Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 2, 2025

Administrator
The Villas At St Paul
445 Galtier Avenue
Saint Paul, MN 55103

RE: CCN: 245340
Cycle Start Date: March 4, 2025

Dear Administrator:

On April 8, 2025, we notified you a remedy was imposed. On May 28, 2025 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 15, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 4, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of April 8, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 4, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on May 15, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 16, 2025

Administrator
The Villas At St Paul
445 Galtier Avenue
Saint Paul, MN 55103

RE: CCN: 245340
Cycle Start Date: March 4, 2025

Dear Administrator:

On April 8, 2025 we informed you of imposed enforcement remedies.

On April 3, 2025, the Minnesota Departments of Health and Public Safety completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

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 Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 4, 2025

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 4, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 4, 2025.

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.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by June 4, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Villas At St Paul will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 4, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

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:

Renee McClellan, 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: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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 September 4, 2025 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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:

Steven.Delich@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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@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

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

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 _____	C 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT ST PAUL	445 GALTIER AVENUE SAINT PAUL, MN 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
E 000	Initial Comments On 3/31/25 to 4/3/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities 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.	E 000		
F 000	INITIAL COMMENTS On 3/31/25-4/3/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H53402323C (MN00105055), (MN00106140). H53402324C (MN00110080) H53402325C (MN00110836) 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	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/23/2025

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.

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F 000	Continued From page 1 validate substantial compliance with the regulations has been attained.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure residents compression stockings were applied correctly for 1 of 1 resident (R20) reviewed for edema. R20's quarterly Minimum Data Set (MDS) dated 12/23/24, indicated moderately impaired cognition and diagnoses of spondylosis with myelopathy (cervical region), muscle weakness, and dementia. It further indicated R20 was independent with activities of daily living (ADL) and mobility. R20's physician's order dated 3/31/25, indicated Thrombo-Emobolic Deterrent stockings (TED) on during the day and off at night, every morning and at bedtime. Remove at hour of sleep (HS) and wash and rinse, hang to dry. R20's nursing assistant care sheet (undated), indicated R20 preferred to put TED stocking on himself, staff to check that they are on during the	F 684	1. R 20 currently resides at The Villas at Saint Paul and received a care plan review and evaluation to ensure compression stocking were applied correctly. 2. The residents that currently have physician orders for compression stocking have the potential to be affected by this practice. These residents received care plan reviews to ensure staff monitor and assessed the compression stocking status and to follow the plan of care. 3. Licensed nurses and nursing assistants have been educated on following the resident’s plan of care as it relates to compression stocking assessment and plan. 4. DON / designee will conduct audits 3 times a week x4 weeks that compression	5/15/25

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F 684	Continued From page 2 day and off at night. R20's care plan dated 3/25/25, indicated self-care deficit related to increased weakness and failure to thrive with the following interventions: -Independent with dressing -Independent with grooming -Assist of 1 with bathing -Provide assistance with oral cares morning, bedtime, and as needed -Call bell/light within reach at all times, answer promptly. -Hair will be washed by nursing department and cut by beauty shop as needed -Nails will be cut by nursing department -Explain all cares while doing them -Assist with personal hygiene (Specify) -Dressing and personal hygiene preferences (Specify) The care plan lacked any indication R20 wore TED stockings or preferences regarding them. During observation and interview on 3/31/25 at 1:20 p.m., R20 was sitting in his wheelchair in his room and was wearing bilateral TED stockings. Both stockings were rolled down to his ankles and the end of the stockings (where the toes should be), had approximately 4-5 inches of the stocking hanging over. There were indentations in the skin of his ankles where the TED stockings were rolled down. He had a dime sized red area on the top of his right ankle where the stocking was rolled down. R20 stated he put on his own TED stockings. During observation and interview on 4/1/25 at 2:42 p.m., R20 was sitting in his room in his wheelchair. He was wearing bilateral TED stockings and they were rolled down to his	F 684	sock plan of care is followed for residents with orders for compression socks. The results of these observations will be shared with the facility QAPI committee for input on need to increase, decrease, or discontinue audits. 5. 5/15/2025	

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F 684	Continued From page 3 ankles. He removed his slippers and the TED stockings were hanging off the ends of his toes approximately 4-5 inches. He also removed his TED stockings and his ankles had indentations in the skin and a red area on the top of his right ankle where the stocking was rolled down. During observation and interview on 4/1/25 at 2:44 p.m., licensed practical nurse (LPN)-A verified R20's TED stockings were not on correctly and nurses and nursing assistants were responsible for applying them. R20 stated he had put on his own TED stockings. During interview on 4/2/25 at 8:39 a.m., LPN-B stated the nurses were responsible for applying residents TED stockings and if the resident prefers to put them on themselves, it was the nurses responsibility to ensure they were on correctly. During interview on 4/2/25 at 9:00 a.m., LPN-C stated nurses were responsible for applying residents TED stockings, but if they wanted to do it themselves, the nurse was still responsible for ensuring they were on correctly, stating "That's part of signing it off in the documentation." During interview on 4/3/25 at 12:12 p.m. the director of nursing (DON) stated R20 wore TED stockings per his preference and also prefers to apply them himself. The DON further stated the nurses were responsible for ensuring he was wearing them during the day, they were on correctly, and removed at night. This was important in order to prevent skin breakdown. A facility policy regarding edema in regards to TED stockings was requested but not received.	F 684		

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F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure expired food items were removed from service, food items were labeled and dated, and food was stored in a manner to prevent cross contamination. Furthermore, the facility failed to ensure dishwasher temperatures were monitored to ensure proper sanitization. This had the potential to impact all residents who reside in the facility. Findings include: Food storage An observation on 3/31/25 at 11:43 a.m., the main kitchen was reviewed. A stand-up freezer	F 812	1. Food storage on units and kitchen were reviewed by Administrator and Dietary Manager and all expired, not dated, or not labeled items were discarded. Kitchen staff were provided with a monthly temperature log for dishwasher monitoring. 2. This deficient practice has the potential to affect all residents. All residents were reviewed, and none were found to have any food borne illness as a result of this deficient practice. 3. Direct Care Staff were educated on the “Food Brought Into Facility” Policy, which	5/15/25

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F 812	Continued From page 5 contained a silver pan with plastic wrap covering it. The plastic wrap was not secured and was loose and lifted off three sides. The plastic wrap had "2/13 beef roast" written on it in black marker. Inside was frozen meat with ice crystals and patches of white frost on it. A stand-up refrigerator was reviewed. Inside contained the following: -a covered, plastic container of cut pineapple with no date. -an opened pack of turkey lunch meat with no date. -two containers of Kemps cultured sour cream, one opened and one unopened. Both containers had a best by date of 2/6/25. On the floor of the dry storage area contained three empty 5 gallon buckets labeled Ecolab liquid laundry chlorine. The buckets had lids, however there were holes in the tops of the lids and small amounts of the contents remained inside. When interviewed on 3/31/25 at 12:06 p.m., cook (C)-A and C-B verified the above findings. C-B stated any food item that is open should be dated and when new stock is delivered, whoever was putting it away should be looking at the dates and throwing out anything expired. C-A stated the 5-gallon buckets were stored there so they could be cleaned out. C-A acknowledged the buckets still having chemicals inside, and verified should not be stored around the food. On 3/31/25 at 12:52 p.m., the 4th floor patient refrigeration was reviewed and the following identified: -an unlabeled opened individual bottle of Kemps 2% milk with approximately 1/3 of the milk left with a use by date of 2/4/25.	F 812	indicates that all food is to be labeled with resident name and date, and food is to be disposed of properly after 3 days. All Dietary staff were educated on the process for dishwasher log temps, and that this is to be completed daily per shift. 4. The DON/Admin/designee will be responsible for completing 5 random observations weekly x4 weeks of food storage areas to confirm food is dated, labeled, or thrown out appropriately. Dietary Manager/Admin/Designee will be responsible for auditing dishwasher temp log daily x4 weeks to ensure log is being completed. The results of these observations will be shared with the facility QAPI committee for input on need to increase, decrease, or discontinue audits. 5. 05/15/2025	

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F 812	Continued From page 6 -a sandwich wrapped in a plastic bag taped to a plastic closed storage container. There was green/gray growth on the sandwich seen through the bag. The tape was dated 12/25/24. -three unlabeled and thawed frozen entrée meals stored on the top shelf of the refrigerator and not in the freezer. -a loaf of cub foods white sandwich bread with a best by date of 3/10/25. -two unlabeled or dated Styrofoam take out containers. -two take-out containers labeled "Lori 3/5". -an unlabeled or dated Wendy's fast-food bag. The freezer had five Ice Brick ice packs piled next to two unlabeled and dated plastic bags tied with unidentified food items inside. When interviewed on /31/25 at 1:16 p.m., nursing assistant (NA)-A verified the above items in the refrigerator and freezer. NA-A stated families often brought in meals for the residents on this floor and should have the residents name and when it was brought in. NA-A verified ice packs should not be in the freezer with food and there was another freezer in the medication room for those. NA-A further stated kitchen staff were responsible for cleaning of the fridge and to ensure items were thrown out but wasn't sure when the last time that happened was. On 3/31/25 at 1:55 p.m., the second floor resident refrigerator was reviewed and the following found: -un unlabeled and undated plastic container with clear lid containing what appeared to be a chicken breast with green and gray growths on the chicken. -an unlabeled take-out container from Kitchen Food Correlation dated 1/25/25. -5 unlabeled and undated several take out plastic	F 812		

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	245340	A. BUILDING _____ B. WING _____	C 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT ST PAUL	445 GALTIER AVENUE SAINT PAUL, MN 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
F 812	Continued From page 7 bags with food containers inside. When interviewed on 3/31/25 at 2:08 p.m., NA-B verified the above findings and further sated when residents want food placed in the refrigerator, the items needed to be labeled and dated. NA-B further stated the kitchen staff monitored for expired items. When interviewed on 4/1/25 at 2:30 p.m., registered nurse (RN)-A was not sure who reviewed the unit refrigerators and felt it may be activities or housekeeping. RN-A verified resident food items should be labeled with the resident name and date it was brought in. Furthermore, RN-A stated ice packs should not be stored with resident food items as it could cause contamination. When interviewed on 4/2/25 at 1:36 p.m., the Director of Nursing (DON) expected staff to ensure all food was labeled with the resident name and date it was received. Anything that was open would be thrown out after three days. DON stated it was a group effort between dietary and nursing to remove expired or outdated items from resident refrigerators. DON verified there should be no ice packs stored in freezers as only disposable ones were utilized. Dishwasher An observation on 4/1/25 at 9:33 a.m., the dishwasher in the main kitchen was observed. On the side of the dishwasher was a sign that directed wash temps to reach 150 degrees Fahrenheit (F) and rinse temps to reach 180 degrees F. Hanging on a clipboard on the wall above the dirty side was a temperature log Dated	F 812		

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F 812	Continued From page 8 April, 2025. The log was blank. Dietary Aide (DA)-A was washing pans from breakfast. DA-A was asked to identify wash and rinse temperatures for the next two cycles. DA-A wasn't sure where to look for temperatures for the cycles until shown. Observation of 2 wash/rinse cycles was completed and the first had a wash temp of 150 and a rinse temperature of 173. The second cycle observed had a wash temperature of 153 and a rinse of 175. DA-A verified the temperatures. DA-A was not aware of monitoring temperatures and was not sure what they should be at. DA-A further stated they were not trained about dishwashing temperatures. When interviewed on 4/1/25 at 9:50 a.m., DA-B stated the dishwasher wash temperature was usually around 140-145 degrees F, while the rinse temperature generally ran around 184 F. DA-B stated there was no official training for the dishwasher and monitoring temperatures and was just told to the new staff during training. DA-B verified temperatures of a cycle that read 153 F for the wash and 178 for the rinse. DA-B further stated maintenance was completed not long ago to help bring up the temperatures as they had been off. DA-B verified the 4/2025 temperature log was blank and stated the cooks generally did the checks. DA0B was not sure where the 3/2025 log was. When interviewed on 4/2/25 at 1:57 p.m., the Corporate Dietary Director (CDD) stated when orders arrive, staff were expected to rotate on a first in, first used method and ensure all items checked for expiration and expected any expired items to be tossed at that time. CDD further stated anything stored in the freezer should be in a sealed container or bag. If the item was not,	F 812		

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F 812	Continued From page 9 staff should switch it out to ensure that. The CDD acknowledged there had been a breakdown on who was monitoring resident food storage and that was in the process of being worked out. CDD verified the dishwasher utilized high temperatures to sanitize dishes. The dishwasher had not been getting to temperatures a few weeks ago and had received maintenance. CDD further stated DA-B had received education for monitoring temperatures at that time, however education to other staff had not been completed. CDD further stated while ideally temperatures would be taken at each mealtime use, an initial one at the start of the day was expected to be done. During that time, CDD had the temperature log for 3/2025, however it had been misplaced and had not yet been found. A facility policy titled Food Brought into Facility revised 9/2012, directed staff to label resident food with the resident's name and date the item was received. Food must be disposed of properly after 3 days. Furthermore, resident refrigerators may not be used for any other purposes other thatn the storage of resident food and beverage. A facility policy for food storage was requested however was not received.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		5/15/25

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F 880	Continued From page 10 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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F 880	Continued From page 11 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to identify and track a potential infection for 1 of 1 residents (R73) who required treatment for latent tuberculosis (a highly contagious lung disease). Furthermore, the facility failed to ensure transmission-based precautions (TBP) were utilized for 2 of 2 residents (R3, R13) who were on contact isolation precautions. Findings include: R73's quarterly Minimum Data Set (MDS) dated 1/10/25, indicated R73 had cognitve impairment and diagnoses of chronic lymphocytic leukemia (blood cancer) and high blood pressure. R73's infectious disease after visit summary dated 1/14/25, indicated R73 had been diagnosed	F 880	1. R 73, R13, and R3 are currently resides at The Villas at Saint Paul and received an infection control care plan review and evaluation. 2. Residents that currently have physician orders for antibiotics to treat latent tuberculosis have the potential to be affected by this practice. These residents received care plan reviews to ensure identifying and tracking and care plan are in place. Also, Residents that are receiving care utilizing enhanced barrier precautions and transmission-based precautions that require staff to wear PPE for high contact care also have the potential to be affected. 3. IP/ DON was educated on identifying	

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F 880	Continued From page 12 with latent TB. While R73 had no symptoms, if left untreated R79 may develop active TB in the future. R73's provider order dated 1/14/25, indicated R73 required rifampin (antibiotic) 600 milligrams (mg) each evening for 4 months for latent TB. A facility document titled Monthly Line Listing InfectionReport for 1/2025- 3/2025 lacked documentation of R73's latent TB infection or antibiotic use. When interviewed on 4/2/25 at 1:09 p.m., the infection preventionist (IP) stated R and R were both on contact precautions for MRSA. Furthermore, IP expected staff to follow the directions on the contact isolation sign posted on R and R 's door. IP stated the interdisciplinary team (IDT) would meet daily and determine if any residents had been started on antibiotics or were admitted with antibiotics. The residents and information were then included on the line listing document and were monitored until the infection cleared and antibiotic was no longer needed. We track when the symptoms, testing, site, and location in the building. The IP verified R73 was not on the Monthly Line Listing report and had not realized R73 and would need to look further into the situation. A follow up interview on 4/3/25 at 11:04 a.m., the IP stated R73 was added to the Monthly Line Listing Infection Report and would be monitored. R3	F 880	and tracking a potential infection who required treatment for Latent Tuberculosis. Staff in all departments, licensed Nurses, and NARs have received education on PPE requirements for Enhance barrier precautions and transmission-based precautions for high contact care, and educated on the risks of multidrug resistant organism acquisition. 4. DON/ Designee will audit, identifying and tracking infections who required treatment for Latent TB weekly x4 weeks, and complete staff observations of Enhanced barrier Precautions and Transmission based precautions are followed appropriately for residents at risk of MDRO acquisition 3 times weekly x4 weeks. The results of these observations will be shared with the facility QAPI committee for input on need to increase, decrease, or discontinue audits. 5. 5/15/25	

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F 880	Continued From page 13 R3's prospective payment system (PPS) 5-day assessment Minimum Data Set (MDS) dated 3/18/25, indicated intact cognition and reported an open lesion on her foot and indicated she was taking an antibiotic during the lookback period. According to the Center for Disease Control (CDC), enhanced barrier precautions (EBP) are an infection control intervention aimed at reducing the transmission of multidrug resistant organisms (MDRO) used during high contact resident care activities. The CDC states contact precautions are put into place to prevent the spread of infectious agents that are spread by direct or indirect contact with the resident or the resident's environment. The CDC recommends using personal protective equipment (PPE), including gown and gloves, for all interactions "that may involve contact with" the resident or the resident's environment. The CDC indicates donning PPE when entering the room and discarding before exiting the room is done to "contain pathogens", or contagious/infectious organisms. R3's care plan dated 1/27/25, indicated she was on EBP related to her incision. The care plan directed staff to follow EBP precautions and don and doff PPE per EBP precautions when providing high contact cares. A provider progress note dated 3/31/25, indicated under the assessment and plan header, "MRSA (methicillin resistant Staphylococcus aureus) infection" wound culture positive for MRSA and SA (staphylococcus aureus). According to the CDC, MRSA is a type of SA germ that can be resistant to several types of antibiotic treatments and is spread through	F 880		

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F 880	Continued From page 14 contact with infected people, wounds, or items that have touched infected skin and are carrying the bacteria. The CDC recommends healthcare providers follow contact precautions when caring for residents with MRSA. R13 R13's quarterly Minimum Data Set (MDS) dated 2/2/25, indicated she had intact cognition and reported her diabetic foot ulcer. R13's care plan indicated she was on contact precautions for wound care related to active MRSA in her right foot and abdominal wound. The care plan directed staff to follow indicated infection control precautions per protocol and "sign on resident's door". During observation on 4/2/25 at 8:58 a.m., a "contact precaution" sign was posted on R3 and R13's door. Nursing assistant (NA)-E entered R3 and R13's shared room without donning PPE and asked if they were done with the breakfast tray. R13 pulled her privacy around her wheelchair and NA-E exited the room. Per interview on 4/2/25 at 9:00 a.m., NA-E stated, "I would assume they are both on contact precautions." NA-E stated staff should wear PPE for "contact cares", or for instances where staff would come into contact with the resident, however, "if I was just feeding them or something, I wouldn't need to wear PPE." During observation on 4/2/25 at 11:35 a.m., licensed practical nurse (LPN)-D knocked on R3's door and entered the room without donning PPE. LPN-D approached R3 and touched her	F 880		

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F 880	Continued From page 15 shoulder and asked if she was coming to lunch. LPN-D then rubbed her back before exiting the room and performing hand hygiene back. During observation on 4/2/25 at 11:43 a.m., NA-F and social services (SS)-A entered R3's room without donning PPE and approached R3's bedside before exiting the room. During interview on 4/2/25 at 11:43 a.m., LPN-D stated both R3 and R13 were on contact precautions for their wounds. LPN-D expected staff to follow the instructions on the sign posted on their door, which stated gown and gloves at the door, however, if staff were only dropping off a meal tray or asking a question, they would not need to wear PPE. When asked how staff would know when to follow the signage on posted on the door and when it did not apply, LPN-D deferred to RN-A. During interview on 4/2/25 at 11:43 a.m., registered nurse (RN)-A stated staff were expected to follow the contact precautions signage posted on the door, which stated staff should don gown and gloves at the door, but if staff were dropping off a room tray, it would be okay to go without PPE. RN-A stated staff would only need to wear PPE if they were providing direct cares with the resident. When asked to clarify if staff should follow the signage posted on the door, which read, "hand hygiene before entry and all staff should d on gown and gloves at the door," or if they should only wear PPE when providing direct cares, RN-A stated staff should follow the signage on the door, however, if they were not providing direct cares, they would not need to don full PPE. LPN-D and RN-A reviewed the contact precautions recommendations on the	F 880		

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F 880	Continued From page 16 CDC website which indicated staff should "wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens," during the interview and RN-A confirmed staff should always follow the signage on the door. During the interview, RN-A and LPN-D confirmed R3's care plan lacked documentation of correct transmission-based precautions. RN-A stated, "I'll change that for her right now." LPN-D verified the deficient practice of not wearing appropriate PPE during the observation and stated NA-F and SS-A should have also worn PPE into the room. A facility policy titled Infection Prevention and Control Program revised 3/13/23, directed staff to use surveillance tools for recognizing the occurrences of infection. Furthermore, infection prevention included identifying possible infections. The policy further directed staff to implement appropriate isolation precautions when necessary.	F 880		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on April 1, 2025, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, The Villas at St. Paul, was found not 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, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/23/2025

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.

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: 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.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 100 beds and had a census of 90 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 200 SS=F	Means of Egress Requirements - Other CFR(s): NFPA 101 Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2 This REQUIREMENT is not met as evidenced by: Based on observation, document review and staff interview the facility was not following the applicable NFPA 101 and NFPA 80, 5.2.3.5.2, for testing and inspecting of the facility fire doors. This deficient finding could have a widespread impact on the residents. Findings include: On 04/01/2024, between 8:00 AM and 10:30 AM, by review of the available documentation at the time of the survey, there was no fire door inspection report available for review.	K 200	1. Maintenance Director completed fire door inspection report. 2. Maintenance Director was educated on the NFPA 80, 5.2.3.5.2 guideline for testing and inspecting of the facility fire doors. 3. Fire inspection report is to be audited monthly to ensure that inspection reports are completed. 4. Maintenance Director 5. 05/15/2025	5/15/25

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K 200	Continued From page 3 An interview with the Regional Maintenance Director verified this deficient finding.	K 200		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1 and 9.6.1.5, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 14.4.5.3.2, and 14.6.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/01/2025 between 8:00 AM and 10:30 PAM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation for the smoke detector sensitivity report for 2024/2025. An interview with the Regional Maintenance Director verified this deficient finding at the time of discovery.	K 345	1. Maintenance Director reached out to Summit to schedule smoke detector sensitivity testing to be completed on 5/8/2025. 2. Maintenance Director was educated on expectation to complete sensitivity testing in accordance with NFPA Life Safety Code guidelines. 3. Smoke detector sensitivity testing report to be audited quarterly to ensure that it is up to date. 4. Maintenance Director 5. 5/15/2025	5/15/25
K 511	Utilities - Gas and Electric	K 511		5/15/25

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	245340	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**04/01/2025**

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K 511 SS=F	Continued From page 4 CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to secure electrical panels per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3 and failed to maintain the Gas and Utility System per NFPA 101 (2012 edition), Life Safety Code section 9.2.2 and NFPA 54 (2012 edition), National Fuel Gas Code, sections 9.2.2 and 10.3.2.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/1/2025, between 8:00 AM and 10:30 AM, it was revealed by observation that the electrical panels located in the North Stairwell and in the Kitchen, were not secured. An interview with the Regional Maintenance Director verified this deficient finding at the time of discovery.	K 511	1. Maintenance Director repaired electrical panels on north stairwell and in the kitchen so that they remain secured. 2. Maintenance Director was educated on the NFPA Life Safety Code expectations for electrical panels, and that they should always be secure. 3. Maintenance Director to audit panels weekly x4 weeks to ensure that they remain secure. 4. Maintenance Director 5. 5/15/2025	
K 541 SS=F	Rubbish Chutes, Incinerators, and Laundry Chu	K 541		5/15/25

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K 541	Continued From page 5 CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain chute doors and safety measures of the laundry and bio-hazard chute systems per NFPA 101 (2012 edition), section 19.5.4, 9.5, 9.5.2 and NFPA 82 (2009 edition), section 5.2.3.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 541	1. Maintenance Director completed repair of trash and linen chute discharge doors so that they can now latch. Spring hinges were installed and latch adjusted. 2. Maintenance director educated that all chute discharge doors should have the ability to latch. 3. Chute door to be audited week x4 weeks to ensure that latch repair remains	

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K 541	Continued From page 6 On 04/01/2025, between 8:30 AM and 10:30 AM, it was revealed by observation in that the Trash and Linen chute discharge door would not latch if needed under fire conditions. An interview with the Regional Maintenance Director verified this deficient finding at the time of discovery.	K 541	in place. 4. Maintenance Director 5. 5/15/2025	
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	K 920	1. Power strip in medical records office	5/15/25

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K 920	Continued From page 7 facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/01/2025 between 18:00 AM and 10:30 AM, it was revealed by observation that there was a power strip (relocatable power tap) being used in Medical Records to provide power to a refrigerator and a printer. An interview with the Regional Maintenance Director verified this deficient finding at the time of discovery.	K 920	for refrigerator and printer was removed and devices plugged directly into wall. All office spaces were audited to ensure that no power strips are in use inappropriately. 2. Maintenance director was educated on the expectation that power cords/extension cords that do not meet NFPA Life Safety Code guidelines must be removed. 3. Offices to be audited weekly x4 weeks to ensure no power cords/extension cords are used inappropriately. 4. Maintenance Director 5. 5/15/2025	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet	K 923		5/15/25

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K 923	Continued From page 8 In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.6.5. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/01/2025 between 8:00 AM and10:30 AM, it was revealed by observation that in the 3rd floor storage room, there was an oxygen concentrator being stored within this room. This room is not rated for this type of storage. An interview with the Regional Maintenance	K 923	1. Maintenance Director removed oxygen concentrator from third floor storage room, and relocated it to the oxygen storage room. 2. Nurses were educated that oxygen is to be stored in the oxygen room located on fourth floor when not in use. 3. Maintenance director to audit storage rooms on second and third floor weekly x4 weeks to ensure no oxygen is stored incorrectly. 4. Maintenance Director 5. 5/15/2025	

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K 923	Continued From page 9 Director verified this deficient finding at the time of discovery.	K 923		