DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
October 23, 2023

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

RE: CCN: 245182
Cycle Start Date: September 11, 2023

Dear Administrator:

On October 11, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

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Electronically delivered

October 23, 2023

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

Re: Reinspection Results
Event ID: TJ2B12

Dear Administrator:

On October 11, 2023 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 September 11, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

DEPARTMENT OF HEALTH

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Electronically delivered
September 26, 2023

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

RE: CCN: 245182
Cycle Start Date: September 11, 2023

Dear Administrator:

On September 11, 2023, 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 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.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by December 11, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 11, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the

Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

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Electronically delivered
September 26, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: TJ2B11

Dear Administrator:

The above facility was surveyed on September 7, 2023 through September 11, 2023 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.

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:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00278	A. BUILDING: _____ B. WING _____	C 09/11/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 9/7/23 through 9/11/23, 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	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed with no deficiency issued: H51825245C(MN00096601),H51825433C(MN00093365), H51825108C(MN00096509), H51825434C (MN00096535), H51825437C (MN00095416) , H51825439C (MN00093350) The following complaints were reviewed. H51825438C(MN00093692) and H51825436C(MN00095770) with a licensing order issued at (0905, 0915, 0920, 1805). 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 State Statutes/Rules, please	2 000		

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2 000	Continued From page 2 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		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by:	2 900		10/9/23

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2 900	Continued From page 3 Based on observation, interview, document review the facility failed to follow the care plan and physician orders for pressure reducing/relieving interventions to prevent or mitigate the risk of deterioration or new pressure ulcer development for 1 of 3 residents (R4) who had impaired skin integrity and was at high risk for pressure ulcers. Findings include R4's Face Sheet identified R4 had diagnoses that included severe protein-calorie malnutrition, diabetes, unspecified anemia, disorder of the skin and subcutaneous tissue and cutaneous abscess of foot. R4's significant change Minimum Data Set (MDS) dated 8/25/23, identified R4 did not have cognitive impairment. R4 required two person assist for bed mobility, transferring, toileting and dressing. R4 was not on a toileting program and was always incontinent of bowel and bladder. R4 was at risk of developing pressure ulcers and had no unhealed pressure ulcers. R4 required pressure reducing device for chair/bed and required application of non-surgical dressings. R4's physician order for skin care included -Air mattress: check that it is inflated and functioning properly every shift (start date 8/18/23). - Prevalon boots on every shift (start date 8/18/23). -Sacral border foam dressing to are for protection; check area daily. If worsening update nurse manager or call the on call nurse (start date 9/8/23). R4's skin integrity care plan dated 10/11/22	2 900	corrected	

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2 900	Continued From page 4 identified R4 had potential for impairment. The care plan directed staff to apply barrier cream, ensure heals are elevated while in bed. Further directed to educate resident/family the importance of changing positions for prevention of pressure ulcers, encourage small frequent position changes, encourage/assist with turning/repositioning every 2-3 hours, monitor skin when providing care, notify nurse if any sink changes or skin appearance. R4's incontinence care plan dated 10/11/22 indicated R4 had bowel incontinence and will remain free from skin break down due to incontinence and brief use. The care plan directed staff to check R4 every 2-3 hours, assist with toileting as needed, observe for pattern of incontinence and initiate toileting schedule if indicated. Provide peri care after each incontinent episode. R4's care guide (abbreviated care plan) did not include R4's reposition schedule, toileting plan, or the physician order for Prevalon boots. R4's Braden scale for predicting pressure sore risk dated 8/18/23, identified R4 was at high risk for pressure ulcer development. R4's physician visit dated 8/22/23, did not indicate R4 had impaired skin integrity to his buttocks. R4's turning and repositioning documentation that directed "Every 2-3 Hour Repositioning" was reviewed between 8/14/23- 9/11/23. The documentation entries were variable from one to three times a day and entries were not completed every 2-3 hours. Based on the documentation it could not consistently be determined if R4 was offered and/or provided with turning and repositioning.	2 900		

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2 900	Continued From page 5 During observation on 9/7/23 at 12:50 p.m., nursing assistant (NA)-A and NA-C transferred R4 from his wheelchair into his bed via a full mechanical lift. NA's positioned R4 on his back and did not put on R4's Prevalon boots that were on the chair next to the bed in accordance with physician orders. During observation and interview on 9/8/23 at 9:32 a.m., R4 laid in bed on his back without the Prevalon boots on. R4's room had a odor that was consistent with urine. R4 stated he was not sure when the last time his incontinent brief was changed. R4 stated he sometimes had to wait hours for brief changes and there had been days when he was left in bed all day. R4 was unsure if staff encouraged him to be on his side and was not aware of when he had last been repositioned. During observation on 9/8/23 at 10:10 a.m., R4 was laying in bed on his back without the Prevalon boots on. NA-A removed R4's incontinent brief which was saturated with urine and stool. R4's bottom was reddened. NA-A asked R4 if any pain was present and R4 indicated barrier cream would be helpful, NA-A applied cream. NA-A offered R4 a pillow for under his legs, however did not place Prevalon boots. R1 was not offered or provided alternative positioning, he remained on his back when NA-A left the room. During interview on 9/8/23 at 10:28 a.m., NA-A stated that was the first time she had provided incontinence cares to R4 since the start of her shift at 6:00 a.m. NA-A indicated the last time R4 was changed was on the previous shift, however was not aware of the time. During observation on 9/8/23 at 3:37p.m., R4 laid	2 900		

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2 900	Continued From page 6 flat on his back in bed with air-mattress. R4 did not have Prevalon boots on. NA-A provided R4 with incontinence cares, R4's bottom continued to have redness. R4 reported to NA-A his mattress was hard in the center and causing discomfort. NA-A explained to R4 she was unable to fix the bed and would have maintenance address the issue. NA-A did not check the level of air in the mattress and/or function, did not offer to turn/reposition for comfort, and did not put R4's Prevalon boots on which were on the chair next to his bed. At 4:37 p.m. licensed practical nurse (LPN)-E entered room and provided R4 with pain medications and informed R4 of the plan to complete a skin check of buttocks. R4's progress note dated 9/8/23 at 10:23 p.m., indicated there was redness to R4's sacrum, barrier cream and protective dressing applied to area. R4 turned and repositioned. Plan to continue to monitor. During interview on 9/8/23 at 1:11 a.m. associate administrator indicated the check and change process is dependent on the individualized plan of care, typically it is two hours depending on bowel and bladder needs. NAs were aware of how frequently check and changes should happen based off care guides. NAs were supposed to communicate verbally on when residents were last changed. During continuous observation on 9/11/23 from 7:28 a.m. to 9:30 a.m. R4 laid flat on his back, Prevalon boots were not on. During observation on 9/11/23 at 12:10 a.m., Director of Nursing (DON) and Regional Nurse Consultant (RGN)-A completed skin assessment for R4's reddened buttocks. RGN-A reported the	2 900		

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2 900	Continued From page 7 area to be red, not macerated, not open and not stageable. RGN-A donned Prevalon boots, educated R4 on importance of being on side and provided off loading. During interview on 9/11/23 at 1:11 p.m., Nurse Practitioner (NP)-A indicated to not see him since this admission due to scheduling barriers. NP-A indicated to fully expect turning and repositioning to be happening every two hours for it to be offered and charted to identify potential complications as well as refusals to be documented. NP-A indicated she was not aware of any redness on bottom on Friday 9/8/23, however may not remember if the area was not open. During interview on 9/11/23 at 11:56 a.m., Director of Nursing (DON) and Regional Nurse Consultant (RGN)-A reported the expectation for Prevalon boots to be on every shift when in bed and to be offloaded onto side every two hours. Policy titled skin assessment and wound management; 1) A pressure ulcer risk assessment (Braden Scale) will be completed per Monarch's Assessment Schedule/Grid. 2) Implement appropriate preventative skin measures. 3) Tissue Tolerance Evaluation is completed on admission, annually, and upon significant change. 4) Staff will perform routine skin inspections (with daily care). 5) Nurses are to be notified if skin changes are identified. 6) A weekly skin inspection will be completed by licensed staff. When a significant alteration in skin integrity is	2 900		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 8 noted; (i.e. large or multiple bruising, large skin tear, or other non-pressure related wounds such as diabetic, venous, or arterial ulcers), the following actions will be taken: 1. Notify MD/Treatment Ordered 2. Notify resident representative 3. Complete education with resident/resident representative including risks & benefits 4. Initiate Weekly Wound Evaluation 5. Notify Nurse Manager/Wound Nurse 6. Referral to dietary, if appropriate 7. Referral to therapies, if appropriate 8. Update Care Plan 9. Update resident care lists 10.Update Care Plan to identify risks for skin breakdown SUGGESTED METHOD OF CORRECTION: The Administrator or designee, should review all residents at risk for skin impairment to assure they are receiving the necessary treatment/services to treat and prevent skin breakdown. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented. The Administrator or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the	2 915		10/9/23

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	00278	A. BUILDING: _____ B. WING _____	C 09/11/2023

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2 915	Continued From page 9 comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure activities of daily living (ADLs) were provided, for 3 of 5 residents (R2, R1, R4) reviewed, who required staff assistance for shaving, oral care, and personal hygiene. Findings include R2 Face Sheet identified R2 had diagnoses that included multiple sclerosis, abnormalities of gait and mobility, anxiety, and adult failure to thrive. R2's quarterly Minimum Data Set (MDS) dated 8/24/23, identified R2 did not have cognitive impairment and did not identify rejection/refusal of care behaviors. R2 required two person assist for transferring and one person assist for dressing,	2 915	corrected	

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2 915	Continued From page 10 toileting and personal hygiene. R2 was always incontinent of bowel and bladder. R2's care plan dated 4/25/23 identified R2's alteration in mobility. Staff were to complete bed mobility, dressing and toileting with extensive assist of 1-2 staff members, eating with set up assist, and assist of one to two staff members dependent on R2's fatigue level. During interview on 9/8/23 at 9:18 a.m., R2 stated when staff complete personal cares she did not feel like they were treating her like a human. R2 indicated staff did not offer nor provide bed baths and personal cares were not thorough. During observation on 9/8/23 at 7:59 a.m. R2 laid in bed with a gown on that had a brown spot on the right breast pocket. Nursing assistant (NA)-A and licensed practical nurse (LPN)-A removed R2's brief that was heavily saturated with urine and stool. LPN-A completed R2's peri cares using only wipes and no wash clothes, a new incontinent brief was then put on R2. R2 was handed a wet wash cloth; no basin or soap was provided. R2's back was not washed and oral care was not provided or offered. R2 remained in the same gown and was not offered to get dressed nor offered to get out of bed. During observation on 9/11/23 at 8:18 a.m., R2 laid in bed with a gown on that had a large brown spot on the right breast pocket. NA-A and NA-B provided and completed R2's personal cares. NAs informed R2 there were no clean gowns. NAs did not offer R2 alternative clothing options. NA-B asked R2 if she was comfortable, however did not offer to offload, turn, reposition or get R2 out of bed. Further R2 was not offered or provided sponge bath or hair care.	2 915		

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2 915	Continued From page 11 During interview on 9/11/23 at 8:31 a.m., R2 explained she had not been washed up since Friday (9/8/23) and had remained in the same soiled gown all weekend. Staff had not offered nor attempted to change it, "it was gross". Further stated she was not provided with opportunity to complete oral care, was not offered to get out of bed, offered or provided a sponge bath, and had to instruct staff to provide incontinence care. R2 stated it was important to her that she was washed up daily. R1's face sheet identified R1's had diagnoses of that included Parkinson's disease. R1's annual Minimum Data Set (MDS) dated 8/31/23, indicated R1 had moderately impaired cognition. R1's care plan dated 12/10/23 identified R1 required extensive to total dependent with facial hair and toilet hygiene. R1 preferred to be clean shaven. R1's mood and behavior monitoring documentation reviewed from 8/13/23 to 9/7/23, indicated R1 did not have behaviors of rejection or refusal of cares. During observation and interview on 9/7/23 at 1:22 p.m., R1 was sitting in his room. R1's hair was not groomed and he was not clean shaven. Additionally he wore a gown with spots of staining. The odor in R1's room was consistent with stale urine. R1 indicated sometimes the care was not good. He was okay wearing a gown, however sometimes he would get cold without pants on. R1 stated his preference to be clean shaven.	2 915		

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2 915	Continued From page 12 During interview on 9/8/23 at 11:34 a.m., LPN-C indicated some residents have limited clothes and there was a delay in getting gowns from laundry. LPN-C indicated there were limited resources, time and staffing to get residents up out of bed and toileted. LPN-C indicated shaving would not be a top priority with limited staff. During interview on 9/8/23 at 12:30 p.m., LPN-A indicated there were not enough staff to get residents up dressed, toileted, oral cares or shaved for the day. There were times when residents were not able to get out of bed for the day. R4's Face Sheet identified R4 had diagnoses that included severe protein-calorie malnutrition, disorder of the skin and subcutaneous tissue, unspecified open wound of left knee. R4's significant change Minimum Data Set (MDS) dated 8/25/23, identified R4 did not have cognitive impairment, required two person assist for bed mobility, transferring, toileting and dressing. R4 was not on a toileting program and was always incontinent of bowel and bladder. R4's care plan dated 2/16/23 identified R4 to be a vulnerable adult and was at risk for decreased cognitive and physical ability related to diagnosis. Staff were to explain what they were doing before providing care, staff to be educated as needed to ensure they are providing cares in a gentle, unrushed, and thorough manner. R4's care plan dated 10/11/22 identified R4 had oral/dental health problems and staff were to provide oral cares. R4's orders dated 8/18/23 instructed staff to	2 915		

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2 915	Continued From page 13 assist with oral hygiene two times a day . R4's progress note dated 8/22/23 identified R4 had left lower dental infection and was on antibiotics. During interview on 9/7/23 at 1:03 p.m.,R4 stated staff do not communicate with him, however just completed the task. R4 declined having oral care completed or offered to shave. During observation on 9/8/23 at 10:10 a.m., NA-A completed peri cares and offered a gown change. NA-A informed R4 he would have a sponge bath later but did not offer one at the time of observation. NA-A did not offer or provide oral care, shaving, or hair care. Policy titled Activities of Daily Living (ADL's)/ Maintain Abilities dated 3/31/23 indicates It is the policy of the facility to specify the responsibility to create and sustain an environment humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and the care and services provided are person-centered, and honor and support each resident's preferences, choices, values and beliefs. 1. Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility will provide the necessary care and services to ensure a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate such diminution was unavoidable. 2. The facility will ensure a resident is given the appropriate treatment and services to maintain or	2 915		

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2 915	Continued From page 14 improve his or her ability to carry out the activities of daily living. 3. The facility will provide care and services for the following activities of daily living: a. Hygiene -bathing, dressing, grooming, and oral care, b. Mobility-transfer and ambulation, including walking, c. Elimination-toileting, d. Dining-eating, including meals and snacks, e. Communication, including: i. Speech, ii. Language, and iii. Other functional communication systems. 4. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; and basic life support, including CPR, when the resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. SUGGESTED METHODS OF CORRECTION: The Administrator or designee could develop, review, and /or revise policies and procedures to ensure all residents have their ADL's completed appropriately. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with	21805		10/9/23

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21805	Continued From page 15 courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure residents were provided care in a dignified and respectful manner for 2 of 4 residents (R2, R4) who were observed during care interactions. Findings include R2's Face Sheet identified R2 had diagnoses that included multiple sclerosis, abnormalities of gait and mobility, anxiety, and adult failure to thrive. R2's quarterly Minimum data Set (MDS) dated 8/24/23, identified R2 was cognitive, required two person assist for transferring and one person assist for dressing, toileting and personal hygiene. R2 was always incontinent of bowel and bladder. R2's care plan dated 4/25/23 identified R2's alteration in comfort and resident is to receive adequate relief from pain as evidence by verbalization and freedom from signs/symptoms of non verbal indicators. Staff to provide non medicinal forms of pain relief such as positioning, rest and massage, and to encourage resident to verbalize discomfort. During interview on 9/7/23 at 11:20 a.m., R2 stated she felt alone, neglected, and was frustrated about the care she was receiving. Throughout the interview R2 covered her face, was crying, and her hands were trembling. R2	21805	corrected	

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21805	Continued From page 16 explained she would turn on her call light and staff would turn the light off without helping her with what she needed. She felt staff did not listen to her when making requests and felt disrespected by the staff's actions and attitude towards her. R2 also felt as though her cares were rushed. During observation on 9/8/23 at 7:59 a.m., R2 was noted to be crying out in pain with nursing assistant (NA)-A in the room. R2 was moaning and crying, she put her hands over her face and cried out, "owe, oh God make it stop" "please please please make it stop" NA-A watched R2 and asked "what you want?, to take your pain pills before I change you or what?" NA-A did not offer any comfort interventions for pain or ask what hurt. Licensed practical nurse (LPN)-A entered room without knocking offering medication to help with pain relief. NA-A stated "you want me to come back or I can change you now". R2 stated yes to changing. NA-A lowered the head of bed, lifted the blankets and R2's gown with the door to her room open. LPN-A shut the door just before NA-A opened her brief exposing peri area. NA-A provided personal cares without explaining or allowing R2 to participate in her care. Without asking R2, NA-A lifted her neck up to place a neck pillow, but R2 stated "no, no I don't want that!" During interview on 9/8/23 at 9:18 a.m., R2 reported some of the staff only would provide medication for pain instead of listening to her pain concerns or trying things such as readjusting. R2 stated she preferred to use pull-ups incontinent briefs because she felt more dignified, however, staff switched to briefs without talking or explaining the reason for the change. R2 stated when staff complete personal cares it's as though	21805		

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21805	Continued From page 17 staff are not treating her like a human with dignity and respect. During interview on 9/8/23 at 8:52 a.m., NA-A indicated R2 was crying out due to pain and staff were supposed to wait because R2 would become increasingly agitated if you kept going. NA-A indicated to not be aware of anything else to do for pain other then pain medication. NA-A indicated positioning would not do anything for R2's comfort, however NA-A stated asking the resident would be the best thing to do. During interview on 9/8/23 at 8:39 a.m., LPN-A stated R2 had pain with repositioning in the morning, but communicating and talking R2 through tasks was helpful. During observation on 9/11/23 at 8:18 a.m., NA-A and NA-B completed cares and notified R2 there were no clean gowns. When the NA's were putting the same soiled gown back on R2, her left breast was completely exposed with the door open, making her breast visible to anyone who may have been walking by at the time. NA-A and NA-B did not offer alternative clothing options to replace the soiled gown. During interview on 9/11/23 at 8:31 a.m., R2 indicated it bothered her the door was open during cares, any male could have walked past and seen her breast exposed. R2 stated the facility was supposed to be her home, she was supposed to feel comfortable. R2 reported to be in the same gown since Friday (with large brown spot on right breast pocket). R2 explained not being able to have the opportunity to change the gown was gross. R4 Face Sheet identified R4 had diagnoses that	21805		

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21805	Continued From page 18 included, severe protein-calorie malnutrition, disorder of the skin and subcutaneous tissue, and unspecified open wound of left knee. R4's significant change Minimum Data Set (MDS) dated 8/25/23, identified R4 did not have cognitive impairment, required two person assist for bed mobility, transferring, toileting and dressing. R4 was always incontinent of bowel and bladder. R4's care plan dated 2/16/23 identified R4 to be a vulnerable adult and was at risk for decreased cognitive and physical ability related to diagnosis and staff were to monitor for signs of emotional distress or mood and behavior changes, staff are to explain what they are doing before providing care, staff to be educated as needed to ensure they are providing cares in a gentle, unrushed, and thorough manner. During observation on 9/7/23 at 12:50 p.m., NA-A and NA-C transferred R4 from wheelchair to bed using a full body mechanical lift. During the transfer the lift sling got stuck on the wheelchair, without explaining to R4, NA-A quickly pulled the sling back which jolted R4's head. R4 stated "ouch that hurt". The NA's talked to each other without involving R4 in the conversation. When R4 asked "what are you saying", neither NA responded to R4's question. Instead NA-C asked NA-A "does he need to be changed?". NA's provided peri care without explaining or offering R4 to be involved in his care. NA-A turned R4 by grasping his shoulders and turned him without communicating the activity. While NA-A provided R4 personal cares, NA-C watched R4's TV. When NA-A lowered the bed, the bed had noticeable quick drop, R4 responded by stating "Geeze!" Neither NA acknowledged R4's remark.	21805		

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21805	Continued From page 19 R4's call light was not provided and left out of his reach when the NAs left his room. During interview on 9/8/23 at 9:32 a.m., R4 indicated the transfer hurt, but not more than usual. R4 stated the staff did not talk to him, but talked to each other during cares which made him feel degraded. At times the staff would laugh with each other and it was bothersome to R4 because he didn't know if they were laughing at him. R4 indicated staff would talk in foreign languages he could not understand or mumble with masks on. R4 did not understand what was expected of him during cares, which caused frustration. R4 explained it was normal for the call light to be out of his reach, he has notified staff, however did not feel he was listened to. Policy titled resident rights guidelines for all nursing procedures dated October 2010, indicates staff are to knock and gain permission before entering the resident's room, verify the identity of the resident, introduce yourself to the resident if he/she is unfamiliar with you, or if he/she may not recognize you due to memory loss. Close the room entrance door and provide resident privacy, explain the procedure to the resident and answer any questions he/she may have. Ask permission to implement the procedure, if the resident refuses, notify your supervisor. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review/revise policies and procedures on resident dignity. The administrator or designee could educate all staff on these policies and procedures. The administrator or designee could audit to ensure all residents are being treated with dignity, and	21805		

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21805	Continued From page 20 report these findings to their QAPI committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21805		

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F 000	INITIAL COMMENTS On 9/7/23 through 9/11/23, 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. The following complaints were reviewed. H51825245C(MN00096601),H51825433C(MN00093365), H51825108C(MN00096509), H51825434C (MN00096535), H51825437C (MN00095416) , H51825439C (MN00093350) The following complaints were reviewed. H51825438C(MN00093692) and H51825436C(MN00095770) with a deficiency issued at (F550,F676,F677,F686) 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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and	F 550		10/9/23

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

Electronically Signed | 10/03/2023

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

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	245182	A. BUILDING _____ B. WING _____	C 09/11/2023

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

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F 550	Continued From page 1 outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure residents were	F 550	R2 and R4 will be treated with dignity and respect while residing at the facility. R2	

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F 550	Continued From page 2 provided care in a dignified and respectful manner for 2 of 4 residents (R2, R4) who were observed during care interactions. Findings include R2's Face Sheet identified R2 had diagnoses that included multiple sclerosis, abnormalities of gait and mobility, anxiety, and adult failure to thrive. R2's quarterly Minimum data Set (MDS) dated 8/24/23, identified R2 was cognitive, required two person assist for transferring and one person assist for dressing, toileting and personal hygiene. R2 was always incontinent of bowel and bladder. R2's care plan dated 4/25/23 identified R2's alteration in comfort and resident is to receive adequate relief from pain as evidence by verbalization and freedom from signs/symptoms of non verbal indicators. Staff to provide non medicinal forms of pain relief such as positioning, rest and massage, and to encourage resident to verbalize discomfort. During interview on 9/7/23 at 11:20 a.m., R2 stated she felt alone, neglected, and was frustrated about the care she was receiving. Throughout the interview R2 covered her face, was crying, and her hands were trembling. R2 explained she would turn on her call light and staff would turn the light off without helping her with what she needed. She felt staff did not listen to her when making requests and felt disrespected by the staff's actions and attitude towards her. R2 also felt as though her cares were rushed.	F 550	and R4 will have care explained to them before care is provided and will be allowed to participate in their care, CPs updated on 9/29/2023 All resident residing at the facility will be treated with dignity and respect All staff were educated on resident rights on 9/28/2023 The DON/Admin/designee will be responsible for auditing staff interactions for residents ensure resident rights are being followed and resident will be asked if they are being treated with dignity and respect 5x/week for 2 weeks, then 3x/week for 1 week, then 2X/week. Audits will be reviewed through the monthly QAPI process for monitoring of trends, patterns, and recommendations for continuation.	

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F 550	Continued From page 3 During observation on 9/8/23 at 7:59 a.m., R2 was noted to be crying out in pain with nursing assistant (NA)-A in the room. R2 was moaning and crying, she put her hands over her face and cried out, "owe, oh God make it stop" "please please please make it stop" NA-A watched R2 and asked "what you want?, to take your pain pills before I change you or what?" NA-A did not offer any comfort interventions for pain or ask what hurt. Licensed practical nurse (LPN)-A entered room without knocking offering medication to help with pain relief. NA-A stated "you want me to come back or I can change you now". R2 stated yes to changing. NA-A lowered the head of bed, lifted the blankets and R2's gown with the door to her room open. LPN-A shut the door just before NA-A opened her brief exposing peri area. NA-A provided personal cares without explaining or allowing R2 to participate in her care. Without asking R2, NA-A lifted her neck up to place a neck pillow, but R2 stated "no, no I don't want that!" During interview on 9/8/23 at 9:18 a.m., R2 reported some of the staff only would provide medication for pain instead of listening to her pain concerns or trying things such as readjusting. R2 stated she preferred to use pull-ups incontinent briefs because she felt more dignified, however, staff switched to briefs without talking or explaining the reason for the change. R2 stated when staff complete personal cares it's as though staff are not treating her like a human with dignity and respect. During interview on 9/8/23 at 8:52 a.m., NA-A indicated R2 was crying out due to pain and staff were supposed to wait because R2 would become increasingly agitated if you kept going.	F 550		

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F 550	Continued From page 4 NA-A indicated to not be aware of anything else to do for pain other then pain medication. NA-A indicated positioning would not do anything for R2's comfort, however NA-A stated asking the resident would be the best thing to do. During interview on 9/8/23 at 8:39 a.m., LPN-A stated R2 had pain with repositioning in the morning, but communicating and talking R2 through tasks was helpful. During observation on 9/11/23 at 8:18 a.m., NA-A and NA-B completed cares and notified R2 there were no clean gowns. When the NA's were putting the same soiled gown back on R2, her left breast was completely exposed with the door open, making her breast visible to anyone who may have been walking by at the time. NA-A and NA-B did not offer alternative clothing options to replace the soiled gown. During interview on 9/11/23 at 8:31 a.m., R2 indicated it bothered her the door was open during cares, any male could have walked past and seen her breast exposed. R2 stated the facility was supposed to be her home, she was supposed to feel comfortable. R2 reported to be in the same gown since Friday (with large brown spot on right breast pocket). R2 explained not being able to have the opportunity to change the gown was gross. R4 Face Sheet identified R4 had diagnoses that included, severe protein-calorie malnutrition, disorder of the skin and subcutaneous tissue, and unspecified open wound of left knee. R4's significant change Minimum Data Set (MDS) dated 8/25/23, identified R4 did not have	F 550		

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F 550	Continued From page 5 cognitive impairment, required two person assist for bed mobility, transferring, toileting and dressing. R4 was always incontinent of bowel and bladder. R4's care plan dated 2/16/23 identified R4 to be a vulnerable adult and was at risk for decreased cognitive and physical ability related to diagnosis and staff were to monitor for signs of emotional distress or mood and behavior changes, staff are to explain what they are doing before providing care, staff to be educated as needed to ensure they are providing cares in a gentle, unrushed, and thorough manner. During observation on 9/7/23 at 12:50 p.m., NA-A and NA-C transferred R4 from wheelchair to bed using a full body mechanical lift. During the transfer the lift sling got stuck on the wheelchair, without explaining to R4, NA-A quickly pulled the sling back which jolted R4's head. R4 stated "ouch that hurt". The NA's talked to each other without involving R4 in the conversation. When R4 asked "what are you saying", neither NA responded to R4's question. Instead NA-C asked NA-A "does he need to be changed?". NA's provided peri care without explaining or offering R4 to be involved in his care. NA-A turned R4 by grasping his shoulders and turned him without communicating the activity. While NA-A provided R4 personal cares, NA-C watched R4's TV. When NA-A lowered the bed, the bed had noticeable quick drop, R4 responded by stating "Geeze!" Neither NA acknowledged R4's remark. R4's call light was not provided and left out of his reach when the NAs left his room. During interview on 9/8/23 at 9:32 a.m., R4 indicated the transfer hurt, but not more than	F 550		

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F 550	Continued From page 6 usual. R4 stated the staff did not talk to him, but talked to each other during cares which made him feel degraded. At times the staff would laugh with each other and it was bothersome to R4 because he didn't know if they were laughing at him. R4 indicated staff would talk in foreign languages he could not understand or mumble with masks on. R4 did not understand what was expected of him during cares, which caused frustration. R4 explained it was normal for the call light to be out of his reach, he has notified staff, however did not feel he was listened to. Policy titled resident rights guidelines for all nursing procedures dated October 2010, indicates staff are to knock and gain permission before entering the resident's room, verify the identity of the resident, introduce yourself to the resident if he/she is unfamiliar with you, or if he/she may not recognize you due to memory loss. Close the room entrance door and provide resident privacy, explain the procedure to the resident and answer any questions he/she may have. Ask permission to implement the procedure, if the resident refuses, notify your supervisor.	F 550		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:	F 676		10/9/23

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F 676	Continued From page 7 §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure activities of daily living (ADLs) were provided, for 3 of 5 residents (R2, R1, R4) reviewed, who required staff assistance for shaving, oral care, and personal hygiene. Findings include R2 Face Sheet identified R2 had diagnoses that	F 676	R1, R2, and R4 will be provided ADL care daily that includes offering oral care, combing hair and dressed in clean clothes. R1, R2, and R4 were all asked what their preference is for a bath date on 10/1/2023. R1 will be offered shaving on their scheduled shower days. R1 was offered a shave on 9/30/23 and 10/1/2023. R1, R2, and R4's care plans were updated on 10/2/2023	

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F 676	Continued From page 8 included multiple sclerosis, abnormalities of gait and mobility, anxiety, and adult failure to thrive. R2's quarterly Minimum Data Set (MDS) dated 8/24/23, identified R2 did not have cognitive impairment and did not identify rejection/refusal of care behaviors. R2 required two person assist for transferring and one person assist for dressing, toileting and personal hygiene. R2 was always incontinent of bowel and bladder. R2's care plan dated 4/25/23 identified R2's alteration in mobility. Staff were to complete bed mobility, dressing and toileting with extensive assist of 1-2 staff members, eating with set up assist, and assist of one to two staff members dependent on R2's fatigue level. During interview on 9/8/23 at 9:18 a.m., R2 stated when staff complete personal cares she did not feel like they were treating her like a human. R2 indicated staff did not offer nor provide bed baths and personal cares were not thorough. During observation on 9/8/23 at 7:59 a.m. R2 laid in bed with a gown on that had a brown spot on the right breast pocket. Nursing assistant (NA)-A and licensed practical nurse (LPN)-A removed R2's brief that was heavily saturated with urine and stool. LPN-A completed R2's peri cares using only wipes and no wash clothes, a new incontinent brief was then put on R2. R2 was handed a wet wash cloth; no basin or soap was provided. R2's back was not washed and oral care was not provided or offered. R2 remained in the same gown and was not offered to get dressed nor offered to get out of bed. During observation on 9/11/23 at 8:18 a.m., R2	F 676	All residents will receive ADL care daily. All resident care plans reviewed on 10/3/2023 for accuracy. Nursing staff were educated on 9/28/2023 on the importance of offering ADL care daily to residents, that includes oral care, combing resident hair, offer shaving on bath days and dressing residents in clean clothes. The DON/Admin/designee will be responsible for auditing ADL care for residents 5x/week for 2 weeks, then 3x/week for 1 week, then 2X/week. Audits will be reviewed through the monthly QAPI process for monitoring of trends, patterns, and recommendations for continuation.	

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F 676	Continued From page 9 laid in bed with a gown on that had a large brown spot on the right breast pocket. NA-A and NA-B provided and completed R2's personal cares. NAs informed R2 there were no clean gowns. NAs did not offer R2 alternative clothing options. NA-B asked R2 if she was comfortable, however did not offer to offload, turn, reposition or get R2 out of bed. Further R2 was not offered or provided sponge bath or hair care. During interview on 9/11/23 at 8:31 a.m., R2 explained she had not been washed up since Friday (9/8/23) and had remained in the same soiled gown all weekend. Staff had not offered nor attempted to change it, "it was gross". Further stated she was not provided with opportunity to complete oral care, was not offered to get out of bed, offered or provided a sponge bath, and had to instruct staff to provide incontinence care. R2 stated it was important to her that she was washed up daily. R1's face sheet identified R1's had diagnoses of that included Parkinson's disease. R1's annual Minimum Data Set (MDS) dated 8/31/23, indicated R1 had moderately impaired cognition. R1's care plan dated 12/10/23 identified R1 required extensive to total dependent with facial hair and toilet hygiene. R1 preferred to be clean shaven. R1's mood and behavior monitoring documentation reviewed from 8/13/23 to 9/7/23, indicated R1 did not have behaviors of rejection or refusal of cares.	F 676		

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F 676	Continued From page 10 During observation and interview on 9/7/23 at 1:22 p.m., R1 was sitting in his room. R1's hair was not groomed and he was not clean shaven. Additionally he wore a gown with spots of staining. The odor in R1's room was consistent with stale urine. R1 indicated sometimes the care was not good. He was okay wearing a gown, however sometimes he would get cold without pants on. R1 stated his preference to be clean shaven. During interview on 9/8/23 at 11:34 a.m., LPN-C indicated some residents have limited clothes and there was a delay in getting gowns from laundry. LPN-C indicated there were limited resources, time and staffing to get residents up out of bed and toileted. LPN-C indicated shaving would not be a top priority with limited staff. During interview on 9/8/23 at 12:30 p.m., LPN-A indicated there were not enough staff to get residents up dressed, toileted, oral cares or shaved for the day. There were times when residents were not able to get out of bed for the day. R4's Face Sheet identified R4 had diagnoses that included severe protein-calorie malnutrition, disorder of the skin and subcutaneous tissue, unspecified open wound of left knee. R4's significant change Minimum Data Set (MDS) dated 8/25/23, identified R4 did not have cognitive impairment, required two person assist for bed mobility, transferring, toileting and dressing. R4 was not on a toileting program and was always incontinent of bowel and bladder. R4's care plan dated 2/16/23 identified R4 to be a	F 676		

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F 676	Continued From page 11 vulnerable adult and was at risk for decreased cognitive and physical ability related to diagnosis. Staff were to explain what they were doing before providing care, staff to be educated as needed to ensure they are providing cares in a gentle, unrushed, and thorough manner. R4's care plan dated 10/11/22 identified R4 had oral/dental health problems and staff were to provide oral cares. R4's orders dated 8/18/23 instructed staff to assist with oral hygiene two times a day . R4's progress note dated 8/22/23 identified R4 had left lower dental infection and was on antibiotics. During interview on 9/7/23 at 1:03 p.m.,R4 stated staff do not communicate with him, however just completed the task. R4 declined having oral care completed or offered to shave. During observation on 9/8/23 at 10:10 a.m., NA-A completed peri cares and offered a gown change. NA-A informed R4 he would have a sponge bath later but did not offer one at the time of observation. NA-A did not offer or provide oral care, shaving, or hair care. Policy titled Activities of Daily Living (ADL's)/ Maintain Abilities dated 3/31/23 indicates It is the policy of the facility to specify the responsibility to create and sustain an environment humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and the care and services provided are person-centered, and honor and	F 676		

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F 676	Continued From page 12 support each resident's preferences, choices, values and beliefs. 1. Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility will provide the necessary care and services to ensure a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate such diminution was unavoidable. 2. The facility will ensure a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living. 3. The facility will provide care and services for the following activities of daily living: a. Hygiene -bathing, dressing, grooming, and oral care, b. Mobility-transfer and ambulation, including walking, c. Elimination-toileting, d. Dining-eating, including meals and snacks, e. Communication, including: i. Speech, ii. Language, and iii. Other functional communication systems. 4. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; and basic life support, including CPR, when the resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.	F 676		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-	F 686		10/9/23

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F 686	Continued From page 13 (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, document review the facility failed to follow the care plan and physician orders for pressure reducing/relieving interventions to prevent or mitigate the risk of deterioration or new pressure ulcer development for 1 of 3 residents (R4) who had impaired skin integrity and was at high risk for pressure ulcers. Findings include R4's Face Sheet identified R4 had diagnoses that included severe protein-calorie malnutrition, diabetes, unspecified anemia, disorder of the skin and subcutaneous tissue and cutaneous abscess of foot. R4's significant change Minimum Data Set (MDS) dated 8/25/23, identified R4 did not have cognitive impairment. R4 required two person assist for bed mobility, transferring, toileting and dressing. R4 was not on a toileting program and was always incontinent of bowel and bladder. R4 was at risk of developing pressure ulcers and had no unhealed pressure ulcers. R4 required pressure reducing device for chair/bed and required application of non-surgical dressings.	F 686	R4 skin interventions will be followed per MD order. R4 care plan was reviewed and updated on 9/21/2023 All residents who have impaired skin integrity and is at high risk for pressure ulcers were reviewed on 9/21/2023 to ensure interventions are in place and care plans were reviewed for accuracy. Nursing staff were educated on skin and skin prevention interventions on 9/14/2023. The DON/Admin/designee will be responsible for auditing skin interventions for residents 5x/week for 2 weeks, then 3x/week for 1 week, then 2X/week. Audits will be reviewed through the monthly QAPI process for monitoring of trends, patterns, and recommendations for continuation.	

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F 686	Continued From page 14 R4's physician order for skin care included -Air mattress: check that it is inflated and functioning properly every shift (start date 8/18/23). - Prevalon boots on every shift (start date 8/18/23). -Sacral border foam dressing to are for protection; check area daily. If worsening update nurse manager or call the on call nurse (start date 9/8/23). R4's skin integrity care plan dated 10/11/22 identified R4 had potential for impairment. The care plan directed staff to apply barrier cream, ensure heals are elevated while in bed. Further directed to educate resident/family the importance of changing positions for prevention of pressure ulcers, encourage small frequent position changes, encourage/assist with turning/repositioning every 2-3 hours, monitor skin when providing care, notify nurse if any sink changes or skin appearance. R4's incontinence care plan dated 10/11/22 indicated R4 had bowel incontinence and will remain free from skin break down due to incontinence and brief use. The care plan directed staff to check R4 every 2-3 hours, assist with toileting as needed, observe for pattern of incontinence and initiate toileting schedule if indicated. Provide peri care after each incontinent episode. R4's care guide (abbreviated care plan) did not include R4's reposition schedule, toileting plan, or the physician order for Prevalon boots. R4's Braden scale for predicting pressure sore risk dated 8/18/23, identified R4 was at high risk for pressure ulcer development.	F 686		

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F 686	Continued From page 15 R4's physician visit dated 8/22/23, did not indicate R4 had impaired skin integrity to his buttocks. R4's turning and repositioning documentation that directed "Every 2-3 Hour Repositioning" was reviewed between 8/14/23- 9/11/23. The documentation entries were variable from one to three times a day and entries were not completed every 2-3 hours. Based on the documentation it could not consistently be determined if R4 was offered and/or provided with turning and repositioning. During observation on 9/7/23 at 12:50 p.m., nursing assistant (NA)-A and NA-C transferred R4 from his wheelchair into his bed via a full mechanical lift. NA's positioned R4 on his back and did not put on R4's Prevalon boots that were on the chair next to the bed in accordance with physician orders. During observation and interview on 9/8/23 at 9:32 a.m., R4 laid in bed on his back without the Prevalon boots on. R4's room had a odor that was consistent with urine. R4 stated he was not sure when the last time his incontinent brief was changed. R4 stated he sometimes had to wait hours for brief changes and there had been days when he was left in bed all day. R4 was unsure if staff encouraged him to be on his side and was not aware of when he had last been repositioned. During observation on 9/8/23 at 10:10 a.m., R4 was laying in bed on his back without the Prevalon boots on. NA-A removed R4's incontinent brief which was saturated with urine and stool. R4's bottom was reddened. NA-A asked R4 if any pain was present and R4	F 686		

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F 686	Continued From page 16	F 686		

indicated barrier cream would be helpful, NA-A applied cream. NA-A offered R4 a pillow for under his legs, however did not place Prevalon boots. R1 was not offered or provided alternative positioning, he remained on his back when NA-A left the room.

During interview on 9/8/23 at 10:28 a.m., NA-A stated that was the first time she had provided incontinence cares to R4 since the start of her shift at 6:00 a.m. NA-A indicated the last time R4 was changed was on the previous shift, however was not aware of the time.

During observation on 9/8/23 at 3:37p.m., R4 laid flat on his back in bed with air-mattress. R4 did not have Prevalon boots on. NA-A provided R4 with incontinence cares, R4's bottom continued to have redness. R4 reported to NA-A his mattress was hard in the center and causing discomfort. NA-A explained to R4 she was unable to fix the bed and would have maintenance address the issue. NA-A did not check the level of air in the mattress and/or function, did not offer to turn/reposition for comfort, and did not put R4's Prevalon boots on which were on the chair next to his bed. At 4:37 p.m. licensed practical nurse (LPN)-E entered room and provided R4 with pain medications and informed R4 of the plan to complete a skin check of buttocks.

R4's progress note dated 9/8/23 at 10:23 p.m., indicated there was redness to R4's sacrum, barrier cream and protective dressing applied to area. R4 turned and repositioned. Plan to continue to monitor.

During interview on 9/8/23 at 1:11 a.m. associate administrator indicated the check and change

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F 686	Continued From page 17 process is dependent on the individualized plan of care, typically it is two hours depending on bowel and bladder needs. NAs were aware of how frequently check and changes should happen based off care guides. NAs were supposed to communicate verbally on when residents were last changed. During continuous observation on 9/11/23 from 7:28 a.m. to 9:30 a.m. R4 laid flat on his back, Prevalon boots were not on. During observation on 9/11/23 at 12:10 a.m., Director of Nursing (DON) and Regional Nurse Consultant (RGN)-A completed skin assessment for R4's reddened buttocks. RGN-A reported the area to be red, not macerated, not open and not stageable. RGN-A donned Prevalon boots, educated R4 on importance of being on side and provided off loading. During interview on 9/11/23 at 1:11 p.m., Nurse Practitioner (NP)-A indicated to not see him since this admission due to scheduling barriers. NP-A indicated to fully expect turning and repositioning to be happening every two hours for it to be offered and charted to identify potential complications as well as refusals to be documented. NP-A indicated she was not aware of any redness on bottom on Friday 9/8/23, however may not remember if the area was not open. During interview on 9/11/23 at 11:56 a.m., Director of Nursing (DON) and Regional Nurse Consultant (RGN)-A reported the expectation for Prevalon boots to be on every shift when in bed and to be offloaded onto side every two hours.	F 686		

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F 686	Continued From page 18 Policy titled skin assessment and wound management; 1) A pressure ulcer risk assessment (Braden Scale) will be completed per Monarch's Assessment Schedule/Grid. 2) Implement appropriate preventative skin measures. 3) Tissue Tolerance Evaluation is completed on admission, annually, and upon significant change. 4) Staff will perform routine skin inspections (with daily care). 5) Nurses are to be notified if skin changes are identified. 6) A weekly skin inspection will be completed by licensed staff. When a significant alteration in skin integrity is noted; (i.e. large or multiple bruising, large skin tear, or other non-pressure related wounds such as diabetic, venous, or arterial ulcers), the following actions will be taken: 1. Notify MD/Treatment Ordered 2. Notify resident representative 3. Complete education with resident/resident representative including risks & benefits 4. Initiate Weekly Wound Evaluation 5. Notify Nurse Manager/Wound Nurse 6. Referral to dietary, if appropriate 7. Referral to therapies, if appropriate 8. Update Care Plan 9. Update resident care lists 10.Update Care Plan to identify risks for skin breakdown	F 686		