Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
October 28, 2024

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

RE: CCN: 245340
Cycle Start Date: September 23, 2024

Dear Administrator:

On October 24, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have 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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 28, 2024

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

Re: Reinspection Results
Event ID: I39112

Dear Administrator:

On October 24, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 23, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any 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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 27, 2024

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

RE: CCN: 245340
Cycle Start Date: September 23, 2024

Dear Administrator:

On September 23, 2024, a survey was completed at your facility by the Minnesota Department of Health 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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)).

DEPARTMENT CONTACT

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

Shannon Gilb, ROM
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: shannon.gilb@state.mn.us
Office: 651-201-4445

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by December 23, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 23, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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 09/23/2024

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 000	INITIAL COMMENTS On 9/19/24, 9/20/24, and 9/23/24, a standard abbreviated survey was conducted at your facility. 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: H53408385C (MN106739), H53407961C (MN106400). Incidental findings were identified with deficiencies cited at F656, F686, F729, and F755. 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 that substantial compliance with the regulations has been attained.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 656		10/22/24

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

Electronically Signed | 10/07/2024

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 656	Continued From page 1 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive, person-centered care plan was developed and adjusted as needed to promote continuity of care	F 656	R1 is no longer residing at the facility, R2 and R3 currently resides at The Villas at Saint Paul. Care plans were reviewed and current.	

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F 656	Continued From page 2 for 3 of 3 residents (R1, R2, and R3) reviewed for care planning. Findings include: R1's admission Minimum Data Set (MDS), dated 3/27/24, identified R1 admitted on 3/21/24 and was cognitively intact. The MDS outlined R1 required substantial physical assistance for toileting and setup/clean up assistance for oral hygiene. The MDS indicated R1 experienced occasional bladder incontinence and frequent bowel incontinence and was free of natural teeth. Further, the MDS outlined multiple Care Area Assessments (CAAs: items to have an in-depth review completed) were triggered for R1 which included, but was not limited to, Urinary Incontinence and Dental Care. Urinary incontinence was identified to be addressed in the care plan for improvement and to minimize risks. Dental care was identified to be addressed in the care plan to maintain current level of functioning and to minimize risks. R1's Bladder Evaluation, locked 3/25/24, identified R1 experienced "occasional incontinence" and requested the bed pan as needed. R1's Admission/Initial Data Collection V-5, locked 3/25/24, identified R1 utilized upper and lower dentures. R1's quarterly MDS, dated 8/15/24, identified R1 required substantial physical assistance for toileting and supervision or touching assistance for oral hygiene (increased assist from admission assessment), continued to experience occasional	F 656	All current residents care plans were updated with appropriate changes to reflect the resident condition.¿ Residents that reside at the villas at Saint Paul have the potential to be affected by this practice. A comprehensive person-centered care plan will be implemented for each resident that includes measurable focus, goal and intervention that are identified in the comprehensive assessment on time no later than 21 days after the admission of the resident.¿¿¿ All Interdisciplinary teams have been educated to ensure that comprehensive care plans to be developed to help meet the resident s medical, physical and psychosocial needs no later than 21 days.¿ ¿¿ DON/Designee will review and audit all new admit and current residents to ensure a comprehensive care plan and assessment completed on time. Audits will be completed on 2x per week x 3 weeks, then monthly x 3 months. All audits will be brought through QAPI and reviewed for continued quality improvement.	

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F 656	Continued From page 3 bladder incontinence and frequent bowel incontinence, and was free of natural teeth. R1's care plan, reviewed 9/19/24, identified multiple areas to record a, "Focus [i.e., problem]," with a corresponding goal and interventions. The care plan identified several focus areas; however, the care plan lacked focused areas for bowel and bladder incontinence and dental status/care. R2's admission MDS and Optional State Assessment (OSA), both dated 4/23/24, identified R2 admitted on 4/17/24 and was cognitively intact. The MDS outlined R1 required supervision for bed mobility, limited physical assist for toileting and transfers, setup/supervision/touching assist for dressing, personal hygiene, and walking short distances, and that R1 did not walk longer distances. In addition, R1 sustained falls within the month prior to admission and the last two to six months prior to admission and received high-risk medications (antipsychotic, antidepressant, diuretic). Further, the MDS outlined multiple CAAs were triggered for R2 which included, but was not limited to, Functional Abilities (Self-Care and Mobility) with improvements to be addressed on the care plan, Urinary Incontinence with improvements to be addressed on the care plan as she required assist with toileting, Falls with goal to minimize risks from immobility and medications addressed on the care plan, and Psychotropic Drug Use to avoid complications to be addressed on the care plan. R2's Admission/Initial Data Collection V-5, locked 4/22/24, identified R2 experienced frequent pain which impacted her sleep and limited her	F 656		

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F 656	Continued From page 4 day-to-day activities, was non-weight bearing to her right leg, and preferred evening showers. R2's quarterly MDS, dated 7/17/24, identified R2 was cognitively intact and required periods of supervision or touching assist with bed mobility; however, was independent with transfers and walking short distances. In addition, the MDS identified R2 reported occasional moderate pain which occasionally limited her day-to-day activities, continued use of high-risk medications, and that occupational therapy (OT) ended 5/21/24 and physical therapy (PT) ended on 5/22/24. R2's care plan, reviewed 9/19/24, identified several focus areas, however, these areas were left blank or not completed including but not limited to: "Fall Risk related to," with an initiated date of 6/11/24 (approximately two months after admission). The focus statement lacked insight into risks. A goal identified "Resident will be safe and free from falls," and the interventions lacked person centered approaches. One intervention was identified: "Follow residents specific fall prevention plan: (Specify)." The fall care plan lacked specifics. "Alteration in mobility related to," with an initiated date of 6/11/24. The focus statement lacked insight into the alteration. A goal identified "Resident will move safely within their environment." Interventions, all initiated on 6/11/24, were written as follows: "PT per MD (medical doctor) order," "Follow PT instructions," "Assist with ambulation (Specify)," "Assist with movement in bed and in/out of bed," "Assist with	F 656		

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F 656	Continued From page 5 transfers (Specify)." The mobility care plan lacked specifics for ambulation, transfers, PT instructions, or R2's wheelchair ability/use and directed for PT to continue despite its discontinuation on 5/22/24. "Self care deficit related to," with an initiated date of 6/11/24. The focus statement lacked insight into the deficit. Goals identified: "Resident will be accept assistance with self cares" and Resident will be dressed, groomed, and bathed per preferences." Interventions, all initiated on 6/11/24, were written as follows: "OT per MD order," "Follow OT instructions," "Assist with bathing (Specify)," "Assist with dressing (Specify)," Assist with personal hygiene (Specify)," "Bathing Preferences (Specify)," "Dressing and personal hygiene preferences (Specify)." The Self care deficit care plan lacked specifics and preferences and directed OT to continue despite its discontinuation on 5/21/24. R2's care plan lacked focused areas for pain, toileting, and high-risk medication usage for antidepressant, antipsychotic, and diuretic use. R3's admission MDS and OSA, both dated 7/18/24, identified R3 admitted on 7/12/24 and was severely cognitively impaired with unclear speech and impairments with understanding and verbalization of need. The MDS outlined R3 required physical assist with cares and mobility, demonstrated total bowel and bladder incontinence, was diagnosed with diabetes, aphasia (impaired communication ability), cerebrovascular accident (CVA - stroke), dementia, hemiplegia/paresis (weakness on one side of body), and seizure disorder, was at risk for pressure ulcers, and was administered high risk	F 656		

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F 656	Continued From page 6 medications (antidepressant - mood altering, hypoglycemic - blood glucose control). Further, the MDS outlined multiple CAAs were triggered for R3 which included, but was not limited to, Communication, Urinary Incontinence, Falls, Pressure Ulcer/Injury, and Psychotropic Drug Use. These identified the areas were to be addressed on the care plan and all areas lacked an overall objective for care planning. An Activities CAA was triggered with an objective for care planning to maintain current level of functioning and minimize risks. R3's Admission/Initial Data Collection V-5, locked 7/16/24, identified R3 preferred sponge baths. R3's nursing progress note, dated 9/3/24, identified R3 was found to have an open wound on her coccyx with a provider order for treatment. R3's nursing progress note, dated 9/16/24, identified the IDT (interdisciplinary team) met and discussed R3's coccyx wound [pressure ulcer]. New orders were discussed and R3 was to be repositioned per facility policy. R3's September 2024 Medication Admission Record (MAR) identified R3 received daily routine pain medications to right arm. R3's care plan, along with care plan revision histories, reviewed 9/19/24 (approximately two months since admission), identified several focus areas, however, these areas were left blank or not completed including but not limited to: "Alteration in skin integrity," created on 8/9/24 (28 days after admission) with a goal that "Resident	F 656		

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F 656	Continued From page 7 will remain free from skin breakdown." The focus statement lacked insight into the alteration and the intervention area remained blank. Additionally, the focus, goals, interventions lacked information related to R3's coccyx ulcer. "Self care deficit related to," created on 8/9/24 with a goal that "Resident will be accept assistance with self cares" and "Resident will be dressed, groomed, and bathed per preferences." The focus statement lacked insight into the deficit and the intervention area remained blank. "Fall Risk related to," created on 8/9/24 with a goal that "Resident will be safe and free from falls." Interventions directed staff to "Follow PT and OT instructions for mobility function." The focus statement lacked insight into the risk and the intervention area remained free of additional interventions or therapy instructions. "Alteration in communication," created on 8/9/24 with a goal that "Residents needs will be anticipated and met by staff." The focus statement lacked insight into the alteration and the intervention area remained blank. "Alteration in elimination," created on 8/9/24, lacked insight into the alteration, and the goal(s) and intervention area remained blank.. "Alteration in mobility related to," created 8/9/24 with a goal that "Resident will move safety within their environment." The focus statement lacked insight into the alteration and the intervention area remained blank. R3's care plan lacked focused areas for right arm pain, activities, and high-risk medication usage	F 656		

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F 656	Continued From page 8 for antidepressant and hypoglycemic use related to depression and diabetes. When interviewed on 9/20/24 at 10:57 a.m., wound care nurse practitioner (NP)-A stated she would expect resident care plans, especially those with wounds, to have a comprehensive care plan that included risk factors and interventions to prevent/decrease the risk for further concerns as the care plan was a main avenue for staff communication of specific resident information. During an interview on 9/20/24 at 1:33 p.m., nursing assistant (NA)-B stated resident Kardexes (NA care plans derived from the comprehensive care plan) were a main source of resident information which she reviewed when she needed details about a resident. When interviewed on 9/20/24 at 2:39 p.m., registered nurse (RN)-A stated the Kardex was utilized by the nursing assistants to know information such as preferences, risks, programs, etc. to keep the residents happy, safe, and free from harm. During an interview on 9/23/24 at 12:08 p.m., nursing assistant (NA)-D stated she utilized the Kardexes for resident information, especially when she was unfamiliar with a resident, and she expected specific information on the Kardex, especially as the group/assignment sheets lacked specific details and was not updated enough to reflect the residents' changing needs. When interviewed on 9/23/24 at 12:19 p.m., licensed practical nurse (LPN)-B stated the nurse managers were responsible for care planning	F 656		

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F 656	Continued From page 9 processes. She was able to look at it but was unsure if she could edit it. LPN-B explained she expected the care plan to be comprehensive and contain enough information to assist with decreased risk factors such as ulcers or other higher risk concerns. During an interview on 9/23/24 at 1:10 p.m., LPN-D stated he was the unit care coordinator; however, care planning was completed by the director of nursing (DON) when the IDT met to discuss the residents. He felt this was a very effective way to ensure the care plans were maintained. He was unaware of any care plan completion concerns and explained he expected the care plan to provide enough information for staff to ensure tasks were performed and needed cares were provided. LPN-D stated if a care plan lacked enough information, risks for neglect would be increased. When interviewed on 9/23/24 at 3:07 p.m., RN-B identified she was a corporate nurse who assisted the facility with the MDS process. She explained the facility usually completed much of the care plan and then once she edited the MDS and completed that process, she checked the care plan and would update anything that needed an update or add any missing items. RN-B stated the comprehensive care plan was expected to have all information needed for the resident to prevent problems, along with identified goals and personalized interventions. RN-B explained risks associated with incomplete care plans would impact the care a resident received which may then led to such things as skin breakdown or safety concerns such as incorrect transfers. During an interview on 9/23/24 at 4:08 p.m., the	F 656		

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F 656	Continued From page 10 DON stated all resident information was expected on the care plan as this information pulled over into the Kardex. All departments were responsible to ensure the care plan was up to date. The DON stated, "Our care plans are not great." She explained staff were afraid to add too many details to it, but she still expected enough information to be present for the residents to be cared for. This information included risks, goals, individualized interventions. The DON identified the facility policy was for the comprehensive care plan to be completed by day 21 of the resident's stay following the MDS process; however, the care plan started on admission with the baseline care plan process. The admitting nurse was expected to review the resident information, initiate the baseline care plan, and tweak the sections as needed within the baseline care plan assessment form, based on the resident information at the time of admission. The floor nurses did not adjust the care plan after that. After admission, and when changes arose, the nurse managers were required to review the care plan and make any additional adjustments as needed. If these processes were not followed, there were risks of missed information and the resident may not get the right care. During an interview on 9/24/24 at 9:49 p.m., RN-C identified she was a corporate nurse who assisted the facility with the MDS process. She explained the comprehensive care plan was expected to be completed when the care plan decision making decision on the MDS was dated. This was expected to be completed on or before the 21st day of a resident's stay. RN-C explained the comprehensive care plan was expected to address weaknesses and strengths for the continued maintenance of current function and to	F 656		

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F 656	Continued From page 11 prevent declines. She stated facility staff were responsible to ensure the care plan was comprehensive and current for communication amongst team members and to meet the goals of the residents and her role was required to ensure things were in place. If this was not completed, this lack of information led to potential injury, falls, social isolation, unidentified or unmet needs, depression, skin breakdown, etc. A Care Planning policy, dated 1/6/22, identified each resident would have a person-centered care plan developed by the IDT for meeting the individual medical, physical, psychosocial, and functional needs. The policy directed the IDT, in conjunction with the resident and the resident representative were to develop and implement a comprehensive individualized care plan no later than the 21st day of admission. The care plan was to be consistent with the identified problem areas and their causes and interventions were to be developed that targeted and were meaningful to the resident. The careplan was to be used to develop daily care routines for the resident and was to be utilized by staff to provide care and services. The care plan was to be modified and updated as the condition and care needs of the resident changed. A Skin Assessment and Wound Management policy, dated 3/2024, directed that when a new skin problem was identified the care plan was to be reviewed and updated to include interventions and risks for skin breakdown.	F 656		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity	F 686		10/22/24

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F 686	Continued From page 12 §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively reassess pressure ulcer risk and adjust the care plan for 1 of 1 residents (R3) who developed an avoidable stage ll (i.e., partial thickness tissue loss) pressure ulcer to R3's coccyx (tailbone area). Findings include: R3's admission MDS and Optional State Assessment (OSA) Item Set, both dated 7/18/24, identified R3 admitted on 7/12/24 from an acute care hospital and was severely cognitively impaired with unclear speech and impairments with understanding and verbalization of need. The MDS outlined R3 required physical assist with cares and mobility, demonstrated total bowel and bladder incontinence, was diagnosed with diabetes, aphasia (impaired communication ability), cerebrovascular accident (CVA - stroke), dementia, diabetes, hemiplegia/paresis (weakness on one side of body), and seizure disorder, and was at risk for pressure ulcers based on clinical assessment and a formal	F 686	R3 currently resides at The Villas at Saint Paul. Care plans were reviewed and current. R3 has been reassessed for risk for skin breakdown and intervention with skin care, has no other ulcers, wounds, or other skin problems. Care plans were updated with appropriate changes to reflect the resident condition. Residents that reside at the Villas at Saint Paul that have wound, and treatment order have the potential to be affected by this practice. The resident that has current wound were reviewed and updated. A process has been put into place to ensure that new admissions have a skin evaluation and skin risk factor assessment completed. Along with quarterly, annually or significant changes for current residents. Staff to complete the skin evaluation and skin risk factor to reflect the resident condition.	

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F 686	Continued From page 13 assessment instrument/tool in which R3 utilized a pressure reducing device for her bed. Despite this, she was free of pressure ulcers or other coded skin impairments. Further, the MDS outlined multiple CAAs were triggered for R3 which included, but was not limited to, Pressure Ulcer/Injury. This CAA identified R3 was at risk for pressure ulcers related to her need for extensive to total physical assist with mobility and activities of daily living (ADLs), bowel and bladder incontinence, a decline in mobility following hospitalization for seizures, history of stroke with dysphagia, aphasia, and right hemiplegia, impaired communication with her being overall non-verbal but was usually able to make needs known, and aspirin medication usage. R3 was assessed to have bilateral upper extremity bruising. Interventions included an incontinent product to keep R3's skin dry, toileting and repositioning every two hours and as needed (PRN), routine skin cares every morning and with evening cares, and weekly skin inspections. R3's Braden Scale for Predicting Pressure Sore Risk, locked 7/13/24, identified R3 was at moderate risk with a score of 13 related to a slightly limited ability to respond to meaningful pressure-related discomfort, rare exposure to moisture, bedfast/confined to bed, immobility and unable to make even slight changes in body or extremity positions without assist, probably inadequate nutritional intake, and potential problem for friction and shearing. R3's nursing progress note, dated 9/3/24, identified R3 was found to have a 2 cm (centimeter) by 2 cm "open wound" on her coccyx	F 686	Clinical nurse managers and licensed nurse have been educated on when a new pressure ulcer is discovered, new admission, quarterly, and annually the skin evaluation and skin risk factor assessment to complete to ensure a proper interventions and planning implemented to prevent worsening or new pressure ulcer. DON/ Designee will conduct audits 2 times a week times 3 weeks, then 3 times a month for 3 months. All audits will be brought through QAPI and reviewed for continued quality improvement.	

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F 686	Continued From page 14 and an "open wound on butt line." The provider was updated, and wound care orders were received. A Risk Management Skin Tear form, dated 9/3/24, identified the open wound as a skin tear. The form lacked additional wound assessment information. Immediate Action Taken described the area was cleansed with normal saline, covered with a foam dressing for protection, and on call provider, husband, and unit manager were updated. The description lacked immediate interventions to prevent additional wound development(s). The sections for Predisposing Physiological and Situation Factors were blank. The form Notes section identified that on 9/6/24, the IDT met and R3 was assessed to have a stage ll pressure ulcer to her coccyx area. Adjusted orders were obtained and the dietician was updated. In addition, R3 received [nutritional] supplements and "will be turning and repositioning" every two to three hours and PRN. A Skin and Wound Evaluation V7.0, locked 9/6/24, identified R3 was assessed for a stage ll pressure ulcer. The form allowed for an "Exact Date" of onset, which was blank. The Wound Measurements were 3.6 cm in length and 0.7 cm in width. Depth was "Not Applicable." Wound Bed, Exudate (drainage), Periwound, Wound Pain, and Orders (Goal of Care) were all blank. An area under Treatment allowed for Additional Care interventions; these were all unchecked. The Progress section identified the area was New; however, the remained of the section questions remained blank. A Wound Consult provider visit form, dated 9/11/24, identified R3's visit was conducted by	F 686		

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F 686	Continued From page 15 nurse practitioner (NP)-A and was for a chief complaint of an unstageable coccyx ulcer, impaired skin integrity, muscle weakness, and limited mobility. The ulcer was "sloughy (dead tissue) with peri wound maceration (wet edges)" which required sharp wound debridement (removal of non-healthy tissue). As R3 had limited mobility, "aggressive repositioning and offloading" was discussed with staff. The form indicated R3 displayed multiple comorbidities for wound healing and wound progression, as well as risk for wounds which included diabetes, hypertension, malnutrition, incontinence, and limited mobility and muscle weakness. A Skin and Wound Evaluation V7.0, initiated on 9/11/24 and completed by NP-A, identified R3 was assessed for an unstageable pressure ulcer due to 100 percent slough and/or eschar covering the wound bed. The Wound Measurements indicated 0.8 cm length by 0.6 cm width. Exudate was moderate and the wound edges were macerated. Additional Care identified the following items were checked: mobility aid(s) provided, moisture barrier and control, nutrition/dietary supplementation, positioning wedge, repositioning device(s), and turning/repositioning program. The wound was "Stable." R3's nursing progress note, dated 9/16/24, identified the IDT (interdisciplinary team) met and discussed R3's coccyx pressure ulcer. New orders were discussed and R3 was to be repositioned per facility policy. A Wound Consult provider visit form, dated 9/18/24, identified R3's visit was conducted by NP-A. R3's wound remained sloughy with peri	F 686		

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F 686	Continued From page 16 wound maceration and increased excoriation (superficial loss of tissue). The wound had "deteriorated some" and appeared "a little more deeper this week." NP-A spoke to the nurse manager about an air mattress and recommended house stock barrier cream for skin protection during peri cares. A Skin and Wound Evaluation V7.0, initiated on 9/18/24 and completed by NP-A, identified R3's unstageable (covered 100 percent with slough) coccyx ulcer measured 1.7 cm in length and 0.7 cm in width. Moderate exudate was present, and the peri wound was excoriated and macerated. Wound Progress was "Deteriorating." R3's medical record, from 9/3/24 through 9/19/24, lacked evidence R3's pressure ulcer risk was comprehensively reassessed by nursing staff after the pressure ulcer was identified. R3's care plan, along with care plan revision histories, reviewed 9/19/24 (approximately two months since admission and 16 days after the pressure ulcer was first discovered), identified multiple areas to record a, "Focus [i.e., problem]," with a corresponding goal and interventions, however, these areas were left blank or not completed including but not limited to: "Alteration in skin integrity," created on 8/9/24 (28 days after admission) with a goal that "Resident will remain free from skin breakdown." The focus statement lacked insight into the alteration and the intervention area was blank. Additionally, the focus, goals, interventions lacked information related to R3's coccyx pressure ulcer or NP-A's wound care/interventions.	F 686		

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F 686	Continued From page 17 "Self care deficit related to," created on 8/9/24 with a goal that "Resident will be accept assistance with self cares" and "Resident will be dressed, groomed, and bathed per preferences." The focus statement lacked insight into the deficit and the intervention area remained blank. "Alteration in communication," created on 8/9/24 with a goal that "Residents needs will be anticipated and met by staff." The focus statement lacked insight into the alteration and the intervention area remained blank. "Alteration in elimination," created on 8/9/24, lacked insight into the alteration and the goal(s) and intervention area remained blank. "Alteration in mobility related to," created 8/9/24 with a goal that "Resident will move safety within their environment." The focus statement lacked insight into the alteration and the intervention area remained blank. R3's comprehensive care plan lacked evidence her pressure ulcer risk, assessed with the CAA process, was care planned to decrease the risk for pressure ulcers. In addition, R3's comprehensive care plan lacked updates reflective of the identified pressure ulcer and wound care recommendations. During an interview on 9/20/24 at 10:57 a.m., NP-A stated R3 displayed limited mobility due to a past stroke and was at risk for pressure ulcers; however, "If [R3] was turned appropriately [the ulcer] could have been avoidable." NP-A expected some kind of interventions in R3's care plan especially interventions for repositioning and some sort of comprehensive assessment within	F 686		

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F 686	Continued From page 18 24 hours after an ulcer is discovered to determine continued pressure ulcer risk and to assess for any changes in resident status. If these were not completed, R3 was at additional increased risk for further skin breakdown or worsening of the current ulcer. When interviewed on 9/20/24 at 1:17 p.m., nursing assistant (NA)-A stated he was unaware of who had pressure ulcers or other alterations in skin integrity. For this information, he explained he would need to review the care plan or the group/assignment sheets. NA-A identified, after he reviewed the group/assignment sheet, this sheet lacked such information, nor did the sheet contain repositioning/toileting plans or interventions to decrease pressure ulcer risks. NA-A stated he was unaware if R3 was on an individualized repositioning plan, toileting plan, or that R3 required any additional care(s) for her skin; however, he explained all those at risk should be repositioned and toileting cares managed every two hours. During an interview on 9/20/24 at 1:33 p.m., NA-B stated she worked with R3 at times and was unaware if R3 had a pressure ulcer. She indicated she would need to follow up with the nurse and/or review the care plan for such information. In addition, she was unaware of R3's individualized pressure ulcer risk interventions; however, she explained everyone was on every two-hour, or as needed, repositioning and toileting plan. When interviewed on 9/23/24 at 11:54 a.m., NP-B identified she was one of R3's providers. She expected R3's care plan included risk factors based on a comprehensive skin/pressure ulcer	F 686		

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F 686	Continued From page 19 risk assessment before, and after, a pressure ulcer was discovered. This ensured proper interventions and planning were implemented to prevent worsening of the area and to avoid any additional open areas. NP-B identified R3 was at a high risk for pressure ulcers, and she expected R3 to be care planned, at least, for every two-hour repositioning. During an interview on 9/23/24 at 12:08 p.m., NA-D stated she expected interventions for resident care to be on the Kardex so that she knew what to do and explained this was important as the group/assignment sheets lacked specific details and was not updated enough to reflect the residents' changing needs. NA-D was aware R3 had a pressure ulcer as that was why they repositioned her every two hours. She was unsure if this was on R3's Kardex; however, she expected it was as many agency staff worked for the facility and they needed to know such information. When interviewed on 9/23/24 at 12:19 p.m., licensed practical nurse (LPN)-B stated R3 had a pressure ulcer; however, she was unsure as to what the care plan identified as interventions for this and additional pressure ulcer risk reduction. She indicated she would need to review R3's care plan for specific details as she expected such interventions to be present. During an interview on 9/23/24 at 4:08 p.m., the DON stated R3's pressure ulcer was considered avoidable as the ulcer was very superficial and R3 sat for "long periods," and if staff repositioned R3 every two to three hours, "it could have been prevented." The DON stated when R3's husband was here, R3 sat up for longer periods of time.	F 686		

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F 686	Continued From page 20 The DON stated if a resident were assessed for increased pressure ulcer risk, especially a Braden of 13 or less, this was expected to be on the care plan and individualized interventions initiated, such as w/c cushion, pressure reduction mattress, offloading every two to three hours and as needed. In addition, once an ulcer was found, the resident's risk should again be reassessed, and the care plan updated to reflect any risks/findings. A Skin Assessment and Wound Management policy, dated 3/2024, directed a pressure ulcer risk assessment (Braden Scale) was to be completed per the assessment schedule/grid and appropriate preventative skin measures were to be implemented such as, but not limited to, mobility and repositioning plans and a pressure reduction plan. When a pressure ulcer was identified, staff were expected to review and update the care plan including interventions, update resident care lists, and update the care plan to identify risks for skin breakdown.	F 686		
F 729 SS=D	Nurse Aide Registry Verification, Retraining CFR(s): 483.35(d)(4)-(6) §483.35(d)(4) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless- (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or (ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and	F 729		10/22/24

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F 729	Continued From page 21 has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. §483.35(d)(5) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual. §483.35(d)(6) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to verify nurse aide registration for 1 of 1 agency nursing assistants (NA-A) prior to allowing the individual to serve as a nurse aide and work directly with facility residents. This had the potential to affect all residents on the transitional care unit (TCU). Findings include: During an interview on 9/20/24 at 1:17 p.m., NA-A stated this was his first time working at the facility. NA-A identified he provided cares that morning to residents that included tasks such as hygiene and dressing cares, feeding, and mechanical lift transfers.	F 729	NA-A nurse aide registration was reviewed and verified. All agency staff and current staff at the Villas at St. Paul nurse aide registration was reviewed and verified. Staffing Coordinator and Human Resources Director have been educated to review and verify all agency staff and current staffs nurse aide registration prior to working at the facility. Administrator/ Designee will conduct audit weekly times 3 weeks and then monthly times 3 months. All audits will be brought	

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	245340	A. BUILDING _____ B. WING _____	C 09/23/2024

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

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F 729	Continued From page 22 When interviewed on 9/20/24 at 2:10 p.m., staffing coordinator (SC) stated 9/20/24 was NA-A's first shift and his agency staffing request was "last minute." SC identified the director of human resources (DHR) managed facility staff and agency paperwork. During an interview on 9/20/24 at 2:25 p.m., DHR stated she only managed facility staff paperwork and did not follow-up on paperwork related to agency staff. She explained agency paperwork was SC's responsibility as SC collaborated with the agencies for staffing needs. When interviewed on 9/20/24 at 2:33 p.m., the administrator stated she expected DHR and SC worked together to ensure agency staff met requirements, which included licensure or nurse aide verification. She explained these processes were required to ensure resident safety. During subsequent interviews on 9/20/24 at 3:37 p.m. and 3:59 p.m., SC stated the agencies were responsible to ensure nursing staff were licensed or registered as a nursing assistant; however, when a new agency staff was confirmed for shift pickup, she requested information from an agency electronic "portal" system that included licensure or nurse aide verification. Based on the specific agency processes, either this information was viewed directly within the portal, or the information was required to be requested via an email link. An email link process was required per NA-A's agency processes. SC stated nursing assistants were required to have an active nurse aide registration before the aide worked with residents which ensured resident safety, but being NA-A's shift request was last minute she	F 729	through QAPI and reviewed for continued quality improvement.	

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F 729	Continued From page 23 was unable to verify NA-A's registration prior to his shift. SC identified she submitted the email link request for NA-A's information that day, "early afternoon or late morning." During the interview, an email, from NA-A's agency to SC, dated 9/20/24 at 2:54 p.m., was provided and identified NA-A's active nurse aide registration. SC stated the facility accessed the portal for agency staff information and thus did not maintain agency staff employee files. An Abuse Prohibition/Vulnerable Adult Policy, dated 3/2024, identified potential employees were screened for a history of abuse, neglect, or mistreating residents and license or nursing assistant registry checks were to be completed on facility employees when indicated.	F 729		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F 755		10/22/24

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F 755	Continued From page 24 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a medicated powder for a fungal skin infection was transcribed when ordered, and thus applied, in accordance with provider orders for 1 of 3 residents (R1) reviewed for skin breakdown. Findings include: A wound care provider progress note, dated 8/28/24, identified R1 was assessed by nurse practitioner (NP)-A for left gluteus (buttocks) moisture associated skin damage (MASD) with observed peri area and groin intertrigo rash (skin condition caused by friction, heat, and moisture between skin folds). NP-A cleansed and applied Nystatin (anti-fungal medication) to R1's "backside." The note directed the continued application of Clortrimazole-Betamethasone cream (anti-fungal medication) as previously ordered; however, did not reflect directions for facility Nystatin use. A Skin and Wound Evaluation form, dated	F 755	R1 no longer resides at The Villas Saint Paul. Residents that reside at the Villas at Saint Paul that have wound treatment order have the potential to be affected by this practice. The residents that has current wound treatment orders were reviewed and updated. A process has been put into place to ensure that the resident wound treatment order is being written and given to the nurse manager and DON during wound round. The nurse manager will bring the actual TO order to the clinical meeting on the next day to ensure the order is created, confirmed and transcribed as prescribed order. The nurse manager and Licensed nurse have been educated on the new process and to follow the current treatment order.	

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F 755	Continued From page 25 8/28/24, completed by NP-A, identified R1 was assessed for left gluteus incontinence associated dermatitis (condition that causes swelling and irritation of the skin). The form lacked measurements and the area demonstrated moderate serosanguineous exudate (blood and blood serum drainage) with an epithelial (tissue that covers damaged skin) wound bed. The area lacked signs of infection or pain. The area's progress was "stable." A wound care provider order, dated 8/28/24, identified the wound care provider ordered Nystatin 100,00 units powder and directed its application to R1's bilateral breast folds, abdominal folds, and groin area three times a day (TID). The order was initialed by health information assistant (HIA)-A and dated 8/28/24. In addition, the order identified licensed practical nurse (LPN)-F's initials. R1's August Medication Administration Record (MAR), identified the 8/28/24 Nystatin order was scheduled to start on 8/29/24. The order was set up to be applied each day at 8:00 a.m., 12:00 p.m., and 4:00 p.m. The MAR from 8/29/24 at 8:00 a.m. through 8/31/24 at 4:00 p.m., indicated nine episodes for application; however, all nine episodes lacked administration identification at the designated dates and time frames. R1's September MAR, identified the 8/28/24 Nystatin order was scheduled to start on 8/29/24. The order was set up to be applied at 8:00 a.m., 12:00 p.m., and 4:00 p.m. The MAR from 9/1/24 at 8:00 a.m. through 9/3/24 at 12:00 p.m., indicated eight episodes for application; however, all eight episodes lacked administration identification at the designated dates and time	F 755	DON/ Designee will conduct audits 1 times a week times 3 weeks, then 3 times a month for 3 months. All audits will be brought through QAPI and reviewed for continued quality improvement.	

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F 755	Continued From page 26 frames. The MAR identified the Nystatin was first applied on 9/3/24 at the designated 4:00 p.m. timeframe by LPN-F. An Order Audit Report, identified R1's Nystatin was ordered on 8/28/24 at 5:07 p.m., and Queued (maintained in the order system until verified by a nurse) on 8/28/24 at 5:12 p.m.; however, the report indicated the order was created, confirmed, and revised on 9/3/24 at 6:11 p.m., by HIA-A. The report lacked information that supported the order was created and confirmed on 8/28/24 when ordered. A wound care provider progress note, dated 9/4/24, identified R1 was assessed by NP-A for the left gluteus/peri area/groin intertrigo rash. NP-A cleansed the area and applied "anti-fungal." Due to a "severe" deterioration with the wound status, the nurse manager, and the director of nursing (DON) were updated. The note directed Nystatin to the areas TID with a dermatology appointment scheduled for 11/12/24. A Skin and Wound Evaluation form, dated 9/4/24, completed by NP-A, identified R1 was assessed for left gluteus incontinence associated dermatitis. The area measured a length of 8.7 cm and a width of 2.9 cm with a granulation (tissue that precedes epithelialization) wound bed. The area continued to demonstrate moderate serosanguineous exudate, lacked signs of infection, and/or pain. The areas progress was "deteriorating." When interviewed on 9/20/24 at 10:57 a.m., NP-A stated R1's peri-groin area excoriation, related to moisture and fungal factors, over the past couple of months appeared to rapidly spread from the	F 755		

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F 755	Continued From page 27 buttocks to the upper back and even into the breast regions which was aggressively treated with oral anti-fungal medication and creams/powders. NP-A stated she was unsure of the cause for the 9/4/24 identified decline, especially as this excoriation fluctuated in status. She denied knowledge of the missed 8/28/24 Nystatin order applications. Once provided MAR information, NP-A indicated she assumed it was not administered as ordered. NP-A explained there was always the potential for R1's skin concerns to deteriorate if the Nystatin was not applied; however, she was not 100 percent sure this was the reason based on R1's many risk factors. During an interview on 9/23/24 at 12:48 p.m., the DON was unaware of any medication concern related to R1. After she reviewed R1's August and September MARs, she stated the Nystatin order was there; however, was not given. The DON reviewed R1's progress notes and identified the progress notes lacked related details. She stated she needed to converse with staff prior to any thoughts on potential reasons for the blank MAR spots. The DON was unaware of any potential risks to R1 related to the potentially missed applications; however, she identified she observed R1's rash on 9/4/24 and the rash lacked improvements. She expected the staff to apply the Nystatin as ordered to help resolve R1's fungal infection. On 9/23/24 at 1:51 p.m., the DON and the administrator approached the surveyor and reported they investigated the missed Nystatin, and it was identified the order process was not initially completed, and the order was revised on 9/3/24. Prior to 9/3/24, because of an unidentified	F 755		

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F 755	Continued From page 28	F 755		

process error, staff were unable to see the order, thus, they were unaware of the need for the Nystatin application. In response, this error was a transcription error. Both denied previous error knowledge despite expectations staff should have alerted them to the error [on 9/3/24].

When interviewed on 9/23/24 at 2:44 p.m., HIA-A stated she initially entered provider orders into the electronic health record which pushed the orders into a que. When in this que, it was then the responsibility of the nurses to double check the order. HIA-A explained if she became aware of any order errors, she was expected to update the floor nurse and the nurse then took care of it. She only updated the DON on order errors when the nurse was unavailable. HIA-A was shown R1's Nystatin order; however, she lacked remembrance to any details surrounding the order and denied any insight into what potentially occurred during the order process(es). HIA-A denied being spoken to about the Nystatin order.

During an interview on 9/23/24 at 2:56 p.m., LPN-F acknowledged the 8/28/24 Nystatin order contained his initials; however, he lacked remembrance to any details surrounding the order, any associated processing concerns, or the date he double checked the order.

On 9/23/24 at 3:31 p.m., the pharmacy was contacted. Pharmacy tech (PT)-A indicated R1's Nystatin order was received on 8/28/24 and supplied to the facility on 8/29/24.

A Medication Error Procedure, dated 1/2020, directed when a medication error occurred, the person responsible for the error, or the person who found the error, was to complete a

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F 755	Continued From page 29 Medication Error Reconciliation Report. In addition, the medical provider was to be updated, facility management was to complete an Investigation Summary, the person(s) making the error were to be followed up with, and the error was to be presented during routine quality assurance meeting(s). This assisted in the prevention and detection of adverse consequences such as adverse drug reactions and side effects. A Medication and Treatment Orders policy, dated 2/2024, identified orders for medications and treatments was to be transcribed accurately and in a timely fashion for consistent principles of safe and effective order writing.	F 755		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 27, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: I39111

Dear Administrator:

The above facility was surveyed on September 19, 2024 through September 23, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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:

Shannon Gilb, ROM
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: shannon.gilb@state.mn.us
Office: 651-201-4445

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 CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00480	A. BUILDING: _____ B. WING _____	C 09/23/2024

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: On 9/19/24, 9/20/24, and 9/23/24, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you	2 000		

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2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H53408385C (MN106739) and H53407961C (MN106400) with licensing orders issued at 0565 and 0900. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. 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/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. The facility is enrolled in ePOC and therefore a signature is	2 000		

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2 000	Continued From page 2 not required at the bottom of the first page of state form. 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.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive, person-centered care plan was developed and adjusted as needed to promote continuity of care for 3 of 3 residents (R1, R2, and R3) reviewed for care planning. Findings include: R1's admission Minimum Data Set (MDS), dated 3/27/24, identified R1 admitted on 3/21/24 and was cognitively intact. The MDS outlined R1 required substantial physical assistance for toileting and setup/clean up assistance for oral hygiene. The MDS indicated R1 experienced occasional bladder incontinence and frequent bowel incontinence and was free of natural teeth.	2 565	corrected	10/22/24

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

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2 565	Continued From page 3 Further, the MDS outlined multiple Care Area Assessments (CAAs: items to have an in-depth review completed) were triggered for R1 which included, but was not limited to, Urinary Incontinence and Dental Care. Urinary incontinence was identified to be addressed in the care plan for improvement and to minimize risks. Dental care was identified to be addressed in the care plan to maintain current level of functioning and to minimize risks. R1's Bladder Evaluation, locked 3/25/24, identified R1 experienced "occasional incontinence" and requested the bed pan as needed. R1's Admission/Initial Data Collection V-5, locked 3/25/24, identified R1 utilized upper and lower dentures. R1's quarterly MDS, dated 8/15/24, identified R1 required substantial physical assistance for toileting and supervision or touching assistance for oral hygiene (increased assist from admission assessment), continued to experience occasional bladder incontinence and frequent bowel incontinence, and was free of natural teeth. R1's care plan, reviewed 9/19/24, identified multiple areas to record a, "Focus [i.e., problem]," with a corresponding goal and interventions. The care plan identified several focus areas; however, the care plan lacked focused areas for bowel and bladder incontinence and dental status/care. R2's admission MDS and Optional State Assessment (OSA), both dated 4/23/24, identified R2 admitted on 4/17/24 and was cognitively intact. The MDS outlined R1 required supervision for bed mobility, limited physical assist for toileting	2 565		

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2 565	Continued From page 4 and transfers, setup/supervision/touching assist for dressing, personal hygiene, and walking short distances, and that R1 did not walk longer distances. In addition, R1 sustained falls within the month prior to admission and the last two to six months prior to admission and received high-risk medications (antipsychotic, antidepressant, diuretic). Further, the MDS outlined multiple CAAs were triggered for R2 which included, but was not limited to, Functional Abilities (Self-Care and Mobility) with improvements to be addressed on the care plan, Urinary Incontinence with improvements to be addressed on the care plan as she required assist with toileting, Falls with goal to minimize risks from immobility and medications addressed on the care plan, and Psychotropic Drug Use to avoid complications to be addressed on the care plan. R2's Admission/Initial Data Collection V-5, locked 4/22/24, identified R2 experienced frequent pain which impacted her sleep and limited her day-to-day activities, was non-weight bearing to her right leg, and preferred evening showers. R2's quarterly MDS, dated 7/17/24, identified R2 was cognitively intact and required periods of supervision or touching assist with bed mobility; however, was independent with transfers and walking short distances. In addition, the MDS identified R2 reported occasional moderate pain which occasionally limited her day-to-day activities, continued use of high-risk medications, and that occupational therapy (OT) ended 5/21/24 and physical therapy (PT) ended on 5/22/24. R2's care plan, reviewed 9/19/24, identified	2 565		

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2 565	Continued From page 5 several focus areas, however, these areas were left blank or not completed including but not limited to: "Fall Risk related to," with an initiated date of 6/11/24 (approximately two months after admission). The focus statement lacked insight into risks. A goal identified "Resident will be safe and free from falls," and the interventions lacked person centered approaches. One intervention was identified: "Follow residents specific fall prevention plan: (Specify)." The fall care plan lacked specifics. "Alteration in mobility related to," with an initiated date of 6/11/24. The focus statement lacked insight into the alteration. A goal identified "Resident will move safely within their environment." Interventions, all initiated on 6/11/24, were written as follows: "PT per MD (medical doctor) order," "Follow PT instructions," "Assist with ambulation (Specify)," "Assist with movement in bed and in/out of bed," "Assist with transfers (Specify)." The mobility care plan lacked specifics for ambulation, transfers, PT instructions, or R2's wheelchair ability/use and directed for PT to continue despite its discontinuation on 5/22/24. "Self care deficit related to," with an initiated date of 6/11/24. The focus statement lacked insight into the deficit. Goals identified: "Resident will be accept assistance with self cares" and Resident will be dressed, groomed, and bathed per preferences." Interventions, all initiated on 6/11/24, were written as follows: "OT per MD order," "Follow OT instructions," "Assist with bathing (Specify)," "Assist with dressing (Specify)," Assist with personal hygiene (Specify)," "Bathing Preferences (Specify),"	2 565		

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2 565	Continued From page 6 "Dressing and personal hygiene preferences (Specify)." The Self care deficit care plan lacked specifics and preferences and directed OT to continue despite its discontinuation on 5/21/24. R2's care plan lacked focused areas for pain, toileting, and high-risk medication usage for antidepressant, antipsychotic, and diuretic use. R3's admission MDS and OSA, both dated 7/18/24, identified R3 admitted on 7/12/24 and was severely cognitively impaired with unclear speech and impairments with understanding and verbalization of need. The MDS outlined R3 required physical assist with cares and mobility, demonstrated total bowel and bladder incontinence, was diagnosed with diabetes, aphasia (impaired communication ability), cerebrovascular accident (CVA - stroke), dementia, hemiplegia/paresis (weakness on one side of body), and seizure disorder, was at risk for pressure ulcers, and was administered high risk medications (antidepressant - mood altering, hypoglycemic - blood glucose control). Further, the MDS outlined multiple CAAs were triggered for R3 which included, but was not limited to, Communication, Urinary Incontinence, Falls, Pressure Ulcer/Injury, and Psychotropic Drug Use. These identified the areas were to be addressed on the care plan and all areas lacked an overall objective for care planning. An Activities CAA was triggered with an objective for care planning to maintain current level of functioning and minimize risks. R3's Admission/Initial Data Collection V-5, locked 7/16/24, identified R3 preferred sponge baths. R3's nursing progress note, dated 9/3/24,	2 565		

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2 565	Continued From page 7 identified R3 was found to have an open wound on her coccyx with a provider order for treatment. R3's nursing progress note, dated 9/16/24, identified the IDT (interdisciplinary team) met and discussed R3's coccyx wound [pressure ulcer]. New orders were discussed and R3 was to be repositioned per facility policy. R3's September 2024 Medication Admission Record (MAR) identified R3 received daily routine pain medications to right arm. R3's care plan, along with care plan revision histories, reviewed 9/19/24 (approximately two months since admission), identified several focus areas, however, these areas were left blank or not completed including but not limited to: "Alteration in skin integrity," created on 8/9/24 (28 days after admission) with a goal that "Resident will remain free from skin breakdown." The focus statement lacked insight into the alteration and the intervention area remained blank. Additionally, the focus, goals, interventions lacked information related to R3's coccyx ulcer. "Self care deficit related to," created on 8/9/24 with a goal that "Resident will be accept assistance with self cares" and "Resident will be dressed, groomed, and bathed per preferences." The focus statement lacked insight into the deficit and the intervention area remained blank. "Fall Risk related to," created on 8/9/24 with a goal that "Resident will be safe and free from falls." Interventions directed staff to "Follow PT and OT instructions for mobility function." The focus statement lacked insight into the risk and the intervention area remained free of additional	2 565		

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2 565	Continued From page 8 interventions or therapy instructions. "Alteration in communication," created on 8/9/24 with a goal that "Residents needs will be anticipated and met by staff." The focus statement lacked insight into the alteration and the intervention area remained blank. "Alteration in elimination," created on 8/9/24, lacked insight into the alteration, and the goal(s) and intervention area remained blank.. "Alteration in mobility related to," created 8/9/24 with a goal that "Resident will move safety within their environment." The focus statement lacked insight into the alteration and the intervention area remained blank. R3's care plan lacked focused areas for right arm pain, activities, and high-risk medication usage for antidepressant and hypoglycemic use related to depression and diabetes. When interviewed on 9/20/24 at 10:57 a.m., wound care nurse practitioner (NP)-A stated she would expect resident care plans, especially those with wounds, to have a comprehensive care plan that included risk factors and interventions to prevent/decrease the risk for further concerns as the care plan was a main avenue for staff communication of specific resident information. During an interview on 9/20/24 at 1:33 p.m., nursing assistant (NA)-B stated resident Kardexes (NA care plans derived from the comprehensive care plan) were a main source of resident information which she reviewed when she needed details about a resident.	2 565		

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2 565	Continued From page 9 When interviewed on 9/20/24 at 2:39 p.m., registered nurse (RN)-A stated the Kardex was utilized by the nursing assistants to know information such as preferences, risks, programs, etc. to keep the residents happy, safe, and free from harm. During an interview on 9/23/24 at 12:08 p.m., nursing assistant (NA)-D stated she utilized the Kardexes for resident information, especially when she was unfamiliar with a resident, and she expected specific information on the Kardex, especially as the group/assignment sheets lacked specific details and was not updated enough to reflect the residents' changing needs. When interviewed on 9/23/24 at 12:19 p.m., licensed practical nurse (LPN)-B stated the nurse managers were responsible for care planning processes. She was able to look at it but was unsure if she could edit it. LPN-B explained she expected the care plan to be comprehensive and contain enough information to assist with decreased risk factors such as ulcers or other higher risk concerns. During an interview on 9/23/24 at 1:10 p.m., LPN-D stated he was the unit care coordinator; however, care planning was completed by the director of nursing (DON) when the IDT met to discuss the residents. He felt this was a very effective way to ensure the care plans were maintained. He was unaware of any care plan completion concerns and explained he expected the care plan to provide enough information for staff to ensure tasks were performed and needed cares were provided. LPN-D stated if a care plan lacked enough information, risks for neglect would be increased.	2 565		

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2 565	Continued From page 10 When interviewed on 9/23/24 at 3:07 p.m., RN-B identified she was a corporate nurse who assisted the facility with the MDS process. She explained the facility usually completed much of the care plan and then once she edited the MDS and completed that process, she checked the care plan and would update anything that needed an update or add any missing items. RN-B stated the comprehensive care plan was expected to have all information needed for the resident to prevent problems, along with identified goals and personalized interventions. RN-B explained risks associated with incomplete care plans would impact the care a resident received which may then led to such things as skin breakdown or safety concerns such as incorrect transfers. During an interview on 9/23/24 at 4:08 p.m., the DON stated all resident information was expected on the care plan as this information pulled over into the Kardex. All departments were responsible to ensure the care plan was up to date. The DON stated, "Our care plans are not great." She explained staff were afraid to add too many details to it, but she still expected enough information to be present for the residents to be cared for. This information included risks, goals, individualized interventions. The DON identified the facility policy was for the comprehensive care plan to be completed by day 21 of the resident's stay following the MDS process; however, the care plan started on admission with the baseline care plan process. The admitting nurse was expected to review the resident information, initiate the baseline care plan, and tweak the sections as needed within the baseline care plan assessment form, based on the resident information at the time of admission. The floor nurses did not adjust the care plan after that. After admission, and when changes arose, the	2 565		

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2 565	Continued From page 11 nurse managers were required to review the care plan and make any additional adjustments as needed. If these processes were not followed, there were risks of missed information and the resident may not get the right care. During an interview on 9/24/24 at 9:49 p.m., RN-C identified she was a corporate nurse who assisted the facility with the MDS process. She explained the comprehensive care plan was expected to be completed when the care plan decision making decision on the MDS was dated. This was expected to be completed on or before the 21st day of a resident's stay. RN-C explained the comprehensive care plan was expected to address weaknesses and strengths for the continued maintenance of current function and to prevent declines. She stated facility staff were responsible to ensure the care plan was comprehensive and current for communication amongst team members and to meet the goals of the residents and her role was required to ensure things were in place. If this was not completed, this lack of information led to potential injury, falls, social isolation, unidentified or unmet needs, depression, skin breakdown, etc. A Care Planning policy, dated 1/6/22, identified each resident would have a person-centered care plan developed by the IDT for meeting the individual medical, physical, psychosocial, and functional needs. The policy directed the IDT, in conjunction with the resident and the resident representative were to develop and implement a comprehensive individualized care plan no later than the 21st day of admission. The care plan was to be consistent with the identified problem areas and their causes and interventions were to be developed that targeted and were meaningful to the resident. The careplan was to be used to	2 565		

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2 565	Continued From page 12 develop daily care routines for the resident and was to be utilized by staff to provide care and services. The care plan was to be modified and updated as the condition and care needs of the resident changed. A Skin Assessment and Wound Management policy, dated 3/2024, directed that when a new skin problem was identified the care plan was to be reviewed and updated to include interventions and risks for skin breakdown. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to creating and implementing a comprehensive person-centered care plan as needed to ensure cares meet the specific needs of each individual resident. The director of nursing or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure individual care plans are created and implemented. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:	2 900		10/22/24

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2 900	Continued From page 13 A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively reassess pressure ulcer risk and adjust the care plan for 1 of 1 residents (R3) who developed an avoidable stage ll (i.e., partial thickness tissue loss) pressure ulcer to R3's coccyx (tailbone area). Findings include: R3's admission MDS and Optional State Assessment (OSA) Item Set, both dated 7/18/24, identified R3 admitted on 7/12/24 from an acute care hospital and was severely cognitively impaired with unclear speech and impairments with understanding and verbalization of need. The MDS outlined R3 required physical assist with cares and mobility, demonstrated total bowel and bladder incontinence, was diagnosed with diabetes, aphasia (impaired communication ability), cerebrovascular accident (CVA - stroke), dementia, diabetes, hemiplegia/paresis (weakness on one side of body), and seizure disorder, and was at risk for pressure ulcers based on clinical assessment and a formal assessment instrument/tool in which R3 utilized a	2 900	corrected	

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2 900	Continued From page 14 pressure reducing device for her bed. Despite this, she was free of pressure ulcers or other coded skin impairments. Further, the MDS outlined multiple CAAs were triggered for R3 which included, but was not limited to, Pressure Ulcer/Injury. This CAA identified R3 was at risk for pressure ulcers related to her need for extensive to total physical assist with mobility and activities of daily living (ADLs), bowel and bladder incontinence, a decline in mobility following hospitalization for seizures, history of stroke with dysphagia, aphasia, and right hemiplegia, impaired communication with her being overall non-verbal but was usually able to make needs known, and aspirin medication usage. R3 was assessed to have bilateral upper extremity bruising. Interventions included an incontinent product to keep R3's skin dry, toileting and repositioning every two hours and as needed (PRN), routine skin cares every morning and with evening cares, and weekly skin inspections. R3's Braden Scale for Predicting Pressure Sore Risk, locked 7/13/24, identified R3 was at moderate risk with a score of 13 related to a slightly limited ability to respond to meaningful pressure-related discomfort, rare exposure to moisture, bedfast/confined to bed, immobility and unable to make even slight changes in body or extremity positions without assist, probably inadequate nutritional intake, and potential problem for friction and shearing. R3's nursing progress note, dated 9/3/24, identified R3 was found to have a 2 cm (centimeter) by 2 cm "open wound" on her coccyx and an "open wound on butt line." The provider was updated, and wound care orders were	2 900		

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2 900	Continued From page 15 received. A Risk Management Skin Tear form, dated 9/3/24, identified the open wound as a skin tear. The form lacked additional wound assessment information. Immediate Action Taken described the area was cleansed with normal saline, covered with a foam dressing for protection, and on call provider, husband, and unit manager were updated. The description lacked immediate interventions to prevent additional wound development(s). The sections for Predisposing Physiological and Situation Factors were blank. The form Notes section identified that on 9/6/24, the IDT met and R3 was assessed to have a stage II pressure ulcer to her coccyx area. Adjusted orders were obtained and the dietician was updated. In addition, R3 received [nutritional] supplements and "will be turning and repositioning" every two to three hours and PRN. A Skin and Wound Evaluation V7.0, locked 9/6/24, identified R3 was assessed for a stage II pressure ulcer. The form allowed for an "Exact Date" of onset, which was blank. The Wound Measurements were 3.6 cm in length and 0.7 cm in width. Depth was "Not Applicable." Wound Bed, Exudate (drainage), Periwound, Wound Pain, and Orders (Goal of Care) were all blank. An area under Treatment allowed for Additional Care interventions; these were all unchecked. The Progress section identified the area was New; however, the remained of the section questions remained blank. A Wound Consult provider visit form, dated 9/11/24, identified R3's visit was conducted by nurse practitioner (NP)-A and was for a chief complaint of an unstageable coccyx ulcer, impaired skin integrity, muscle weakness, and	2 900		

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2 900	Continued From page 16 limited mobility. The ulcer was "sloughy (dead tissue) with peri wound maceration (wet edges)" which required sharp wound debridement (removal of non-healthy tissue). As R3 had limited mobility, "aggressive repositioning and offloading" was discussed with staff. The form indicated R3 displayed multiple comorbidities for wound healing and wound progression, as well as risk for wounds which included diabetes, hypertension, malnutrition, incontinence, and limited mobility and muscle weakness. A Skin and Wound Evaluation V7.0, initiated on 9/11/24 and completed by NP-A, identified R3 was assessed for an unstageable pressure ulcer due to 100 percent slough and/or eschar covering the wound bed. The Wound Measurements indicated 0.8 cm length by 0.6 cm width. Exudate was moderate and the wound edges were macerated. Additional Care identified the following items were checked: mobility aid(s) provided, moisture barrier and control, nutrition/dietary supplementation, positioning wedge, repositioning device(s), and turning/repositioning program. The wound was "Stable." R3's nursing progress note, dated 9/16/24, identified the IDT (interdisciplinary team) met and discussed R3's coccyx pressure ulcer. New orders were discussed and R3 was to be repositioned per facility policy. A Wound Consult provider visit form, dated 9/18/24, identified R3's visit was conducted by NP-A. R3's wound remained sloughy with peri wound maceration and increased excoriation (superficial loss of tissue). The wound had "deteriorated some" and appeared "a little more deeper this week." NP-A spoke to the nurse	2 900		

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2 900	Continued From page 17 manager about an air mattress and recommended house stock barrier cream for skin protection during peri cares. A Skin and Wound Evaluation V7.0, initiated on 9/18/24 and completed by NP-A, identified R3's unstageable (covered 100 percent with slough) coccyx ulcer measured 1.7 cm in length and 0.7 cm in width. Moderate exudate was present, and the peri wound was excoriated and macerated. Wound Progress was "Deteriorating." R3's medical record, from 9/3/24 through 9/19/24, lacked evidence R3's pressure ulcer risk was comprehensively reassessed by nursing staff after the pressure ulcer was identified. R3's care plan, along with care plan revision histories, reviewed 9/19/24 (approximately two months since admission and 16 days after the pressure ulcer was first discovered), identified multiple areas to record a, "Focus [i.e., problem]," with a corresponding goal and interventions, however, these areas were left blank or not completed including but not limited to: "Alteration in skin integrity," created on 8/9/24 (28 days after admission) with a goal that "Resident will remain free from skin breakdown." The focus statement lacked insight into the alteration and the intervention area was blank. Additionally, the focus, goals, interventions lacked information related to R3's coccyx pressure ulcer or NP-A's wound care/interventions. "Self care deficit related to," created on 8/9/24 with a goal that "Resident will be accept assistance with self cares" and "Resident will be dressed, groomed, and bathed per preferences." The focus statement lacked insight into the deficit	2 900		

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2 900	Continued From page 18 and the intervention area remained blank. "Alteration in communication," created on 8/9/24 with a goal that "Residents needs will be anticipated and met by staff." The focus statement lacked insight into the alteration and the intervention area remained blank. "Alteration in elimination," created on 8/9/24, lacked insight into the alteration and the goal(s) and intervention area remained blank. "Alteration in mobility related to," created 8/9/24 with a goal that "Resident will move safety within their environment." The focus statement lacked insight into the alteration and the intervention area remained blank. R3's comprehensive care plan lacked evidence her pressure ulcer risk, assessed with the CAA process, was care planned to decrease the risk for pressure ulcers. In addition, R3's comprehensive care plan lacked updates reflective of the identified pressure ulcer and wound care recommendations. During an interview on 9/20/24 at 10:57 a.m., NP-A stated R3 displayed limited mobility due to a past stroke and was at risk for pressure ulcers; however, "If [R3] was turned appropriately [the ulcer] could have been avoidable." NP-A expected some kind of interventions in R3's care plan especially interventions for repositioning and some sort of comprehensive assessment within 24 hours after an ulcer is discovered to determine continued pressure ulcer risk and to assess for any changes in resident status. If these were not completed, R3 was at additional increased risk for further skin breakdown or worsening of the current ulcer.	2 900		

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2 900	Continued From page 19 When interviewed on 9/20/24 at 1:17 p.m., nursing assistant (NA)-A stated he was unaware of who had pressure ulcers or other alterations in skin integrity. For this information, he explained he would need to review the care plan or the group/assignment sheets. NA-A identified, after he reviewed the group/assignment sheet, this sheet lacked such information, nor did the sheet contain repositioning/toileting plans or interventions to decrease pressure ulcer risks. NA-A stated he was unaware if R3 was on an individualized repositioning plan, toileting plan, or that R3 required any additional care(s) for her skin; however, he explained all those at risk should be repositioned and toileting cares managed every two hours. During an interview on 9/20/24 at 1:33 p.m., NA-B stated she worked with R3 at times and was unaware if R3 had a pressure ulcer. She indicated she would need to follow up with the nurse and/or review the care plan for such information. In addition, she was unaware of R3's individualized pressure ulcer risk interventions; however, she explained everyone was on every two-hour, or as needed, repositioning and toileting plan. When interviewed on 9/23/24 at 11:54 a.m., NP-B identified she was one of R3's providers. She expected R3's care plan included risk factors based on a comprehensive skin/pressure ulcer risk assessment before, and after, a pressure ulcer was discovered. This ensured proper interventions and planning were implemented to prevent worsening of the area and to avoid any additional open areas. NP-B identified R3 was at a high risk for pressure ulcers, and she expected R3 to be care planned, at least, for every	2 900		

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2 900	Continued From page 20 two-hour repositioning. During an interview on 9/23/24 at 12:08 p.m., NA-D stated she expected interventions for resident care to be on the Kardex so that she knew what to do and explained this was important as the group/assignment sheets lacked specific details and was not updated enough to reflect the residents' changing needs. NA-D was aware R3 had a pressure ulcer as that was why they repositioned her every two hours. She was unsure if this was on R3's Kardex; however, she expected it was as many agency staff worked for the facility and they needed to know such information. When interviewed on 9/23/24 at 12:19 p.m., licensed practical nurse (LPN)-B stated R3 had a pressure ulcer; however, she was unsure as to what the care plan identified as interventions for this and additional pressure ulcer risk reduction. She indicated she would need to review R3's care plan for specific details as she expected such interventions to be present. During an interview on 9/23/24 at 4:08 p.m., the DON stated R3's pressure ulcer was considered avoidable as the ulcer was very superficial and R3 sat for "long periods," and if staff repositioned R3 every two to three hours, "it could have been prevented." The DON stated when R3's husband was here, R3 sat up for longer periods of time. The DON stated if a resident were assessed for increased pressure ulcer risk, especially a Braden of 13 or less, this was expected to be on the care plan and individualized interventions initiated, such as w/c cushion, pressure reduction mattress, offloading every two to three hours and as needed. In addition, once an ulcer was found, the resident's risk should again be reassessed,	2 900		

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2 900	Continued From page 21 and the care plan updated to reflect any risks/findings. A Skin Assessment and Wound Management policy, dated 3/2024, directed a pressure ulcer risk assessment (Braden Scale) was to be completed per the assessment schedule/grid and appropriate preventative skin measures were to be implemented such as, but not limited to, mobility and repositioning plans and a pressure reduction plan. When a pressure ulcer was identified, staff were expected to review and update the care plan including interventions, update resident care lists, and update the care plan to identify risks for skin breakdown. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers, and those who have pressure ulcers, to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers based off of their comprehensive, person-centered, care plan. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. In addition the director of nursing or designee should conduct care plan audits to ensure pressure ulcer risk, goals, and interventions are in place and/or revised when a pressure ulcer is identifed. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring.	2 900		

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2 900	Continued From page 22 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		