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	03/04/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44654 Based on interview and document review, the facility failed to ensure neglect did not occur when a staff member nursing assistant (NA)-A failed to answer call lights for a resident timely and instructed the resident to not use their call light unless it was an emergency for 1 of 3 residents (R1) reviewed for neglect. Findings include: R1's admission Minimum Data Set (MDS) comprehensive assessment was not completed as R1 was in the facility just over 24 hours. R1's 48-hour care plan was not completed as he had been in the facility just over 24 hours. R1's progress notes dated 2/26/25 at 11:05 p.m., indicated R1 was admitted on [DATE] around 6:30 p.m., and was alert and oriented. R1's progress notes dated 2/27/25 at 9:30 a.m., indicated staff offered R1 psychiatric services due to R1 had fears related to health and his recent amputation. R1's progress note dated 2/27/25 at 5:31 p.m., indicated R1 called 911 to go to the hospital and left the facility at 6:40 p.m. on 2/27/25. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/4/25 at 2:20 p.m., NA-A stated R1 arrived at night, appeared confused, and R1 would try to remove his incontinence brief. When NA-A checked on him, his underwear was down to his knees. NA-A stated he would inquire if R1 needed to use the bathroom and R1 did not understand what he was asking. NA-A indicated, I assumed something was wrong with him cognitively. NA-A stated when R1 activated his call light, R1 wanted his brief changed almost every time and needed to be changed only once. NA-A indicated R1 activated his light when he wanted water, ice, a pain pill, a different blanket, and asked for Ensure twice. NA-A stated he assessed if R1 would continue to use his call light, and further stated, I waited ten minutes to respond and then went back to check on him to see if he really needed something more than a cup of water or ice. The light would keep going off until I responded. I knew it was him, because the roommate was out of the room a lot of the time. If the call light was going off in the other rooms, I looked to see if others needed lights answered first. If someone pulls a bathroom alarm, that's a different light, and I answered those first. I would just check in on him periodically, like every 10 minutes, instead of answering the light. Additionally, NA-A stated, When [R1] needed his wound wrapped, I would say the nurses will get to you when the nurses get to you. I would leave and he would press it [the call light] again. Maybe something could happen in the 5 seconds when I was just there. I have been doing this for a while. It was a behavioral issue. I am experienced. I have been here 3 months. I was a CNA in [another city] for 6 months. I did let him know, unless it was something super important, like an emergency, he needed to ease off the light. I don't think he would remember most things. I did tell him he needed to ease up on the frequency of the call light. Maybe he didn't remember pressing the call light. We really did try to accommodate him. After a time, it was taking away from all the other residents with his confusion. the only thing he really needed was his wound changed. We had others who needed theirs done too. During an interview on 3/4/25 at 3:02 p.m., registered nurse (RN)-A stated R1 used his call light frequently however, expected that as it was R1's first day at the facility and R1 was adjusting to the new environment. RN-A stated it was not acceptable if NA-A made R1 wait for a call light response. We wouldn't know if it was important unless we answered the light. RN-A stated R1 had the right to use his call light and should not have been told to not use it. RN-A stated she was unaware NA-A was not answering R1's light and would have written NA-A up and told the nurse manager if she had known. RN-A stated, In a sense, it is neglect. During an interview on 3/4/25 at 3:09 p.m., RN-B stated he did not know NA-A was not answering R1's call lights, and was also not aware NA-A instructed R1 to not use his call light so frequently. RN-B stated call lights were answered by priority for those with physical needs, medication needs, treatments, and wound cares, however, further acknowledged staff would not know the urgency of the need until they answered the light. RN-B indicated when a resident arrived at night, was elderly, or had cognitive impairment, like R1, the resident may use the call light more. RN-B stated if he had known NA-A told R1 to stop using his light so much, he would have reported the NA to the director of nursing (DON) and would inquire about reporting the NA to the State Agency. During an interview on 3/4/25 at 5:08 p.m., the administrator stated she expected staff to answer call lights within five to 10 minutes and if they were not able to, they should ask for assistance from another staff. The administrator stated she was not aware NA-A told R1 to limit the use of his call light and it did not align with the facility ideals. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/4/25 at 5:21 p.m., DON stated she expected staff to answer call lights within five minutes, every time the resident activated it, and answering it every ten minutes was not acceptable, and stated, If could be an emergency, it could be life and death, and you don't know until you go in the room. Review of facility policy titled The Abuse Prohibition/Vulnerable Adult Plan dated 2/2/2023, indicated neglect was the failure of the facility, its employees or service providers to provide goods and services to a resident that were necessary to avoid physical harm, mental anguish, or emotional distress.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 44654 Based on observation, interview and document review, the facility failed to follow infection control guidelines to ensure beard nets were worn by staff who prepared food in the kitchen. This practice had the potential to affect all the residents, staff, and visitors who ate food prepared in the kitchen. Findings include: During an observation on 3/4/25 at 12:41 p.m., cook (CK)-A was observed working in the kitchen where food was being prepared by other staff. CK-A had a full beard, was not wearing a beard net and walked by where the food was being prepared. CK-A stated he worked preparing food on 3/4/25 and 3/5/25, without a beard net because the facility was out of them. CK-A stated he knew he was supposed to wear a beard net to prevent hair from getting into the food. During an interview on 3/4/25 at 12:49 p.m., dietary aide (DA)-A stated the kitchen manager was not in the facility as she left to buy beard covers. During an interview on 3/4/25 at 5:08 p.m., the administrator stated she expected staff to wear a beard cover while preparing food, and if the facility did not have a supply, staff should have communicated the need to her so she could borrow from a sister facility if needed. Review of The Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices facility policy dated October 2017, indicated hair nets and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils, and linens.