to St Cloud. Resident did have his vehicle parked near facility, denies driving while under influence."</p> <p>-On 6/6/24 at 12:02 p.m., "30 day (notice of intent to discharge) NOD issued to resident today to (to be determined) TBD location as resident no longer requires SNF care. Resident refused to sign NOD. Writer explained the appeal process to resident, who verbalized understanding. Writer offered resident a copy of the NOD paperwork and provided to resident. (Medical Director) MD updated and NOD mailed to ombudsman office."</p> <p>-On 6/6/24 at 12:07 p.m., "Resident back from</p>	F 623	<p>memeber responsible for issuing facility initiated DC to the resident/resident representative, was educated by the regional director of operation on 8/28/2024 that all resident must receive written notification of a facility initiated discharge in a language that the resident/resident representative understands and that the resident/resident representative cannot be under the influence when given the written notification</p> <p>NHA/designee will be responsible for auditing all facility initiated discharges to ensure notification was received by resident/resident representative in writing for 3 months. Audits will be reviewed by the administrator/DON and brought through the monthly QAPI process for monitoring of trends, patterns, and recommendations for continuation.</p>	

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F 623	<p>Continued From page 5</p> <p>(leave of absence) LOA @8 am. Resident appeared intoxicated. Resident has slurred speech, appears flushed, teary eyes and tipsy walking. VS BP 100/53 R22 P 81 O2:92% T 97.5 When asked about his drinking, resident states that he started drinking between 10 PM and 2 am had 4 beers max. Provider notified, requested for resident to be sent in. Provider sent order. Resident notified that he had to go in for detoxify since when he starts having withdrawal symptoms, facility is not equipped to care for him, resident refused and stated that if they call (emergency medical services) EMS he would leave (against medical advice) AMA. Resident upset and angry at writer stating that we need to call his lawyer. MT called, administrator applied for emergency hold since resident was upset and adamantly refusing to go in. MT and police arrived @11:45 am, resident agreed to leave with (emergency medical technician) MT. Resident left building @11:55 am sent to Methodist hospital. Paperwork sent with resident".</p> <p>-On 6/6/24 at 1:16 p.m., resident returned to the facility this morning around 7:30 am. resident visibly intoxicated and belligerent, slurring his words and stumbling when walking and a strong ETOH (scientific abbreviation for ethanol, the chemical compound that is found in alcohol) odor coming from resident. resident declined drinking ETOH, but bottles of alcohol were confiscated from resident this morning and yesterday. EMS called to send resident in for detoxify. Resident refused to go and was stating he was going to get into his car and leave AMA. Police arrived prior to EMS and attempted to get keys from resident, but he refused to allow police to enter his room. resident told writer he would not go to the (emergency room) ER for detoxify and told writer to "Call my lawyer." Police officers recommended</p>	F 623		

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F 623	<p>Continued From page 6</p> <p>facility fill out a transport hold on resident. Transport hold filled out and resident was transferred to the ER by EMS. MD updated". -On 6/6/24 at 4:35 p.m., "MD okay with 30 day NOD".</p> <p>Review of R1's doctor's order dated 6/6/24 at 9:14 a.m., "please send patient to ED for alcohol intoxication".</p> <p>Review of R1's discharge notification dated 6/6/24, checkbox selected stated "The residents health has improved sufficiently so the resident no longer needs services provided by the facility". R1's discharge notification revealed R1 refused to sign the form and the administrator signed as the witness.</p> <p>R1's medical record lacked documentation R1 or R1's representative had received a written notification of discharge.</p> <p>During an interview on 8/6/24 at 3:55 p.m., the administrator indicated emergency medical service (EMS) arrived to transfer R1 to detoxify. The administrator further indicated she issued a 30-day involuntary discharge on 6/6/24, however was unaware of the time. The administrator said R1 was very impaired when the 30-day involuntary discharge was discussed and given to R1. The administrator further said, "he might not have understood the discharge and if he would have come back to the facility I would have had to discuss it with him again. I would have probably had to create a new 30-day discharge notice".</p> <p>During a telephone interview on 8/7/24 at 9:26 a.m., R1 indicated the administrator came to his room and informed him he was going to detoxify</p>	F 623		

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F 623	Continued From page 7 and that she placed a hold on him. R1 further indicated three police and EMS were at the facility to take him into the emergency room (ER). R1 stated the administrator never gave him a 30-day written notice before sending him to the ER. R1 indicated the social worker at the hospital was the one who told him he only had 30 days left at the facility. R1 stated he was discharged from the hospital and was going to stay with a friend because he felt the administrator was kicking him out. Review of facility policy titled Discharge Planning Policy dated 11/16, Discharge planning was completed to assure continuity of care to meet the needs of a resident returning to independent living in the community or discharged to another facility or institution when and if possible. Involuntary discharge policies were covered in a separate policy. They were written to include interpretive guidelines under Federal Statute 483.12(a)(1). Review of facility policy titled Transfer or Discharge Notice for Facility-Initiated Discharges updated 7/24, residents and/or representatives were notified in writing, and in a language and format they understand, at least thirty (30) days prior to a transfer or discharge for all facility-initiated discharge.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the	F 625		9/4/24

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F 625	<p>Continued From page 8</p> <p>nursing facility must provide written information to the resident or resident representative that specifies-</p> <p>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;</p> <p>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;</p> <p>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and</p> <p>(iv) The information specified in paragraph (e)(1) of this section.</p> <p>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review, the facility failed to ensure the resident or resident's representative was informed of the bed hold policy at the time of hospitalization for 1 of 5 residents (R1) reviewed for hospitalization.</p> <p>Findings include:</p> <p>R1's quarterly Minimum Data Set (MDS) dated 8/1/24, indicated R1's diagnoses included seizures, anxiety, depression and was cognitively intact. Identified R1 was independent with transfers and activities of daily living (ADLs).</p>	F 625	<p>R1 is discharged from the facility, no further action can be taken</p> <p>All residents should receive written notification of facilities bed hold policy at the time of a transfer and/or therapeutic leave</p> <p>Nursing and Social services were educated on facilities bed hold policy on 8/29/2024.</p> <p>NHA/designee will be responsible for auditing 10% of transfers our to the hospital/therapeutic leave to ensure facilities bed hold policy was followed 5x/week for 2 weeks, then 3x/week for 1</p>	

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F 625	<p>Continued From page 9</p> <p>R1's care plan dated 6/7/24, identified R1 had a history of and diagnosis of substance use. Staff were to monitor and check vitals if R1 was under the influence of a substance. Identified R1 would have an appropriate discharge plan. R1 would make safe and appropriate decision regarding discharge.</p> <p>Review of R1's progress notes from 4/12/24 to 6/7/24, identified the following: -On 6/6/24 at 12:07 p.m., "Resident back from (leave of absence) LOA @8 am. Resident appeared intoxicated. Resident has slurred speech, appears flushed, teary eyes and tipsy walking. VS BP100/53 R22 P81 O2:92% T97.5 When asked about his drinking, resident states that he started drinking between 10 pm and 2 am had 4 beers max. Provider notified, requested for resident to be sent in. Provider sent order. Resident notified that he had to go in for detox since when he starts having withdrawal symptoms, facility is not equipped to care for him, resident refused and started that if they call (emergency medical services) EMS he would leave (against medical advice) AMA. Resident upset and angry at writer stating that we need to call his lawyer. EMT called, administrator applied for emergency hold since resident was upset and adamantly refusing to go in. EMT and police arrived @11:45 am, resident agreed to leave with (emergency medical technician) EMT. Resident left building @11:55 am sent to Methodist hospital. Paperwork sent with resident".</p> <p>R1's medical record lacked documentation R1 or family/legal representative had been provided information on the facility's bed hold policy at the time of the hospital transfer.</p>	F 625	week, then 2X/week. Audits will be reviewed by the administrator/DON and brought through the monthly QAPI process for monitoring of trends, patterns, and recommendations for continuation.	

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F 625	<p>Continued From page 10</p> <p>During an interview on 8/6/24 at 11:38 a.m., administrator stated she did not have a bed hold for R1 as he was not coherent or of sound mind to sign a bed hold.</p> <p>During an interview on 8/6/24 at 3:40 p.m., director of nursing (DON) stated if a resident was going to be transferred to another facility in a medical emergency a bed hold should have been completed. If the resident was unable to be provided a bed hold, the facility should have reached out to the family/legal representative.</p> <p>During an interview on 8/6/24 at 3:55 p.m., the administrator indicated EMS arrived to transfer R1 to detox. The administrator stated R1 was very impaired when he was getting ready to leave the facility. The administrator said "we did not feel he could understand his bed hold agreement at that time therefore, one was not provided".</p> <p>During a telephone interview on 8/7/24 at 9:26 a.m., R1 indicated the administrator came to his room and informed him he was going to detox and that she placed a hold on him. R1 stated three police officers and EMS staff were at the facility to take him into the emergency room (ER). R1 stated he was not aware of a bed hold and he never received a form to sign.</p> <p>Review of facility policy Bed-Holds and Returns updated 5/24, When a resident was temporarily transferred on an emergency basis to an acute care facility, this type of transfer was considered to be a facility-initiated transfer and a notice of transfer must be provided to the resident and/or resident representative as soon as practicable before the transfer, according to 42 CFR §483.15(c)(4)(ii)(D). Prior to a transfer, written</p>	F 625		

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F 625	Continued From page 11 information would be provided to the resident and the resident representatives that explains in detail: -The rights and limitations of the resident regarding bed-holds; -The reserve bed payment policy as indicated by the state plan (Medicaid residents); -The facility per diem rate required to hold a bed (non-Medicaid residents), or to hold a bed beyond the state bed-hold period (Medicaid residents); and -The details of the transfer (per the Notice of Transfer). Review of facility policy titled Transfer or Discharge Notice for Facility-Initiated Discharges updated 7/24, the resident and representative were notified in writing of the following information: the facility bed-hold policy.	F 625		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention 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	F 880		9/4/24

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F 880	<p>Continued From page 12</p> <p>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;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (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. <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p>	F 880		

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F 880	<p>Continued From page 13</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§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 appropriate donning/doffing of personal protective equipment (PPE) was performed in order to prevent the spread of infection for 2 of 2 residents (R3, R26) observed for enhanced barrier precautions (EBP) (an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. In addition, the facility failed to ensure appropriate donning/doffing of PPE was performed and that the door remained closed for 1 of 1 resident (R31) observed for enhanced respiratory precautions (ERP) (used to protect others from illnesses spread through the air).</p> <p>Findings include:</p> <p>Review of Centers for Disease Control and Prevention (CDC) guidance dated 4/1/24, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) indicated Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: Dressing, Bathing/showering, Transferring, Providing</p>	F 880	<p>R26 discharged from the facility on 8/22/2024, no further action can be taken. R3 had no adverse reaction by this practice and is back to baseline. R31 graduated off enhanced respiratory precautions on 8/8/2024 and had no adverse reactions from this practice. All residents were reviewed on 8/27/2024 by the director of nursing and residents requiring on EBP and ERP were identified and appropriate precautions were put in place. All staff will be educated on 8/29/2024 on facilities infection control policy, including EBP and ERP. The DON/designee will be responsible for auditing 10% enhanced barrier precautions and/or enhanced respiratory precautions residents for 5x/week for 2 weeks, then 3x/week for 1 week, then 2X/week to ensure the facilities infection control policy was followed. Audits will be reviewed by the administrator/DON and brought through the monthly QAPI process for monitoring of trends, patterns, and recommendations for continuation.</p>	

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F 880	<p>Continued From page 14</p> <p>hygiene, Changing linens, Changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing.</p> <p>According to Minnesota Department of Health, Enhanced Respiratory Precautions (ERP) require staff to gown, apply a N95 respirator or higher level respirator, eye protection (goggles or a faceshield), and a pair of gloves. Only essential personnel should enter the room and the door should be kept closed if possible. The resident should be placed in an Airborne Infection Isolation Room (AIIR) if available.</p> <p>According to the CDC guidelines dated 4/3/24, in a setting where Airborne Precautions cannot be implemented due to limited engineering resources, masking the patient and placing the patient in a private room with the door closed would reduce the likelihood of airborne transmission.</p> <p>EBP</p> <p>R3</p> <p>R3's quarterly Minimum Data Set (MDS) dated 6/4/24, identified R3 had moderate cognitive impairment and diagnoses which included hypertension (elevated blood pressure), neurogenic bladder (name given to a number of urinary conditions in people who lack bladder control due to a brain, spinal cord or nerve problem.), and diabetes mellitus (DM). Identified R3 required extensive assistance for activities of daily living (ADL's) which included toileting, transfer and dressing. Indicated R3 had a foley</p>	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	<p>Continued From page 15 catheter.</p> <p>R3's annual Comprehensive Care area Assessment (CAA) dated 1/21/24, identified R3 had a foley catheter and indicated staff provided catheter care and emptied catheter.</p> <p>R3's care plan revised 5/2/24, indicated R3 had a foley catheter. Care plan instructed staff to position the catheter below the level of the bladder, provide catheter care per policy and monitor for signs of a urinary tract infection (UTI).</p> <p>During an observation on 8/6/24 at 7:27 a.m., there was no PPE located near R3's room for staff to wear while providing care for R3 (who was on EBP).</p> <p>During an observation on 8/6/24 at 7:35 a.m., nursing assistant (NA)-A was standing next to R3's bed wearing gloves and a surgical mask and was putting R3's pants on. NA-A had no gown on. NA-B entered R3's room wearing gloves and a surgical mask and had no gown on. NA-A and NA-B assisted R3 to roll over as NA-A pulled up R3's pants and placed a hoyer lift sheet under R3. NA-A and NA-B proceeded to use a hoyer lift to transfer R3 into her wheelchair. NA-A and NA-B removed gloves and sanitized hands.</p> <p>During an observation on 8/6/24 at 8:44 a.m., NA-A and NA-B while wearing a surgical mask and gloves and had no gown on, entered R3's room, hooked R3 up to a hoyer lift and transferred R3 into bed. NA-A and NA-B rolled R3 over and removed the hoyer sheet. NA-A and NA-B removed gloves and sanitized hands.</p> <p>During a joint interview on 8/6/24 at 8:50 a.m.,</p>	F 880		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	<p>Continued From page 16</p> <p>NA-A and NA-B verified they had not worn a gown while dressing or transferring R3. NA-A and NA-B stated R3 had a foley catheter and the only PPE that was required while providing care to R3 was a surgical mask and gloves. NA-A and NA-B indicated they were unaware that a gown was required while providing cares to R3.</p> <p>R26</p> <p>R26's admission MDS dated 7/23/24, identified R26 was cognitively intact and required moderate assistance with activities of daily living ADL's for dressing and transfer, supervision with toileting, and required use of a wheelchair. Indicated R26 had diagnoses of acute osteomyelitis (infection of bone caused by bacteria, injury or surgery), type two diabetes with foot ulcer, stage three (moderate) chronic kidney disease and generalized muscle weakness. Identified R26 had a peripherally inserted central catheter (PICC) and received intravenous (IV) medication through the PICC line. Indicated R26 had a wound vacuum-assisted closure (VAC) device that used negative pressure to pull the edges of a wound together and promote healing on R26's left foot on the heel of the foot.</p>	F 880		

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F 880	<p>Continued From page 17</p> <p>R26's admission CAA dated 7/28/24, identified R26 had a left heel ulcer and was on IV antibiotics.</p> <p>R26's care plan dated 7/17/24, identified R26 had a PICC line that was to be flushed before and after IV medication administration and to monitor for signs or symptoms of infection and infiltration. The care plan dated 7/24/24, identified R26 had an alteration in skin integrity related to a wound on R26's left heel. Staff were to provide treatment to open area per order. The care plan lacked documentation on use of EBP for R26.</p> <p>During an observation on 8/6/24 at 12:15 p.m., registered nurse (RN)-A removed gloves from the PPE supply bin hanging over the outside of R26's door and entered R26's room. RN-A placed the IV supplies and IV medication onto R26's bedside table and applied gloves. RN-A proceeded to connect the IV medication to R26's PICC line. RN-A removed the gloves, disposed of the gloves into the garbage can and exited R26's room.</p> <p>During an interview on 8/6/24 at 12:19 p.m., R26 stated staff wore gloves when completing IV cares and a gown and gloves when providing wound cares to the left foot. R26 stated some staff wore a gown and gloves when providing IV PICC line care and or assisting with personal cares however not all staff did so.</p> <p>During an interview on 8/6/24 at 12:22 p.m., RN-A verified she only wore gloves and had no gown on when completing the IV PICC line cares and administering IV medication for R26. RN-A stated staff only needed to wear a gown when providing wound cares and not for any other cares.</p>	F 880		

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F 880	<p>Continued From page 18</p> <p>ERP</p> <p>R31</p> <p>R31's quarterly Minimum Data Set (MDS) dated 5/16/24 identified R31 had severe cognitive impairment and diagnoses which included heart failure, aphasia (a language disorder caused by damage to parts of the brain that control speech and understanding of language), and anxiety. Identified R31 was independent with activities of daily living (ADL's) which included toileting, transfer and dressing.</p> <p>R31's care plan revised 3/6/24, lacked documentation R31 was to be in ERP.</p> <p>R31's Order Review History Report dated 8/7/24, indicated the following: -staff to follow: ERP every shift active 8/1/24. -Amoxicillin-Pot Clavulanate (antibiotic used to treat bacterial infections) oral tablet 875-125 milligrams (mg) give one tablet by mouth two times a day for Pneumonia for five days starting 8/01/2024 to 8/06/2024.</p> <p>During an observation on 8/6/24 at 11:32 a.m., R31 had a sign on the door that stated R31 was in ERP. R31's door was open and R31 was laying on her bed with her eyes closed and television playing.</p> <p>During an observation on 8/6/24 at 12:08 p.m., R31's door was open and she was sitting on the</p>	F 880		

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F 880	<p>Continued From page 19</p> <p>edge of her bed finishing eating her lunch. R31's tray had been removed and R31's door remained open.</p> <p>During an interview on 8/6/24 at 9:59 a.m., infection preventionist (IP) verified R3 had a foley catheter and was on EBP. IP stated the facility had just started implementing EBP therefore, there were not enough over the door PPE bins for all resident on EBP. IP stated her expectation was all staff would have worn the appropriate PPE while performing high-contact cares for R3 to prevent the spread of infection.</p> <p>During an interview on 8/6/24 at 10:20 a.m., director of nursing (DON) verified the facility had just started to implement EBP. DON stated they were hoping to have all PPE and supplies by last week however were not able to obtain all the supplies that were ordered. DON indicated her expectation was all staff would have worn the appropriate PPE during high- contact activities for residents on EBP.</p> <p>During a follow-up interview on 8/6/24 at 4:54 p.m., IP confirmed R31 was on ERP due to pneumonia. IP indicated R31's door was to remain closed at all times. IP further indicated she was not aware R31's door was open and stated the facility had a plan for ERP however it had not been fully implemented yet.</p> <p>During a follow-up interview on 8/6/24 at 4:55 p.m., IP verified R26 had a PICC line and was on EBP. IP stated the expectation of staff was to wear a gown and gloves when providing PICC line cares for R26 to prevent the spread of infection. IP stated the facility was still in the process of providing education to staff about EBP</p>	F 880		

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F 880	<p>Continued From page 20</p> <p>and had not fully implemented EBP in the facility at the time as there were not enough over the door PPE bins for all residents on EBP.</p> <p>During an interview on 8/6/24 at 5:07 p.m., the administrator verified the facility was still in the process of implementing EBP and were not able to obtain all the supplies that were ordered. Administrator stated the expectation was that staff would follow the current CDC guidelines for use of EBP to prevent the spread of infection.</p> <p>Review of a facility policy titled Enhanced Barrier Precautions dated 4/1/24, identified it was the practice of the facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Policy stated the use of gown and gloves was expected during high-contact resident activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices (e.g., central lines, hemodialysis catheters, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident was not known to be infected or colonized with a MDRO.</p> <p>Requested a facility policy on ERP, however one was not received.</p>	F 880		

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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 8/5/24 to 8/7/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE _____	(X6) DATE 08/27/24
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2 000	<p>Continued From page 1</p> <p>and identify the date when they will be completed.</p> <p>The following complaints were reviewed with no deficiency issued.</p> <p>H51823751C (MN00103267). H51826429C (MN00095439). H51826430C (MN00086856). H51826431C (MN00085857). H5182163C (MN00080317). H5182162C (MN00077505). H5182164C (MN00076394). H5182175C (MN00075687). H5182166C (MN00074640). H5182173C (MN00073826). H5182171C (MN00072803). H5182169C (MN00067208). H5182165C (MN00066849). H5182168C (MN00065532). H5182170C (MN00058316). H5182172C (MN00058554). H5182174C (MN00058281). H5182167C (MN00053794). H5182176C (MN00051724). H5182164C (MN00051223).</p> <p>AND</p> <p>The following complaints were reviewed. H51824735C (MN00104246) with a licensing order issued at (1925). H51824562C (MN00104061) with a licensing order issued at (1390).</p> <p>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</p>	2 000		
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2 000	<p>Continued From page 2</p> <p>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 evidenced by." Following the surveyors findings are the suggested Method of Correction and Time Period for Correction.</p> <p>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 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.</p> <p>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.</p>	2 000		
21390	<p>MN Rule 4658.0800 Subp. 4 A-I Infection Control</p> <p>Subp. 4. Policies and procedures. The infection</p>	21390		9/4/24

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21390	<p>Continued From page 3</p> <p>control program must include policies and procedures which provide for the following:</p> <ul style="list-style-type: none"> A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. <p>This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate donning/doffing of personal protective equipment (PPE) was performed in order to prevent the spread of infection for 2 of 2 residents (R3, R26) observed for enhanced barrier precautions (EBP) (an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove</p>	21390	corrected	
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21390	<p>Continued From page 4</p> <p>use during high contact resident care activities. In addition, the facility failed to ensure appropriate donning/doffing of PPE was performed and that the door remained closed for 1 of 1 resident (R31) observed for enhanced respiratory precautions (ERP) (used to protect others from illnesses spread through the air).</p> <p>Findings include:</p> <p>Review of Centers for Disease Control and Prevention (CDC) guidance dated 4/1/24, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) indicated Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing.</p> <p>According to Minnesota Department of Health, Enhanced Respiratory Precautions (ERP) require staff to gown, apply a N95 respirator or higher level respirator, eye protection (goggles or a faceshield), and a pair of gloves. Only essential personnel should enter the room and the door should be kept closed if possible. The resident should be placed in an Airborne Infection Isolation Room (AIIR) if available.</p> <p>According to the CDC guidelines dated 4/3/24, in a setting where Airborne Precautions cannot be implemented due to limited engineering resources, masking the patient and placing the patient in a private room with the door closed</p>	21390		
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21390	<p>Continued From page 5</p> <p>would reduce the likelihood of airborne transmission.</p> <p>EBP</p> <p>R3</p> <p>R3's quarterly Minimum Data Set (MDS) dated 6/4/24, identified R3 had moderate cognitive impairment and diagnoses which included hypertension (elevated blood pressure), neurogenic bladder (name given to a number of urinary conditions in people who lack bladder control due to a brain, spinal cord or nerve problem.), and diabetes mellitus (DM). Identified R3 required extensive assistance for activities of daily living (ADL's) which included toileting, transfer and dressing. Indicated R3 had a foley catheter.</p> <p>R3's annual Comprehensive Care area Assessment (CAA) dated 1/21/24, identified R3 had a foley catheter and indicated staff provided catheter care and emptied catheter.</p> <p>R3's care plan revised 5/2/24, indicated R3 had a foley catheter. Care plan instructed staff to position the catheter below the level of the bladder, provide catheter care per policy and monitor for signs of a urinary tract infection (UTI).</p> <p>During an observation on 8/6/24 at 7:27 a.m., there was no PPE located near R3's room for staff to wear while providing care for R3 (who was on EBP).</p> <p>During an observation on 8/6/24 at 7:35 a.m., nursing assistant (NA)-A was standing next to R3's bed wearing gloves and a surgical mask and was putting R3's pants on. NA-A had no gown</p>	21390		

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NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET SAINT LOUIS PARK, MN 55426
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21390	<p>Continued From page 6</p> <p>on. NA-B entered R3's room wearing gloves and a surgical mask and had no gown on. NA-A and NA-B assisted R3 to roll over as NA-A pulled up R3's pants and placed a hoyer lift sheet under R3. NA-A and NA-B proceeded to use a hoyer lift to transfer R3 into her wheelchair. NA-A and NA-B removed gloves and sanitized hands.</p> <p>During an observation on 8/6/24 at 8:44 a.m., NA-A and NA-B while wearing a surgical mask and gloves and had no gown on, entered R3's room, hooked R3 up to a hoyer lift and transferred R3 into bed. NA-A and NA-B rolled R3 over and removed the hoyer sheet. NA-A and NA-B removed gloves and sanitized hands.</p> <p>During a joint interview on 8/6/24 at 8:50 a.m., NA-A and NA-B verified they had not worn a gown while dressing or transferring R3. NA-A and NA-B stated R3 had a foley catheter and the only PPE that was required while providing care to R3 was a surgical mask and gloves. NA-A and NA-B indicated they were unaware that a gown was required while providing cares to R3.</p> <p>R26</p> <p>R26's admission MDS dated 7/23/24, identified R26 was cognitively intact and required moderate assistance with activities of daily living ADL's for dressing and transfer, supervision with toileting, and required use of a wheelchair. Indicated R26 had diagnoses of acute osteomyelitis (infection of bone caused by bacteria, injury or surgery), type two diabetes with foot ulcer, stage three (moderate) chronic kidney disease and generalized muscle weakness. Identified R26 had a peripherally inserted central catheter (PICC) and received intravenous (IV) medication through</p>	21390		

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21390	<p>Continued From page 7</p> <p>the PICC line. Indicated R26 had a wound vacuum-assisted closure (VAC) device that used negative pressure to pull the edges of a wound together and promote healing on R26's left foot on the heel of the foot.</p> <p>R26's admission CAA dated 7/28/24, identified R26 had a left heel ulcer and was on IV antibiotics.</p> <p>R26's care plan dated 7/17/24, identified R26 had a PICC line that was to be flushed before and after IV medication administration and to monitor for signs or symptoms of infection and infiltration. The care plan dated 7/24/24, identified R26 had an alteration in skin integrity related to a wound on R26's left heel. Staff were to provide treatment to open area per order. The care plan lacked documentation on use of EBP for R26.</p> <p>During an observation on 8/6/24 at 12:15 p.m., registered nurse (RN)-A removed gloves from the PPE supply bin hanging over the outside of R26's door and entered R26's room. RN-A placed the IV supplies and IV medication onto R26's bedside table and applied gloves. RN-A proceeded to connect the IV medication to R26's PICC line. RN-A removed the gloves, disposed of the gloves into the garbage can and exited R26's room.</p> <p>During an interview on 8/6/24 at 12:19 p.m., R26 stated staff wore gloves when completing IV cares and a gown and gloves when providing wound cares to the left foot. R26 stated some staff wore a gown and gloves when providing IV PICC line care and or assisting with personal cares however not all staff did so.</p> <p>During an interview on 8/6/24 at 12:22 p.m., RN-A</p>	21390		
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21390	<p>Continued From page 8</p> <p>verified she only wore gloves and had no gown on when completing the IV PICC line cares and administering IV medication for R26. RN-A stated staff only needed to wear a gown when providing wound cares and not for any other cares.</p> <p>ERP</p> <p>R31</p> <p>R31's quarterly Minimum Data Set (MDS) dated 5/16/24 identified R31 had severe cognitive impairment and diagnoses which included heart failure, aphasia (a language disorder caused by damage to parts of the brain that control speech and understanding of language), and anxiety. Identified R31 was independent with activities of daily living (ADL's) which included toileting, transfer and dressing.</p> <p>R31's care plan revised 3/6/24, lacked documentation R31 was to be in ERP.</p> <p>R31's Order Review History Report dated 8/7/24, indicated the following: -staff to follow: ERP every shift active 8/1/24. -Amoxicillin-Pot Clavulanate (antibiotic used to treat bacterial infections) oral tablet 875-125 milligrams (mg) give one tablet by mouth two times a day for Pneumonia for five days starting 8/01/2024 to 8/06/2024.</p> <p>During an observation on 8/6/24 at 11:32 a.m., R31 had a sign on the door that stated R31 was in ERP. R31's door was open and R31 was laying on her bed with her eyes closed and television playing.</p> <p>During an observation on 8/6/24 at 12:08 p.m., R31's door was open and she was sitting on the</p>	21390		
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21390	<p>Continued From page 9</p> <p>edge of her bed finishing eating her lunch. R31's tray had been removed and R31's door remained open.</p> <p>During an interview on 8/6/24 at 9:59 a.m., infection preventionist (IP) verified R3 had a foley catheter and was on EBP. IP stated the facility had just started implementing EBP therefore, there were not enough over the door PPE bins for all resident on EBP. IP stated her expectation was all staff would have worn the appropriate PPE while performing high-contact cares for R3 to prevent the spread of infection.</p> <p>During an interview on 8/6/24 at 10:20 a.m., director of nursing (DON) verified the facility had just started to implement EBP. DON stated they were hoping to have all PPE and supplies by last week however were not able to obtain all the supplies that were ordered. DON indicated her expectation was all staff would have worn the appropriate PPE during high- contact activities for residents on EBP.</p> <p>During a follow-up interview on 8/6/24 at 4:54 p.m., IP confirmed R31 was on ERP due to pneumonia. IP indicated R31's door was to remain closed at all times. IP further indicated she was not aware R31's door was open and stated the facility had a plan for ERP however it had not been fully implemented yet.</p> <p>During a follow-up interview on 8/6/24 at 4:55 p.m., IP verified R26 had a PICC line and was on EBP. IP stated the expectation of staff was to wear a gown and gloves when providing PICC line cares for R26 to prevent the spread of infection. IP stated the facility was still in the process of providing education to staff about EBP and had not fully implemented EBP in the facility</p>	21390		
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21390	<p>Continued From page 10</p> <p>at the time as there were not enough over the door PPE bins for all residents on EBP.</p> <p>During an interview on 8/6/24 at 5:07 p.m., the administrator verified the facility was still in the process of implementing EBP and were not able to obtain all the supplies that were ordered. Administrator stated the expectation was that staff would follow the current CDC guidelines for use of EBP to prevent the spread of infection.</p> <p>Review of a facility policy titled Enhanced Barrier Precautions dated 4/1/24, identified it was the practice of the facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Policy stated the use of gown and gloves was expected during high-contact resident activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices (e.g., central lines, hemodialysis catheters, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident was not known to be infected or colonized with a MDRO.</p> <p>Requested a facility policy on ERP, however one was not received.</p> <p>SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could assure clear directions for staff to follow regarding infection control practices, specific to isolation processes when providing cares to residents to minimize the spread of infection. The Director of nursing or designee could assure staff are trained, randomly monitored, supervised and systems evaluated to assure good infection control practice.</p>	21390		
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21390	Continued From page 11	21390		
21925	<p>MN St. Statute 144.651 Subd. 29 Patients & Residents of HC Fac.Bill of Rights</p> <p>Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure that written notifications required for transfers were given to the resident and/or resident representative for 1 of 5 residents</p>	21925	corrected	9/4/24

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21925	<p>Continued From page 12</p> <p>(R1) reviewed for admission, discharge and transfers.</p> <p>Findings include:</p> <p>R1's quarterly Minimal Data Set (MDS) dated 8/1/24, indicated R1 was cognitively intact and had diagnoses which included seizures, anxiety and depression. Identified R1 was independent for transfers and activities of daily living (ADLs).</p> <p>R1's care plan dated 6/7/24, stated R1 had a history and diagnosis of substance use. Staff were to monitor and check vitals if R1 was under the influence of a substance. Identified R1 would have an appropriate discharge plan. R1 would make a safe and appropriate decision regarding discharge.</p> <p>Review of R1's progress notes from 4/12/24 to 6/7/24, identified the following:</p> <p>-On 6/6/24 at 8:45 a.m., "resident returned to facility this AM around 8 am intoxicated. Resident stated he drank 4 beers from 10 PM to 2 am. Resident was stumbling and had difficulty focusing. Resident became upset when asked about his alcohol use. The smell of alcohol was noted in room. Resident became upset when asked if he would be willing to be seen in the ED stating he would just go home to St Cloud. Resident did have his vehicle parked near facility, denies driving while under influence."</p> <p>-On 6/6/24 at 12:02 p.m., "30 day (notice of intent to discharge) NOD issued to resident today to (to be determined) TBD location as resident no longer requires SNF care. Resident refused to sign NOD. Writer explained the appeal process to resident, who verbalized understanding. Writer offered resident a copy of the NOD paperwork and provided to resident. (Medical Director) MD</p>	21925		
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21925	<p>Continued From page 13</p> <p>updated and NOD mailed to ombudsman office." -On 6/6/24 at 12:07 p.m., "Resident back from (leave of absence) LOA @8 am. Resident appeared intoxicated. Resident has slurred speech, appears flushed, teary eyes and tipsy walking. VS BP 100/53 R22 P 81 O2:92% T 97.5 When asked about his drinking, resident states that he started drinking between 10 PM and 2 am had 4 beers max. Provider notified, requested for resident to be sent in. Provider sent order. Resident notified that he had to go in for detoxify since when he starts having withdrawal symptoms, facility is not equipped to care for him, resident refused and stated that if they call (emergency medical services) EMS he would leave (against medical advice) AMA. Resident upset and angry at writer stating that we need to call his lawyer. MT called, administrator applied for emergency hold since resident was upset and adamantly refusing to go in. MT and police arrived @11:45 am, resident agreed to leave with (emergency medical technician) MT. Resident left building @11:55 am sent to Methodist hospital. Paperwork sent with resident".</p> <p>-On 6/6/24 at 1:16 p.m., resident returned to the facility this morning around 7:30 am. resident visibly intoxicated and belligerent, slurring his words and stumbling when walking and a strong ETOH (scientific abbreviation for ethanol, the chemical compound that is found in alcohol) odor coming from resident. resident declined drinking ETOH, but bottles of alcohol were confiscated from resident this morning and yesterday. EMS called to send resident in for detoxify. Resident refused to go and was stating he was going to get into his car and leave AMA. Police arrived prior to EMS and attempted to get keys from resident, but he refused to allow police to enter his room. resident told writer he would not go to the (emergency room) ER for detoxify and told writer</p>	21925		
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21925	<p>Continued From page 14</p> <p>to "Call my lawyer.' Police officers recommended facility fill out a transport hold on resident. Transport hold filled out and resident was transferred to the ER by EMS. MD updated". -On 6/6/24 at 4:35 p.m., "MD okay with 30 day NOD".</p> <p>Review of R1's doctor's order dated 6/6/24 at 9:14 a.m., "please send patient to ED for alcohol intoxication".</p> <p>Review of R1's discharge notification dated 6/6/24, checkbox selected stated "The residents health has improved sufficiently so the resident no longer needs services provided by the facility". R1's discharge notification revealed R1 refused to sign the form and the administrator signed as the witness.</p> <p>R1's medical record lacked documentation R1 or R1's representative had received a written notification of discharge.</p> <p>During an interview on 8/6/24 at 3:55 p.m., the administrator indicated emergency medical service (EMS) arrived to transfer R1 to detoxify. The administrator further indicated she issued a 30-day involuntary discharge on 6/6/24, however was unaware of the time. The administrator said R1 was very impaired when the 30-day involuntary discharge was discussed and given to R1. The administrator further said, "he might not have understood the discharge and if he would have come back to the facility I would have had to discuss it with him again. I would have probably had to create a new 30-day discharge notice".</p> <p>During a telephone interview on 8/7/24 at 9:26 a.m., R1 indicated the administrator came to his room and informed him he was going to detoxify</p>	21925		
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21925	<p>Continued From page 15</p> <p>and that she placed a hold on him. R1 further indicated three police and EMS were at the facility to take him into the emergency room (ER). R1 stated the administrator never gave him a 30-day written notice before sending him to the ER. R1 indicated the social worker at the hospital was the one who told him he only had 30 days left at the facility. R1 stated he was discharged from the hospital and was going to stay with a friend because he felt the administrator was kicking him out.</p> <p>Review of facility policy titled Discharge Planning Policy dated 11/16, Discharge planning was completed to assure continuity of care to meet the needs of a resident returning to independent living in the community or discharged to another facility or institution when and if possible. Involuntary discharge policies were covered in a separate policy. They were written to include interpretive guidelines under Federal Statute 483.12(a)(1).</p> <p>Review of facility policy titled Transfer or Discharge Notice for Facility-Initiated Discharges updated 7/24, residents and/or representatives were notified in writing, and in a language and format they understand, at least thirty (30) days prior to a transfer or discharge for all facility-initiated discharge.</p> <p>SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review and/or develop policy and procedures that written notification was provided to the resident and their representative before a transfer. The facility could educate staff on these policies and audit periodically to ensure compliance. The results of these audits will be reviewed by the quality assessment committee to</p>	21925		
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21925	Continued From page 16 ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21925		