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	06/26/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to provide adequate supervision to prevent elopement for 1 of 1 residents (R37) who was reviewed for elopement. This resulted in Immediate Jeopardy (IJ) for R37 when she left the facility and was found approximately 4.5 miles away at her previous home by neighbors, which placed R37 at likelihood for serious harm or death. The IJ began on 8/30/25, when R37 exited the building without staff awareness. An unknown culinary staff had witnessed R37 outside and informed registered nurse (RN)-A who searched and was unable to find R37. The facility was contacted by family member (FM)-A who informed them R37 was found approximately 4.5 miles away without her walker, by R37's previous neighbors after missing for approximately 2.5 hours. It was unknown how R37 had gotten to her previous home and travel was through a busy metropolitan area with double laned roads and light rail systems. The administrator and director of nursing (DON) were notified of the immediate jeopardy on 6/24/26 at 2:25 p.m. The facility had implemented immediate corrective action, and the immediacy was removed on 8/31/25 to prevent reoccurrence, so the IJ was issued at past non-compliance. Findings include: R37's annual Minimum Data Set (MDS) dated [DATE], indicated severely impaired cognition and diagnoses of Alzheimer's disease with other signs and symptoms involving cognitive functions and awareness, and surgical repair for hip fracture. It further indicated R37 was ambulatory, used a walker, was independent with mobility, and had a history of a hip fracture. Furthermore, R37 did not have a wander/elopement alarm. R37's cognitive loss/dementia care area assessment (CAA) dated 6/25/26, triggered due to scoring a 7.0 on the brief interview for mental health status (BIMS) assessment, indicative of severe cognitive impairment. Furthermore, R37's CAA stated all possible problem areas, goals, and interventions will be care planned to promote the highest level of cognitive well-being. Social Services will continue to monitor and follow up as needed. R37's Elopement Risk Evaluation dated 3/17/25, indicated R37 was not at risk for elopement. R37 was readmitted to the facility after a hip fracture, was assist of one for transfers and had no exit seeking behaviors. However, R37's care plan for elopement triggers and interventions included remained checked. They included: elopement risk care plan which indicated R37 was at risk for elopement related to signs and symptoms involving cognitive function and awareness with five interventions available. All five of the interventions were checked and were as follows: wander guard in place (placement left wrist exp. 4/11/25), wander guard will be monitored for proper functioning, door alarms will be answered promptly, family will be kept informed, and R37 will be invited to activities and gatherings. R37's Elopement Risk Evaluation dated 5/14/25, indicated R37 had a history of wandering/attempts to leave the building, was ambulatory or able to self-propel wheelchair, had a cognitive deficit, and was taking opioid /psychotropic medications which may cause confusion. It further indicated an elopement risk score of 4 which indicated potential for elopement. It also included an elopement risk care plan which indicated R37 was at risk for elopement related to signs and symptoms involving cognitive function and awareness with five interventions available. All five of the interventions were checked and were as follows: wander guard in place (placement left wrist exp. 4/11/25), wander guard will be monitored (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	for proper functioning, door alarms will be answered promptly, family will be kept informed, and R37 will be invited to activities and gatherings. R37's Elopement Risk Evaluation dated 6/24/25, indicated R37 had a history of wandering/attempts to leave the building, was ambulatory or able to self-propel her wheelchair, and had a cognitive deficit. It further indicated an elopement risk score of 4. A score of 4 or more indicated potential for elopement. It further included an elopement risk care plan which indicated R37 was at risk for elopement related to signs and symptoms involving cognitive function and awareness with door alarms will be answered promptly, family will be kept informed, Wander guard in place (placement left wrist exp. 4/11/25) and wander guard will be monitored for proper functioning, were not checked as interventions. There were also additional considerations which included R37 was at risk for elopement, had a wander guard on, no concerns, and will continue to monitor. R37's fall risk assessment dated [DATE], indicated R37 was a fall risk due to multiple falls in the past 6 months, inability to remember they were in a nursing home, location of room or staff names, minimal difficulty with hearing/vision, loss of balance, use of a walker and daily or more behaviors of wandering, verbal/physical abuse or social inappropriate behaviors. The assessment indicated R37 required 15-minute checks for safety. R37's care conference form dated 6/25/25, indicated R37 scored a 7/15 on her BIMS (severely impaired cognition), was at risk for falls, and continued to need minimal assistance with activities of daily living (ADL). It further indicated, R37 was able to ambulate using her two wheeled walker and her wander guard was discontinued this past quarter. R37 spent time throughout the day walking around the unit and walked up and down the hallways. Attendees included: R37, SW (unknown), and nurse manager (unknown). R37's care plan dated 6/25/25, indicated the following: -R37 was a fall risk related to gait instability, occasional age-related tiredness, cognitive impairment, chronic venous insufficiency, hip fracture, dementia/Alzheimer's disease, hypertension, peripheral vascular disease (PVD), alcohol use, malnutrition, and muscle weakness. It further indicated the following interventions: offer to toilet at night every 2-3 hours and as needed, a sign will be posted inside the room for staff to be cautious and open door slowly as people may be approaching from other side, assist of one with ADLS, soft touch call light in reach, stop sign to door to open door slowly, follow PT/OT (physical therapy/occupational therapy) instructions for mobility function, keep room clean and free of clutter, bed in a low position, call light within reach, and monitor/document on safety.-R37 had an alteration in mobility due to gait instability, hip fracture, cognitive impairment, and PVD. It further indicated the following interventions: PT per physician's order, follow PT instructions, grab bars to bed to aid in bed mobility, was independent with ambulation using a walker, independent with movement in bed. -R37 required supervision when leaving the facility and would follow the leave of absence (LOA) policy, -R37 was at risk for elopement related to signs and symptoms involving cognitive functions and awareness and would be monitored for safety during the evenings. It also included the following interventions: door alarms will be answered promptly, family will be kept informed, and R37 would be invited to activities and gatherings. A review of R37's nursing and physician's orders indicated the following: -On 8/28/23, R37 required monitoring of placement of wander guard to left wrist and to check the wander guard function every shift. This order was discontinued on 3/17/25. -On 5/5/25, R37 required 15-minute checks for safety. This order was discontinued on 8/18/25, 12 days before R37 eloped. R37's nursing progress notes indicated the following: -on 3/23/25 at 4:33 a.m., R37 was up this shift until 3:15 a.m. She was rolling in her wheelchair, up and down the hallway. She was going in other residents' rooms and talking loudly. It further indicated R37 was attempting to get on the elevator and set off the alarm over ten times. The nursing assistant (NA) sat with her from 1:00 a.m. to 3:15 a.m. as able in between responding to call lights. R37's behavior was hard to redirect. -on 3/24/2025 at 10:04 a.m., interdisciplinary team (IDT) met to review a fall where R37 was found on the bathroom floor. R37 was active during the night due to her diagnosis of dementia. She had progressed in therapy and was able to ambulate more independently than previously (up to 50 feet). She would benefit from being offered toileting during the night. Care plan was updated, therapy on going, and no complaints of pain or (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	injury. The provider was updated and family was notified. IDT will review as needed. -4/24/25 Writer spoke with resident's daughter this morning and she stated R37 seemed upset and wanted a ride home. The writer explained this happened occasionally and with her dementia it was ok to let her know you can give her a ride home but can't come until later that day. That was what the writer had told R37 in the past, when R37 had asked her for a ride home. R37 would forget and continue on with her day. -on 5/15/25 at 2:33 p.m., R37 was seen wandering on the first floor on 5/12/25 around 9 p.m. R37 was accompanied back up to 3rd floor. She was unable to explain what she was doing or where she was going. IDT agreed to place her on 15-minute checks. Provider updated. -on 6/1/25 at 10:23 a.m., R37 was going through roommate's drawers. R37 was restless and walked down the hallway several times, easily redirected by staff. -on 8/30/25 at 9:18 p.m., indicated culinary staff (unknown) reported to RN-A that around 5:35 p.m. they saw R37 outside the building. RN-A went outside but was unable to locate her so they returned to the facility and notified the police, administrator, and director of nursing (DON). Then RN-A called the hospital, while another nurse drove around the immediate area to see if they could find her. Once the police arrived (at approximately 7:10 p.m.), RN-A gave them a description of R37 and they left. RN-A called FM-A to notify her, and she stated R37 was at the neighbor's house. She had hitch-hiked to her previous residence but was unable to gain access to the home so she went to the neighbor's. The neighbors then called FM-A who had tried to call the facility several times, but no one answered. R37 refused to return to the facility and wanted to be taken to the hospital so she was taken there for evaluation. The hospital called the facility stating R37 was returning to the facility. Report was given to the oncoming nurse along with a wander guard to be applied to R37's ankle or wrist upon arrival. -on 9/2/25 at 4:54 p.m., indicated follow up call with R37's daughter occurred. The Director of Nursing (DON) explained R37 had Wander guard in placed but it was removed following R37's hip fracture and no longer considered independent with mobility and no attempts at leaving. R37 had a plan to visit previous home, left facility and was able to get there safely. R37 was safe and able to return safely. A new elopement assessment was completed and indicated a high risk for elopement and a Wander guard was placed. R37's after visit summary (AVS) dated 8/30/25, indicated the police were notified at 5:30 p.m. that R37 was missing from the facility. It further indicated had a past medical history of dementia who presented to the emergency department (ED) for evaluation of confusion after R37 somehow got 4.5 miles from the facility to her previous address. She was called in as a missing person at 5:30 p.m. and found by her previous neighbors. Spoke with R37's daughter who stated R37 had Alzheimer's disease and was living in memory care. She had a history of escaping and traveling to her old house. She had been living at the facility for over 2 years and was supposed to have a Wanderguard on, but it had been removed recently as they thought she wasn't as mobile due to a recent admission of a hip fracture. During observation on 6/24/26 at 7:28 a.m., R37 was walking up and down the hallway using her 2 wheeled walker. During interview on 6/23/26 at 10:20 a.m., family member (FM)-A stated on 8/20/25, they had received a call from her previous neighbors, informing them R37 was trying to get into her old house. FM-A called the facility, but no one answered so they called 911. FM-A stated they were very upset because when R37 was admitted , they told them she needed to have a wander guard on. The facility told them since R37 had broken her hip, they didn't think she was mobile enough to elope. FM-A was unaware of how R37 got to her previous residence since she didn't have any money. R37 told them she took the bus, but FM-A didn't believe that, as she would have had to transfer to another bus to get there. She had escaped once before in the middle of the night and was trying to hitchhike. She was swearing and throwing things. All the staff could do was follow behind her. They ended up sending her to the hospital. During interview on 6/24/26 at 7:10 a.m., registered nurse (RN)-A stated on 8/30/26, during dinner, an unknown culinary staff reported she saw R37 downstairs. RN-A immediately searched R37's room, the facility, and the surrounding area. They asked the residents (unknown) who were sitting outside the building, and they stated they saw R37 outside walking down the street. RN-A went back into the facility and called a code pink (missing person). They searched (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the facility and the immediate area again, but they were unable to locate R37. They called the policy, administrator and the DON. Once the police arrived, they gave them a description. They asked RN-A if they thought R37 may have tried to go home and they stated No, because she was demented. The police left and RN-A called R37's daughter who reported they found her at her previous address. The daughter stated she had hitch-hiked and was trying to break in. RN-A further stated R37 was not wearing a wander guard when she left. She used to have one but then she fell and broke her hip and was immobile for a while. Then she started to get better and that's when it (elopement) happened. When R37 came back that night they put a wander guard on her. RN-A stated residents who are not allowed to leave the floor unsupervised, have a wander guard. If a resident gets on the elevator and the alarm doesn't go off, they are safe to leave the floor. Also, each resident was assessed upon admission whether they were at risk for elopement and the resident's care plan indicated if they required supervision when going on a (LOA). During interview on 6/24/26 at 7:35 a.m., NA-E stated residents who are unable to leave the floor/facility unsupervised wear a wander guard. If the alarm by the elevator goes off, that's how they know the resident can't leave unsupervised. During interview on 6/24/26 at 7:59 a.m., NA-F stated they would know if a resident had a wander guard because it would go off when the resident walked by the elevator. If the alarm goes off, the resident was not supposed to leave the floor/facility unsupervised. If it doesn't go off, the resident is able to leave by themselves. During interview on 6/24/26 at 10:05 a.m., the director of nursing (DON) stated if a resident eloped, staff were expected to search the facility and the surrounding area. If they were unable to locate the resident, they should trigger a code pink (missing person) and then all staff would search for the resident. If the resident was still unable to be located, they would call the police and notify the DON and administrator. Staff should then call family, update the provider, call any contacts, and report it to the state agemcy (SA). The DON further stated R37 wasn't an elopement risk when she eloped on (8/30/25) because she had a status change due to a hip fracture. She used to be mobile and went from being independent to requiring staff assistance with ambulation. Her plan of care changed after she returned from the hospital, and she didn't have any exit seeking behavior. That's when the facility decided to discontinue the wander guard. When she eloped, she had a plan to go to her previous address, was able to remember the address, had intention, and had gotten there safely. The DON was unable to determine how she got there. They did not report it to OHFC because R37 wasn't at risk for elopement due to her declining. The DON also stated they determine if a resident needs a wander guard based on their cognition, elopement risk assessment, therapy assessment, history, level of consciousness (LOC) and a doctor's order. In order to determine whether it's safe to remove a residents wander guard; it's usually prompted by a decline in cognition, mobility, or if they can't exhibit exit seeking behaviors. During interview on 6/24/26 at 1:04 p.m., the nurse practitioner (NP)-A stated at the time of elopement, R37 was physically able to ambulate independently but would not be safe by herself cognitively, out in the community. The NP further stated R37 had exit seeking behaviors intermittently which appeared to increase in March of 2025. During interview on 6/25/26 at 1:08 p.m. the administrator stated they didn't consider R37 to have eloped because she didn't have exit seeking behavior, needed assistance with mobility, and wasn't at risk for elopement. The facility policy regarding elopement dated June of 2023, indicated documentation for residents who were at risk for elopement should:-be assessed upon admission, which may indicate potential to wander or exit the facility-care plan that address the potential to wander or exit facility and the measures taken to prevent wandering/elopement. -all attempts to elope, efforts to locate, notification and results of efforts.-full observation/visualization after and elopement for any injuries or new symptoms or conditions which may have developed.-entries that are time specific to reflect the responsiveness and timeliness of actions taken to locate and assess the resident.-bracelet alarm/device is in place and functioning (per TAR or other form of documentation), if applicable. The past non-compliance immediate jeopardy began on 8/30/25 and was removed on 8/31/25, when the facility implemented a systemic plan to ensure all residents were safe. The (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	following actions were implemented prior to survey: -R37 was assessed for possible injury in the emergency department.-R37's elopement risk assessment was updated and placed a wander guard on R37.-R37's care plan was reviewed/revised. -Facility wide audit to identify residents at risk for elopement to ensure interventions and care plan in place/updated. -Staff were educated staff on resident safety (Response to unsupervised residents outside the facility).-Elopement policy was reviewed/revised.-Facility elopement drills were conducted.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure an elopement was reported to the state agency (SA), within 24 hours for 1 of 1 resident (R37) reviewed for elopement. Findings include: R37's annual Minimum Data Set (MDS) dated [DATE], indicated severely impaired cognition and diagnoses of Alzheimer's disease with other signs and symptoms involving cognitive functions and awareness, and surgical repair for hip fracture. It further indicated R37 was ambulatory, used a walker, and was independent with mobility. R27's progress note dated 8/30/25 at indicated culinary staff (unknown) reported to RN-A that around 5:35 p.m. they saw R37 outside the building. RN-A went outside but was unable to locate her so they returned to the facility and notified the police, administrator, and director of nursing (DON). Then RN-A called the hospital, while another nurse drove around the immediate area to see if they could find her. Once the police arrived (at approximately 7:10 p.m.), RN-A gave them a description of R37 and they left. RN-A called FM-A, and FM-A stated R37 was at the neighbor's house. R37 had hitch-hiked to her previous residence but was unable to gain access to the home so she went to the neighbor's. The neighbors then called FM-A who had tried to call the facility several times, but no one answered. R37 refused to return to the facility and wanted to be taken to the hospital so she was taken there for evaluation. The hospital called the facility stating R37 was returning to the facility. Report was given to the oncoming nurse along with a wander guard to be applied to R37's ankle or wrist upon arrival. During interview on 6/24/26 at 10:05 a.m., the director of nursing (DON) stated if a resident eloped, staff were expected to search the facility and the surrounding area. If they were unable to locate the resident, they should trigger a code pink (missing person) and then all staff would search for the resident. If the resident was still unable to be located, they would call the police and notify the DON and administrator. Staff should then call family, update the provider, call any contacts, and report it to the SA. DON further stated R37 wasn't an elopement risk when she eloped on (8/30/25) because she had a status change due to a hip fracture. R37 used to be mobile and went from being independent to requiring staff assistance with ambulation. Her plan of care changed after she returned from the hospital, and she didn't have any exit seeking behavior. That's when they decided to discontinue the wander guard. When R37 eloped, she had a plan to go to her previous address, was able to remember the address, had intention, and had gotten there safely. They did not report it to the SA because R37 wasn't at risk for elopement due to her declining in mobility. During interview on 6/25/26 at 1:08 p.m., the administrator stated they have to follow the Minnesota Department of Health's (MDH) guidelines when determining what types of things they report and the timeline for reporting. The administrator statedR37's incident was not reported due to the incident was not considered an elopement. R37 did not have exit seeking behavior, needed assistance with mobility, and wasn't at risk for elopement. R37 had a plan to go to the address, and she made it there safely. The facility policy regarding elopement dated June of 2023, indicated following an elopement, the administrator or designee shall notify the SA, as necessary by state requirements, family/family representative, and the physician.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was coded accurately for 2 of 3 residents (R7, R56) reviewed for MDS accuracy. Findings include: R7's quarterly MDS dated [DATE], identified in section K that while a resident a tube feeding was recorded. Diagnoses included diabetes mellitus, and no active diagnoses for nutrition.R7's physician orders dated 3/1/26 through 6/24/26, lacked identification for tube feeding. R7's nutritional assessments dated 3/37/26 and 6/23/26, lacked identification for tube feeding. R7's alteration in nutrition care plan 5/28/25, lacked identification for tube feeding. During an observation on 6/22/26 at 12:01 p.m., R7 had her eyes closed while lying in bed and no tube feeding was observed. During an interview on 6/23/26 at 1:11 p.m., the MDS coordinator reviewed R7's MDS section K and stated the indication for tube feeding must have been a mistake and should have been coded for IV (intravenous) fluids received while in the hospital. The MDS coordinator stated dietary would fill in section K for nutrition, then MDS coordinator would check it for accuracy. The MDS coordinator stated tube feeding would not affect facility reimbursement; however, IV fluids would have. R56's quarterly MDS dated [DATE], identified no rejection of care and cognition was moderately impaired. Diagnoses included Alzheimer's disease with late-onset, hypertension and adult failure to thrive.R56's physician order dated 8/21/25, identified furosemide oral tablet (a diuretic medication which helps reduce the amount of fluid in the body) give one tablet by mouth one time a day for edema.R56's Medication Administration Record (MAR) dated 6/6/26 through 6/12/16, during the 7-day MDS lookback period, identified the medication was refused by the resident 5 out of 7 days.R56's nursing progress notes dated 6/6/26 through 6/12/26, during the 7-day MDS lookback period, identified on 6/12/26 at 9:30 a.m., the doctor was notified of the resident's intermittent refusal of medication.R56's diuretic care plan, lacked identification of refusal of the medications.During an interview on 6/24/26 at 12:04 p.m., the MDS coordinator stated social services (SS)-A filled in the information for section E behaviors on the MDS and she was unaware of what resources SS-A reviewed to gather information about behaviors. The MDS coordinator stated they should follow the indications in the MDS 3.0 RAI Manual.During an interview on 6/24/26 at 12:46 p.m., SS-A stated she would review progress notes and the miscellaneous section in the resident electronic health record (EHR) to check for refusals during the ARD. SS-A reviewed R56's progress notes and stated there was one note in the lookback period that identified refusal of medications so she should have coded it as refused 1 to 3 days. SS-A then reviewed R56's MAR and noticed a medication was refused 5 out of 7 times in the lookback and she should have coded it higher as behavior occurred 4 to 6 days but less than daily. SS-A stated she does not typically review the MAR for medication refusals. During a follow-up email on 6/24/26 at 1:25 p.m., the MDS coordinator identified R56's behavior section was coded incorrectly as he declined medications within the lookback period. The MDS could be modified and corrected following the MDS 3.0 RAI Manual which identified if the resident indicated intention was to decline or refuse, then the resident should be asked about the reasons for rejecting care and about their goals for health care and well-being. If the resident was unable or unwilling to respond to questions about their rejection of care or goals for health care and well-being, then interview the family or significant other to ascertain the resident's health care preferences and goals.Coding Instructions included: Code 0, behavior not exhibited: if rejection of care consistent with goals was not exhibited in the last 7 days. Code 1, behavior of this type occurred 1-3 days: if the resident rejected care consistent with goals 1-3 days during the 7-day look-back period, regardless of the number of episodes that occurred on any one of those days. Code 2, behavior of this type occurred 4-6 days, but less than daily: if the resident rejected care consistent with goals 4-6 days during the 7-day look-back period, regardless of the number of episodes that occurred on any one of those days. Code 3, behavior of this type occurred daily: if the resident rejected care consistent with goals daily in the 7-day look-back period, (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regardless of the number of episodes that occurred on any one of those days.During an interview on 6/25/26 at 9:05 a.m., the director of nursing (DON) stated she expected accuracy of the documentation of the MDS. The MDS Coordinator was responsible for accuracy. An MDS policy was requested but not provided.

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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** Based on observation, interview and document review, the facility failed to develop a care plan which included resident goals and desired outcomes, care and services provided to attain the highest practicable level of wellbeing, and action taken by the facility to educate the resident regarding alternatives and consequences for 1 of 1 resident (R56) who refused medications.Findings include: R56's quarterly Minimum Data Set (MDS) dated [DATE], identified moderately impaired cognition, was independent with bed mobility and wheelchair mobility and, required supervision or touching assistance for lower body dressing. Diagnoses included non-Alzheimer's dementia, hypertension, and adult failure to thrive. R56 took high-risk medications including a diuretic (reduces amount of fluid from the body) and had no rejection of care.R56's self-care deficit care plan dated 4/3/24, identified he refused to wear his ted hose (compression stockings) and he was able to put them on himself and chooses to do so. The care plan did not address refusal of diuretic medication.R56's diuretic care plan dated 1/20/26, identified a goal to be free of dehydration. Staff were directed to administer medication as ordered, encourage adequate fluid intake, monitor labs and monitor for dehydration and to report suspected symptoms to the provider. The care plan did not address refusal of diuretic medication.R56's physician order dated 8/21/25, identified furosemide oral tablet (a diuretic medication which helps reduce the amount of fluid in the body) give one tablet by mouth one time a day for edema.R56's Medication Administration Record (MAR) dated 4/1/26 through 4/30/26, identified furosemide was refused 11 out of 30 days.R56's MAR dated 5/1/26 through 5/31/26, identified furosemide was refused 23 out of 31 days.R56's MAR dated 6/1/26 through 6/22/26, identified furosemide was refused 18 out of 22 days.R56's weight and blood pressure from 4/1/26 through 6/23/26 remained at baseline.R56's Risk vs Benefits Form dated 4/29/26, identified R56 refused medications at times and was occasionally noncompliant with cares. R56 was at increased risk of worsening health condition, unmanaged symptoms, hospitalization, falls, infection, safety/wellbeing due to refusal of medication and intermittent care. The Risk vs Benefits form was not included in the care plan and did not identify goals and desired outcomes related to diuretic medication, alternatives to a diuretic; or specific consequences such as fluid retention, swelling in the legs, feet or abdomen, elevated blood pressure and headaches. A care plan was triggered; however, goals and interventions were not. Therefore, R56's care plan had not identified focus areas, goals and interventions related to refusal of medications.R56's nurse practitioner (NP) note dated 6/11/26, identified no swelling or edema noted in lower limbs.During an observation and interview on 6/22/26 at 1:00 p.m., R56 was seated in his wheelchair. Both lower legs had hard red skin with edema. R56's socks were creating an indentation on his lower legs. R56 said it was painful, and he had it for 5 days. He said staff were not doing anything and he could not remember who he told.During an observation and interview on 6/22/26 at 1:05 p.m., the day shift nursing assistant (NA)-A entered R56's room to assist him to the bathroom. At 1:10 p.m., NA-A exited the room. NA-A stated she worked at the facility regularly and was not sure if she had noticed his legs swollen before today but would update the nurse.During an interview on 6/23/26 at 9:40 a.m., licensed practical nurse (LPN)-A stated R56 would refuse medications, and staff would discuss risks and benefits of refusal such as it could affect his health. LPN-A did not state specifically the side effects of refusing a diuretic. LPN-A worked with R56 routinely and had not noticed edema. With a change in condition staff would document the assessment and update the provider. The nurse care coordinator would update the care plans if needed.During an interview on 6/23/26 at 3:58 p.m., R56 stated he took his diuretic today. R56 said historically he was informed of the risks of not taking his diuretic but not specifically about the leg swelling like he had currently. When R56 was asked why he refused his diuretic, he stated he did not like medications. He also said he was compromising and would at least take the diuretic now. He said nursing advised him to start (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	elevating his legs today which he said he was trying to do.During an interview on 6/24/26 at 7:55 a.m., the LPN care coordinator (LPN)-B stated if a resident refused a medication, they would do a Risk vs Benefit form and review it with the resident. No other forms were provided to the resident, such as specific medication side effects, and details would be documented about the conversations with the resident. She said the provider would discuss alternatives.During an interview on 6/24/26 at 8:04 a.m., LPN care coordinator-C stated if a resident refused a medication, they would do a Risk vs Benefit form and review with the resident. No other forms were provided to the resident such as specific medication side effects and details would be documented about the conversations with the resident. She said the provider would discuss alternatives. Nursing would document everything that was discussed in the medical record. During a follow up interview on 6/24/26 at 8:41 a.m., LPN-A stated they had advised R56 edema was a risk of not taking diuretic medication. She also said everything nursing discusses would be documented in the medical record. During a follow up interview on 6/24/26 at 8:46 a.m., R56 stated no one had discussed alternatives to diuretics with him. He said he did not want to take any more pills and did not know what else he could do. During an interview on 6/24/26 at 10:58 a.m., nurse practitioner (NP)-A stated a diuretic taken sometimes was better than not taking it at all, so that was why the medication had not been discontinued despite frequent refusals. Risks of not taking a diuretic included edema and heart problems. She stated R56's rationale for not taking his diuretic was that he thought it made his symptoms worse. NP-A was not sure if a specific discussion about edema side effects related to refusals was discussed. She stated she would expect the facility to follow their care planning policies and procedures related to medication refusals. During an interview on 6/24/26 at 9:05 a.m., the director of nursing (DON) stated refusals of high-risk medications such as diuretics should be in the care plan with resident goals and interventions.The facility's Refusal of Care procedure dated 11/2025, identified when a resident refused care, treatment, medications, assessments, etc., staff would attempt to reapproach the resident, continued refusals of care would be documented in the progress notes. If a pattern of refusals was identified an interdisciplinary (IDT) would update the care plan accordingly. The facility's Care Planning policy dated 11/2024, identified the care plan was derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The care plan was to be modified and updated as the condition and care needs of the resident changed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to revise a care plan to reflect accurate status when care needs changed for 1 of 19 residents (R12) in the sample. Findings include:R12's significant change Minimum Data Set (MDS) dated [DATE], identified R12 had intact cognition, required substantial/maximal assistance with bed mobility, dependent on staff for toileting, and was always incontinent of bowel and bladder. R12's diagnoses included Alzheimer's disease, diverticulitis of large intestine (a painful digestive condition causing bulging pouches in the wall of the large intestine which become inflamed and infected), enterocolitis due to clostridium difficile (C-diff-a highly contagious bacterial infection in the large intestine causing severe watery diarrhea and colon inflammation), and pressure ulcer of sacral region. R12's care plan printed 6/23/26, indicated, Resident has a current infection r/t [related to] C-Diff (infection) , was on Vancomycin (antibiotic medication), and required isolation precautions per protocol. R12's care plan lacked evidence of Prevlon boot 24/7 (heel protector designed to offload heel to continuously relieve pressure) intervention for alteration in skin integrity. R12's progress note dated 6/5/26 at 8:41 a.m., indicated R12 completed antibiotics for C-diff and had no more loose stools. Furthermore, contact precautions removed and placed on EBP [enhanced barrier precautions] due to wounds. Care plan reviewed and updated. R12's provider order dated 6/19/27, indicated R12 required wound rounds daily for right lateral malleolus and to use Prevlon boot 24/7. R12's treatment administration record (TAR) indicated, Staff to follow: Contact Precautions due to CDIFF every shift with a start date 4/16/26. With the exception of one shift, the task had been signed off three times a day (every shift) for the entire month of June. During observation on 6/22/26 at 1:11 p.m., R12's room had signage for EBP and PPE (personal protective equipment). A pair of Prevlon boots was observed on R12's dresser. During interview on 6/23/26 at 2:20 p.m., registered nurse (RN)-B stated R12 had previously had C-diff and was on contact precautions for that, but since that resolved she was just on EBP currently for her wounds. RN-B stated the orders, and care plan should have been updated to accurately reflect R12's status. RN-B stated it was the responsibility of either nurse manager or the DON (who was also the infection preventionist) to make those changes. RN-B could not explain why R12's orders and care plan showed contact precautions were required. During interview on 6/24/26 at 2:48 p.m., RN-C stated R12 had wounds currently and gown was required for wound care. RN-C stated R12 did not have C-diff any longer and could not explain why the order for contact precautions was still active and why he had been signing off in the TAR that contact precautions were being followed. RN-C was not sure what was on R12's care plan and stated would have to look at it. During interview on 6/25/26 at 12:02 p.m., director of nursing (DON) stated expectation for resident orders and care plans to be updated to reflect accurate resident status. DON stated R12 should be on EBP and no longer on contact isolation precautions. Facility policy Care Planning dated 11/2024, indicated, The care plan is to be modified and updated as the condition and care needs of the resident change.

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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** Based on observation, interview, and document review, the facility failed to ensure pressure ulcer interventions were in place for 1 of 1 residents (R12) reviewed for pressure ulcers (PU).Findings include:R12's significant change Minimum Data Set (MDS) dated [DATE], identified R12 had intact cognition, required substantial/maximal assistance with bed mobility, dependent on staff for toileting, and was always incontinent of bowel and bladder. R12's diagnoses included Alzheimer's disease, diabetes, peripheral vascular disease, and pressure ulcer of sacral region.R12's care plan printed 6/23/26, indicated, R12 had an alteration in skin integrity related to current wounds. R12 had a stage 4 PU on the coccyx (tailbone) stage 4 and unstageable Pressure ulcer on the right outer ankle. R12's care plan interventions for skin integrity included, Pressure air mattress to bed.Low air loss air bed, pressure redistribution. R12's care plan lacked evidence of Prevlon boot 24/7 (heel protector designed to offload heel to continuously relieve pressure) intervention for alteration in skin integrity.R12's provider order dated 2/12/26, indicated, Mattress: Air mattress for wound care. Check function every shift.R12's provider order dated 6/19/26, indicated R12 required wound rounds daily for right lateral malleolus and to use Prevlon boot 24/7.R12's wound round progress note dated 6/10/26, indicated R12 had a stage 4 PU on coccyx and an unstageable PU on right malleolus. Interventions for pressure relief/off-loading included, pressure redistribution mattress, and heel offloading. During observation and interview on 6/22/26 at 1:11 p.m., R12 was lying in bed on her back and stated was not aware of any current open areas (pressure ulcers or wounds) and was not sure if she received wound care. Wound care supplies were observed on R12's nightstand. A pair of Prevlon boots was observed on R12's dresser. R12 did not have a pillow under her legs, therefore, her feet were not offloaded. R12's air mattress controller had a yellow flashing light indicating low pressure.During observation on 6/23/26 at 8:57 a.m., R12 in bed eating breakfast. R12 was not wearing boots and air mattress controller flashing yellow light indicating low pressure.During observation and interview on 6/23/26 at 9:08 a.m., nursing assistant (NA)-B entered R12's room. NA-B stated she was going to perform incontinent care but would wait a while longer since the nurse was not available to do the dressing changes. NA-B removed the boots from the dresser and applied them to R12's feet. NA-B stated she had just removed the boots and that they had been on all night. NA-B adjusted the sheet over R12's feet at the end of the bed just in front of the air mattress controller and did not check the function of the air mattress. NA-B left the room.During interview on 6/23/26 at 9:15 a.m., R12 stated she did not have the boots overnight and that the NA did not just take them off this morning. R12 stated would not refuse the boots and she often did have them on while in bed.During observation on 6/23/26 at 10:25 a.m., NA-C into R12's room to perform incontinent care. R12's brief removed and exposed a dressing on the coccyx with the bottom part not attached to the skin and slightly soiled with bowel movement. NA-C wiped R12's bottom, placed a new brief, adjusted R12' blankets and left the room without checking the function of the air mattress.During observation and interview on 6/23/26 at 11:02 a.m., registered nurse (RN)-B into R12's room to check on wound care supplies. RN-B stated they would wait a while to do wound care since R12 was experiencing pain on her bottom and rated the pain 8 out of 10 on a pain scale. RN-B stated they would provide pain medication and allow time for it to take effect prior to completing wound care. RN-B further stated R12's bottom pain was worse for some reason today. RN-B readjusted the pillow under R12 to provide a slight left tilt. RN-B left the room without addressing the air mattress. During observation on 6/23/26 at 11:06 a.m., licensed practical nurse (LPN)-D into R12's room and administered pain medication. LPN-D did not address the air mattress. During observation on 6/23/26 at 11:15 a.m., RN-B brought additional wound care supplies into R12's room and did not address the air mattress. During observation on 6/23/26 at 11:44 a.m., director of nursing (DON) into R12's room to check on her. DON looked to ensure R12 had the boots on and then left the room. DON did not address the air mattress.During observation on 6/23/26 at 11:47 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a.m., DON, administrator, and scheduling coordinator (SC) entered R12's room. All three appeared to adjust the bottom of the bed as if they noticed something wrong with the alignment of the mattress. During the adjustment of foot of the bed, the air mattress controller slid to the one side almost dislodging from the footboard. The administrator placed both hands on the controller and repositioned it to the center of the footboard. The air mattress controller still flashing yellow light indicating low pressure. All three staff left the room and none of them addressed the air mattress malfunction.During interview on 6/23/26 at 11:54 a.m., R12 stated her bottom was more painful today than it had been in a while.During interview on 6/23/26 at 12:42 p.m., LPN-D stated was surprised that R12 was complaining about increased pain and that she normally said she was fine.During observation and interview on 6/23/26 at 12:54 p.m., RN-B and LPN-D went into R12's room. Wound care and dressing change were completed. R12 repositioned in bed, sheet adjusted over her and then they left the room. Neither RN-B nor LPN-D addressed the air mattress malfunction. During interview on 6/23/26 at 2:10 p.m., LPN-D stated PU interventions for R12 included frequent repositioning, boots to offload feet, nutrition support, and air mattress. LPN-D into to R12's room and confirmed the air mattress was indicating low pressure. LPN-D stated the controller was supposed to sound an alarm if it was not working and that staff were supposed to check the function regularly.During interview on 6/23/26 at 2:20 p.m., RN-B stated would expect R12 to have a working air mattress and that staff would check the function at least once per shift.During interview on 6/24/26 at 7:40 a.m., nurse practitioner (NP)-B stated an air mattress was the number one priority for someone with a coccyx PU. NP-B stated would expect R12's air mattress to function properly and that a non-functioning air mattress could cause increased pain.During interview on 6/24/26 at 2:48 p.m., RN-C stated thought he remembered R12's air mattress beeping on the 6/22/26 overnight shift and that the alarm could be silenced. RN-C further stated he thought he had fixed the air mattress but could not provide any further details.During interview on 6/25/26 at 12:02 p.m., DON stated PU prevention interventions should be in place as ordered. DON further stated maintenance had looked at R12's bed and found that it was malfunctioning and had to replace the air mattress.Facility policy Skin Assessment and Wound Management dated 2/2025, directed staff to Implement appropriate preventative skin measures. Examples include, but are not limited to-nutritional interventions, mobility and repositioning plan, pressure redistribution plan.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R3) received appropriate nutrition assessment and support who was at risk for weight loss and dehydration, and was reviewed for dialysis. Findings include:R3's quarterly Minimum Data Set (MDS) dated [DATE], indicated R3 had intact cognition, was independent with eating, received dialysis, and required a therapeutic diet. R3's diagnoses included diabetes mellitus and end stage renal disease. R3's care plan printed 6/24/26, indicated R3 had diabetes, was at risk for hypo and hyper glycemia, and instructed staff to monitor compliance with diet and document any problems. R3's care plan further indicated R3 was at risk for dehydration and instructed staff to, Encourage adequate fluid intake. In addition, the care plan indicated R3 had potential nutritional problem related to protein calorie malnutrition and other diagnoses and instructed staff to, Provide supplements as ordered. R3's Clinical Nutrition Evaluation dated 4/16/26, indicated R3 had a weight loss of 5% or more in the last month or of 10% or more in the last 6 months, and was not on a prescribed weight-loss regimen. Provider order dated 4/24/26, indicated, 1500 ml [milliliter] restriction. Dietary to provide: 1080 ml/day. Dietary was to give 360 ml fluids at breakfast that included 1 Ensure Clear (nutritional supplement), 360 cc at lunch, 360 cc at supper. Nursing was to provide 420 ml fluid and to document oral fluid intake every shift. Provider order dated 4/22/26, indicated, required Ensure Clear daily, provided by culinary at breakfast for unplanned weight loss. R3's treatment administration record (TAR) for June 2026, indicated R3 consumed 100% of Ensure Clear every morning from 6/1/26 through 6/23/26. During observation on 6/23/26 at 11:11 a.m., R3's bedside table and dresser contained 19 unopened, Ensure bottles and one opened and half empty Ensure bottle. One of the unopened bottles had a date on the cap 6/23. During interview on 6/23/26 at 11:15 a.m., culinary services director (CSD) while collecting R3's meal tray stated the nursing assistants (NA) would round after meals take note of dietary and fluid amounts and notify the nurse. CSD, CSD would also go by the nurses' station and let the nurse or nursing assistants know and give them a chance to see the tray. During observation and interview on 6/23/26 at 11:58 a.m., director of nursing (DON) and registered nurse (RN)-B in R3's room and collected all the Ensure bottles. DON and RN-B verified R3 had 19 unopened Ensure bottles stored in his room and stated the culinary staff include an Ensure with R3's breakfast every day. DON could not explain why there were so many unopened Ensure bottles and further verified R3's June TAR indicated R3 had consumed 100% of the Ensure delivered during the month of June. During interview on 6/23/26 at 2:32 p.m., RN-B expected nurses to document intake accurately. During interview on 6/24/26 at 8:47 a.m., R3 stated he did not drink all the Ensure they provide because he was concerned about how it would affect his blood glucose since he had diabetes. R3 confirmed he was capable of opening the Ensure containers and stated he consumed one bottle every couple days or so. During interview on 6/24/26 at 12:58 p.m., registered dietician (RD) stated R3 was at nutritional risk and his intake was closely monitored. RD stated she relied on the documentation in the electronic medical record (EMR) to assist in formulating and modifying resident nutrition plans and orders. RD stated would expect documentation of food, fluid and supplement intake would be accurately documented so that her assessment and nutrition plan of care would be appropriate for the resident. RD stated was not aware of R3's reluctance to consume the Ensure due to the affect on his blood glucose, and that she would have changed to a more diabetic friendly supplement if she had known. During follow up interview on 6/25/26 at 12:14 p.m., DON stated she would expect staff to document R3's intake of nutritional supplement accurately so (RD) would have accurate information for her assessment and any necessary adjustments to R3's nutritional plan of care. Facility policy Assessment of Nutritional Status and Integrated Nutrition in the Comprehensive Care Plan dated 9/2012, indicated the resident would be restored to or maintained at a healthful level of nutritional status. The resident will receive the highest quality nutritional care through.Comprehensive (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment of nutritional status.Individualized care planning.Evaluation of outcome oriented measurements. The policy further indicated residents identified as at nutritional risk would be assessed by the RD for review and recommendations.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to provide appropriate monitoring of dialysis access site for 1 of 1 resident (R3) reviewed for dialysis care. Findings include:R3's quarterly Minimum Data Set (MDS) dated [DATE], indicated R3 had intact cognition and received dialysis. R3's diagnoses included diabetes mellitus and end stage renal disease. R3's Clinical Resident Profile printed 6/24/26, indicated, Special Instructions: Dialysis.Enhanced Barrier precaution (EBP) due to dialysis port upper right chest wall. R3's care plan reviewed 6/23/26, indicated R3 was at risk for complications related to dialysis and instructed staff to monitor central dialysis catheter port site for signs of bleeding every shift. R3's provider orders dated 1/15/26, indicated the following: -Dialysis-Review post dialysis treatment report for updates-Monitor dialysis site for bleeding-Dialysis-vital signs after dialysis R3's provider orders lacked evidence of monitoring for bruit and thrill assessment (Bruit - a swishing sound assessed with a stethoscope; thrill- a gently vibration felt by palpation. Bruit and thrill assessment for blood flow through an arterial/venous-AV fistula). In addition, R3's provider orders lacked evidence of direction to avoid blood pressures taken on the left arm due to the presence of an AV fistula. R3's Dialysis Treatment Details Report (TDR) dated 4/14/26, indicated R3 had dialysis access via a Central Venous Catheter (CVC) in the right chest. R3's after visit summary (AVS) dated 4/15/26, indicated, Surgical Procedure: Left Brachiobasilic AVF (surgically created connection-fistula-between the brachial artery and basilic vein for hemodialysis access). R3's AV fistula was ok to use in dialysis. R3's TDR dated 4/17/26, indicated R3's dialysis access was an AV Fistula located in the left upper arm. R3's AVS dated 5/11/26, indicated, You had your tunneled venous catheter [CVC] removed today. During interview on 6/24/26 at 8:37 a.m., registered nurse (RN)-D stated they assess resident's vital signs and weight prior to leaving for dialysis and will document in the electronic medical record (EMR) which then goes onto the dialysis communication form that was sent to dialysis with the resident. RN-D stated upon return from dialysis, the nurse would review the communication form to see if there were any complications with the dialysis session. RN-D further stated the nurse should look at the dialysis site and monitor for bleeding. RN-D stated R3 had a port in his right chest as an access site and was not aware of any required monitoring for bruit or thrill. RN-D stated was not aware R3 had an AV fistula in his left arm. During observation and interview on 6/24/26 at 8:47 a.m., R3 exposed his right chest area to display no CVC site and pulled up his left sleeve to expose the AV fistula site. RN-B could not explain why she was not aware of the site change, but agreed it was very important to know for accurate post dialysis assessment. During interview on 6/24/26 at 10:46 a.m., RN-B stated the nurse should complete the pre and post dialysis assessment and review the dialysis communication form for any changes or complications. RN-B stated appropriate dialysis site assessment for a resident with an AV fistula would include checking for bruit and thrill and would not perform a blood pressure check on the same arm with an AV fistula. RN-B stated R3's dialysis site assessment should have included bruit and thrill and avoidance of BPs on left arm since the fistula was created approximately two months prior and confirmed the EMR lacked evidence of appropriate monitoring. During interview on 6/25/26 at 12:15 p.m., director of nursing (DON) would expect nurses to know the correct location of a resident's dialysis access site and to accurately assess complications and care for the site according to where and what type of access it was. DON stated nurses should have been assessing R3's AV fistula site appropriately for the last two months since the fistula was created and used for dialysis. Facility policy Hemodialysis dated 11/22/19, indicated, Ongoing assessment/evaluation of the resident's condition and monitoring for complications should occur before and after dialysis treatments [i.e. infection and patency of fistula or graft].patency - feel the access for a thrill, listen with a stethoscope for a bruit.No blood pressures should be taken of the access arm.

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	06/26/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure medical records contained accurate documentation for 2 of 2 residents (R3, R12) reviewed for medical record accuracy. Findings include:R3R3's quarterly Minimum Data Set (MDS) dated [DATE], indicated R3 had intact cognition, was independent with eating, received dialysis, and required a therapeutic diet. R3's diagnoses included diabetes mellitus and end stage renal disease. R3's care plan printed 6/24/26, indicated R3 had diabetes, was at risk for hypo and hyper glycemia, and instructed staff to monitor compliance with diet and document any problems. R3's care plan further indicated R3 was at risk for dehydration and instructed staff to, Encourage adequate fluid intake. In addition, the care plan indicated R3 had potential nutritional problem related to protein calorie malnutrition and other diagnoses and instructed staff to, Provide supplements as ordered.R3's Clinical Nutrition Evaluation dated 4/16/26, indicated R3 had a Loss of 5% or more in the last month or of 10% or more in the last 6 months, and was not on a prescribed weight-loss regimen. Provider order dated 4/24/26, indicated, 1500 ml [milliliter] restriction. Dietary to provide: 1080 ml/day. Dietary to give 360 cc [ml] at breakfast [includes 1 Ensure Clear], 360 cc at lunch, 360 cc at supper. Nursing to provide: 420 ml fluid/day.Document oral fluid intake every shift.Provider order dated 4/22/26, indicated, Other.in the morning for unplanned weight loss Ensure Clear QD [every day] provided by culinary at breakfast.R3's treatment administration record (TAR) for June 2026, indicated R3 consumed 100% of Ensure Clear every morning from 6/1/26 through 6/23/26. During observation on 6/23/26 at 11:11 a.m., R3's bedside table and dresser contained 19 unopened, Ensure bottles and one opened and half empty Ensure bottle. One of the unopened bottles had a date on the cap 6/23. During interview on 6/23/26 at 11:15 a.m., culinary services director (CSD) while collecting R3's meal tray stated the nursing assistants (NA) would round after meals take note of dietary and fluid amounts and notify the nurse. CSD, But I also will swing by the nurse's station and let the nurse or nursing assistant know and give them a chance to see the tray. During observation and interview on 6/23/26 at 11:58 p.m., director of nursing (DON) and registered nurse (RN)-B in R3's room and collected all the Ensure bottles. DON and RN-B verified R3 had 19 unopened Ensure bottles stored in his room and stated the culinary staff include an Ensure with R3's breakfast every day. DON could not explain why there were so many unopened Ensure bottles and further verified R3's June TAR indicated R3 had consumed 100% of the Ensure delivered during the month of June. During interview on 6/23/26 at 2:32 p.m., RN-B stated would expect nurses to document intake accurately. During interview on 6/24/26 at 8:47 a.m., R3 stated he did not drink all the Ensure they provide because he was concerned about how it would affect his blood glucose since he had diabetes. R3 confirmed he was capable of opening the Ensure containers and stated he consumed one bottle every couple days or so. During interview on 6/24/26 at 12:58 p.m., registered dietician (RD) stated R3 was at nutritional risk and his intake was closely monitored. RD stated she relied on the documentation in the electronic medical record (EMR) to assist in formulating and modifying resident nutrition plans and orders. RD stated would expect documentation of food, fluid and supplement intake would be accurately documented so that her assessment and nutrition plan of care would be appropriate for the resident. During follow up interview on 6/25/26 at 12:14 p.m., DON stated would expect staff to document R3's intake of nutritional supplement accurately so (RD) would have accurate information for her assessment and any necessary adjustments to R3's nutritional plan of care. R12R12's significant change MDS dated [DATE], identified R12 had intact cognition, required substantial/maximal assistance with bed mobility, dependent on staff for toileting, and was always incontinent of bowel and bladder. R12's diagnoses included Alzheimer's disease, diverticulitis of large intestine (a painful digestive condition causing bulging pouches in the wall of the large intestine which become inflamed and infected), enterocolitis (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	due to clostridium difficile (C-diff-a highly contagious bacterial infection in the large intestine causing severe watery diarrhea and colon inflammation), and pressure ulcer of sacral region. R12's care plan printed 6/23/26, indicated, Resident has a current infection r/t [related to] C-Diff and was on isolation precautions per protocol. R12's progress note dated 6/5/26 at 8:41 a.m., indicated, Resident completed antibiotics for C-diff. Resident is not having any more loose stools. Provider updated. Contact precautions removed per guidelines. Resident placed on EBP [enhanced barrier precautions] due to wounds. Care plan reviewed and updated.R12's treatment administration record (TAR) indicated, Staff to follow: Contact Precautions due to CDIFF every shift.start date 4/16/26. With the exception of one shift, the task had been signed off three times a day (every shift) for the entire month of June.During observation on 6/22/26 at 1:11 p.m., R12's room had signage for EBP and PPE (personal protective equipment). During interview on 6/23/26 at 2:32 p.m., RN-B stated would expect staff to document cares accurately in the medical record. During interview on 6/24/26 at 2:48 p.m., RN-C stated R12 had wounds currently and gown was required for wound care. RN-C stated R12 did not have C-diff any longer, and could not explain why the order for contact precautions was still active and why he had been signing off in the TAR that contact precautions were being followed. During interview on 6/25/26 at 12:02 p.m., director of nursing (DON) stated expectation for resident orders to be updated to reflect accurate resident status. DON stated R12 should be on EBP and no longer on contact isolation precautions and would expect staff to document accurately in the medical record. A policy on accuracy of documentation was requested but not provided.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure 2 of 5 residents (R12, R27) were offered and/or provided updated vaccination for pneumococcal disease, in accordance with Centers for Disease Control (CDC). Findings include:Review of current, 2/25/26, CDC Pneumococcal Vaccine Recommendations, located at https://www.cdc.gov/pneumococcal/hcp/vaccine-recommendations/index.html, adults [AGE] years of age and older who received the PCV13 at any age and the PPSV23 at 65 years or older recommended based on shared clinical decision making, to get PCV20 or PCV21, or to not get additional pneumococcal vaccines. The site further indicated adults [AGE] years of age and older who received PCV13 at any age and PPSV23 while under the age of 65, a single dose of PCV21 or PCV20 should be given at least 5 years after the last pneumococcal vaccine dose. R12's admission Minimum Data Set (MDS) dated [DATE], indicated R12 was over the age of 65 and was not up to date on pneumococcal vaccination and was not offered the pneumococcal vaccination. R12's diagnoses include type 2 diabetes mellitus (DM2), kidney failure, and deep vein thrombosis (DVT). R12's Resident Vaccine Administration Consent Form signed 2/9/26, indicated Vaccine(s) to be given per primary care provider's (PCP) order and CDC guidelines. Furthermore, a pneumococcal vaccine was not indicated and R12 was up to date with the pneumococcal vaccine. R12's Minnesota Immunization Information Connection (MICC) report printed 6/25/26, identified R12 received PCV13 on 2/9/16 and PPSV23 on 3/17/15. R12's MICC lacked evidence of PCV20 or PCV21 administration. R27's admission MDS dated [DATE], indicated R27 was older than 50 and younger than 65. R27's pneumococcal vaccination was up to date. R27's diagnoses included coronary artery disease, thyroid disease, and malnutrition. R27's Resident Vaccine Administration Consent Form signed 3/20/26, indicated vaccine(s) to be given per PCP order and CDC guidelines. Furthermore, R27's pneumococcal vaccine was not indicated and R27 was up to date with the pneumococcal vaccine. R27's MICC report printed 6/25/26, indicated R27 received PPSV23 on 7/30/18, and lacked evidence of PCV20 or PCV21 administration. During interview on 6/25/26 at 11:43 a.m., director of nursing (DON) who was also the Infection Preventionist (IP) stated all residents were assessed upon admission for vaccine status using the MIIC report and a pneumococcal vaccination application and would be offered any recommended vaccines. DON further stated would expect all residents and/or resident representative be offered, educated on, and provided all recommended vaccinations. Facility policy Pneumococcal Policy dated 2/2024, indicated residents would be assessed within 5 days of admission on immunization status and their eligibility to receive the pneumococcal vaccine. Then within 30 days of admission, residents would be offered the vaccine when indicated. The policy further indicted staff to refer to the current CDC recommended adult immunization schedule to determine recommended vaccines.