Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 3, 2024

Administrator
The Villas At The Cedars
7900 West 28th Street
Saint Louis Park, MN 55426

RE: CCN: 245187
Cycle Start Date: August 13, 2024

Dear Administrator:

On August 30, 2024, 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.

Sincerely,

Sarah Lane

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

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September 3, 2024

Administrator
The Villas At The Cedars
7900 West 28th Street
Saint Louis Park, MN 55426

Re: Reinspection Results
Event ID: VHV612

Dear Administrator:

On August 30, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 13, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 16, 2024

Administrator
The Villas At The Cedars
7900 West 28th Street
Saint Louis Park, MN 55426

RE: CCN: 245187
Cycle Start Date: August 13, 2024

Dear Administrator:

On August 13, 2024, 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:

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 November 13, 2024 (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 February 13, 2025 (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,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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Electronically delivered
August 16, 2024

Administrator
The Villas At The Cedars
7900 West 28th Street
Saint Louis Park, MN 55426

Re: State Nursing Home Licensing Orders
Event ID: VHV611

Dear Administrator:

The above facility was surveyed on August 12, 2024 through August 13, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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

Please feel free to call me with any questions.

Sincerely,

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

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

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 08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT THE CEDARS	**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 8/12/24 through 8/13/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H51875681C (MN00104836) H51876085C (MN00105090) H51876203C (MN00105070) with a deficiency issued at F842. 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 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F 842		8/28/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/16/2024

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

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F 842	Continued From page 1	F 842		

§483.70(h) Medical records.
§483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(h)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or

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F 842 Continued From page 2

(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(h)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure accurate documentation of medications and treatments when residents were hospitalized for 2 of 3 (R1, R3) residents reviewed for documentation.

Findings include:

R1's admission Minimum Data Set (MDS) dated 6/24/24, indicated R1 was cognitively intact, and required a two person assist for transferring and toileting.

R1's Face Sheet undated, indicated R1 had diagnoses of peripheral vascular disease, type II diabetes, personal history of venous thrombosis and embolism.

R1's June medication administration record (MAR) had the following omissions:

-Hydromorphone Hydrochloride (narcotic pain

F 842 (Provider's Plan of Correction)

R1 and R3 have been discharged from the facility. R3 did not receive any medications and was at the hospital at the time.

All residents have the potential to be affected by the deficient practice.

Education will be provided to nursing staff related to accurate documentation when administering medication.

Audits will be completed by the DON and/or designee for all affected residents: Reviewing MAR/TAR of 1 resident per day, 7 residents per week for 4 weeks and then twice a month for 1 month and then 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule is

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F 842	Continued From page 3 medication) tablet 4 milligrams (mg). Give 4 milligrams by mouth every 4 hours for pain, start date 6/19/25. On 6/23 at 8:00 p.m., the box was left blank. LPN-D was assigned to R1 for that shift. -Acticoat (silver dressing) dry to incision line Xeroform (occlusive dressing) and the rest, cover with gauze and tape to secure. One time a day for wound. Start date 6/26/24. On 6/28/24, the box was left blank. -Daily weight one time a day, start date 6/18/24. 6/21/24 and 6/25/24 were left blank. R3's 6/16/24 quarterly MDS indicated R3 was severely cognitively impaired, and required a one person assist for all activities of daily living. R3's Face Sheet undated, indicated R3 had diagnoses of dementia, and rheumatoid arthritis. On 8/12/24 an email from the director of nursing (DON) stated R3 left the facility to go to the hospital on 7/19/24 at 6:05 a.m. R3's July MAR had the following medications and treatments marked as administered: -Melatonin Oral Tablet 10 milligrams, give 1 tablet by mouth at bedtime for sleep. On 7/19/24 at 8 p.m. it was administered by LPN-A. On 7/20/24 at 8:00 p.m. it documented as administered by licensed practical nurse (LPN)-B. -Seroquel oral tablet, give 50 milligrams by mouth at bedtime. On 7/19/24 at 8 p.m. it was documented as administered by LPN-A. On 7/20/24 at 8:00 p.m. it was documented as administered by LPN-B.	F 842	needed.	

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F 842	Continued From page 4	F 842		

-Barrier cream to coccyx area twice daily with cares and incontinent episodes every day and evening shift for prevention. On the 7/19/24 evening shift it was documented as administered by LPN-A. On the 7/20/24 evening shift it was documented as administered by LPN-B.

-Depakote (seizure medication) Oral tablet delayed release 250 mg by mouth two times a day for seizures. On 7/19/24 at 8 p.m. it was documented as administered by LPN-A. On 7/20/2024 at 8:00 p.m. it was documented as administered by LPN-B.

-2 Calorie Supplement after meals 120 milliliters HiKcal or Med Pass for weight loss. On 7/19/24 at 7 p.m. it was documented as administered by LPN-A. On 7/20/24 at 7:00 p.m. it was documented as administered by LPN-B.

-House supplement with meals three times a day with meals for weight loss. On 7/19/24 at 5 p.m., LPN-A documented 40 ounces were given. On 7/20/24 at 5 p.m., LPN-B documented 4 ounces were given.

-Resident specific targeted interventions for behaviors, monitor resident for signs and symptoms of medication side effects every shift. On the 7/19/24 evening shift, LPN-A documented it as completed. On the 7/20/24 evening shift, LPN-B documented it as completed.

-Artificial tears Ophthalmic Solution 0.1-0.3%, instill 2 drop in both eyes four times a day for excessive cornea and conjunctive dryness. On 7/19/24 at 4:00 p.m. and 8:00 p.m., LPN-A documented it as administered. On 7/20/24 at

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F 842	Continued From page 5	F 842		

4:00 p.m. and 8:00 p.m., LPN-B documented it as administered.

-Sleep monitoring document hours of sleep during shift every evening and night shift for sleep behavior. On the 7/19/24 evening shift, LPN-A documented it as completed.

-Follow enhanced barrier precautions while providing urinary catheter maintenance, contact with the catheter, tubing and collection bag, and other high contact care activities. On the 7/19/24 evening shift, LPN-A documented it as completed.

-Monitor catheter output every shift for catheter related to obstructive and reflux uropathy. On the 7/19/24 evening shift, LPN-A documented that R3 had 500 milliliters of urine output.

-Monitor effectiveness of fall interventions, hourly checks on resident until interdisciplinary meet Monday post fall times 72 hours, every shift for bruises to heal. On the 7/19/24 evening shift, LPN-A documented it as completed.

-Monitor for pain daily. On the 7/19/24 evening shift, LPN-A documented it as completed.

-Monitor for seizure activity. On the 7/19/24 evening shift, LPN-A documented it as completed.

On 8/13/24 at 9:45 a.m., LPN-E stated she was not working the day R3 went to the hospital, and was unaware nurses were documenting medications and treatments as administered while R3 was hospitalized. She would check with the nurses why they were signing off medications

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F 842	Continued From page 6	F 842		

and treatments for a resident who wasn't there. She would make sure the orders were discontinued while R3 was in the hospital. She was unaware of medication administration boxes being left blank for R1, and unaware of any processes already in place to manage blank boxes in the electronic health record (EHR) MAR.

On 8/13/24 at 10:25 a.m., registered nurse (RN)-A stated no box in the MAR should be left blank, and the 24-hour report should pull any omissions in the MAR. She was not aware of any issues with staff documenting medications and treatments were administered while the resident was not in the facility.

On 8/13/24 at 12:25 p.m., LPN-B confirmed she worked on the evening of 7/20/24. Her coworkers informed her R3 went to the hospital the prior day. When asked why she documented medications as administered for R3 when R3 was not at the facility. she stated it must have been a mistake, and everyone knew R3 was gone.

On 8/13/24 at 11:03 a.m., and 12:58 p.m., the director of nursing (DON) stated when a medication was not administered, the number 9 should be documented in that space for "Other" and a nurse's note should be entered to explain the medication was not given. She was unaware R1's wound care and daily weights were not completed as ordered. She was also unaware nurses were charting medications and treatments as administered while residents were not in the facility. She had a lot of concerns about that, and nurses should pull the resident out of the system while they are in the hospital to avoid that mistake.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT THE CEDARS	**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 842	Continued From page 7 On 8/13/24, LPN-A, LPN-C and LPN-D were called for interview requests and did not return the call. The facility policy Medication Error Procedure last reviewed in 2023, directed the interdisciplinary team evaluates medication usage in order to prevent and detect adverse consequences and medication related problem. Medication errors should be assessed, documented, and reported according to federal or state guidelines.	F 842		

Minnesota Department of Health

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	00144	A. BUILDING: ______ B. WING ______	08/13/2024

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2 000	Initial Comments	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 8/12/24 through 8/13/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed: H51875681C (MN00104836) H51876085C (MN00105090) H51876203C (MN00105070) with a licensing order issued at 4658.0450 Subp. 1. 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 the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is	2 000		

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2 000	Continued From page 2 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		
2 605	MN Rule 4658.0445 Subp. 1 Clinical Record Subpart 1. Unit record. A resident's clinical record must be started at admission and incorporated into a central unit record system. The clinical record must contain sufficient information to identify the resident, contain a record of resident assessments, the comprehensive plan of care, progress notes on the implementation of the care plan, and a summary of the resident's condition at the time of discharge. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure accurate documentation of medications and treatments when residents were hospitalized for 2 of 3 (R1, R3) residents reviewed for documentation. Findings include: R1's admission Minimum Data Set (MDS) dated 6/24/24, indicated R1 was cognitively intact, and required a two person assist for transferring and toileting. R1's Face Sheet undated, indicated R1 had	2 605	R1 and R3 have been discharged from the facility. R3 did not receive any medications and was at the hospital at the time. All residents have the potential to be affected by the deficient practice. Education will be provided to nursing staff related to accurate documentation when administering medication. Audits will be completed by the DON and/or designee for all affected residents: Reviewing MAR/TAR of 1 resident per	8/28/24

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2 605	Continued From page 3 diagnoses of peripheral vascular disease, type II diabetes, personal history of venous thrombosis and embolism. R1's June medication administration record (MAR) had the following omissions: -Hydromorphone Hydrochloride (narcotic pain medication) tablet 4 milligrams (mg). Give 4 milligrams by mouth every 4 hours for pain, start date 6/19/25. On 6/23 at 8:00 p.m., the box was left blank. LPN-D was assigned to R1 for that shift. -Acticoat (silver dressing) dry to incision line Xeroform (occlusive dressing) and the rest, cover with gauze and tape to secure. One time a day for wound. Start date 6/26/24. On 6/28/24, the box was left blank. -Daily weight one time a day, start date 6/18/24. 6/21/24 and 6/25/24 were left blank. R3's 6/16/24 quarterly MDS indicated R3 was severely cognitively impaired, and required a one person assist for all activities of daily living. R3's Face Sheet undated, indicated R3 had diagnoses of dementia, and rheumatoid arthritis. On 8/12/24 an email from the director of nursing (DON) stated R3 left the facility to go to the hospital on 7/19/24 at 6:05 a.m. R3's July MAR had the following medications and treatments marked as administered: -Melatonin Oral Tablet 10 milligrams, give 1 tablet by mouth at bedtime for sleep. On 7/19/24 at 8 p.m. it was administered by LPN-A. On 7/20/24 at 8:00 p.m. it documented as administered by	2 605	day, 7 residents per week for 4 weeks and then twice a month for 1 month and then 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule is needed.	

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licensed practical nurse (LPN)-B.

-Seroquel oral tablet, give 50 milligrams by mouth at bedtime. On 7/19/24 at 8 p.m. it was documented as administered by LPN-A. On 7/20/24 at 8:00 p.m. it was documented as administered by LPN-B.

-Barrier cream to coccyx area twice daily with cares and incontinent episodes every day and evening shift for prevention. On the 7/19/24 evening shift it was documented as administered by LPN-A. On the 7/20/24 evening shift it was documented as administered by LPN-B.

-Depakote (seizure medication) Oral tablet delayed release 250 mg by mouth two times a day for seizures. On 7/19/24 at 8 p.m. it was documented as administered by LPN-A. On 7/20/2024 at 8:00 p.m. it was documented as administered by LPN-B.

-2 Calorie Supplement after meals 120 milliliters HiKcal or Med Pass for weight loss. On 7/19/24 at 7 p.m. it was documented as administered by LPN-A. On 7/20/24 at 7:00 p.m. it was documented as administered by LPN-B.

-House supplement with meals three times a day with meals for weight loss. On 7/19/24 at 5 p.m., LPN-A documented 40 ounces were given. On 7/20/24 at 5 p.m., LPN-B documented 4 ounces were given.

-Resident specific targeted interventions for behaviors, monitor resident for signs and symptoms of medication side effects every shift. On the 7/19/24 evening shift, LPN-A documented it as completed. On the 7/20/24 evening shift, LPN-B documented it as completed.

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-Artificial tears Ophthalmic Solution 0.1-0.3%, instill 2 drop in both eyes four times a day for excessive cornea and conjunctive dryness. On 7/19/24 at 4:00 p.m. and 8:00 p.m., LPN-A documented it as administered. On 7/20/24 at 4:00 p.m. and 8:00 p.m., LPN-B documented it as administered.

-Sleep monitoring document hours of sleep during shift every evening and night shift for sleep behavior. On the 7/19/24 evening shift, LPN-A documented it as completed.

-Follow enhanced barrier precautions while providing urinary catheter maintenance, contact with the catheter, tubing and collection bag, and other high contact care activities. On the 7/19/24 evening shift, LPN-A documented it as completed.

-Monitor catheter output every shift for catheter related to obstructive and reflux uropathy. On the 7/19/24 evening shift, LPN-A documented that R3 had 500 milliliters of urine output.

-Monitor effectiveness of fall interventions, hourly checks on resident until interdisciplinary meet Monday post fall times 72 hours, every shift for bruises to heal. On the 7/19/24 evening shift, LPN-A documented it as completed.

-Monitor for pain daily. On the 7/19/24 evening shift, LPN-A documented it as completed.

-Monitor for seizure activity. On the 7/19/24 evening shift, LPN-A documented it as completed.

On 8/13/24 at 9:45 a.m., LPN-E stated she was

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not working the day R3 went to the hospital, and was unaware nurses were documenting medications and treatments as administered while R3 was hospitalized. She would check with the nurses why they were signing off medications and treatments for a resident who wasn't there. She would make sure the orders were discontinued while R3 was in the hospital. She was unaware of medication administration boxes being left blank for R1, and unaware of any processes already in place to manage blank boxes in the electronic health record (EHR) MAR.

On 8/13/24 at 10:25 a.m., registered nurse (RN)-A stated no box in the MAR should be left blank, and the 24-hour report should pull any omissions in the MAR. She was not aware of any issues with staff documenting medications and treatments were administered while the resident was not in the facility.

On 8/13/24 at 12:25 p.m., LPN-B confirmed she worked on the evening of 7/20/24. Her coworkers informed her R3 went to the hospital the prior day. When asked why she documented medications as administered for R3 when R3 was not at the facility. she stated it must have been a mistake, and everyone knew R3 was gone.

On 8/13/24 at 11:03 a.m., and 12:58 p.m., the director of nursing (DON) stated when a medication was not administered, the number 9 should be documented in that space for "Other" and a nurse's note should be entered to explain the medication was not given. She was unaware R1's wound care and daily weights were not completed as ordered. She was also unaware nurses were charting medications and treatments as administered while residents were not in the facility. She had a lot of concerns about that, and

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nurses should pull the resident out of the system while they are in the hospital to avoid that mistake.

On 8/13/24, LPN-A, LPN-C and LPN-D were called for interview requests and did not return the call.

The facility policy Medication Error Procedure last reviewed in 2023, directed the interdisciplinary team evaluates medication usage in order to prevent and detect adverse consequences and medication related problem. Medication errors should be assessed, documented, and reported according to federal or state guidelines.

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and/or develop policy and procedures for identifying omissions in the medication and treatment records. The DON or designee could provide staff education on how to document medications that have run out, and how to verify a resident is in the facility before completing documentation. The DON or designee could complete audits on medication and treatment record accuracy. The results of these audits could be reviewed by the quality assessment committee to ensure compliance.

TIME PERIOD FOR CORRECTION: Twenty one (21) days.