

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245340	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/28/2025
NAME OF PROVIDER OR SUPPLIER The Villas at St Paul		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Upon observation, interview, and record review the facility failed provide the necessary services of oral hygiene for 5 of 6 residents (R1, R2, R3, R4, R5) reviewed for activity of daily living.</p> <p>Findings include:</p> <p>R1's admission Minimum Data Set, dated [DATE] indicated R1's Brief Inventory of Mental Status (BIM)s score was 00 indicating R1 was severely mentally impaired. R1 required moderate assistance with oral hygiene and eating. He required maximum assistance with dressing and transferring. R1's pertinent diagnose were alcoholic cirrhosis of the liver (severe liver disease caused by excessive alcohol), adult failure to thrive, and cachexia (weight loss of more than 10% in a person not trying to lose weight).</p> <p>R1's care plan dated 3/13/25 indicated R1 was to receive minimum assistant of 1-2 with personal hygiene.</p> <p>Upon observation and interview on 3/27/25 at 2:18 p.m. R1 was lying in bed wearing a hospital gown, two friends were visiting. A plastic basis was observed in his room with an unopened toothbrush wrapped, an unopened box of toothpaste and toothettes (a disposable single use oral care swab with a sponge on one side of the stick used for oral cares. When a toothette was held up to show R1 he stated he did not know what that was. R1 stated he had never been assisted with oral cares at the facility.</p> <p>Upon interview on 3/27/25 at 3:20 p.m. nursing assistant (NA)-A stated he was not certain if the toothettes were to be used with R1 how often, or if he has to use a toothbrush. He stated he had not worked with R1 prior to the day of the survey. He stated orals are to be completed every a.m. and every p.m.</p> <p>R2's significant change MDS dated [DATE] indicated R2 BIMs score was a four indicating R2 was cognitively impaired. R2 was totally dependent upon staff for eating, oral cares, toileting, bathing, dressing, hygiene and transferring. R2's significant diagnoses were paranoid schizophrenia (delusions and hallucinations), hyperparathyroidism (thyroid dysfunction when the glands produce too much parathyroid hormone), and bullous pemphigoid (autoimmune skin disorder characterized by large blisters).</p> <p>R2's care plan dated 3/28/25 indicated R2 had an alteration in dental care related to missing teeth. She was to have oral cares and every and per her request.</p> <p>(continued on next page)</p>

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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Upon observation and interview on 3/28/25 at 9:12 a.m. R2 did not have oral care supplies in her room. She stated staff did not assist her with caring for her mouth.</p> <p>R3's nursing admission note dated 3/24/25 indicated R3 was able to make his needs know.</p> <p>R3's care plan dated 3/25/25 indicated R3 required staff assistance with dressing and personal hygiene. The plan did not indicate oral hygiene specifically.</p> <p>R3's admission MDS dated [DATE] was not completed on the date of survey.</p> <p>Upon observation and interview R3 had a plastic basin in his room with an unopened toothbrush wrapped in plastic and an unopened tube of toothpaste. R3 stated he had not brushed his teeth since his admission. He stated he was not certain whether staff was assisting him with that or not.</p> <p>R4's care plan dated 3/6/25 indicated R4 was at risk for dehydration, staff was to education resident, family on the importance of fluid intake. Staff was to observe R4 for dehydration, decreased skin turgor, dry mucous membranes, lethargy, fatigue, low urine output, hypotension (low blood pressure) and increased in falls.</p> <p>R4's annual MDS dated [DATE] indicated a BIMs score was not indicated. R4 was dependent on staff for eating, oral hygiene, toileting hygiene, bathing, dressing, and transferring. R4's pertinent diagnoses were autistic disorder (development disorder that impairs the ability communicate and interact), adjustment disorder with mixed anxiety and depression and drug induced dyskinesia (involuntary repetitive, and abnormal movements).</p> <p>Upon observation and interview on 3/28/25 at 9:35 a.m. R4 was in bed. R4 stated staff was to assist him with brushing his teeth as had mouth issues, however he had oral cares approximately 2-3 times a week.</p> <p>R5's admission MDS dated [DATE] indicated R5's BIMs score was a seven indicating R5 was cognitively impaired.</p> <p>R5 required set-up for eating, moderate assistance for oral hygiene, dressing, and transferring.</p> <p>Upon observation and interview on 3/28/25 at 10:09 a.m. R5 oral supplies were not observed in his room. He stated he was able to brush his own teeth, however needed the equipment to do so.</p> <p>Upon interview on 3/28/25 at 12:19 a.m. the director of nursing (DON) stated if assistance with oral care was on the care plan the staff was to assist them with oral care every morning and evening.</p> <p>A facility policy titled Activities of Daily Living (ADL's) Maintain Abilities Policy indicated: Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility would provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>individual's clinical condition demonstrate that such diminution was unavoidable.</p> <p>2. The facility will ensure a resident is given the appropriate treatment and services to maintain or improve their ability to carry out the activities of daily living.</p> <p>3. The facility will provide care and services for the following activities of daily living:</p> <ul style="list-style-type: none"> a. hygiene, bathing, dressing, grooming, and oral care, b. Mobility-transfer and ambulation, including walking, c. Elimination-toileting, d. Dining-eating, including meals and snacks. e. Communication, including speech, language, and other functional communication systems. <p>4. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; and basic life support.</p>

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<p>F 0807</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Upon observation, interview, and record review the facility failed to provide drinks, including water consistent with the resident needs and preferences and sufficient to maintain resident hydration for 5 of 6 residents (R1, R2, R3, R5, and R6) reviewed for hydration.</p> <p>Findings include:</p> <p>R1's Clinical Nutritional assessment dated [DATE] indicated R1's goal was for R1 to remain as nourished and hydrated as possible within the disease process.</p> <p>R1's admission Minimum Data Set, dated [DATE] indicated R1's Brief Inventory of Mental Status (BIM)s score was 00 indicating R1 was severely mentally impaired. R1 required moderate assistance with oral hygiene and eating. He required maximum assistance with dressing and transferring. R1's pertinent diagnose were alcoholic cirrhosis of the liver (severe liver disease caused by excessive alcohol), adult failure to thrive, and cachexia (weight loss of more than 10% in a person not trying to lose weight).</p> <p>R1's care plan dated 3/13/25 indicated staff was to offer fluids and snacks between meals.</p> <p>Upon observation and interview on 3/27/25 at 2:18 p.m. R1 was lying in bed wearing a hospital gown. R1 had two friends visiting him. One of the friends stated R1 never had water when he visited. R1's friend gave him a drink of water out of the cup she was drinking from. R1's mouth was dry, and he did not have fresh water or other liquids in his room to drink. A professional interpreter was called. R1 stated he only received fluids with his meals and with his medications. He would have liked water throughout the day.</p> <p>Upon interview on 3/27/25 at 3:20 p.m. nursing assistant (NA)-A stated he was not certain whether R1 was supposed to have water or not because R1 had an Aspira catheter (an indwelling catheter that removes flood from the abdominal area) in place and R1 was a relatively new resident.</p> <p>R2's physician orders dated 6/27/25 indicated staff was to observe R1 for dehydration, decreased skin turgor (elasticity of the skin), dry mucous membranes, lethargy, fatigue, low urine output, hypotension (low blood pressure) and increased in falls.</p> <p>R2's significant change MDS dated [DATE] indicated R2 BIMs score was a four indicating R2 was cognitively impaired. R2 was totally dependent upon staff for eating, oral cares, toileting, bathing, dressing, hygiene and transferring. R2's significant diagnoses were paranoid schizophrenia (delusions and hallucinations), hyperparathyroidism (thyroid dysfunction when the glands produce too much parathyroid hormone), and bullous pemphigoid (autoimmune skin disorder characterized by large blisters).</p> <p>R2's nutritional assessment dated [DATE] indicated R2's goal was to remain as nourished and hydrated as possible within the disease state process.</p> <p>R2's care plan dated 3/28/25 indicated R2 required staff assistance with drinking liquids and was to have a sippy cup.</p> <p>(continued on next page)</p>		

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<p>F 0807</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Upon observation and interview on 3/28/25 at 9:12 a.m. R2 was fully dressed seated in her room in her wheelchair. She did not have water in her room. She stated she got thirst there was water in her bathroom.</p> <p>R3's nursing admission note dated 3/24/25 indicated R3 was able to make his needs known.</p> <p>R3's care plan dated 3/25/25 indicated R3 required staff assistance with dressing and personal hygiene\</p> <p>R3's admission MDS dated [DATE] was not completed on the date of survey.</p> <p>Upon observation and interview on 3/28/25 at 9:35 a.m. R3 was seated in his wheelchair dressed watching television. He did not have a glass with water or other liquids in his room. He stated he would like water to be available in between meals.</p> <p>R5's admission MDS dated [DATE] indicated R5's BIMs score was a seven indicating R5 was cognitively impaired. R5 required set-up for eating, moderate assistance for oral hygiene, dressing, and transferring.</p> <p>Upon observation and interview on 3/28/25 at 10:09 a.m. R5 was lying on his bed fully dressed. He did not have a glass with water or other liquids in his room. He stated he would like water throughout the day.</p> <p>R6's admission MD dated 11/13/24 indicated R4 had a BIMs score of 15 indicated he was cognitively intact. R6 was independent with eating, oral hygiene, toileting, dressing, and personal hygiene. R6's pertinent diagnoses were right and left leg below the knee amputations, hepatic encephalopathy (loss of brain functions when the liver does not remove toxins) and cirrhosis of the liver.</p> <p>Upon observation and interview on 3/28/25 at 10:21 a.m. R6 was standing outside of his room waiting to speak with surveyor. Upon observation of his room R6 did not have water readily available. He stated when he wanted water between meals and medication passes, he wound find the nurse or the nurses cart, get a glass and fill it in his bathroom.</p> <p>Upon interview on 3/28 at 10:48 a.m. NA-B stated the floor she was working on did not have the reuseable plastic mugs to fill with ice and water for the residents like the other floors had. She stated staff was supposed to fill the small disposable plastic cups the nurses use for their medications on that floor. The cups were four ounces (oz), cups.</p> <p>Upon interview on 3/28/25 at 12:19 a.m. the director of nursing (DON) stated all residents have water readily available. She believed staff were passing water in the morning and if the residents requests more the staff was to provide more. The staff was expected to check each residents room before leaving to ensure they had water.</p> <p>A facility policy titled Monitoring Food and Fluid Consumption dated 9/2012 indicated the facility was to maintain adequate nutritional intake and hydration for all the residents.</p>		