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	12/11/2024

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 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49338 Based on interview and document review, the facility failed to ensure timely follow-up on ordered radiologic studies for 1 of 3 residents (R2) reviewed for radiological services. Findings include: R2's quarterly Minimum Data Set (MDS) dated [DATE], indicated R2 had one unhealed stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.) and treatments including pressure ulcer/injury care. R2's wound care note by nurse practitioner (NP)-A dated 9/3/24, indicated R2 had a stage 4 sacral (located on the sacrum) ulcer. NP-A's treatment plan included wound care to sacrum, application of ointment to the surrounding area, aggressive offloading and repositioning, up for meals only and back in bed side to side, follow wound care team weekly, and order MRI (magnetic resonance imaging, a medical imaging test that produces a detailed picture of the inside of the body). R2's physician orders included an order dated 9/3/24, for MRI with or without contrast of sacral/coccyx area d/t [due to] sacral wound with bone exposure. R2's wound care note by NP-A dated 9/10/24, included pending MRI. R2's wound care note by NP-A dated 9/17/24, included pending MRI at this time. R2's wound care note by NP-A dated 9/24/24, included MRI is pending at this time. Nurse manager informed to follow up asap with HUC [health unit coordinator] regarding getting MRI schedule [sic] asap due to concerns of this wound and potential risk of bone infection. Review of R2's progress notes dated 9/3/24 to 9/25/24, did not identify any information regarding follow up on the ordered MRI. R2's progress note by the health information assistant (HIA) dated 9/26/24, indicated the HIA called a hospital to schedule the MRI, was asked to fax over information, would receive a form from the hospital to complete, and updated nurse managers. (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

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's progress note dated 9/29/24, indicated the MRI was to be scheduled to rule out osteomyelitis (infection of the bone). R2's wound care note by NP-A dated 10/1/24, included pending MRI - Nurse manager to follow up asap. Spoke with HUC - informed to schedule asap due to severity of nonhealing wound. R2's progress note by HIA dated 10/1/24, indicated the wound care provider spoke to the HIA and asked if the MRI had been scheduled yet. The HIA informed the provider that forms were faxed to a hospital and she was waiting to receive a form from the hospital to complete. The HIA called the hospital and was informed the MRI could not be scheduled there due to R2's insurance. The HIA contacted another hospital and faxed them requested information with plan to call later that day or the next morning to confirm receipt. The HIA updated nurse managers. R2's progress note by HIA dated 10/2/24, indicated the HIA called the hospital to follow up and scheduled the MRI for the first available appointment which was on 10/21/24. R2's wound care note by NP-A dated 10/8/24, included MRI scheduled for 10/21/24. R2's wound care note by NP-A dated 10/15/24, included MRI scheduled for 10/21/24. R2's wound care note by NP-A dated 10/22/24, included MRI scheduled for 10/21/24 - with pending results. In an interview on 12/11/24 at 9:54 a.m., NP-A stated she was previously R2's wound care provider but a different provider took over in December. NP-A stated R2 had a stage 4 sacral pressure ulcer and the bone was exposed. NP-A noted any time bone is exposed we worry about osteomyelitis and standard protocol was to complete an x-ray and then an MRI. NP-A noted an x-ray was ordered and completed and didn't show anything, so she put in the order for an MRI. She noted the MRI was a diagnostic tool intended to rule out if R2 had osteomyelitis. She stated, the issue I had with [R2] was why it took so long to get the MRI scheduled, I have no idea . I continuously inquired about it and had the nurse manager follow up on it . it should not have taken as long as it took to get an appointment in. NP-A stated waiting a week or two would have been fine and MRI appointments were usually scheduled a few weeks out, but she didn't know what took so long to even get her scheduled. NP-A stated she would have expected to see attempts to schedule the MRI ordered on 9/3/24 prior to 9/26/24. NP-A further stated, at least within two weeks I would expect to have an appointment scheduled. In an interview on 12/11/24 at 10:21 a.m., the HIA stated she recalled R2's MRI was difficult to schedule because of R2's insurance. The HIA noted nursing staff typically entered orders into the electronic health record (EHR) of residents and then made a copy for health information staff so they would know they needed to process things. The HIA stated she did not recall when she was made aware of R2's ordered MRI, but a copy would hopefully have come to health information so they were aware it needed to be scheduled. The HIA noted she recalled a nurse manager speaking to her about the urgent need to schedule R2's MRI and she then scheduled the MRI. The HIA stated she did not recall any efforts to schedule it prior to 9/26/24 and didn't think she had been aware of the order prior to that date. (continued on next page)

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/11/24 at 2:16 p.m., the director of nursing (DON) confirmed R2 had an MRI of the sacral/coccyx area ordered on 9/3/24. The DON confirmed the first noted follow-up on scheduling the MRI in R2's EHR was the progress note by the HIA dated 9/26/24 and it should have been sooner. She noted the nurse managers should have been following up to ensure it was scheduled. She stated she would not consider the MRI to have been scheduled in a timely manner and was not sure what had happened. The DON stated she was not aware of a policy related to imaging and diagnostics and thought it was important for the facility to have a better process in place. The DON stated the MRI order was placed late in the day on Tuesday 9/3/24 and should have been scheduled by Friday 9/6/24 or Monday 9/9/24 at the latest. The DON noted the situation did not meet her expectations or the needs of R2 for timeliness in scheduling the ordered MRI. The DON stated the facility was responsible for ensuring appointments were scheduled and orders were completed in a timely manner and the expectation was that orders would be executed as they were received. Facility policy titled Medication and Treatment Orders dated 2/2024, included Orders for medications and treatments will be consistent with principles of safe and effective order writing. Facility policy regarding imaging and diagnostic services requested but not received. Facility policy regarding completion of physician orders requested but not received.