STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245340	A. Building B. Wing	09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at St Paul	445 Galtier Avenue Saint Paul, MN 55103

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43080 Based on interview and document review, the facility failed to ensure a comprehensive, person-centered care plan was developed and adjusted as needed to promote continuity of care for 3 of 3 residents (R1, R2, and R3) reviewed for care planning. Findings include: R1's admission Minimum Data Set (MDS), dated [DATE], identified R1 admitted on [DATE] and was cognitively intact. The MDS outlined R1 required substantial physical assistance for toileting and setup/clean up assistance for oral hygiene. The MDS indicated R1 experienced occasional bladder incontinence and frequent bowel incontinence and was free of natural teeth. Further, the MDS outlined multiple Care Area Assessments (CAAs: items to have an in-depth review completed) were triggered for R1 which included, but was not limited to, Urinary Incontinence and Dental Care. Urinary incontinence was identified to be addressed in the care plan for improvement and to minimize risks. Dental care was identified to be addressed in the care plan to maintain current level of functioning and to minimize risks. R1's Bladder Evaluation, locked 3/25/24, identified R1 experienced occasional incontinence and requested the bed pan as needed. R1's Admission/Initial Data Collection V-5, locked 3/25/24, identified R1 utilized upper and lower dentures. R1's quarterly MDS, dated [DATE], identified R1 required substantial physical assistance for toileting and supervision or touching assistance for oral hygiene (increased assist from admission assessment), continued to experience occasional bladder incontinence and frequent bowel incontinence, and was free of natural teeth. R1's care plan, reviewed 9/19/24, identified multiple areas to record a, Focus [i.e., problem], with a corresponding goal and interventions. The care plan identified several focus areas; however, the care plan lacked focused areas for bowel and bladder incontinence and dental status/care. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's admission MDS and Optional State Assessment (OSA), both dated 4/23/24, identified R2 admitted on [DATE] and was cognitively intact. The MDS outlined R1 required supervision for bed mobility, limited physical assist for toileting and transfers, setup/supervision/touching assist for dressing, personal hygiene, and walking short distances, and that R1 did not walk longer distances. In addition, R1 sustained falls within the month prior to admission and the last two to six months prior to admission and received high-risk medications (antipsychotic, antidepressant, diuretic). Further, the MDS outlined multiple CAAs were triggered for R2 which included, but was not limited to, Functional Abilities (Self-Care and Mobility) with improvements to be addressed on the care plan, Urinary Incontinence with improvements to be addressed on the care plan as she required assist with toileting, Falls with goal to minimize risks from immobility and medications addressed on the care plan, and Psychotropic Drug Use to avoid complications to be addressed on the care plan. R2's Admission/Initial Data Collection V-5, locked 4/22/24, identified R2 experienced frequent pain which impacted her sleep and limited her day-to-day activities, was non-weight bearing to her right leg, and preferred evening showers. R2's quarterly MDS, dated [DATE], identified R2 was cognitively intact and required periods of supervision or touching assist with bed mobility; however, was independent with transfers and walking short distances. In addition, the MDS identified R2 reported occasional moderate pain which occasionally limited her day-to-day activities, continued use of high-risk medications, and that occupational therapy (OT) ended 5/21/24 and physical therapy (PT) ended on 5/22/24. R2's care plan, reviewed 9/19/24, identified several focus areas, however, these areas were left blank or not completed including but not limited to: Fall Risk related to, with an initiated date of 6/11/24 (approximately two months after admission). The focus statement lacked insight into risks. A goal identified Resident will be safe and free from falls, and the interventions lacked person centered approaches. One intervention was identified: Follow residents specific fall prevention plan: (Specify). The fall care plan lacked specifics. Alteration in mobility related to, with an initiated date of 6/11/24. The focus statement lacked insight into the alteration. A goal identified Resident will move safely within their environment. Interventions, all initiated on 6/11/24, were written as follows: PT per MD (medical doctor) order, Follow PT instructions, Assist with ambulation (Specify), Assist with movement in bed and in/out of bed, Assist with transfers (Specify). The mobility care plan lacked specifics for ambulation, transfers, PT instructions, or R2's wheelchair ability/use and directed for PT to continue despite its discontinuation on 5/22/24. Self care deficit related to, with an initiated date of 6/11/24. The focus statement lacked insight into the deficit. Goals identified: Resident will be accept assistance with self cares and Resident will be dressed, groomed, and bathed per preferences. Interventions, all initiated on 6/11/24, were written as follows: OT per MD order, Follow OT instructions, Assist with bathing (Specify), Assist with dressing (Specify), Assist with personal hygiene (Specify), Bathing Preferences (Specify), Dressing and personal hygiene preferences (Specify). The Self care deficit care plan lacked specifics and preferences and directed OT to continue despite its discontinuation on 5/21/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's care plan lacked focused areas for pain, toileting, and high-risk medication usage for antidepressant, antipsychotic, and diuretic use. R3's admission MDS and OSA, both dated 7/18/24, identified R3 admitted on [DATE] and was severely cognitively impaired with unclear speech and impairments with understanding and verbalization of need. The MDS outlined R3 required physical assist with cares and mobility, demonstrated total bowel and bladder incontinence, was diagnosed with diabetes, aphasia (impaired communication ability), cerebrovascular accident (CVA - stroke), dementia, hemiplegia/paresis (weakness on one side of body), and seizure disorder, was at risk for pressure ulcers, and was administered high risk medications (antidepressant - mood altering, hypoglycemic - blood glucose control). Further, the MDS outlined multiple CAAs were triggered for R3 which included, but was not limited to, Communication, Urinary Incontinence, Falls, Pressure Ulcer/Injury, and Psychotropic Drug Use. These identified the areas were to be addressed on the care plan and all areas lacked an overall objective for care planning. An Activities CAA was triggered with an objective for care planning to maintain current level of functioning and minimize risks. R3's Admission/Initial Data Collection V-5, locked 7/16/24, identified R3 preferred sponge baths. R3's nursing progress note, dated 9/3/24, identified R3 was found to have an open wound on her coccyx with a provider order for treatment. R3's nursing progress note, dated 9/16/24, identified the IDT (interdisciplinary team) met and discussed R3's coccyx wound [pressure ulcer]. New orders were discussed and R3 was to be repositioned per facility policy. R3's September 2024 Medication Admission Record (MAR) identified R3 received daily routine pain medications to right arm. R3's care plan, along with care plan revision histories, reviewed 9/19/24 (approximately two months since admission), identified several focus areas, however, these areas were left blank or not completed including but not limited to: Alteration in skin integrity, created on 8/9/24 (28 days after admission) with a goal that Resident will remain free from skin breakdown. The focus statement lacked insight into the alteration and the intervention area remained blank. Additionally, the focus, goals, interventions lacked information related to R3's coccyx ulcer. Self care deficit related to, created on 8/9/24 with a goal that Resident will be accept assistance with self cares and Resident will be dressed, groomed, and bathed per preferences. The focus statement lacked insight into the deficit and the intervention area remained blank. Fall Risk related to, created on 8/9/24 with a goal that Resident will be safe and free from falls. Interventions directed staff to Follow PT and OT instructions for mobility function. The focus statement lacked insight into the risk and the intervention area remained free of additional interventions or therapy instructions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Alteration in communication, created on 8/9/24 with a goal that Residents needs will be anticipated and met by staff. The focus statement lacked insight into the alteration and the intervention area remained blank. Alteration in elimination, created on 8/9/24, lacked insight into the alteration, and the goal(s) and intervention area remained blank Alteration in mobility related to, created 8/9/24 with a goal that Resident will move safety within their environment. The focus statement lacked insight into the alteration and the intervention area remained blank. R3's care plan lacked focused areas for right arm pain, activities, and high-risk medication usage for antidepressant and hypoglycemic use related to depression and diabetes. When interviewed on 9/20/24 at 10:57 a.m., wound care nurse practitioner (NP)-A stated she would expect resident care plans, especially those with wounds, to have a comprehensive care plan that included risk factors and interventions to prevent/decrease the risk for further concerns as the care plan was a main avenue for staff communication of specific resident information. During an interview on 9/20/24 at 1:33 p.m., nursing assistant (NA)-B stated resident Kardexes (NA care plans derived from the comprehensive care plan) were a main source of resident information which she reviewed when she needed details about a resident. When interviewed on 9/20/24 at 2:39 p.m., registered nurse (RN)-A stated the Kardex was utilized by the nursing assistants to know information such as preferences, risks, programs, etc. to keep the residents happy, safe, and free from harm. During an interview on 9/23/24 at 12:08 p.m., nursing assistant (NA)-D stated she utilized the Kardexes for resident information, especially when she was unfamiliar with a resident, and she expected specific information on the Kardex, especially as the group/assignment sheets lacked specific details and was not updated enough to reflect the residents' changing needs. When interviewed on 9/23/24 at 12:19 p.m., licensed practical nurse (LPN)-B stated the nurse managers were responsible for care planning processes. She was able to look at it but was unsure if she could edit it. LPN-B explained she expected the care plan to be comprehensive and contain enough information to assist with decreased risk factors such as ulcers or other higher risk concerns. During an interview on 9/23/24 at 1:10 p.m., LPN-D stated he was the unit care coordinator; however, care planning was completed by the director of nursing (DON) when the IDT met to discuss the residents. He felt this was a very effective way to ensure the care plans were maintained. He was unaware of any care plan completion concerns and explained he expected the care plan to provide enough information for staff to ensure tasks were performed and needed cares were provided. LPN-D stated if a care plan lacked enough information, risks for neglect would be increased. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 9/23/24 at 3:07 p.m., RN-B identified she was a corporate nurse who assisted the facility with the MDS process. She explained the facility usually completed much of the care plan and then once she edited the MDS and completed that process, she checked the care plan and would update anything that needed an update or add any missing items. RN-B stated the comprehensive care plan was expected to have all information needed for the resident to prevent problems, along with identified goals and personalized interventions. RN-B explained risks associated with incomplete care plans would impact the care a resident received which may then led to such things as skin breakdown or safety concerns such as incorrect transfers. During an interview on 9/23/24 at 4:08 p.m., the DON stated all resident information was expected on the care plan as this information pulled over into the Kardex. All departments were responsible to ensure the care plan was up to date. The DON stated, Our care plans are not great. She explained staff were afraid to add too many details to it, but she still expected enough information to be present for the residents to be cared for. This information included risks, goals, individualized interventions. The DON identified the facility policy was for the comprehensive care plan to be completed by day 21 of the resident's stay following the MDS process; however, the care plan started on admission with the baseline care plan process. The admitting nurse was expected to review the resident information, initiate the baseline care plan, and tweak the sections as needed within the baseline care plan assessment form, based on the resident information at the time of admission. The floor nurses did not adjust the care plan after that. After admission, and when changes arose, the nurse managers were required to review the care plan and make any additional adjustments as needed. If these processes were not followed, there were risks of missed information and the resident may not get the right care. During an interview on 9/24/24 at 9:49 p.m., RN-C identified she was a corporate nurse who assisted the facility with the MDS process. She explained the comprehensive care plan was expected to be completed when the care plan decision making decision on the MDS was dated. This was expected to be completed on or before the 21st day of a resident's stay. RN-C explained the comprehensive care plan was expected to address weaknesses and strengths for the continued maintenance of current function and to prevent declines. She stated facility staff were responsible to ensure the care plan was comprehensive and current for communication amongst team members and to meet the goals of the residents and her role was required to ensure things were in place. If this was not completed, this lack of information led to potential injury, falls, social isolation, unidentified or unmet needs, depression, skin breakdown, etc. A Care Planning policy, dated 1/6/22, identified each resident would have a person-centered care plan developed by the IDT for meeting the individual medical, physical, psychosocial, and functional needs. The policy directed the IDT, in conjunction with the resident and the resident representative were to develop and implement a comprehensive individualized care plan no later than the 21st day of admission. The care plan was to be consistent with the identified problem areas and their causes and interventions were to be developed that targeted and were meaningful to the resident. The careplan was to be used to develop daily care routines for the resident and was to be utilized by staff to provide care and services. The care plan was to be modified and updated as the condition and care needs of the resident changed. A Skin Assessment and Wound Management policy, dated 3/2024, directed that when a new skin problem was identified the care plan was to be reviewed and updated to include interventions and risks for skin breakdown.

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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** 43080 Based on interview and document review, the facility failed to comprehensively reassess pressure ulcer risk and adjust the care plan for 1 of 1 residents (R3) who developed an avoidable stage ll (i.e., partial thickness tissue loss) pressure ulcer to R3's coccyx (tailbone area). Findings include: R3's admission MDS and Optional State Assessment (OSA) Item Set, both dated 7/18/24, identified R3 admitted on [DATE] from an acute care hospital and was severely cognitively impaired with unclear speech and impairments with understanding and verbalization of need. The MDS outlined R3 required physical assist with cares and mobility, demonstrated total bowel and bladder incontinence, was diagnosed with diabetes, aphasia (impaired communication ability), cerebrovascular accident (CVA - stroke), dementia, diabetes, hemiplegia/paresis (weakness on one side of body), and seizure disorder, and was at risk for pressure ulcers based on clinical assessment and a formal assessment instrument/tool in which R3 utilized a pressure reducing device for her bed. Despite this, she was free of pressure ulcers or other coded skin impairments. Further, the MDS outlined multiple CAAs were triggered for R3 which included, but was not limited to, Pressure Ulcer/Injury. This CAA identified R3 was at risk for pressure ulcers related to her need for extensive to total physical assist with mobility and activities of daily living (ADLs), bowel and bladder incontinence, a decline in mobility following hospitalization for seizures, history of stroke with dysphagia, aphasia, and right hemiplegia, impaired communication with her being overall non-verbal but was usually able to make needs known, and aspirin medication usage. R3 was assessed to have bilateral upper extremity bruising. Interventions included an incontinent product to keep R3's skin dry, toileting and repositioning every two hours and as needed (PRN), routine skin cares every morning and with evening cares, and weekly skin inspections. R3's Braden Scale for Predicting Pressure Sore Risk, locked 7/13/24, identified R3 was at moderate risk with a score of 13 related to a slightly limited ability to respond to meaningful pressure-related discomfort, rare exposure to moisture, bedfast/confined to bed, immobility and unable to make even slight changes in body or extremity positions without assist, probably inadequate nutritional intake, and potential problem for friction and shearing. R3's nursing progress note, dated 9/3/24, identified R3 was found to have a 2 cm (centimeter) by 2 cm open wound on her coccyx and an open wound on butt line. The provider was updated, and wound care orders were received. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Risk Management Skin Tear form, dated 9/3/24, identified the open wound as a skin tear. The form lacked additional wound assessment information. Immediate Action Taken described the area was cleansed with normal saline, covered with a foam dressing for protection, and on call provider, husband, and unit manager were updated. The description lacked immediate interventions to prevent additional wound development(s). The sections for Predisposing Physiological and Situation Factors were blank. The form Notes section identified that on 9/6/24, the IDT met and R3 was assessed to have a stage II pressure ulcer to her coccyx area. Adjusted orders were obtained and the dietician was updated. In addition, R3 received [nutritional] supplements and will be turning and repositioning every two to three hours and PRN. A Skin and Wound Evaluation V7.0, locked 9/6/24, identified R3 was assessed for a stage II pressure ulcer. The form allowed for an Exact Date of onset, which was blank. The Wound Measurements were 3.6 cm in length and 0.7 cm in width. Depth was Not Applicable. Wound Bed, Exudate (drainage), Periwound, Wound Pain, and Orders (Goal of Care) were all blank. An area under Treatment allowed for Additional Care interventions; these were all unchecked. The Progress section identified the area was New; however, the remained of the section questions remained blank. A Wound Consult provider visit form, dated 9/11/24, identified R3's visit was conducted by nurse practitioner (NP)-A and was for a chief complaint of an unstageable coccyx ulcer, impaired skin integrity, muscle weakness, and limited mobility. The ulcer was sloughy (dead tissue) with peri wound maceration (wet edges) which required sharp wound debridement (removal of non-healthy tissue). As R3 had limited mobility, aggressive repositioning and offloading was discussed with staff. The form indicated R3 displayed multiple comorbidities for wound healing and wound progression, as well as risk for wounds which included diabetes, hypertension, malnutrition, incontinence, and limited mobility and muscle weakness. A Skin and Wound Evaluation V7.0, initiated on 9/11/24 and completed by NP-A, identified R3 was assessed for an unstageable pressure ulcer due to 100 percent slough and/or eschar covering the wound bed. The Wound Measurements indicated 0.8 cm length by 0.6 cm width. Exudate was moderate and the wound edges were macerated. Additional Care identified the following items were checked: mobility aid(s) provided, moisture barrier and control, nutrition/dietary supplementation, positioning wedge, repositioning device(s), and turning/repositioning program. The wound was Stable. R3's nursing progress note, dated 9/16/24, identified the IDT (interdisciplinary team) met and discussed R3's coccyx pressure ulcer. New orders were discussed and R3 was to be repositioned per facility policy. A Wound Consult provider visit form, dated 9/18/24, identified R3's visit was conducted by NP-A. R3's wound remained sloughy with peri wound maceration and increased excoriation (superficial loss of tissue). The wound had deteriorated some and appeared a little more deeper this week. NP-A spoke to the nurse manager about an air mattress and recommended house stock barrier cream for skin protection during peri cares. A Skin and Wound Evaluation V7.0, initiated on 9/18/24 and completed by NP-A, identified R3's unstageable (covered 100 percent with slough) coccyx ulcer measured 1.7 cm in length and 0.7 cm in width. Moderate exudate was present, and the peri wound was excoriated and macerated. Wound Progress was Deteriorating. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's medical record, from 9/3/24 through 9/19/24, lacked evidence R3's pressure ulcer risk was comprehensively reassessed by nursing staff after the pressure ulcer was identified. R3's care plan, along with care plan revision histories, reviewed 9/19/24 (approximately two months since admission and 16 days after the pressure ulcer was first discovered), identified multiple areas to record a, Focus [i.e., problem], with a corresponding goal and interventions, however, these areas were left blank or not completed including but not limited to: Alteration in skin integrity, created on 8/9/24 (28 days after admission) with a goal that Resident will remain free from skin breakdown. The focus statement lacked insight into the alteration and the intervention area was blank. Additionally, the focus, goals, interventions lacked information related to R3's coccyx pressure ulcer or NP-A's wound care/interventions. Self care deficit related to, created on 8/9/24 with a goal that Resident will be accept assistance with self cares and Resident will be dressed, groomed, and bathed per preferences. The focus statement lacked insight into the deficit and the intervention area remained blank. Alteration in communication, created on 8/9/24 with a goal that Residents needs will be anticipated and met by staff. The focus statement lacked insight into the alteration and the intervention area remained blank. Alteration in elimination, created on 8/9/24, lacked insight into the alteration and the goal(s) and intervention area remained blank. Alteration in mobility related to, created 8/9/24 with a goal that Resident will move safety within their environment. The focus statement lacked insight into the alteration and the intervention area remained blank. R3's comprehensive care plan lacked evidence her pressure ulcer risk, assessed with the CAA process, was care planned to decrease the risk for pressure ulcers. In addition, R3's comprehensive care plan lacked updates reflective of the identified pressure ulcer and wound care recommendations. During an interview on 9/20/24 at 10:57 a.m., NP-A stated R3 displayed limited mobility due to a past stroke and was at risk for pressure ulcers; however, If [R3] was turned appropriately [the ulcer] could have been avoidable. NP-A expected some kind of interventions in R3's care plan especially interventions for repositioning and some sort of comprehensive assessment within 24 hours after an ulcer is discovered to determine continued pressure ulcer risk and to assess for any changes in resident status. If these were not completed, R3 was at additional increased risk for further skin breakdown or worsening of the current ulcer. When interviewed on 9/20/24 at 1:17 p.m., nursing assistant (NA)-A stated he was unaware of who had pressure ulcers or other alterations in skin integrity. For this information, he explained he would need to review the care plan or the group/assignment sheets. NA-A identified, after he reviewed the group/assignment sheet, this sheet lacked such information, nor did the sheet contain repositioning/toileting plans or interventions to decrease pressure ulcer risks. NA-A stated he was unaware if R3 was on an individualized repositioning plan, toileting plan, or that R3 required any additional care(s) for her skin; however, he explained all those at risk should be repositioned and toileting cares managed every two hours. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/20/24 at 1:33 p.m., NA-B stated she worked with R3 at times and was unaware if R3 had a pressure ulcer. She indicated she would need to follow up with the nurse and/or review the care plan for such information. In addition, she was unaware of R3's individualized pressure ulcer risk interventions; however, she explained everyone was on every two-hour, or as needed, repositioning and toileting plan. When interviewed on 9/23/24 at 11:54 a.m., NP-B identified she was one of R3's providers. She expected R3's care plan included risk factors based on a comprehensive skin/pressure ulcer risk assessment before, and after, a pressure ulcer was discovered. This ensured proper interventions and planning were implemented to prevent worsening of the area and to avoid any additional open areas. NP-B identified R3 was at a high risk for pressure ulcers, and she expected R3 to be care planned, at least, for every two-hour repositioning. During an interview on 9/23/24 at 12:08 p.m., NA-D stated she expected interventions for resident care to be on the Kardex so that she knew what to do and explained this was important as the group/assignment sheets lacked specific details and was not updated enough to reflect the residents' changing needs. NA-D was aware R3 had a pressure ulcer as that was why they repositioned her every two hours. She was unsure if this was on R3's Kardex; however, she expected it was as many agency staff worked for the facility and they needed to know such information. When interviewed on 9/23/24 at 12:19 p.m., licensed practical nurse (LPN)-B stated R3 had a pressure ulcer; however, she was unsure as to what the care plan identified as interventions for this and additional pressure ulcer risk reduction. She indicated she would need to review R3's care plan for specific details as she expected such interventions to be present. During an interview on 9/23/24 at 4:08 p.m., the DON stated R3's pressure ulcer was considered avoidable as the ulcer was very superficial and R3 sat for long periods, and if staff repositioned R3 every two to three hours, it could have been prevented. The DON stated when R3's husband was here, R3 sat up for longer periods of time. The DON stated if a resident were assessed for increased pressure ulcer risk, especially a Braden of 13 or less, this was expected to be on the care plan and individualized interventions initiated, such as w/c cushion, pressure reduction mattress, offloading every two to three hours and as needed. In addition, once an ulcer was found, the resident's risk should again be reassessed, and the care plan updated to reflect any risks/findings. A Skin Assessment and Wound Management policy, dated 3/2024, directed a pressure ulcer risk assessment (Braden Scale) was to be completed per the assessment schedule/grid and appropriate preventative skin measures were to be implemented such as, but not limited to, mobility and repositioning plans and a pressure reduction plan. When a pressure ulcer was identified, staff were expected to review and update the care plan including interventions, update resident care lists, and update the care plan to identify risks for skin breakdown.

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	245340	A. Building B. Wing	09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at St Paul	445 Galtier Avenue Saint Paul, MN 55103

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. 43080 Based on interview and document review, the facility failed to verify nurse aide registration for 1 of 1 agency nursing assistants (NA-A) prior to allowing the individual to serve as a nurse aide and work directly with facility residents. This had the potential to affect all residents on the transitional care unit (TCU). Findings include: During an interview on 9/20/24 at 1:17 p.m., NA-A stated this was his first time working at the facility. NA-A identified he provided cares that morning to residents that included tasks such as hygiene and dressing cares, feeding, and mechanical lift transfers. When interviewed on 9/20/24 at 2:10 p.m., staffing coordinator (SC) stated 9/20/24 was NA-A's first shift and his agency staffing request was last minute. SC identified the director of human resources (DHR) managed facility staff and agency paperwork. During an interview on 9/20/24 at 2:25 p.m., DHR stated she only managed facility staff paperwork and did not follow-up on paperwork related to agency staff. She explained agency paperwork was SC's responsibility as SC collaborated with the agencies for staffing needs. When interviewed on 9/20/24 at 2:33 p.m., the administrator stated she expected DHR and SC worked together to ensure agency staff met requirements, which included licensure or nurse aide verification. She explained these processes were required to ensure resident safety. During subsequent interviews on 9/20/24 at 3:37 p.m. and 3:59 p.m., SC stated the agencies were responsible to ensure nursing staff were licensed or registered as a nursing assistant; however, when a new agency staff was confirmed for shift pickup, she requested information from an agency electronic portal system that included licensure or nurse aide verification. Based on the specific agency processes, either this information was viewed directly within the portal, or the information was required to be requested via an email link. An email link process was required per NA-A's agency processes. SC stated nursing assistants were required to have an active nurse aide registration before the aide worked with residents which ensured resident safety, but being NA-A's shift request was last minute she was unable to verify NA-A's registration prior to his shift. SC identified she submitted the email link request for NA-A's information that day, early afternoon or late morning. During the interview, an email, from NA-A's agency to SC, dated 9/20/24 at 2:54 p. m., was provided and identified NA-A's active nurse aide registration. SC stated the facility accessed the portal for agency staff information and thus did not maintain agency staff employee files. An Abuse Prohibition/Vulnerable Adult Policy, dated 3/2024, identified potential employees were screened for a history of abuse, neglect, or mistreating residents and license or nursing assistant registry checks were to be completed on facility employees when indicated.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43080 Based on interview and document review, the facility failed to ensure a medicated powder for a fungal skin infection was transcribed when ordered, and thus applied, in accordance with provider orders for 1 of 3 residents (R1) reviewed for skin breakdown. Findings include: A wound care provider progress note, dated 8/28/24, identified R1 was assessed by nurse practitioner (NP)-A for left gluteus (buttocks) moisture associated skin damage (MASD) with observed peri area and groin intertrigo rash (skin condition caused by friction, heat, and moisture between skin folds). NP-A cleansed and applied Nystatin (anti-fungal medication) to R1's backside. The note directed the continued application of Clortrimazole-Betamethasone cream (anti-fungal medication) as previously ordered; however, did not reflect directions for facility Nystatin use. A Skin and Wound Evaluation form, dated 8/28/24, completed by NP-A, identified R1 was assessed for left gluteus incontinence associated dermatitis (condition that causes swelling and irritation of the skin). The form lacked measurements and the area demonstrated moderate serosanguineous exudate (blood and blood serum drainage) with an epithelial (tissue that covers damaged skin) wound bed. The area lacked signs of infection or pain. The area's progress was stable. A wound care provider order, dated 8/28/24, identified the wound care provider ordered Nystatin 100,00 units powder and directed its application to R1's bilateral breast folds, abdominal folds, and groin area three times a day (TID). The order was initialed by health information assistant (HIA)-A and dated 8/28/24. In addition, the order identified licensed practical nurse (LPN)-F's initials. R1's August Medication Administration Record (MAR), identified the 8/28/24 Nystatin order was scheduled to start on 8/29/24. The order was set up to be applied each day at 8:00 a.m., 12:00 p.m., and 4:00 p.m. The MAR from 8/29/24 at 8:00 a.m. through 8/31/24 at 4:00 p.m., indicated nine episodes for application; however, all nine episodes lacked administration identification at the designated dates and time frames. R1's September MAR, identified the 8/28/24 Nystatin order was scheduled to start on 8/29/24. The order was set up to be applied at 8:00 a.m., 12:00 p.m., and 4:00 p.m. The MAR from 9/1/24 at 8:00 a.m. through 9/3/24 at 12:00 p.m., indicated eight episodes for application; however, all eight episodes lacked administration identification at the designated dates and time frames. The MAR identified the Nystatin was first applied on 9/3/24 at the designated 4:00 p.m. timeframe by LPN-F. An Order Audit Report, identified R1's Nystatin was ordered on 8/28/24 at 5:07 p.m., and Queued (maintained in the order system until verified by a nurse) on 8/28/24 at 5:12 p.m.; however, the report indicated the order was created, confirmed, and revised on 9/3/24 at 6:11 p.m., by HIA-A. The report lacked information that supported the order was created and confirmed on 8/28/24 when ordered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A wound care provider progress note, dated 9/4/24, identified R1 was assessed by NP-A for the left gluteus/peri area/groin intertrigo rash. NP-A cleansed the area and applied anti-fungal. Due to a severe deterioration with the wound status, the nurse manager, and the director of nursing (DON) were updated. The note directed Nystatin to the areas TID with a dermatology appointment scheduled for 11/12/24. A Skin and Wound Evaluation form, dated 9/4/24, completed by NP-A, identified R1 was assessed for left gluteus incontinence associated dermatitis. The area measured a length of 8.7 cm and a width of 2.9 cm with a granulation (tissue that precedes epithelialization) wound bed. The area continued to demonstrate moderate serosanguineous exudate, lacked signs of infection, and/or pain. The areas progress was deteriorating. When interviewed on 9/20/24 at 10:57 a.m., NP-A stated R1's peri-groin area excoriation, related to moisture and fungal factors, over the past couple of months appeared to rapidly spread from the buttocks to the upper back and even into the breast regions which was aggressively treated with oral anti-fungal medication and creams/powders. NP-A stated she was unsure of the cause for the 9/4/24 identified decline, especially as this excoriation fluctuated in status. She denied knowledge of the missed 8/28/24 Nystatin order applications. Once provided MAR information, NP-A indicated she assumed it was not administered as ordered. NP-A explained there was always the potential for R1's skin concerns to deteriorate if the Nystatin was not applied; however, she was not 100 percent sure this was the reason based on R1's many risk factors. During an interview on 9/23/24 at 12:48 p.m., the DON was unaware of any medication concern related to R1. After she reviewed R1's August and September MARs, she stated the Nystatin order was there; however, was not given. The DON reviewed R1's progress notes and identified the progress notes lacked related details. She stated she needed to converse with staff prior to any thoughts on potential reasons for the blank MAR spots. The DON was unaware of any potential risks to R1 related to the potentially missed applications; however, she identified she observed R1's rash on 9/4/24 and the rash lacked improvements. She expected the staff to apply the Nystatin as ordered to help resolve R1's fungal infection. On 9/23/24 at 1:51 p.m., the DON and the administrator approached the surveyor and reported they investigated the missed Nystatin, and it was identified the order process was not initially completed, and the order was revised on 9/3/24. Prior to 9/3/24, because of an unidentified process error, staff were unable to see the order, thus, they were unaware of the need for the Nystatin application. In response, this error was a transcription error. Both denied previous error knowledge despite expectations staff should have alerted them to the error [on 9/3/24]. When interviewed on 9/23/24 at 2:44 p.m., HIA-A stated she initially entered provider orders into the electronic health record which pushed the orders into a que. When in this que, it was then the responsibility of the nurses to double check the order. HIA-A explained if she became aware of any order errors, she was expected to update the floor nurse and the nurse then took care of it. She only updated the DON on order errors when the nurse was unavailable. HIA-A was shown R1's Nystatin order; however, she lacked remembrance to any details surrounding the order and denied any insight into what potentially occurred during the order process(es). HIA-A denied being spoken to about the Nystatin order. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/23/24 at 2:56 p.m., LPN-F acknowledged the 8/28/24 Nystatin order contained his initials; however, he lacked remembrance to any details surrounding the order, any associated processing concerns, or the date he double checked the order. On 9/23/24 at 3:31 p.m., the pharmacy was contacted. Pharmacy tech (PT)-A indicated R1's Nystatin order was received on 8/28/24 and supplied to the facility on [DATE]. A Medication Error Procedure, dated 1/2020, directed when a medication error occurred, the person responsible for the error, or the person who found the error, was to complete a Medication Error Reconciliation Report. In addition, the medical provider was to be updated, facility management was to complete an Investigation Summary, the person(s) making the error were to be followed up with, and the error was to be presented during routine quality assurance meeting(s). This assisted in the prevention and detection of adverse consequences such as adverse drug reactions and side effects. A Medication and Treatment Orders policy, dated 2/2024, identified orders for medications and treatments was to be transcribed accurately and in a timely fashion for consistent principles of safe and effective order writing.