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	11/19/2024

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44649 Based on interview and record review the facility failed to implement the baseline care plan developed for 1 of 5 resident (R1) reviewed. R1's care plan indicated he had cognitive concerns, and he was to have one-to-one staff care for him and 15-minute checks. R1 opened a facility fire door seated in his wheelchair and fell from his wheelchair on the concrete outside the facility door. The facility did not follow the safety measures outlined on the care plan. Findings include: R1's nursing progress note dated 10/27/24 at 12:00 p.m. indicated R1 was brought to the facility by emergency medical services (EMS). R1 was alert and oriented only to self. R1 was assist of one staff member with walker and a gait belt. R1 was a fall risk. R1 appeared confused and tried to leave the room towards the nursing stating wanting to return to his previous facility during the assessment. The nurse attempted to reorient and redirect patient. R1 was offered snacks. R1's baseline care plan dated 10/28/24 indicated safety monitoring would be implemented as needed to ensure residents safety, 15-minute safety checks and 1:1 staff to resident ratio. R1's admission Minimum Data Set (MDS) dated [DATE] indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 5 indicating R1 was severely cognitively impaired. R1's admitting diagnosis was encephalopathy (a brain condition often due to restricted blood or oxygen flow with symptoms including, confusion, agitation, personality changes, memory loss, twitching and seizures) and aphasia (a language disorder that affects a person's ability to understand, speak, read, and write). R1's nursing progress note dated 10/30/24 at 3:53 p.m. indicated at 1:30 p.m. R1 was found sitting on his bottom outside the building. R1 was unable to state what happened or how he got outside. A small skin tear was noted on his right arm. No other injuries noticed. R1 was sent to the hospital for observations due to the unwitnessed fall. Upon interview on 11/18/24 at 11:43 a.m. registered nurse (RN)-A stated he admitted R1. During the assessment R1 was confused talking about going to back to independent living. R1 was unable to process why he was at the facility. R1 was unrested during the assessed and needed to be redirected multiple times. R1 was given snacks until his family came to the facility to assist. RN-A stated he reported to the nurse manager that R1 was an elopement and fall risk. (continued on next page)

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon interview on 11/18/24 at 12:01 p.m. licensed practical nurse (LPN)-A stated she was the nurse manager on duty when R1 was admitted . She did not recall being told he was an elopement or fall risk. She stated if someone is admitted as an elopement risk the resident is given a Wander Guard bracelet (a technology system that helps keep at risk people safe to move around a facility freely) and the nurse practitioner is notified to get an order processed. Upon interview on 11/18/24 at 3:37 p.m. LPN-B stated after reading R1's baseline care plan she did not believe 15-minute safety checks were implemented or 1:1. She stated she is not certain what the nursing assistants (NA) see as a care plan when residents are admitted because most of the NA's use a hard copy daily assignment sheet, which doesn't get updated for 24-48 hours. Upon interview on 11/18/24 at 3:45 p.m. nursing assistant (NA)-A stated she took care of R1, and she did not recall seeing that R1 was to be 15-minute safety checks and he did not have 1:1 staff assigned. She stated R1 wandered frequently and was confused. NA-A stated when residents are on 15-minute safety checks the nursing assistants document the safety checks on a piece of paper. Upon interview on 11/19/24 at 10:30 a.m. NA-B stated he worked the day R1 ended up outside and falling. He stated R1's NA care plan did not have any interventions for his wandering. He stated R1 moved around the unit most of the day and NA-B redirected frequently away from doors. Upon interview on 11/19/24 at 11:03 a.m. RN-B stated she was the nurse who added the 15-minute checks and 1:1 to the nursing baseline care plan. She stated the interventions were autogenerated in the software system when she applied his diagnosis. She stated she left the intervention on the baseline care plan to make sure the NAs were aware R1 was an elopement risk due to wandering. She stated the facility was waiting for a Wander Guard order for R1. Upon interview on 11/19/24 at 11:22 a.m. NA-C stated when working with R1 the staff was constantly redirecting R1. NA-C stated she did see on R1's care plan that he should have been receiving 1:1 care and 15-minute safety checks. She stated she did mention it to an unidentified nurse and was told the facility was waiting for a Wander Guard for R1. Upon interview on 11/19/24 at 11:40 a.m. the director of nursing (DON) stated she was unable to find documentation for any safety checks for R1 because he was not on any. She stated the information on the care plan was autogenerated until the comprehensive care plan would be completed and should not have been on there. A facility policy titled Baseline Care Plan dated 7/2015 indicated the interdisciplinary team review the healthcare practitioner's orders and implement a baseline care plan within 48 hours of admission to meet the resident's immediate base care needs.