Electronically delivered
April 27, 2020

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

SUBJECT: SURVEY RESULTS
CCN: 245182
Cycle Start Date: Cycle Start Date: April 14, 2020

Dear Administrator:

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-20-All, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS

On April 14, 2020, the Minnesota Department of Health completed a complaint investigation and a COVID-19 Focused Survey at The Villa At St Louis Park to determine if your facility was in compliance with Federal requirements related to the complaint and implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the electronically delivered CMS 2567.

PLAN OF CORRECTION

You must submit an acceptable plan of correction (POC) for the enclosed deficiencies that were cited during the April 14, 2020 survey. The Villa At St Louis Park may choose to delay submission of a POC until after the survey and enforcement suspensions have been lifted. The provider will have ten days

from the date the suspensions are lifted to submit a POC. An acceptable POC will serve as your allegation of compliance. Upon receipt of an acceptable POC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. Please note that if an onsite revisit is required, the revisit will be delayed until after survey and enforcement suspensions are lifted. The failure to submit an acceptable POC can lead to termination of your Medicare and Medicaid participation.

To be acceptable, a provider's POC 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; and
- The date that each deficiency will be corrected.

The POC must be signed and dated by an official facility representative. Please send your POC by fax or email to:

Susanne Reuss, Unit Supervisor
Fax: (651) 215-9697
Email: susanne.reuss@state.mn.us

INFORMAL DISPUTE RESOLUTION

You have one opportunity to dispute the deficiencies cited on the April 14, 2020 survey through Informal Dispute Resolution (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Susanne Reuss, Unit Supervisor
Fax: (651) 215-9697
Email: susanne.reuss@state.mn.us

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the

Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

The Villa At St Louis Park may choose to delay a request for an IDR until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a request for an IDR in accordance with the instructions above.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at https://qioprogram.org/. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at https://qioprogram.org/locate-your-qio.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
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
	245182	A. BUILDING _____ B. WING _____	C 04/14/2020

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

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E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted 4/13/2020 and 4/14/2020, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was in full compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facilty acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 4/13/2020 and 4/14/2020, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5182076C. Deficiency issued at F Tag F684 and F686. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/06/2020

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 000	Continued From page 1 with the regulations has been attained in accordance with your verification. In Addition, A COVID-19 Focused Infection Control survey was conducted 4/13/2020 and 4/14/2020, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined not to be in compliance. Deficiency issued at F880. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an revisit of your facility will be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 684	1. Immediate: Resident was offered and	5/21/20

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F 684	Continued From page 2 review the facility failed to develop and implement interventions to prevent worsening of skin conditions for 1 of 3 residents (R3) reviewed for non-pressure related skin injuries. Findings include: R2's Admission Record indicated diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, chronic respiratory failure, diabetic polyneuropathy, muscle weakness, chronic pain, morbid obesity and contracture. R2's significant change Minimum Data Set (MDS) dated 3/23/20 indicated R2 required extensive assist of two staff members for bed mobility, transfers, toileting, personal hygiene, and was non-ambulatory. The MDS indicated R2 was frequently incontinent of bladder and always incontinent of bowel. R2's MDS further indicated he was at risk of developing pressure ulcers and was not on a turning/repositioning program. The MDS indicated R2 did not have moisture associated skin damage (MASD) at the time of the assessment. R2's care plan, (undated) indicated R2 required assist of two staff members for repositioning and turning in bed every two to three hours and as necessary. It further indicated R2 preferred to stay in his tilt in space wheelchair to sleep. The care plan indicated R2 had limited physical mobility related to a history of cerebral vascular accident (CVA) and left sided weakness with an intervention for staff to provide supportive care and assist with mobility as needed. It further indicated that R2 spent long periods of time in his	F 684	accepted repositioning while MDH was still conducting their survey in the facility. Reviewed care plan and group sheets, and added to MAR for nurse to sign-off on ensuring nursing assistants and nurses are offering repositioning. 2. All like residents in power wheelchairs have been reviewed and orders added to MAR, POC, care plans, and group sheets to ensure nursing assistants and nurses offer repositioning. 3. All direct care staff were educated on offering repositioning per resident care plan. 4. Facility will audit two residents weekly for one month, then two residents per month for two months. 5. Audit results will be reviewed monthly in QAPI by DON or designee.	

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F 684	Continued From page 3	F 684		

wheelchair. The care plan further identified a potential for impairment to skin integrity related to immobility, CVA with hemiparesis, and incontinence with an intervention for staff to encourage and educate on importance of taking time out of electric wheelchair to allow skin to offload and heal.

R2's nursing assistant care sheet, (undated) indicated staff should offer and encourage R2 to turn and reposition every two to three hours.

R2's wound assessment, dated 4/8/20, identified MASD on left buttock due to incontinence.

R2's skin observations dated 2/7/29, 2/19/20, and 3/11/20 indicated R2 had redness present on buttocks.

During observation on 4/13/20, from 11:06 a.m. to 2:36 p.m. R2 was sitting in his electric wheelchair. Staff entered his room at 12:04 p.m. to drop off his lunch tray and 1:00 p.m. to remove it. Staff did not offer to reposition R2 and R2 did not reposition himself.

During interview on 4/13/20, at 3:05 p.m. nursing assistant (NA)-A said that R2 doesn't have a repositioning schedule and if R2 needed something he would've let staff know. She also said that staff didn't go in R2's room because he would get mad and stated R2 could "move his chair on his own."

During interview on 4/14/20, at 3:00 p.m. The director of nursing (DON) said that R2's repositioning schedule was every two to three hours when he was in bed. She said R2 was able

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F 684	Continued From page 4 to reposition himself when he was in his wheelchair by tilting it. The DON also said R2 directed a lot of his own care and if he needed something, he would've asked for it when staff was in his room.	F 684		
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- (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 interview and document review the facility failed to develop care planned interventions to reduce the risk from worsening of pressure ulcers for 1 of 3 residents (R1) reviewed with skin impairments and failed to notify the physician of a decline in wound status. Findings include: R1's admission Minimum Data Set (MDS) dated 2/25/20, indicated he had intact cognition and required extensive assistance from two staff for bed mobility, transfers and toileting. The MDS indicated R1 was frequently incontinent of bowel	F 686	1. Resident was discharged from the facility on 3/26/2020. 2. All like residents with pressure ulcers were reviewed to ensure appropriate turning and repositioning schedules are in place. IDT will review pressure ulcers weekly, complete physician notification on worsening pressure ulcers, and request treatment change if applicable. 3. All nursing staff were educated on turning and repositioning schedules, and physician notification with worsening	5/21/20

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F 686	Continued From page 5 and had an indwelling foley catheter. R1's MDS identified one unstageable pressure ulcer during the assessment period. R1's care plan dated 2/19/20, identified a self care deficit related to paraplegia. The care plan directed staff to provide total assistance from two staff for transfers using a mechanical lift. The care plan identified incontinence and directed staff to assist with personal cares after incontinent episodes. R1's care plan further identified skin impairment related to pressure ulcer to coccyx/buttock on admission and indicated he refused the use of an air mattress. The care plan was updated on 3/13/20, to include pillows/offloading if he allowed and use of a draw sheet. The care plan lacked evidence of a turning and repositioning schedule. R1's Nursing Evaluation dated 2/18/20, identified two open areas on his medial buttocks. R1's Wound Assessment Details Reports identified the following: 2/19/20 - Unstageable pressure ulcer to coccyx identified 2/18/20, measuring 4.9 centimeters (cm) x 9 cm. Intact Skin 70%, Bright Pink or Red 20%, Slough White Fibrinous=10%. 2/26/20, Unstageable pressure ulcer to coccyx measuring 4.7 cm x 6.5 cm x .10 cm. Intact Skin 70%, Bright Pink or Red 20%, Slough White Fibrinous 10%. 3/4/20, Unstageable pressure ulcer to coccyx measuring 5.0 cm x .7 cm x .10 cm. Bright Pink or Red 50%, Slough Loosely Adherent 50%.	F 686	pressure ulcers. 4. Facility will complete weekly audits for one month, then monthly audits for two months of physician notification of worsening pressure ulcers, and care plan interventions. 5.Audit results will be reviewed monthly in QAPI by DON or designee.	

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F 686	Continued From page 6 3/6/20, Pressure ulcer healed per patient. 3/12/20, R1 agreed to strict trial of every two hour repositioning during a.m. and p.m. shifts, did not agree to over night. 3/12/20, Unstageable pressure ulcer to coccyx measuring 6.0 cm x 4.5 cm x .10 cm. Bright pink or red 75%, Necrotic Soft, Adherent 25%, 3/18/20, Unstageable pressure ulcer to coccyx measuring 6 x 4.5 x unknown. Necrotic soft, adherent 100%. 3/25/20, Unstageable pressure ulcer to coccyx measuring 11.00 x 9.00 x Unknown. Necrotic soft, adherent 100%. A review of R1' nurse practioner Progress Notes indicated the following: During interview on 4/14/20, at 12:02 p.m. the clinical consultant (CC) stated R1's turning and repositioning schedule was set up on 3/13/20, but she was unable to verify if the schedule had been implemented. The CC stated any resident who admitted to the facility should have been on a turning and repositioning schedule. LPN-A stated when a a resident admitted on the transitional care unit the facility had a "closet care plan" and stated if offloading was on the closet care plan it would have been added to the comprehensive care plan. The director of nursing stated the closet care plan should have been uploaded into the electronic health record but they were unable to find it. In regard to notification to the physican or nurse practitioner,	F 686		

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F 686	Continued From page 7 the CC stated the NP should have been notified of the decline sooner. The CC further stated a more comprehensive assessment should have been put in the medical record. On 4/14/20, at 12:52 a.m. family member (FM)-A stated R1 had a lot of pain and had tried an air mattress in the hospital but when R1 would start to get comfortable, the mattress would shift and cause him discomfort. FM-A stated no one had told her R1's pressure ulcer was getting worse and stated if they had known R1 would have reconsidered the air mattress. FM-A stated she did not think R1 had been made aware the wound had been progressing. FM-A stated after R1 discharged from the facility, the home care nurse saw his pressure ulcer and recommended sending him to the hospital. FM-A stated R1 had the wound debrided and was receiving antibiotics. FM-A stated when R1 admitted to the facility, he had a wound on his butt cheek and nothing on his coccyx. She further stated on admission, the nursing staff had described the wound as "not so bad."	F 686		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		5/21/20

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F 880	Continued From page 8 and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct	F 880		

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F 880	Continued From page 9 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure proper sanitizing of re-useable equipment. This had the potential to affect all residents who required the use of the equipment. Findings include: On 4/13/20, at 8:58 a.m. nursing assistant (NA)-B exited a resident room with a mechanical lift. NA-B placed the lift in the hallway, then entered a resident room and removed a package of personal cleansing wipes. NA-B used the personal cleansing wipes to wipe down the lift. At 9:08 a.m. licensed practical nurse (LPN)-A entered the unit and gave LPN-B a container of bleach wipes which LPN-B placed in a bag hanging on the vitals machine. The mechanical lift was not re-cleaned using the bleach wipes. At 9:55 a.m. the lift was brought to another resident	F 880	1. Resident was transferred out of the facility on 4/24/2020. 2. All residents that utilize shared equipment have the potential to be affected. Cleaning supplies were moved to a new location with increased accessibility. 3. Immediate education was completed with the observed staff persons. Facility staff educated on using the correct cleaning products on shared equipment. 4. Audits will be done weekly for one month, then monthly for two months. 5. Audit results will be reviewed monthly in QAPI by DON or designee.	

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F 880	Continued From page 10 room. At 11:47 a.m. staff entered room 213. Room 213 had an infection cart outside the door with a sign on it that indicated droplet precautions were required when entering. On top of the cart was a container labeled hand sanitizing wipes. At 12:20 p.m. staff removed a mechanical lift from room 213 and wiped it down using the hand sanitizing wipes on the cart. The social worker was observed periodically using the same wipes to clean an I-Pad. At 12:48 p.m. a house keeper entered the room to clean. Upon exiting room 213, LPN-A directed the house keeper to clean her equipment. The house keeper used the hand sanitizing wipes to clean the handles of the equipment she had used in the room. During interview on 4/13/20, at 1:00 p.m. LPN-C verified the wipes on the cart were hand sanitizing wipes and stated, "I doubt they will disinfect." At 1:02 p.m. LPN-A stated the hand sanitizing wipes were only good for cleaning hands. LPN-A stated the staff should know the difference between the different wipes. LPN-A stated she had not looked at the wipes when she directed the house keeper to use them. LPN-A verified bleach wipes were not currently available on the unit and stated central supply was responsible for stocking the wipes. LPN-A said she would call central supply and have sanitizing wipes brought to the unit. She further stated she was unsure why sanitizing wipes were brought to the other unit that day but not room 213's unit. At 1:08 p.m., NA-A and NA-D stated they were	F 880		

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	245182	A. BUILDING _____ B. WING _____	C 04/14/2020

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F 880	Continued From page 11 not aware they were using the incorrect wipes to clean the equipment. NA-D removed the hand sanitizing wipes from the cart and put them away in a drawer. At 1:10 p.m. the central supply staff member stated the bleach sanitizing wipes were locked in her office. She stated she was here every day and stocked the wipes when staff told her they were running low. She further stated if she was not in the building staff did not have access to the supplies. At 1:15 p.m. the administrator stated the central supply staff member was responsible for stocking of supplies. The administrator stated when the central supply staff member was not in the building she was responsible to prepare ahead of time. At 1:41 p.m. NA-A stated sometimes the bleach wipes were in a bag on the machines. NA-A stated when staff arrived today they were not available and staff could not access them because they were locked up. NA-A stated someone must have grabbed the hand sanitizing wipes thinking they were the same thing.	F 880		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 27, 2020

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

Re: State Nursing Home Licensing Orders
Event ID: BHGE11

Dear Administrator:

The above facility was surveyed on April 13, 2020 through April 14, 2020 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:

Susanne Reuss, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793

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.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
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 04/14/2020

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/13/2020 and 4/14/2020, a survey was conducted to determine compliance for state licensure. The following correction orders are issued. H5182076C was investigated and cited at State Tag 0905.	2 000		

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2 000	Continued From page 1 Please indicate on your electronic plan of correction that you have reviewed these orders, and identify the date when they will be corrected.	2 000		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to develop care planned interventions to reduce the risk from worsening of pressure ulcers for 1 of 3 residents (R1) reviewed with skin impairments and failed to notify the physician of a decline in wound status. Findings include: R1's admission Minimum Data Set (MDS) dated 2/25/20, indicated he had intact cognition and required extensive assistance from two staff for bed mobility, transfers and toileting. The MDS indicated R1 was frequently incontinent of bowel and had an indwelling foley catheter. R1's MDS identified one unstageable pressure ulcer during the assessment period.	2 905	Corrected.	5/21/20

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2 905	Continued From page 2 R1's care plan dated 2/19/20, identified a self care deficit related to paraplegia. The care plan directed staff to provide total assistance from two staff for transfers using a mechanical lift. The care plan identified incontinence and directed staff to assist with personal cares after incontinent episodes. R1's care plan further identified skin impairment related to pressure ulcer to coccyx/buttock on admission and indicated he refused the use of an air mattress. The care plan was updated on 3/13/20, to include pillows/offloading if he allowed and use of a draw sheet. The care plan lacked evidence of a turning and repositioning schedule. R1's Nursing Evaluation dated 2/18/20, identified two open areas on his medial buttocks. R1's Wound Assessment Details Reports identified the following: 2/19/20 - Unstageable pressure ulcer to coccyx identified 2/18/20, measuring 4.9 centimeters (cm) x 9 cm. Intact Skin 70%, Bright Pink or Red 20%, Slough White Fibrinous=10%. 2/26/20, Unstageable pressure ulcer to coccyx measuring 4.7 cm x 6.5 cm x .10 cm. Intact Skin 70%, Bright Pink or Red 20%, Slough White Fibrinous 10%. 3/4/20, Unstageable pressure ulcer to coccyx measuring 5.0 cm x .7 cm x .10 cm. Bright Pink or Red 50%, Slough Loosely Adherent 50%. 3/6/20, Pressure ulcer healed per patient. 3/12/20, R1 agreed to strict trial of every two hour repositioning during a.m. and p.m. shifts, did not	2 905		

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2 905	Continued From page 3 agree to over night. 3/12/20, Unstageable pressure ulcer to coccyx measuring 6.0 cm x 4.5 cm x .10 cm. Bright pink or red 75%, Necrotic Soft, Adherent 25%, 3/18/20, Unstageable pressure ulcer to coccyx measuring 6 x 4.5 x unknown. Necrotic soft, adherent 100%. 3/25/20, Unstageable pressure ulcer to coccyx measuring 11.00 x 9.00 x Unknown. Necrotic soft, adherent 100%. A review of R1' nurse practioner Progress Notes indicated the following: During interview on 4/14/20, at 12:02 p.m. the clinical consultant (CC) stated R1's turning and repositioning schedule was set up on 3/13/20, but she was unable to verify if the schedule had been implemented. The CC stated any resident who admitted to the facility should have been on a turning and repositioning schedule. LPN-A stated when a a resident admitted on the transitional care unit the facility had a "closet care plan" and stated if offloading was on the closet care plan it would have been added to the comprehensive care plan. The director of nursing stated the closet care plan should have been uploaded into the electronic health record but they were unable to find it. In regard to notification to the physican or nurse practitioner, the CC stated the NP should have been notified of the decline sooner. The CC further stated a more comprehensive assessment should have been put in the medical record. On 4/14/20, at 12:52 a.m. family member (FM)-A	2 905		

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2 905	Continued From page 4 stated R1 had a lot of pain and had tried an air mattress in the hospital but when R1 would start to get comfortable, the mattress would shift and cause him discomfort. FM-A stated no one had told her R1's pressure ulcer was getting worse and stated if they had known R1 would have reconsidered the air mattress. FM-A stated she did not think R1 had been made aware the wound had been progressing. FM-A stated after R1 discharged from the facility, the home care nurse saw his pressure ulcer and recommended sending him to the hospital. FM-A stated R1 had the wound debrided and was receiving antibiotics. FM-A stated when R1 admitted to the facility, he had a wound on his butt cheek and nothing on his coccyx. She further stated on admission, the nursing staff had described the wound as "not so bad." Suggested Method of Correction: The Director of Nursing or designee could review policies and procedures, train staff, and implement measures to assure residents are receiving the necessary services to prevent or improve areas from occurring. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure care plans are accurate, implemented and appropriate care and services are monitored; to better ensure implementation of treatment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 905		