Electronically delivered
September 26, 2021

Administrator
Texas Terrace A Villa Center
7900 West 28th Street
Saint Louis Park, MN 55426

RE: CCN: 245187
Cycle Start Date: September 10, 2021

Dear Administrator:

On September 10, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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" tag), i.e., the plan of correction should be directed to:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 10, 2021 (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 10, 2022 (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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245187	A. BUILDING _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEXAS TERRACE A VILLA CENTER	**7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 9/9/21, throught 9/10/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints was found to be SUBSTANTIATED: H5187171C (MN76489) with no deficiencies due to action taken byt the facility prior to survey H5187172C (MN75406) with a deficiency cited at F584 H5187174C (MN76542) with a deficiency cited at F7600 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 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-	F 584		10/14/21

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

Electronically Signed | 10/02/2021

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F 584	Continued From page 1 §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain clean bedsheets and linens for 5 of 8 residents (R4, R5, R6, R7, and R8) reviewed for environmental concerns.	F 584	1. R4, R5, R6, R7, and R8 have been provided with clean bed linens and beds have been made. 2. All residents at Texas Terrace a Villa Center have the potential to be affected	

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F 584	Continued From page 2 Findings include: When observed on 9/9/21, at 11:21 a.m. R4 had a silver dollar size stain on her white pillowcase that was yellow in color with reddish flecks. Registered nurse (RN)-A verified the stain on R4's pillow, and stated it was likely "drainage" from a wound on R4's back. RN-A verified pillowcases and bed linens should be changed daily or as needed and stated he had "no idea" the pillowcase was dirty. When observed on 9/9/21, at 11:30 a.m. R5 had a large yellow stain on his white bed sheet measuring approximately 14 inches (in) by 12 in. R5 stated he was not sure what the stain was, but stated he saw bugs flying around his room at night. Nursing assistant (NA)-V verified the stain on R5's bed and stated it was "probably urine" as it was "yellowish" in color. NA-A stated he was not sure how R5's sheets would be stained with urine as R5 was continent. RN-B also verified the stain and stated she didn't know what it could be as R5 was continent of both bowel and bladder. When observed on 9/9/21, at 11:38 a.m. R6 had three dark yellow and light brown stains on a pillow sitting atop an armchair in his room. The stains measured approximately 3 in by 1 in, 2 in by 1 in, and 1 in by 1 in. Additionally, there were 2 stains on R6's bed pillow which measured approximately 2 in by 2 in and 3 in by 3 in, and were dark yellow and light brown in color. At 11:49 a.m. RN-B verified the stains on both pillows, and stated, she did not know what the stains were. RN-B stated she expected the soiled linens to be linens as needed, which could be daily.	F 584	by these practices. Residents are being provided with clean bed linens on bath days and as needed. 3. Nursing staff will be provided with education regarding the provision of clean linen and bed making to residents by 10/14/2021. 4. DON/designee will audit 5 resident rooms per week to ensure bed linens are clean. Results of the audits will be shared at QAPI. Audits will continue until discontinued by QAPI.	

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F 584	Continued From page 3 When observed on 9/9/21, at 11:40 a.m. R7 had a yellow stain on her bedsheet which measured approximately 3 in by 2 in. RN-B verified the stain on the sheets, and stated R7 ate in bed. When observed on 9/9/21, at 11:42 a.m. R8 had a reddish purple which measures approximately 3 in by 1 in inch on his pillowcase. There were several additional droplets on R8's bed sheet. RN-B verified the stain on the sheets, and stated she believed it was grape juice and would get R8's sheets and pillowcase changed. When interviewed on 9/9/21, at 3:15 p.m. the director of nursing (DON) stated changing linens was the responsibility of nursing staff, and linens should be changed on shower days or when visibly soiled. The DON stated this was part of the job duties for nursing assistants and and nurses. A policy regarding clean linens was requested but not provided by the facility.	F 584		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or	F 600		10/14/21

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F 600	Continued From page 4 physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents were free from abuse for 1 of 3 residents (R3) reviewed for verbal abuse by staff. Findings include: R3's Face Sheet printed 9/10/21, indicated diagnosis included vascular dementia, and hemiplegia (paralysis) affecting the left side. R3's quarterly Minimum Data Set (MDS) dated 8/3/21, indicated R3 had a moderate cognitive impairment and required assistance with bed mobility, transfers, dressing, and personal hygiene. In addition, the MDS indicated R3 had adequate hearing, clear speech, was able to be understood and could understand others. R3's care plan dated 2/15/18, indicated R3 was at risk for abuse/neglect as a vulnerable adult, and would be free from abuse/neglect. The plan directed staff to be compassionate, and report all allegations of abuse/neglect per facility policy. On 9/9/21, at 10:26 a.m. family member (FM)-A was interviewed. FM-A stated on 9/4/21, around 2:00 p.m. she went to visit R3. FM-A stated R3 was still in bed, and was wearing a gown. FM-A stated she approached registered nurse (RN)-C and asked why R3 was still in bed. RN-C stated R3 had refused to get up earlier in the day. FM-A requested R3 be gotten out of bed and dressed, at which time RN-A asked nursing assistant (NA)-A to help R3 get up. As FM-A opened the	F 600	1. R3 states he feels safe at the facility and has not had any further incidents of abuse or neglect. 2. All residents who reside at Texas Terrace a Villa Center have the potential to be affected by these practices. All residents have been interviewed and all residents reported feeling safe at this facility with no further reports of abuse. The facility has reviewed policies and procedures relating to abuse and neglect, and the policies remain current. 3. Staff from all departments will be re-educated on the abuse policy and reporting and investigating allegations of abuse, neglect, mistreatment, injuries of unknown injury, and misappropriation of resident property by 10/14/2021. 4. NHA/designee will interview 5 random residents per week to ensure residents are free from abuse and neglect. Results of the audits will be shared at QAPI. Audits will continue until discontinued by QAPI.	

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F 600	Continued From page 5	F 600		

door and reentered R3's room, she heard NA-A ask R3, "Are you ready to get the f*** out of bed?" FM-A stated she asked "What?" to NA-A, who replied, "What my a**." FM-A stated she went out of the room and reported NA-A's behavior to RN-D. FM-D stated RN-D went into R3's room and attempted to calm NA-A down, at which time NA-A swore at RN-D. FM-A stated she asked NA-A to stop swearing, however, NA-A continued to swear and approached FM-A who thought NA-A wanted to fight. FM-A stated RN-D stood between FM-A and NA-A, and then NA-A pushed RN-D. FM-A stated she was removed from R3's room by RN-D, however RN-D and NA-A remained in R3's room. FM-A stated she located additional staff who came and assisted NA-A to leave the building. FM-A stated R3 appeared "scared" and "sad," and continued to repeat "yes ma'am, I'm sorry ma'am" to NA-A throughout the altercation. FM-A stated R3 later told her he felt he was to blame for the altercation as he had declined to get up earlier that morning when NA-A had offered.

On 9/9/21, at 1:26 p.m. R3 stated NA-A did not want to get him out of bed that afternoon as he had refused to get up earlier. R3 stated NA-A told him, "F* you" at which time FM-A replied, "What?" R3 stated NA-A continued to swear and it exploded into a big fight. R3 stated he was afraid of NA-A and stated, "I didn't want her to hit me." R3 stated another staff came in to help while FM-A and NA-A swore to each other. R3 stated the altercation exploded into a more than it should have.

On 9/9/21, at 1:51 p.m. NA-A was interviewed. NA-A stated she was frustrated as there were only three staff on the floor that day, and she was

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F 600	Continued From page 6	F 600		

helping other staff with their work in addition to hers. NA-A stated, "Maybe I am overworked and stressed out." NA-A stated she had tried to help R3, but felt FM-A yelled at her. NA-A stated RN-D had entered the room, yelled at her, and pushed her. NA-A stated RN-C also entered the room and told her to, "Shut up." NA-A stated she assisted R3 with lunch, and FM-A came to visit R3 around 1:00 p.m. NA-A stated the voices of herself, FM-A, and RN-D were "elevated, " but she denied cursing at R3 or FM-A. NA-A stated R3 was upset about the interaction.

On 9/9/21, at 3:27 p.m. RN-D was interviewed and stated she was passing medications down the hallway from R3's room when FM-A exited R3's room and approached her. RN-D stated FM-A approached her and told her that NA-A had cursed at her. RN-D stated as she was speaking with FM-A, NA-A exited R3's room and approached them. NA-A stated FM-A had lied to RN-D. FM-A returned to R3's room and NA-A and RN-D followed. RN-D stated NA-A told her she could not tell her what to do. RN-D told NA-A she would help get R3 up, NA-A stated she did not want help, and called FM-A and liar. RN-D stated NA-A then threatened to, "Kick her a**." NA-A pushed RN-D out of C3's room and slammed the door. RN-D stated NA-A threatened FM-A, RN-D reentered the room and removed FM-A, and told NA-A to leave the floor. RN-D stated NA-A yelled in the hallway she would, "F* me up," and told RN-D and FM-A to go back to Africa. RN-D stated NA-A was eventually removed from the floor by leadership.

On 9/9/21, at 3:42 p.m. RN-C stated she was the nurse who initially directed NA-A to get R3 up to go outside because his wife and family were

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F 600	Continued From page 7	F 600		

there. RN-C stated after she spoke with NA-A, she had gone to feed a resident in a nearby room when she heard "distressed" female voices. RN-C observed FM-A outside R3's room, attempting to get in and heard NA-A and RN-D arguing inside R3's room. RN-C entered the room and NA-A was "freaking out" and yelling that everyone was "haters." RN-C stated NA-A exited R3's room and began "flipping the bird" to RN-C, RN-D, and FM-A. RN-C stated NA-A said she would "f*** up" FM-A. NA-A also made racial comments to RN-C, RN-D, and FM-A. RN-C stated NA-A was "definitely out of control" and was eventually removed from the floor by leadership. RN-C stated the altercation occurred in front of R3 who stated he was fine but seemed "upset to some degree."

The facility document Interview/Statement Record undated, indicated NA-A admitted to raising her voice, giving the finger when leaving the floor, having a problem with anger, and telling FM-A and RN-D to go back to their country when interviewed by the administrator.

The facility policy Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property dated 11/28/17, directed verbal abuse included oral, written, or gestured language that willfully included disparaging and derogatory terms to residents or their families, or within their hearing distance. Examples of verbal abuse include of harm. The policy further indicated abuse includes verbal and mental abuse or anything that causes mental anguish.

Electronically delivered
September 26, 2021

Administrator
Texas Terrace A Villa Center
7900 West 28th Street
Saint Louis Park, MN 55426

Re: State Nursing Home Licensing Orders
Event ID: YO8E11

Dear Administrator:

The above facility was surveyed on September 9, 2021 through September 10, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

"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:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
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You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00144	A. BUILDING: _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEXAS TERRACE A VILLA CENTER	7900 WEST 28TH 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 9/9/21, through 9/10/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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

Electronically Signed | 10/02/21

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2 000	Continued From page 1 The following complaint were found to be SUBSTANTIATED: H5187171C (MN76489) with no licensing orders issued. H5187172C (MN75406) with a licensing order issued at 584. H5187174C (MN76542) with no licensing orders issued. 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 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 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	2 000		

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2 000	Continued From page 2 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		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to maintain clean bedsheets and linens for 5 of 8 residents (R4, R5, R6, R7, and R8) reviewed for environmental concerns. Findings include: When observed on 9/9/21, at 11:21 a.m. R4 had a silver dollar size stain on her white pillowcase that was yellow in color with reddish flecks. Registered nurse (RN)-A verified the stain on R4's pillow, and stated it was likely "drainage" from a wound on R4's back. RN-A verified pillowcases and bed linens should be changed daily or as needed and stated he had "no idea"	21695	1. R4, R5, R6, R7, and R8 have been provided with clean bed linens and beds have been made. 2. All residents at Texas Terrace a Villa Center have the potential to be affected by these practices. Residents are being provided with clean bed linens on bath days and as needed. 3. Nursing staff will be provided with education regarding the provision of clean linen and bed making to residents by 10/14/2021. 4. DON/designee will audit 5 resident rooms per week to ensure bed linens are clean. Results of the audits will be shared	10/14/21

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21695	Continued From page 3 the pillowcase was dirty. When observed on 9/9/21, at 11:30 a.m. R5 had a large yellow stain on his white bed sheet measuring approximately 14 inches (in) by 12 in. R5 stated he was not sure what the stain was, but stated he saw bugs flying around his room at night. Nursing assistant (NA)-V verified the stain on R5's bed and stated it was "probably urine" as it was "yellowish" in color. NA-A stated he was not sure how R5's sheets would be stained with urine as R5 was continent. RN-B also verified the stain and stated she didn't know what it could be as R5 was continent of both bowel and bladder. When observed on 9/9/21, at 11:38 a.m. R6 had three dark yellow and light brown stains on a pillow sitting atop an armchair in his room. The stains measured approximately 3 in by 1 in, 2 in by 1 in, and 1 in by 1 in. Additionally, there were 2 stains on R6's bed pillow which measured approximately 2 in by 2 in and 3 in by 3 in, and were dark yellow and light brown in color. At 11:49 a.m. RN-B verified the stains on both pillows, and stated, she did not know what the stains were. RN-B stated she expected the soiled linens to be linens as needed, which could be daily. When observed on 9/9/21, at 11:40 a.m. R7 had a yellow stain on her bedsheet which measured approximately 3 in by 2 in. RN-B verified the stain on the sheets, and stated R7 ate in bed. When observed on 9/9/21, at 11:42 a.m. R8 had a reddish purple which measures approximately 3 in by 1 in inch on his pillowcase. There were several additional droplets on R8's bed sheet. RN-B verified the stain on the sheets, and stated she believed it was grape juice and would get	21695	at QAPI. Audits will continue until discontinued by QAPI.	

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21695	Continued From page 4 R8's sheets and pillowcase changed. When interviewed on 9/9/21, at 3:15 p.m. the director of nursing (DON) stated changing linens was the responsibility of nursing staff, and linens should be changed on shower days or when visibly soiled. The DON stated this was part of the job duties for nursing assistants and and nurses. A policy regarding clean linens was requested but not provided by the facility. SUGGESTED METHOD OF CORRECTION: The administrator, nursing supervisor, or designee could ensure an environmental cleaning program was developed to include linen changes and accurately reflect ongoing housekeeping/linen cleaning scheduled or needed in the facility on a routine basis. The facility could create policies and procedures, educate staff on these changes and perform environmental rounds/audits periodically. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		