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	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas 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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43082 Based on observation, interview and document review, the facility failed to comprehensively assess the use of a restrictive device (bed sheet tied around legs with a knot) as a potential restraint for 1 of 1 resident (R1) reviewed. Findings include: Review of R1's annual Minimum Data Set (MDS) dated [DATE], identified R1 had intact cognition, and diagnoses included hypertension, heart failure, diabetes, anxiety disorder, depression, post-traumatic stress disorder, morbidly obese. Further MDS indicated R1 required substantial assistance for activities of daily living (ADL's) which included bed mobility and transfers. MDS did not indicate a use of restraints. Review of R1's skin assessment dated [DATE], indicated no injuries to skin on R1's lower legs where a bed sheet had been placed to restrain legs to assist from falling off the bed per residents request. Review of R1's current physician active orders dated 7/11/24, did not identify an order for a restraint. R1's medical record lacked any evidence a restraint assessment had been completed. Review of R1's care plan revised 5/17/24, identified R1 had a self-care deficit related bed mobility, was an extensive assist of 1-2 with transfers, total assist of 2 with hoyer lift, monitor and document on safety making, changes to plan of care as needed. R1 care plan further identified being a fall risk related to weakness, wheelchair bound and lower extremity wounds. R1 had chronic pain and the use of non-medicinal forms of pain relief such as positioning, rest, and massage. R1 also used pain medication and was to verbalize discomfort. During an observation and interview on 7/10/24 at 3:52 p.m., R1 was in bed lying on his back with head of bed elevated, R1 was leaning to the right side, bed sheet covering R1's body. R1's legs were in ace bandages and a bed sheet was wrapped around his calves with a knot tied. R1 confirmed he was not able to move legs out of knotted sheet. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 7/11/24 at 11:05 a.m., R1 was in bed, leaning toward his right side, bed sheet covering R1's body. Under bed sheet R1 legs had a bed sheet wrapped around calves and a knot was tied, R1 was not able to move legs out of the knotted sheet. During interview on 7/10/24 at 3:52 a.m., R1 stated, I am shackled right now and they do that so my feet don't go off the bed. R1 stated there had been no other interventions tried before using the sheet tied around his calves in a knot. R1 was unsure who decided to use the sheet to hold his legs with a knot. R1 stated he was scared to fall and felt this method did help him fell like he would not fall. During interview on 7/10/24 at 4:08 p.m., registered nurse (RN)-A stated R1 requested staff to put his legs in a bed sheet and knot them so they stay in position and do not fall off the bed. RN-A stated, we do what he says or he yells at us. RN-A recalled there was a doctors order to have his legs restrained. During interview on 7/11/24 at 11:15 a.m., nurses aide (NA)-A stated R1 directed his care and R1 requested to have his legs tide with a sheet so his legs do not fall off the bed. NA-A recalled R1 had requested this intervention for maybe a year or so. During interview on 7/11/24 at 11:23 a.m., licensed practical nurse (LPN)-A stated R1 asked LPN-A to wrap his legs in a sheet and directed his own care. LPN-A stated it was unknown if an assessment was completed to have R1 legs tied with a sheet, this was R1 preference. LPN-A stated they had been wrapping his legs with a sheet for a couple of weeks. LPN-A state it was not thought to be a restraint because R1 was requesting to have legs tied together and agreed R1 would not be able to get out of knot due to weakness and weight. During interview on 7/11/24 at 11:36 a.m., assistant director of nursing (ADON) stated R1 was requesting a sheet be wrapped around his legs but did not recall staff knotting the sheets. ADON stated neither an assessment nor an updated care plan had been completed at the time of the survey. ADON stated physical or occupational therapy had not been contacted and R1's physician was also not updated on R1's request for this procedure to be used on his legs. During interview on 7/11/24 at 11:47 a.m., director of nursing (DON) stated she was not aware of a sheet being used to restrain R1's legs from falling of the bed. DON confirmed assessments and recommendations needed to be completed before implementing a restraint and this process was not followed. Review of a facility policy titled [NAME] of Rights, modified dated 2/1/17, indicated 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. The facility must: A. Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.