STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245182	A. BUILDING _____ B. WING _____	04/14/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record 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 REDACTED]. R2's significant change Minimum Data Set ((MDS) dated [DATE] 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 [MEDICAL CONDITIONS] 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 wheelchair. The care plan further identified a potential for impairment to skin integrity related to immobility,[MEDICAL CONDITIONS], 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 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 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE], 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. R1's care plan dated 2/19/20, identified a self care deficit related to [MEDICAL CONDITION]. 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 [MEDICATION NAME]=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 [MEDICATION NAME] 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 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 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 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) 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 room. At 11:47 a.m. staff entered room [ROOM NUMBER]. room [ROOM NUMBER] 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 [ROOM NUMBER] 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 [ROOM NUMBER], 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 [ROOM NUMBER]'s unit. At 1:08 p.m., NA-A and NA-D stated they were 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.