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	04/01/2026

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to identify the indication for the administration of narcotic medications and failed to ensure non-pharmacological interventions were attempted/offered and documented prior to the administration of as needed (PRN) narcotic medications for 1 of 3 residents (R3) reviewed for pain.Findings include:R3's admission Minimum Data Set (MDS) dated [DATE] indicated intact cognition.R3's diagnoses list dated 3/31/26 included retroperitoneal abscess (collection of pus behind the abdominal cavity lining), acidosis (excess acid buildup in body fluids), malnutrition, acute kidney failure, and sepsis.R3's care plan dated 3/19/26 included a focus of alteration in comfort related to pain with interventions including but not limited to provide non-medical forms of pain relief such as positioning, rest, massage etcetera.R3's provider order dated 3/18/26 instructed Oxycodone (a narcotic pain relieving medication) Give 5 milligrams (mg) by mouth every six hours as needed for pain with no further indication identified.R3's medication administration record (MAR) for March 2026 identified R3 received Oxycodone the following three times:-3/23/26 at 11:56 a.m. R3 received PRN Oxycodone which was recorded as E [effective]. There was no corresponding progress note dated 3/23/26 to identify the medication was administered, any recorded symptoms R3 was experiencing or what, if any, non-pharmacological interventions had been attempted or offered prior to the narcotic being provided.-3/23/26 at 7:37 p.m. R3 received PRN Oxycodone which was recorded as E. There was no corresponding progress note dated 3/23/26 to identify the medication was administered, any recorded symptoms R3 was experiencing or what, if any, non-pharmacological interventions had been attempted or offered prior to the narcotic being provided.-3/24/26 at 10:21 a.m. R3 received PRN Oxycodone which was recorded as U [unknown]. There was no corresponding progress note dated 3/23/26 to identify the medication was administered, any recorded symptoms R3 was experiencing or what, if any, non-pharmacological interventions had been attempted or offered prior to the narcotic being provided.During an interview on 3/31/2026 at 2:31 p.m., licensed practical nurse (LPN)-A stated a resident complaining of pain would be assessed for pain location and asked to rate their pain on a scale of 0 (no pain) to 10 (worst pain ever). The resident would be offered a non-pharmacological pain intervention prior to offering PRN pain medication. Non-pharmacological interventions included repositioning, ice, food and beverages. After administering narcotic pain-relieving medication, the nurse should document the time the medication was administered and the resident's stated pain scale rating. The nurse would return to the resident later to assess the effectiveness of the medication and obtain a new pain scale rating. LPN-A stated non-pharmacological interventions were documented once a shift.During an interview on 3/31/2026 at 3:54 p.m., registered nurse (RN)-A stated a resident in pain would be assessed for pain location, characteristics of pain, pain rating on scale of 0-10 then offered a non-pharmacological intervention like repositioning or ice. If the non-pharmaceutical intervention was not effective or the resident refused, a PRN pain medication would be administered based on provider order. After administering a narcotic medication, the nurse should document administration time and the resident's stated pain level. Any non-pharmacological intervention offered should be documented in a progress note.During an interview on 4/1/2026 at 4:04 p.m., nurse practitioner (NP)-A stated non-pharmaceutical pain (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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions should be offered prior to PRN medication administration. Non-pharmaceutical pain interventions included repositioning, ice, heat, food, distraction and anything the resident stated helped with pain relief. After non-pharmaceutical pain interventions had been offered and refused or attempted and were not effective, a PRN pain relieving medication could be administered. The nurse should document medication administered, time of administered, location and characteristics of the pain, any non-pharmaceutical interventions attempted and the resident's stated pain rating.During an interview on 4/1/2026 at 2:32 p.m., director of nursing (DON) stated when a resident was having pain, the nurse should assess the resident, ask the resident pain level and location. Based on the information obtained, the nurse should offer non-pharmaceutical interventions. If the non-pharmaceutical intervention was refused or attempted and not effective, the nurse could offer PRN pain medication. The nurse should document the medication administered, time of administration, non-pharmacological interventions offered or attempted, location of pain and resident's stated pain rating. DON confirmed R3's EMR documentation with Oxycodone administration did not identify the location of the pain or any non-pharmaceutical interventions offered or attempted.The Medication Administration policy dated January 2026 instructed when PRN medications are administered the following documentation is provided: date and time of administration, dose, route of administration, complaints or symptoms for which the medication was given, results achieved from giving the dose, and the time results were noted.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** Based on interview and document review, the facility failed to obtain and administrator routine medications according to the physician orders for 1 of 3 (R1) residents reviewed for medication administration.Findings include:R1's diagnoses list dated 2/13/26 included thoracic aortic aneurysm (a dangerous, often silent, weakening and ballooning of the aorta in the chest), neurogenic bowel (loss of normal bowel function due to nerve damage, causing constipation, incontinence, and abdominal pain and bloating), and neuropathic bladder (nerve damage interrupts signals between the brain, spinal cord, and bladder, causing urinary incontinence or retention).R1's admission Minimum Data Set (MDS) dated [DATE] indicated intact cognition.R1's provider order dated 2/13/26 instructed Cranberry oral capsule, give 250 milligrams (mg) by mouth one time a day for urinary tract infection prophylaxis (prevent or reduce the risk).R1's medication administration record (MAR) for February 2026 indicated R1 did not receive cranberry on 2/14/26 through 2/18/26, 2/20/26, 2/22/26, and 2/23/26 with a chart code of 9 which indicated see nursing note, for a total of 8 missed doses.R1's nursing notes dated 2/14/26 through 2/23/26 identify the cranberry capsules were on order, med not here, not available. Pharmacy call, waiting for delivery, and awaiting house stock delivery. R1's provider order dated 2/14/25 instructed lactobacillus (probiotic), give one capsule one time a day for diarrhea.R1's MAR for February 2026 and March 2026 indicated R1 did not receive lactobacillus on 2/14/26, 2/16/26, 2/17/26, 2/18/26, 2/20/26 through 2/28/26, and 3/2/26 through 3/8/26 with a chart code of 9 for a total of 20 missed doses.R1's nursing notes dated 2/14/26 through 3/8/26 identify the lactobacillus capsules were on order, awaiting medication from pharmacy pending delivery, awaiting medication from pharmacy, and awaiting delivery.During an interview on 3/31/2026 at 2:31 p.m., licensed practical nurse (LPN)-A stated when a medication was unavailable, it would be charted as 9 with a nursing note explaining why the medication was not administered. LPN-A would look back to see if the medication had been re-ordered. If it had already been re-ordered, he would call the pharmacy to find out when it would be delivered. Over the counter (OTC) medications and supplements were stocked in the facility. A nurse needed to confirm the ordered dose could be obtained with the stocked medication or supplement. If the order was different, the nurse would fill out a house stock OTC medication form to request the appropriate dose. The resident's provider would be contacted if the resident missed doses or if the pharmacy could not fill the prescription.During an interview on 4/1/2026 at 4:04 p.m., nurse practitioner (NP)-A stated when a resident missed medications, she should be contacted for new orders. NP-A confirmed she had not been contacted about the missing cranberry and lactobacillus doses. NP-A did not consider the missing doses a significant medication error but would have wanted to be contacted so the order could be changed or placed on hold.During an interview on 4/1/2026 at 2:32 a.m., director of nursing (DON) stated any OTC medication or supplement could be requested from the pharmacy by filling out the house stock request form and faxing it to the pharmacy. The provider should be contacted if the pharmacy cannot provide the ordered medication. DON further stated a medication error was when a medication was not administered as prescribed. When an error occurred, a nurse should fill out the medication error form if they made the error or would report the error to the nurse manager or DON if a different nurse made the error.The Medication Administration policy dated January 2026 instructed medications are administered in accordance with written orders of the prescriber.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure that a resident was free from a significant medication error for 1 of 3 residents (R3) reviewed for medication errors. Findings include:R3's diagnoses list dated 3/31/26 included retroperitoneal abscess, acidosis, malnutrition, acute kidney failure, and sepsis.R3's admission Minimum Data Set (MDS) dated [DATE] indicated R3 did not have cognitive impairment R3's hospital Discharge summary dated [DATE] included a diagnosis of hypomagnesemia. R3's magnesium laboratory (lab) result on 3/18/26 was low at 1.3. with instructions to monitor and treat accordingly. Magnesium replacement was ordered. The following order was included in the Start taking these medications list: Magnesium, take 250 milligrams(mg) by mouth daily for hypomagnesemia.R3's provider order dated 3/19/26 instructed Magnesium, take 250 milligrams(mg) by mouth one time a day for hypomagnesemia with a start date of 3/19/26.R3's medication administration record (MAR) for March 2026 indicated R3 did not receive magnesium on 3/19, 3/20, 3/21, 3/22, or 3/23 with a chart code of 9 which indicated see nurse note.R3's nursing note dated 3/19/26 at 2:31 p.m., documented the magnesium was on order.R3's nursing note dated 3/20/26 at 8:22 a.m., documented the magnesium was awaiting medication from pharmacy.R3's nursing note dated 3/21/26 at 8:18 a.m., documented the magnesium was awaiting medication from pharmacy.R3's nursing note dated 3/22/23 at 8:11 a.m., documented the magnesium was awaiting medication from pharmacy.R3's nursing note dated 3/23/26 at 7:48 a.m., documented the magnesium was awaiting medication from pharmacy.R3's nurse practitioner (NP)-B note dated 3/23/26 at 3:41 p.m., included R3's 3/20/26 magnesium lab result was 1.2 and I do not see this was replaced. An order was written to add magnesium to R3's next lab draw on 3/24/26.R3's social services note dated 3/23/26 at 3:46 p.m. identified during a care conference therapy expressed concerns R3 had made little progress in therapy due to complaints of tiredness. The care conference team also expressed concerns related to R3 not eating well due to nausea and dry heaves.R3's social services note dated 3/24/26 at 11:45 a.m., identified R3's family member (FM)-A talked with social services and the nurse manager. FM-A was concerned about R3's lethargy with being difficult to arouse and with R3's lack of eating.R3's MAR for March 2026 indicated R3 received Oxycodone 5mg at 10:21 a.m. for pain rated 8/10. There was no corresponding progress note dated 3/23/26 to identify the medication was administered, nor any recorded symptoms R3 was experiencing, and where the pain was located.R3's electronic MAR (eMAR) note dated 3/24/26 at 12:27 p.m. indicated R3 had received Tylenol 500 mg. The note did not identify any recorded symptoms R3 was experiencing, or where the pain was located.R3's nursing note dated 3/24/26 at 12:31 p.m., identified the facility had received a call from the lab of a critical low lab value of magnesium 1.0 mg/dL (deciliter). The provider was notified, and the facility was waiting to hear back with instructions.R3's telephone encounter NP-C note dated 3/24/26 at 12:44 p.m., identified R3's magnesium level was down to 1.0. R3 was on magnesium supplement 250 mg daily, but nurse at the facility had not started it yet because they only have 400 mg tablets at the facility and the pharmacy has not delivered the 250 mg tablets yet. NP-B suspected R3's nausea, poor intake, and significant weakness could be at least partially related to her low magnesium. R3 also had a temperature of 100 degrees Fahrenheit (F) and body wide pain that was 10/10 in her legs.R3's nursing note dated 3/24/26 at 1:32 p.m., identified R3 was sent to the hospital for a temperature of 100.0 degrees F, lethargy, and critical lab of magnesium 1.0 mL/dL. When emergency personnel arrived R3's blood pressure was 78/53.R3's hospital Discharge summary dated [DATE] indicated R3 had been admitted to the hospital for possible sepsis and had received magnesium supplementation during her stay.During an interview on 3/31/2026 at 3:38 p.m., FM-A stated she was concerned because R3 had been sleeping more, eating less due to nausea, and had new pain in her legs. R3 had chronic back pain as well as abdominal pain from the current illness. A nurse told her they would talk to the provider about making medication changes. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	FM-A was not informed R3 was not receiving her magnesium supplement.During an interview on 3/31/2026 at 2:31 p.m., licensed practical nurse (LPN)-A stated when a medication was unavailable, it would be charted as 9 with a nursing note explaining why the medication was not administered. LPN-A would look back to see if the medication had been re-ordered. If it had already been re-ordered, he would call the pharmacy to find out when it would be delivered. Over the counter (OTC) medications and supplements were stocked in the facility. Magnesium was an OTC supplement that was stocked in the facility. A nurse needed to confirm the ordered dose could be obtained with the stocked medication or supplement. If the order was different, the nurse would fill out a house stock OTC medication form to request the appropriate dose. The resident's provider should be contacted if the resident missed doses or if the pharmacy could not fill the prescription.During an interview on 4/1/2026 at 9:41 a.m., medical doctor (MD) stated with a magnesium lab result of 1.2, he would have doubled R3's magnesium dose if she was at her baseline or would have sent her to the hospital for intravenous replacement if she had symptoms of low magnesium. Symptoms of low magnesium included weakness, tiredness, and nausea. When the pharmacy cannot provide a medication or supplement, the nurse should reach out to the provider for a new order.On 4/1/2026 at 1:40 p.m., a message was left for NP-B with no return phone call.During an interview on 4/1/2026 at 4:04 p.m., NP-A stated when a resident missed medications, she should be contacted for new orders. NP-A confirmed she had not been contacted about the missing magnesium doses.During an interview on 4/1/2026 at 11:38 a.m., Doctor of Pharmacology (Pharm-D) stated signs and symptoms of low magnesium included leg cramps, fatigue, nausea, and weakness. Due to R3's pain to legs, fatigue, and not eating due to nausea, Pharm-D would consider missing five doses of magnesium a significant medication error. Pharm-D confirmed magnesium had not been sent for R3 because it was an OTC medication that was stocked at the facility. The pharmacy had not received a request for Magnesium 250mg.During an interview on 4/1/2026 at 2:32 a.m., director of nursing (DON) stated magnesium was an OTC supplement stocked in the facility, but the strength was not 250mg. Any OTC medication or supplement could be requested from the pharmacy by filling out the house stock request form and faxing it to the pharmacy. The provider should be contacted if the pharmacy cannot provide the ordered medication. DON further stated a medication error was when a medication was not administered as prescribed. When an error occurred, a nurse should fill out the medication error form if they made the error or would report the error to the nurse manager or DON if a different nurse made the error. DON confirmed she was not notified about the missing magnesium doses for R3 and only discovered the error during review of R3's chart on 4/1/26.The Medication Administration policy dated January 2026 instructed medications are administered in accordance with written orders of the prescriber.