DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 13, 2026

Administrator
THE VILLAS AT ST PAUL
445 GALTIER AVENUE
SAINT PAUL, MN 55103

RE: CCN: 245340
Cycle Start Date: June 26, 2026

Dear Administrator:

On June 26, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J). The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found other deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On August 31, 2025, the situation of immediate jeopardy to potential health and safety cited at F689 was removed.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 26, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 26, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 26, 2026.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your

obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

- Civil money penalty. (42 CFR 488.430 through 488.444)

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, The Villas at St. Paul is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective June 26, 2026. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Lynn Nelson, RN Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: Lynn.nelson@state.mn.us
Office: 651-201-4392 Mobile: 651-279-5474

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 26, 2026 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board’s Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days

after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies. A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an

explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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Administrator
THE VILLAS AT ST PAUL
445 GALTIER AVENUE
SAINT PAUL, MN 55103

Re: State Nursing Home Licensing Orders
Event ID: 231D21-H1

Dear Administrator:

The above facility survey was completed on June 26, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Lynn Nelson, RN Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: Lynn.nelson@state.mn.us
Office: 651-201-4392 Mobile: 651-279-5474

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245340	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT ST PAUL	445 GALTIER AVENUE , SAINT PAUL, Minnesota, 55103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments On 6/22/26 through 6/26/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		07/13/2026
F0000	INITIAL COMMENTS On 6/22/26 through 6/26/26, a standard recertification survey (S5340040) was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H53402965C(2739122), H53402962C(2805174), H53402964C(2746803) H53402967C(2726974), H53402961C(2971026), H53402963C(2799446), H53402957C(3025755), H53402960C(2993976). NO deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		07/13/2026

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245340	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/26/2026

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F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: 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 6/25/25, 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	F0689	"Past Noncompliance - no plan of correction required"	08/14/2026

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F0689 SS = SQC-J	Continued from page 2 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 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	F0689		08/14/2026

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F0689 SS = SQC-J	Continued from page 3 wander guard on, no concerns, and will continue to monitor. R37's fall risk assessment dated 3/31/25, 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	F0689		08/14/2026

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THE VILLAS AT ST PAUL	445 GALTIER AVENUE , SAINT PAUL, Minnesota, 55103

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F0689 SS = SQC-J	Continued from page 4 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 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	F0689		08/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245340	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT ST PAUL	445 GALTIER AVENUE , SAINT PAUL, Minnesota, 55103

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F0689 SS = SQC-J	Continued from page 5 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	F0689		08/14/2026

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THE VILLAS AT ST PAUL	445 GALTIER AVENUE , SAINT PAUL, Minnesota, 55103

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F0689 SS = SQC-J	Continued from page 6 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 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	F0689		08/14/2026

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F0689 SS = SQC-J	Continued from page 7 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 following actions were implemented prior to survey: -R37 was assessed for possible injury in the emergency department.-R37's	F0689		08/14/2026

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F0689 SS = SQC-J	Continued from page 8 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.	F0689		08/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245340	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **06/24/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/24/2026. At the time of this survey, The Villas at St. Paul was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. The Villas at St Paul is a 4-story building with a basement that was built in 1963 and was determined to be of Type II(222) construction. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The fire alarm system is monitored for automatic fire department notification. The facility has a capacity of 100 beds and had a census of 92 at time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are MET.	K0000		

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 reverse for further 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