STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245083	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at the Park	4415 West 36 1/2 Street Saint Louis Park, MN 55416

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on observation, interview, and document review, the facility failed to ensure a self administration assessment (SAM) and a physician's order was completed to allow a resident to safely administer their own medication for 1 of 1 resident (R18) observed with medication at the bedside. Findings include: R18's quarterly Minimum Data Set (MDS) dated [DATE], indicated R18 had intact cognition, and cardiorespiratory conditions, pneumonia, respiratory failure, asthma, chronic obstructive pulmonary disease, or chronic lung disease. R18's Medical Diagnosis form undated, indicated R18 had chronic respiratory failure with hypoxia (low oxygen levels in the body), pneumonia due to other gram-negative bacteria, obstructive sleep apnea, dyspnea (shortness of breath), other specified chronic obstructive pulmonary disease, emphysema, and bronchiectasis (a condition where the airways widen and causes coughing with mucus and frequent infections) uncomplicated. R18's Physician Orders form indicated the following orders: 4/16/24, Advair diskus inhalation aerosol powder breath activated 500-50 microgram (MCG)/ACT (actuation) give 1 puff orally twice a day for asthma, administered by clinician. 4/18/24, Ipratropium-Albuterol inhalation solution 0.5-2.5 milligrams (MG) per 3 milliliters (ML) (nebulizer) inhale orally four times a day related to chronic respiratory failure with hypoxia. 8/28/24, ok for resident to self administer nebulizer after nursing set up medication. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R18's Self Administration of Medication Evaluation form dated 8/28/24, indicated R18 was capable of self administration of inhalation medication to include nebulizer administration of medication. A box below indicated R18 was able to self administer nebulizer after set up by the nurse. Instruction for self administration of medications with the resident was completed by the nurse. R18 was able to demonstrate to the satisfaction of the nurse manager or designee the following: knowledge of what the medication was for, ability to recognize the medication and verbalize understanding of the purpose of the medication, the manual dexterity sufficient to self administer the medication accurately. Five check boxes were left unmarked which included: knowledge of the correct times to take medication, the ability to produce all currently used medication containers and that these reflect the current physician prescribed medications, that all medications are stored properly (if stored in resident's room), the ability to read the label/instructions on the medication container/package, and the ability to accurately report the medication use to nursing staff. The form lacked information R18 was capable of self-administering Advair powder which was not a nebulizer. R18's care plan dated 8/28/24, indicated R18 chose to self-administer nebulizer treatments after the nurse set the medication up. Interventions indicated to monitor usage of nebulizer treatments after resident completed nebulizer and nursing to administer all other medications and monitor response and side effects as needed. During interview and observation on 10/21/24 at 5:54 p.m., R18 had an Advair diskus on the bedside table. R18 stated they changed it so it could be left in the room so he could keep an eye on it. During observation on 10/22/24 at 3:01 p.m., R18 had the Advair diskus on the bedside table. During observation on 10/23/24 at 7:28 a.m., R18 was in bed and the Advair diskus was located at the bedside. During observation on 10/24/24 at 7:20 a.m., trained medication aide (TMA)-A entered R18's room to check his vital signs and moved the bedside table the Advair was located on. At 7:22 a.m., TMA-A stated they looked at the care plan to know what kind of cares a resident required. If a resident refused cares, it was reported to the supervisor and documented in the progress notes. TMA-A further stated in order for a resident to self administer a medication, they had to have a physician's order and stated R18 could not self administer medications. TMA-A stated they set up the nebulizer and timed it and went back. TMA-A stated he would have to look up whether R18 could self administer the Advair. At 7:26 a.m., TMA-A went into R18's room and verified Advair was located on the bedside table and asked R18 if someone left the medication there the night before and R18 stated, it's always there. At 7:27 a.m., TMA-A looked at the electronic medical record and viewed the medication administration record (MAR) and stated he did not see an order for R18 to self administer the Advair and called licensed practical nurse (LPN)-B over at 7:29 a.m. LPN-B viewed the orders form, opened the Advair order, and stated they did not have an order for R18 to self administer the Advair. LPN-B further stated they evaluated the patient and if the patient could administer a medication by themselves, they obtained an order from the provider. LPN-B opened the Self Administration of Medication Evaluation form dated 8/28/24, and verified the evaluation form did not mention the Advair inhaler and stated the items a resident could self-administer were checked in the check boxes, and if a resident was not able to do something the item was not checked. LPN-B further stated, according to the evaluation, R18 could not self administer the Advair. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 10/24/24 at 7:39 a.m., LPN-A stated they completed a SAM assessment and obtained an order from the provider and the order would only include whichever medications were approved to self administer. LPN-A stated if there were unchecked items in the Self Administration of Medication Evaluation form, it indicated the resident could not do that portion of the assessment. During interview on 10/24/24 at 7:47 a.m., the director of nursing (DON) stated unless there was a physician's order and a completed SAM, a resident could not self administer a medication. The DON further stated the physician wrote the order for the nebulizer treatment and verified the SAM evaluation form did not indicate Advair and only the nebulizer. A policy on self administration of medications was requested. A policy, Self-Administration of Medications, dated 2/2024, indicated residents have the right to self-administer medications if the interdisciplinary team (IDT) has determined that it is clinically appropriate and safe for the resident to do so. As part of the evaluation comprehensive assessment, the IDT assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. The IDT considers the following factors when determining whether SAM is safe and appropriate for the resident: the medication is appropriate for self-administration, the resident is able to read and understand medication labels, the resident can follow directions and tell time to know when to take the medication, the resident comprehends the medication's purpose, proper dosage, timing, signs of side effects and when to report these to the staff, the resident has the physical capacity to open medication bottles, remove medications from a container and to ingest and swallow the medications and the resident is able to safely and securely store the medication. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42579 Based on observation, interview, and document review, the facility failed to ensure freedom of movement was not restricted when multiple pillows were placed by nursing staff adjacent to the resident's body, blocking the egress section of a perimeter mattress, underneath the fitted sheet which could not be removed easily by the resident for 1 of 1 resident (R104) reviewed for potential restraints. Findings include: R104's admission Minimum Data Set (MDS) dated [DATE], identified he had severely impaired cognition, and hallucinations and delusions had occurred. There was no behavior directed toward others and no rejection of care. Diagnoses included traumatic brain injury and anxiety. Falls occurred prior to entry but none since admission. Trunk restraints were not used. Extensive assist of two staff were required for bed mobility and transfers. R104's Care Area Assessment (CAA) for falls dated 10/22/24, was triggered due to a potential for falling due to poor muscle control and use of psychotropic meds. He was found on the floor several times since admission to TCU (transitional care unit), but it was determined that he crawled out of bed and put himself on the floor. R104's care plan dated 10/11/24, identified he was at risk for falls related to diffuse traumatic brain injury with loss of consciousness status unknown. Resident consistently made attempts and crawled out of low bed. Resident always had two fall mats on either side of bed and a perimeter mattress. A soft touch call light was in place and staff were also directed to follow any physical and occupational therapy instructions. Interventions lacked placing pillows under the sheet over the perimeter mattress egress section. R104's admission care conference form dated 10/7/24, lacked discussion of pillows under the fitted sheet. R104's progress notes identified the following: 10/7/24 at 11:30 a.m., after discussion with family members, family members say resident often rolled out of bed during hospital stay. Resident family members express concern about this. Perimeter mattress provided to resident along with bilateral fall mats. Resident family member inquired about side rails as well. Will update provider and provide resident with adequate bed mobility devices. 10/8/24 at 1:15 p.m., resident exhibited inconsolable behaviors. Resident was unable to be redirected and exhibited visual hallucinations, agitation, and attempting to crawl out of bed on to floor repeatedly. DON (director of nursing) by bedside as 1:1 while provider and family were contacted. Resident was sent out to the hospital. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/10/24 at 2:24 p.m., resident was readmitted back to the facility from the hospital and presented with an episode of exhibiting inconsolable behavior with visual hallucination and attempting to crawl out of bed multiple times. 10/11/24 11:03 a.m., IDT (interdisciplinary team) met to review resident behaviors. Behaviors include crawling from bed, calling out, outbursts of screaming, disrobing, visual/ auditory hallucinations. Per family/ POA, behaviors are like what resident exhibited in hospital post traumatic brain injury. Fall mats in place with low bed and perimeter mattress to help reduce resident desire to crawl out of bed and safety with these behaviors. 10/13/24 10:17 a.m., resident was on the floor and ss (social services) assisted cnas (nursing assistants) to get him to bed. Resident was agitated and ss spent time with resident to keep him company and distracted. 10/14/24 at 8:24 p.m., throughout the first half of shift resident continuously tried to propel himself out of bed. Resident had one leg dangling outside the bed while screaming numerous times. Medications were administered and staff were provided for 1:1 supervision. 10/15/24 at 1:02 p.m., resident continues to exhibit baseline impulsive behaviors. 1:1 not needed at this time due to safety precautions in place and baseline behavior for resident post TBI. Therapy continues to work with resident, PT recommending Hoyer lift (full body lift) currently. 10/16/24 at 1:15 p.m., a care conference was held with the resident's power of attorney and IDT team and noted to refer to form for detail. The associated care conference form dated 10/24/24, lacked mention of using pillows over the perimeter mattress egress section. During observations and interviews on 10/21/24 at 5:28 p.m., R104 was in a low bed, the bed had bilateral grab bars and the left side of the bed was placed against the wall. On the right side of the bed facing out to the room, there were two large, cushioned mats on the floor. R104 attempted to crawl out of bed but could not get his legs up over pillows which were placed next to him, under the fitted sheet of the bed and over the perimeter mattress egress section in the middle of the mattress. Nursing assistant (NA)-E and NA-F entered R104's room, R104 was trying to get his knees on the ground, his upper body was still on the bed behind the pillows, and he was grabbing out at the air with his hands. NA-E stated R104 was a fall risk and that's why the mats were on the floor and pillows under the sheet to keep him from crawling out of bed. NA-F stated R104 could not walk, needed to be transferred with a Hoyer lift and could not get out of bed per therapy recommendations. NA-E and NA-F positioned R104 him back into a central position in bed and adjusted three pillows back into place under the fitted sheet; two standard bed pillows and one decorative plush pillow. NA-E said R104 could not remove pillows under sheet next to him. During another observation at 10/21/24 at 5:39 p.m., NA-C entered the room with NA-E and NA-F and changed R104's incontinence brief and wet bed linen. No skin breakdown was observed. Then, NA-C placed the same pillows in the same position. NA-C stated the pillows were placed to keep him from falling out of bed, along with the floor mats and low bed. NA-C stated R104 required 1:1 staff over the weekend due to behaviors. When asked if the pillows as a fall intervention was listed on the care plan, NA-C, NA-E and NA-F stated they did not know. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/21/24 at 5:52 p.m., R104's guardian (FM)-A stated she had removed extra pillows from his bed before helping him to eat. Otherwise, the only other fall interventions she was aware of was floor mat, side rails (grab bars), perimeter mattress and a room change to be closer to the nurse's station. FM-A could not recall if pillows were placed under the fitted sheet. FM-a stated he could crawl out of bed but couldn't likely stand due to his brain injury. During an interview and observation on 10/22/24 at 9:49 a.m., NA-B and NA-A stated they completed his morning cares already. R104 had floor mats next to the bed and pillows were again observed next to R104, under the fitted sheet blocking the mattress egress section. R104 made no attempts to get out of bed. During an interview and observation on 10/22/24 at 1:46 p.m., registered nurse (RN)-A stated fall interventions were listed on the care plan and on the Kardex for nursing assistants. RN-A went into R104's room and opened the closet to find the Kardex form, which was not in the plastic laminated paper holder. When asked about the pillows placed under R104's fitted bed sheet, he stated he believed those were in place to prevent rolling out of bed. R104's care plan was reviewed with RN-A, and the pillow intervention was not found. When asked if the pillows would create additional hazards during R104's attempts to crawl out of bed, he agreed it might increase the risk of injury or behaviors if he could not move around in bed. RN-A stated he did not think R104 had the cognitive capabilities to know how to remove the pillows from under the fitted sheet. During an interview on 10/22/24 at 1:55 p.m., RN-B stated she would not typically use pillows to block a perimeter mattress egress to keep a resident in bed, but pillows could be used on top of the sheet to prevent pressure sores, such as under the heels. RN-B stated the pillows would keep R104 from crawling out of bed, because he liked to turn onto his stomach in bed and put his knees on the ground. During an interview and observation on 10/22/24 at 2:16 p.m., the director of nursing (DON) stated R104 required assistance to turn and reposition safety but could make movements on his own to roll the lower half of his body off the bed. The DON stated due to frequently crawling out of bed, R104's fall interventions included low bed, perimeter mattress, mats on the floor, soft call light, grab bars, and psychology review or medications. The DON stated pillows under the mattress were not included as a fall intervention and doubted it would qualify as a restraint, but agreed restricted movement could potentially contribute to skin integrity issues or mood or behavior issues. The DON and administrator accompanied surveyor to R104's room but were unable to view the pillows as they had been removed. The DON and administrator accompanied surveyor to talk to RN-B to see who removed the pillows. RN-B stated he removed the pillows in case they were considered a restraint. The administrator and DON asked RN-B if family requested staff to place pillows under the sheet and RN-B said no. The administrator stated if restraints were used there needed to be a thorough assessment first of the system used, with IDT and physician involvement, and in this case, there was not, and staff education should be completed. During an interview on 10/22/24 at 2:31 p.m., the physical therapist (PT) stated she had evaluated R104 upon admission and he would have a hard time removing pillows under a fitted sheet. The PT stated she would not want pillows blocking the egress on the perimeter mattress as it was not a realistic intervention. Mobility should be allowed with the least number of obstacles in the way. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During follow up observation on 10/23/24 at 7:16 a.m., NA-B was seated in R104's room. NA-B stated R104 started on 1:1 supervision today so her job was to sit here and redirect him. During an interview on 10/23/24 at 8:07 a.m., licensed practical nurse (LPN)-A stated she was unsure how R104's night went but they got him a ceiling projector for entertainment and to keep his focus. A policy on restraints was requested and not provided. The facility's policy titled Fall Prevention and Management dated 2/2024, identified facility staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. If falling recurred despite initial interventions, staff would implement additional or different interventions, or indicate why the current approach remains relevant. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on the nature of or type of fall, until falling is reduced or stopped or until the reason for the continuation of the falling is identified as unavoidable. Staff may also identify and implement relevant interventions to try to minimize serious consequences of falling. Staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. The policy lacked guidance on how to ensure different interventions were not restraints.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on observation, interview, and document review, the facility failed to ensure orders for compression were implemented for 2 of 2 residents (R40, R45) reviewed for edema. Findings include: R40's Optional State Assessment (OSA) dated 9/8/24, indicated R40 had intact cognition, did not reject cares, and required limited assistance with bed mobility, transfers, and toilet use. R40's admission Minimum Data Set (MDS) dated [DATE], indicated they had no impairment to range of motion, used a walker, and required partial to moderate assistance for showering/bathing, dressing lower body, and donning and doffing footwear. R40's Medical Diagnosis form undated indicated the following diagnoses: heart failure, difficulty in walking, cognitive communication deficit, neoplasm (tumor) of unspecified behavior of brain, malignant neoplasm of unspecified part of right bronchus or lung, secondary malignant neoplasm of brain, and metabolic encephalopathy. R40's Physician Orders form indicated the following orders; 10/11/24, torsemide 40 milligrams (MG) give 40 mg by mouth twice daily for heart failure and lower extremity edema. 10/18/24, Knee high compression stockings on every day and evening shiftt. R40's care plan dated 9/3/24, indicated R40 had an alteration in cognition due to a neoplasm of the brain and metabolic encephalopathy (brain dysfunction). R40's care plan dated 9/3/24, indicated R40 had a self care deficit due to a neoplasm of the brain and metabolic encephalopathy and required partial moderate assistance with lower body dressing. The care plan lacked information R40 required compression stockings, or had edema. R40's nursing assistant care guide indicated R40 was independent with dressing, required assistance of one staff with activities of daily living (ADLs), and lacked information R40 had compression stockings, or had edema. R40's progress notes were reviewed and lacked documentation R40 refused compression stockings. During interview and observation on 10/21/24 at 1:58 p.m., R40 was in bed, legs were swollen, and feet were up in the bed. R40 stated she had compression stockings she wore at bedtime. R40 was not wearing any compression stockings. During observation on 10/21/24 at 2:17 p.m., R40's compression stockings were not visible in R40's room. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 10/22/24 at 9:56 a.m., R40 had white compression socks on the left hand rail on the side of the bed towards the window. During observation on 10/22/24 at 10:11 a.m., R40 was in bed and her compression stockings were located on the hand rail. During interview on 10/23/24 at 10:40 a.m., R40 did not have compression stockings on, stated she just started using them, and then stated she could not tell if she was using them at this time. R40 had compression stockings located on the bed rail closest to the window. R40 stated the compression stockings did not hurt her legs. During interview on 10/23/24 at 11:01 a.m., nursing assistant (NA)-A stated R40 got up to use the bathroom independently and further stated R40 could get dressed by herself. NA-A thought R40's family member put clothing out for R40 and thought either the nurse or therapy put on R40's compression stockings. During interview on 10/23/24 at 11:16 a.m., registered nurse (RN)-A stated in general nursing assistants are educated on how to put on compression stockings and stated the NAs knew what kind of cares a resident required based on the care plan and a Kardex. RN-A further stated R40 had swollen legs two weeks earlier, was monitored closely, torsemide was increased due to retention of fluid, and compression stockings were ordered to reduce swelling. RN-A stated R40 was not able to put on or take off the compression stockings by herself and added R40 was confused. Further, RN-A stated they provided education to the aides and stated the NAs should be applying R40's compression stockings and stated the Kardex was usually in the closet, but stated it was not located in R40's closet. R40 was in bed and dressed and stated the compression stockings could be applied. R40 asked repeatedly whether she wore the stockings in the morning and at night. At 11:25 a.m., RN-A donned both compression stockings and stated it was the NA's responsibility to donn the compression stockings and would have been beneficial to have the Kardex in the room. During interview on 10/23/24 at 11:39 a.m., the director of nursing (DON) stated aides documented in point of care where the tasks are and used care guides to know what cares a resident required. The DON stated they did not use Kardex and revamped the careguides and the nurses had access to the care plans. The DON verified R40 had an order for compression stockings. 51577 R45's quarterly Minimum Data Set (MDS) dated [DATE], indicated R45 was cognitively intact and had diagnoses of chronic venous insufficiency (improper functioning of the vein valves in the leg, causing swelling and skin changes) and leg pain. Had no rejection of care and required maximum assistance with lower extremity cares. R45's provider orders dated 9/18/24, indicated R45 required compression socks on in the morning and off in the evening. R45's Medical Administration Record (MAR) and Treatment Administration Record (TAR) dated 10/2024, lacked documentation R45 used or refused compression socks. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R45's progress note dated 10/22/24 at 3:16 p.m., stated R45 had edema and utilized compression socks. The note also indicated R45 wore compression socks before admission. R45's care plan reviewed 10/22/24, lacked identification of R45's edema and intervention of compressions socks. During observation on 10/22/24 at 8:23 a.m., registered nurse (RN)-B was in R45's room helping them get dressed and could only find one compression stocking, so they were not applied. RN-B stated that they would see if they could find another. RN-B assisted R45 to stand, pulled up their pants, and helped them walk to a chair with bare feet. During observation on 10/23/24 at 7:27 a.m., R45 was wheeling in their wheelchair into the elevator and was not wearing compression socks. During observation and interview on 10/22/24 at 8:23 a.m., R45 stated staff did not put his compression socks on him because they could not find them, and the socks needed to be ordered. R45 stated they were required to reduce the swelling in his lower legs. R45's lower legs had hard, pitting edema on the ankles and skin folds. When interviewed on 10/23/24 7:59 a.m., R45 stated the facility did not have their socks, as the workers misplaced one of them. R45 stated their legs felt better when wearing them, and they had been missing for about a week. R45 stated one sock was on the commode rail, however, was not visible. R45 was unsure if the compression socks were ordered. When interviewed on 10/23/24 at 9:11 a.m., nursing assistant (NA)-J stated they helped R45 with their cares such as pulling up pants. NA-J stated they did not usually work on this side of facility, and did not have a current care plan sheet. NA-J stated they did what resident requested, and did not see or know if compression socks were ordered for R45. When interviewed 10/23/24 at 10:41 a.m., RN-B stated the cares that are expected to be done for edema would be to follow doctor's orders, including compression socks, diuretics and weight checks, and to update the provider if there are changes. RN-B did not know if R45 had orders for compression socks, and confirmed they were not listed on the care plan or electronic medical record. When interviewed 10/23/24 1:43 p.m., licensed practical nurse (LPN)-A stated if a resident had edema, staff would gather information and call the doctor to get orders for medication and compression socks, and these would be listed in the electronic record and the care guide sheets. They expected staff to document cares and medications given on the MAR/TAR. They confirmed R45 should wear compression socks due to a diagnosis of chronic venous insufficiency. When interviewed on 10/23/24 at 2:00 p.m., the director of nursing (DON) stated the expectation of staff was to follow orders for wearing compression socks and document them in a progress note. They stated it was important to follow doctor's orders to treat the diagnosis and be compliant. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245083	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at the Park	4415 West 36 1/2 Street Saint Louis Park, MN 55416

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy regarding edema management and following orders was requested but not provided. A policy, Activities of Daily Living dated 3/31/23, indicated the facility will provide the necessary care and services to ensure that a resident's abilities in ADLs do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. The facility will ensure a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the ADLs.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42579 Based on observation, interview, and document review, the facility failed to comprehensively assess and implement pressure ulcer interventions for 2 of 2 residents (R30, R33) identified at risk for pressure ulcers. This resulted in actual harm when R30 developed two deep tissue injuries which worsened to unstageable pressure injuries on the heels after admission, and R33 developed a stage two pressure ulcer after admission that worsened to an unstageable pressure ulcer. Additionally, the facility failed to reposition 1 of 2 residents (R30) in accordance with the current care plan, and failed to accurately stage a pressure ulcer and failed to accurately assess nutritional needs and implement provider ordered nutritional interventions to aide in healing for 1 of 2 residents (R33) reviewed for facility acquired pressure ulcers. Findings include: The National Pressure Injury Advisory Panel (NPIAP) guidance dated 2016, identified a deep tissue pressure injury (DTPI or DTI) as persistent non-blanchable deep red, maroon, or purple discoloration with intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration, or epidermal separation revealing a dark wound bed or blood-filled blister. Pain and temperature changes often preceded skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle, or other underlying structures are visible, this indicates a full thickness pressure injury (unstageable, stage 3 or stage 4). An unstageable pressure injury was defined as obscured full-thickness skin and tissue loss, full-thickness skin, and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it was obscured by slough or eschar (dead tissue). If slough or eschar was removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. Additionally, the NPIAP Evolution of Deep Tissue Pressure Injury process dated 1/8/21, identified DTI was one of the most serious forms of pressure injury. The process leading to DTI included: 1. 48 hours after a pressure event a DTI presents as intact, discolored skin from pressure 2. 24 to 48 hours after intact skin color change, the discolored skin blisters 3. Seven to 10 days after intact skin color change the DTI is classified as an unstageable pressure injury related to necrosis (death of body tissue). (continued on next page)

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	245083	A. Building B. Wing	10/24/2024

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R30's admission Minimum Data Set (MDS) dated [DATE], identified she had intact cognition, no behaviors, and no rejection of care. Substantial/maximal assistance was required for lower body dressing and putting on/taking off footwear. Walking was not attempted due to medical condition or safety concerns. Diagnoses included adult failure to thrive, cauda equina syndrome (spinal disc compression with symptoms that may include less or changed sensation between the legs, the back of the legs, the feet, or the heels), lumbosacral radiculopathy (compressed nerve roots in lower back which include symptoms of numbness, tingling or reduced sensation in the legs), and presence of left artificial knee joint. R30 was at risk for pressure ulcers but had none. Pressure reducing device for chair and bed were selected as current treatments. Turning and repositioning program was not selected. R30's admission pressure ulcer Care Area Assessment (CAA) dated 7/2/24, was triggered due to risk of potential alteration in skin integrity related to frequent incontinence of bowel. Staff assistance was required for bed mobility and transfers, and the Braden skin risk assessment identified her to be at risk for pressure ulcers. Risk was further complicated by presence of indwelling urinary catheter, several significant comorbidities, recent complicated hospitalization s, and history of noncompliance and refusal of cares. R30 had no pressure injuries and worked with physical and occupational therapy. R30's hospital progress note (prior to facility admission) dated 6/19/24, identified she was unable to move her legs and had diminished sensation. R30's admission 48-hour care plan dated 6/27/24, identified she required assist with bathing, dressing, hygiene, transfers, and movement in bed. A pressure redistribution mattress was present on the bed and chair, and skin integrity would be monitored daily during cares and weekly by nurses. Turn and reposition or reminders were not selected as an intervention. R30's comprehensive care plan dated 6/27/24, identified she had an alteration in skin integrity due to adult failure to thrive and surgical incision. The care plan lacked risk factors affecting sensation in the lower legs such as cauda equina syndrome and lumbosacral radiculopathy. Interventions lacked floating heels, heel protection, or to turn and reposition every two to three hours and as needed. R30's comprehensive care plan updated 8/8/24, identified she had an alteration in skin integrity related to adult failure to thrive, history of coccyx ulcer pressure injury, surgical incision, and DTI on bilateral heels. New interventions also dated 8/8/24, included heel lift boots at all times when in bed; and on 8/24/24, an intervention was added to turn and reposition or give reminders to offload every two to three hours and as needed. R30's quarterly MDS dated [DATE], identified additional diagnoses of anxiety, neurogenic bladder, osteoarthritis of the knee, muscle weakness, and difficulty walking. R30 was at risk for pressure ulcers and now had two unstageable pressure ulcers with suspected DTI in evolution. Nutrition interventions were in place to manage skin problems, and pressure ulcer care treatment was provided. R30's admission Braden Scale for Predicting Pressure Sore Risk dated 6/26/24, had not identified any sensory perception problems in the lower legs, which would have increased the risk scoring. (continued on next page)

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	245083	A. Building B. Wing	10/24/2024

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R30's nurse practitioner (NP) admission note from the in-house provider group dated 6/28/24 at 12:00 a.m., identified she was severely deconditioned from long hospitalization as well as recent total knee arthroplasty (replacement) on 5/2024. R30's admission Skin Evaluation and Skin Risk Factors assessment dated [DATE], identified an overall Braden score of 15-18, which was mild risk. A surgical incision was present on the lower back. A pressure reducing ultra foam mattress was in place, however turning and repositioning schedule or floating the heels were not identified as an intervention. R30's Occupational Therapy (OT) Evaluation and Plan of Treatment dated 6/27/24 through 7/25/24, identified therapy attempted to transfer R30 to wheelchair with EZ stand (standing lift). R30 complained of too much pain even before hips were lifted off the bed. Further transfers were declined. Additionally, R30 required maximum assist of staff to sit on edge with both hands supporting her body on the sides of her hips. Once her hands were lifted, she was unable to maintain sitting balance for more than a few seconds. R30's OT Discharge Summary dated 6/27/24 through 8/15/24, identified she had achieved the highest practical level. She required maximum assistance with Hoyer for transfer (full body mechanical lift) and maximum assistance for lower body dressing. R30's mobility function score was zero (score range zero to 12; with 12 being the highest function). R30's Physical Therapy (PT) Evaluation and Plan of Treatment dated 6/28/24 through 7/27/24, identified a medical history of osteoarthritis (OA) and surgical procedure (s/p) bilateral total knee arthroplasty (TKA), right knee being done on 5/1/24, and recent prolonged hospitalization for osteomyelitis and discitis. R30 could not care for herself at home and required placement in the transitional care unit (TCU). Right and left lower extremity strength was impaired. R30's PT Discharge Summary dated 6/28/24 through 8/15/24, identified she had exhausted benefits and declined treatment. A Hoyer lift was still recommended due to lower extremity weakness and low tone. R30 was unable to stand due to poor leg strength and poor tone. R30's mobility function score was three (score range zero to 12; with 12 being the highest function). R30's Weekly Skin Assessments dated 6/26/24 through 8/8/24 had not noted the heels were offloaded. R30's progress note dated 8/8/24 at 2:10 p.m., identified discoloration (DTI) noted on bilateral heels during wound rounds. The progress note identified R30 consistently offloaded heels with pillows in bed, however, this was not listed as an intervention in the care plan or nursing assistant tasks or documented prior to the DTI. R30's weekly NP-A Wound Consult forms identified the following: -8/1/24, seen for post-surgical spinal wound routine wound evaluation. R30 had multiple comorbidities affecting wound healing and wound progression, as well as risk for wounds including risk for malnutrition, limited mobility, muscle weakness which predisposed patient to wounds due to weakness, and inability to move about or reposition. Reposition per facility protocol/policy, encourage good nutrition and movement habits, continue to follow-up per routine schedule or sooner if needed. Heel ulcers were not noted on this consultation. (continued on next page)

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	245083	A. Building B. Wing	10/24/2024

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- 8/8/2024, seen for surgical incision, impaired skin integrity, limited mobility, and muscle weakness. R30 was resting in bed on her back and accepting to wound cares. DTIs were noted on bilateral heels, and it was again noted R30 had limited mobility especially in her lower extremities. Skin prep (topical barrier) was applied, and heels were offloaded with pillows to free float heels. Nursing was instructed to provide Prevalon boot (heel protection boot) for offloading when available. Wound care orders included: Skin prep/open to air-daily, float heels, Prevalon boot on daily when available, follow wound care team weekly. The wounds were identified as new, in-house acquired with the right heel DTI measuring 4.62 centimeters (cm) long and 4.92 cm wide. The left heel DTI measured 3.21 cm long by 3.13 cm wide. -8/15/24, resting in bed on her back and accepting to wound cares. The DTI to bilateral heels increased in size and she had limited mobility especially lower extremities. Skin prep applied and offloaded with bunny boots (foam cushioned boot). Prevalon boots were on order. Continue to encourage aggressive offloading. Wound care orders otherwise remained the same. The right heel DTI measured 4.21 cm long and 3.61 cm wide. The left heel DTI increased in size and measured 3.21 cm long by 3.73 cm wide. - 8/23/24, resting in bed on her back and accepting to wound cares. Bilateral heel DTIs were stable and drying. No new open areas noted. Bunny boots were on for offloading. Aggressive offloading and repositioning were encouraged. Wound care orders otherwise remained the same. The right heel DTI measured 3.31 cm long and 3.08 cm wide. The left heel DTI measured 3.1 cm long by 3.75 cm wide. -8/29/24, Wound care orders otherwise remained the same. The right heel DTI increased in size and measured 3.84 cm long and 4.64 cm wide. The left heel DTI measured 2.97 cm long by 3.69 cm wide. -9/5/24, resting in bed on her back and accepting to wound cares. Bilateral heels are stable and eschar now. R30 continues to wear offloading boots. No new open areas noted. Encouraged aggressive offloading and repositioning. Wound care orders otherwise remained the same. The right heel DTI measured 3.89 cm long and 4.07 cm wide. The left heel DTI measured 3.4 cm long by 3.21 cm wide. -9/12/24, resting in bed on her back and accepting to wound cares. Bilateral heels were improving and getting smaller. Heels are now eschar and dry. Wound care orders otherwise identified: skin prep/open to air-daily, float heels, Prevalon boot on daily when available, heel protectors on both feet always when in bed. Must float heels with folded pillows in addition to heel boots every shift. The right heel DTI measured 3.64 cm long and 4.04 cm wide. The left heel DTI increased in size measured 2.53 cm long by 4.01 cm wide. - 9/19/24, bilateral heels were stable, however the wounds were peeling and draining at the edges. R30 was compliant with wearing her Prevalon boots. Wound care orders otherwise remained the same. The DTI were now classified as in-house acquired unstageable pressure ulcers due to slough and/or eschar covering the wound bed. The right heel unstagable pressure ulcer measured 2.84 cm long and 3.03 cm wide. The left heel unstagable pressure ulcer increased in size measured 3.69 cm long by 2.35 cm wide. (continued on next page)

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	245083	A. Building B. Wing	10/24/2024

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- 9/26/24, identified bilateral heels were stable, however the wounds were peeling but appeared to be smaller. R30 was compliant with wearing her Prevalon boots. Wound care orders included: stable, clean with wound cleanser, apply Medihoney, cover with foam dressing one time a day AND as needed, float heels, Prevalon boots on daily when available, heel protectors on both feet always when in bed. Must float heels with folded pillows in addition to heel boots every shift. The right heel unstageable pressure ulcer measured 3.33 cm long and 1.94 cm wide. The left heel unstageable pressure ulcer measured 2.7 cm long and 2.79 cm wide. -10/2/24, bilateral heel unstageable pressure sores are improving. All wounds mechanically debrided (removal of dead tissue) and redressed. Wound care orders otherwise remained the same. The right heel unstageable pressure ulcer measured 2.15 cm long and 3.14 cm wide. The left heel unstageable pressure ulcer measured 1.96 cm long and 2.97 cm wide. -10/10/24, R30 was in bed resting on her back with pillow offloading her feet and accepting to wound cares. Noncompliant with Prevalon boots although strongly encouraged to wear to promote wound healing. The wound dressing removed from the heels was not as ordered. Nurse manager was present when dressings were removed. The bilateral heel wounds were deteriorating. The wound beds were very sloughy (soft and watery) with drainage. All wounds mechanically debrided and redressed. Unable to sharps debride due to intolerance. Always discussed importance of aggressive offloading and repositioning and compliance with Prevalon boots. The right heel unstageable pressure ulcer increased in size measured 2.98 cm long and 3. 45 cm wide. The left heel unstageable pressure ulcer measured 2.1 cm long and 1.43 cm wide. -10/17/24, R30's right heel wound deteriorated. Left heel was stable. The open wound beds were very sloughy with necrotic tissue and drainage. All wounds mechanically debrided and redressed. Unable to sharps debride due to intolerance. Wound culture was collected. Wound care orders remained the same. The right heel unstageable pressure ulcer increased in size measured 4.52 cm long and 4.79 cm wide. The left heel unstageable pressure ulcer measured 1.81 cm long and 2.23 cm wide. R30's corresponding progress note dated 10/17/24 at 1:41 p.m., identified wound care orders changed to Santyl ointment instead of Medihoney. During the start of a continuous observation on 10/23/24 at 7:05 a.m., R30 was in bed on her back, eyes closed. The head of the bed was elevated about 10 degrees. R20 had blue cushioned boots on both feet with wedge cushion underneath her calves, visible because blankets were pulled up over her feet. -At 8:12 a.m., licensed practical nurse (LPN)-A entered R30's room with a breakfast tray. R30 remained in the same position without moving in bed and was not offered to offload and reposition. -At 8:15 a.m., nursing assistant (NA)-D entered R30's room and said good morning, ok you want to sleep. R30 remained in the same position without moving in bed and was not offered to offload and reposition. -At 10:00 a.m., LPN-A entered and removed her breakfast tray. R30 remained in the same position without moving in bed and was not offered to offload and reposition. (continued on next page)

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	245083	A. Building B. Wing	10/24/2024

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-At 10:02 a.m., LPN-A entered R30's room. R30 asked LPN-A to pull the blanket over her feet. R30 remained in the same position without moving in bed and was not offered to offload and reposition. -At 10:10 a.m., trained medical assistant (TMA)-A knocked and entered R20's room for a safety check and exited. R30 remained in the same position without moving in bed and was not offered to offload and reposition. It was three hours and five minutes since R30 has been repositioned. -At 10:26 a.m., TMA-A brought R30 her medications. R30 brought the medication cup to her mouth and then drank from a cup of water, without elevating her head of bed or offloading her body. R30 remained in the same position without moving in bed and was not offered to offload and reposition. When asked, TMA-A stated R30 was not able to fully offload her lower body and staff were expected to do that for her. During a follow up interview with R30, she stated staff were supposed to come in and move her upper and lower body and they had not. R30 was agreeable to get staff to help her reposition. -During a follow up interview at 10:31 a.m., NA-D stated a resident was typically repositioned every two to three hours. When night shift left and day shift came on, last repositioning times were discussed. NA-D stated he did not recall if R30's repositioning was discussed. -During an interview at 10:32 a.m., RN-A stated staff should review the care plan to determine how often to reposition. RN-A was not aware it had been almost three and a half hours since R30 was last repositioned, and he would get the NAs to help her because R30 could not move her lower body to fully offload. RN-A was not sure if orders to float her heels were present before the development of pressure ulcers. RN-A stated if a resident had reduced feeling in the legs, they would consider adding in the intervention to float heels to prevent pressure ulcers. RN-A stated he would get staff to reposition R30. -At 10:35 a.m., NA-A and NA-D entered R30's room. NA-A stated R30's legs and knees do not bend. NA-A and NA-D stated R30 was currently compliant with floating her heels and wearing the boots in bed. NA-A stated R30 should have been repositioned by now, but they were busy and R30 had not called for assistance. -At 10:55 a.m., the end of the continuous observation, NA-A and NA-D assisted R30 to turn to her side with maximal assist and provided personal cares. Wrinkles from the mattress and pillows were noted on her back and legs. There were indentations on lower legs from the wedges floating her heels. It was three hours and 50 minutes since R30 was last repositioned. During an interview on 10/23/24 at 12:10 p.m., the wound care consultant nurse practitioner (NP)-A stated R30 was at high risk for pressure ulcers upon admission, due to surgery, not able to move on her own, and malnutrition, and had to be pushed to adequately reposition. R30's level of assist required for offloading had not improved since her admission. NP-A stated the root cause of DTI was most likely laying in bed with the heels always on her bed. NP-A stated R30's heels were at high risk for breakdown when she was admitted , and floating the heels would be a standard intervention for someone with limited mobility. NP-A stated heel protection measures such as cushioned boots or floating the heels could have prevented the pressure ulcers. NP-A stated prior to the pressure ulcer development, she did not observe R30's heels floated during weekly wound rounds. NP-A stated repositioning every two to three hours, per care plan, should be appropriate if she's compliant, going almost 4 hours could contribute to further pressure ulcers due to R30 not being able to offload. NP-A stated the pressure wounds at this point were unstageable and were classified as facility acquired. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/24/24 at 11:11 a.m., the director of nursing (DON), stated risk factors for pressure ulcers included being in bed most of the time, malnutrition, and improper footwear. The DON stated the main intervention to prevent pressure ulcers on the heels were weekly nursing assessments, and interventions included turn and reposition, float the heels, and offload pressure. The DON stated R30 was at risk upon admission and after the development of the pressure ulcers she was at moderate risk. The DON stated R30 was given a risk and benefits form for not complying with wound care, but this was after the pressure ulcers had developed. The DON stated heel protection was not included in R30's care plan upon admission due to determined risk. Additionally, R30 had pigmented skin color which made it more difficult to see pressure ulcer formation. When asked if pigmented skin color would have increased R30's risk for the admission skin assessment the DON stated she was unsure. When asked about a root cause analysis, the DON stated the pressure ulcers developed after admission and she could find a root cause analysis form to share, however, she did not have the form at this time. The DON stated development of a DTI was likely from being in bed most of the shift. The DON stated after R30's pressure ulcers, education was completed with the staff on assessing pigmented skin color and on pressure ulcer prevention measures. The DON stated refusals of repositioning would be listed in R30's Tasks section of the electronic medical record, however, this documentation was not provided. The undated Pressure Injury Root Cause Analysis (RCA), identified due to pigment of resident skin, staff did not perceive the discoloration on heels to be pressure related. The RCA lacked a cause such as medical devices mattress pressure, friction or shearing, wheelchair foot rest pressure, or type of footwear utilized. During an interview on 10/24/24 at 12:42 p.m., the PT who had worked with R30 stated the amount of movement R30 had in her lower legs upon admission was the level of someone that was a paraplegic (paralyzed from the waist down). The PT stated R30's status remained the same because she still needed a full Hoyer lift to transfer. The PT stated R30 could not fully offload, especially in the lower body. 46885 The State Operations Manual (SOM) defined the various presure ulcers as follows: A stage one pressure injury is intact skin with a localized area of redness that is non-blanchable (does not turn white when pressed). A stage two pressure ulcer is partial thickness loss of the skin with exposed dermis, presenting as a shallow open ulcer. It may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar (dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like) are not present. A stage three pressure ulcer is full thickness loss of the skin in which subcutaneous fat may be visible. Additionally, slough (non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture) or eschar may be visible but does not obscure the depth of the tissue loss. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A stage four pressure ulcer is full thickness loss of the skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and or eschar may be visible on some parts of the wound bed. Undermining and or tunneling often occur. If slough or eschar obscures the wound bed, it is an unstageable pressure ulcer. An unstageable pressure ulcer is obscured full thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. If slough or eschar is removed, a stage three or stage four pressure ulcer will be revealed. If the anatomical depth of the tissue damage involved can be determined, then reclassified stage should be assigned. A deep tissue pressure injury (DTPI) is intact skin with localized area of persistent non blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. This injury results from intense and or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue (deepest layer of skin), granulation tissue (new connective tissue), fascia (connective tissue), muscle or other underlying structures are visible, this indicates a full thickness pressure ulcer. Once a deep tissue injury opens to an ulcer, reclassify the ulcer into the appropriate stage. R33's Medical Diagnoses form indicated a right knee effusion, mild cognitive impairment, muscle weakness, difficulty in walking, deficiency of other specified B group vitamins, type 2 diabetes mellitus with diabetic polyneuropathy (a type of nerve damage that affects multiple nerves in the body), disease of the spinal cord, other tear of the lateral meniscus, current injury of the right knee, and chronic pain. R33's quarterly MDS dated [DATE], identified intact cognition, did not reject care, had impairment in range of motion (ROM) to one side of upper and lower extremities, was independent in rolling from lying on the back to the left and right side, was 60 inches tall and weighed 229 pounds, and had no or unknown weight loss. R33's quarterly MDS dated [DATE], identified a cognitive assessment was not completed, did not reject care, was 72 inches tall and weighed 230 pounds, did not have 5% or more weight loss in the last month. Further, R33 was at risk for pressure ulcer development and had one or more stage one pressure ulcer. R33's Optional State Assessment (OSA) MDS dated [DATE], identified R33 required extensive assistance with bed mobility, transfers, and toileting. R33's CAA dated 5/30/24, identified R33 was at risk for pressure ulcers due to the need for extensive assistance with bed mobility and incontinence, and did not have a pressure ulcer but would be addressed in the care plan to avoid complications and minimize risks. R33's nutritional status care plan dated 5/27/24, identified R33 was on a regular diet with no concerns reported. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245083	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at the Park	4415 West 36 1/2 Street Saint Louis Park, MN 55416

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R33 had the following interventions: diet per physician order, obtain weight monthly, registered dietician or culinary director to consult as needed, the resident is on a regular diet with no concerns. Further an intervention dated 7/10/24, was written, Dietary Preferences (Specify). No dietary preferences were documented. R33's alteration in mobility care plan dated 5/27/24, identified R33 required an assist of two with transfers and partial to moderate assistance with rolling left to right in bed. R33's risk for alteration in skin integrity care plan dated 5/28/24, indicated R33 had a stage one pressure ulcer to the left heel and had the following interventions: 5/28/24, pressure redistribution cushion to wheelchair, and chair. 6/14/24, monitor skin integrity daily during cares. Weekly skin inspection by the nurse. 6/14/24, turn and reposition or reminders to offload every two to three hours and as needed as resident allows. 9/19/24, heel boots at all times while in bed. 10/21/24, low air loss air bed, pressure redistribution. The care plan lacked an intervention for a wedge cushion in the bed. R33's skin integrity care plan dated 9/24/24, indicated staff were to follow current risk/benefit form, and interventions included a risk benefit form was completed an on file for skin integrity noncompliance with skin interventions 9/24/24. R33's alteration in blood sugar care plan dated 10/2/24, indicated R33 had a potential for alteration in blood sugar due to diabetes, and interventions included providing a diet as ordered and encourage R33 to follow the prescribed diet. R33's group sheet indicated R33 had wounds and required assist of one for bed mobility. R33's physician orders indicated the following orders: 5/27/24, regular diet, regular texture, regular thin consistency. 8/8/24, weekly skin inspection by licensed nurse. 9/19/24, 1. left heel wound, skin prep to heel and allow to dry. 2. boots and float heels freely. 10/21/24, air mattress monitor working order and replace as needed. The physician orders were reviewed and lacked any orders for any nutritional supplement. R33's Braden Scale for Predicting Pressure Sore Risk forms were reviewed and identified the following: (continued on next page)

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	245083	A. Building B. Wing	10/24/2024

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F 0686 Level of Harm - Actual harm Residents Affected - Few	7/9/24, R33 scored a 16 indicating R33 was at risk for developing a pressure sore. 9/19/24, R33 scored a 16 on the Braden scale. 9/26/24, R33 scored a 14 indicating R33 was at moderate risk for developing pressure ulcers. R33's weights were reviewed and indicated the following: 5/25/24, 232.8 pounds 5/26/24, 230 pounds 6/2/24, 231.5 pounds 6/16/24, 230.7 pounds 6/30/24, 230 pounds 7/7/24, 229 pounds 8/4/24, 230 pounds 9/24/24, 219 pounds 10/11/24, 217 pounds R33's Clinical Nutrition Evaluation form dated 5/30/24, indicated R33's height was documented as 60 inches and weighed 230 pounds and BMI (body mass index) was not documented. R33's Clinical Nutrition Evaluation form dated 7/10/24, Under the heading, Dietary Preferences Likes/Dislikes indicated large portions, likes cereal, bacon, eggs, and toast, juice, milk. Further, under the heading, Skin Condition indicated R33 had no skin issues noted. Under the heading, Additional Information indicated R33's current weight was 230 pounds and his height was 72 inches tall with a BMI of 31.1 with preferences for large portions. R33's Clinical Nutrition Evaluation dated 9/22/24, indicated a height of 75 inches and the most recent weight of 230 pounds was from 8/4/24. Under the heading, Supplements indicated, NA. Further, under the heading, Skin Condition indicated No skin issues noted and R33 preferred large portions. R33's nurse practitioner noted dated 9/16/24, indicated R33 had bilateral foot pain specifically in the heels without breakdown in hands or heels. R33's PT notes dated 10/21/24, indicated R33 was given a heel float wedge to improve his ability to float heels if he did exercises or bed mobility on his own. Pillows required much re-adjusting to truly float heels. R33's progress notes were reviewed and indicated the following: (continued on next page)

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	245083	A. Building B. Wing	10/24/2024

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F 0686 Level of Harm - Actual harm Residents Affected - Few	5/28/24 at 12:18 p.m., R33 did not have skin breakdown upon admission and presented with a poor appetite. 6/12/24, physician note indicated R33 had a poor appetite. 9/19/24, at 8:52 a.m., R33 had an unstated pressure sore on the left heel and verbalized pain. 9/19/24 at 1:25 p.m., indicated nursing staff found an area of discoloration on the left heel and pressure injury interventions were initiated including heel boots and offloading while in bed and would be followed on wound rounds. 9/20/24 at 12:10 p.m., R33 was compliant with heel boots and floating heels. 9/26/24 at 1:42 p.m., R33 preferred floating heels with pillows versus boots and a risk versus benefits was on file. 10/4/24 at 3:11 p.m., monthly nutrition risk note from the dietary department indicated R33 had a stage one pressure ulcer on his heel with an effusion to the right knee, mild cognition impairment, muscle weakness, diabetes with a current weight of 219 pounds which was down from 230 pounds on 8/4/24. The note indicated R33 ate 100% and preferred large portions. Large portion and double meat would be added, would offer a sandwich at bedtime, and would monitor and document meal intakes and obtain weights per policy. The note lacked documentation R33 was provided Glucerna or equivalent per facility protocol, Juven or Prosource 30 milliliters by mouth twice da [TRUNCATED]

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42579 Based on observation, interview, and document review, the facility failed to ensure an occupational therapy (OT) ordered hand splint program was implemented for 1 of 2 residents (R14) reviewed for positioning and mobility. Findings include: R14's quarterly Minimum Data Set (MDS) dated [DATE], identified he could understand with clear comprehension and could be understood. The cognitive assessment was not completed. Diagnoses included hemiplegia (paralysis and weakness) affecting right dominant side and muscle weakness. Extensive assistance of two staff was required for bed mobility. R14's quarterly MDS's dated 10/3/24, 8/13/24, and 5/16/24, identified no rejection of care and no days of restorative splint or brace assistance occurred. R14's activities of daily living (ADL) Care Area Assessment (CAA) dated 2/27/24, was triggered due to extensive assist of one to two staff for bed mobility, toileting, dressing, and personal hygiene, and total assist with two staff for Hoyer transfers was required. R30 was non-ambulatory and was at risk for further decline in ADL's, falls, contractures, further isolation, and complications of immobility: pressure ulcers, muscle atrophy, incontinence, and contractures. Proceed to care plan to prevent/minimize risks; work with resident to maintain current level of functioning. R14's care plan dated 10/10/24, identified he required the use of a splint for his right hand for positioning and contracture management. Goals include to wear the splint on the right hand for 15 minutes/24 hours or to tolerance to prevent contractures/increase PROM (passive range of motion), decrease pain, reduce muscle tightness, and allow participation in ADL's. Interventions included: 1. Check for skin breakdown under right hand brace 2. PROM exercises 3. Resident refuses to wear splint as it is uncomfortable. Therapy to follow up to indicate if bracing is still indicated. 4. Resident splint: unless medically contraindicated don splint or brace by putting thumb in first and spinning to don. Don/doff per schedule and as tolerated. Observe skin for complication related to use every shift and with each removal and application. Observe and report pain, offer medication as needed. R14's OT note dated 10/16/23, identified R14 declined use of previous right wrist splint, and said it rubbed on his hand and fingers and hurts to wear it for any length of time. OT modified palm guard by inserting red foam roll to provide some prolonged pressure and slow stretch into his right hand. The resident did report that this felt better than the splint as it did not rub nearly as much. OT placed in hand and checked after 2-3 hours for use with no increased pain noted by the resident. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R14's OT discharge summary dated 10/26/23, identified the goal was met for hand roll splint toleration wearing schedule of six to eight hours daily to prevent further contracture of his right fingers, hand, and wrist. Staff demonstrated ability to don and doff right palm guard with hand roll. Discharge recommendations the identified splint/brace (palm guard with roll) prognosis was good if staff consistently followed through. R14's progress notes dated 10/23/23 through 10/24/24, lacked documentation he refused the OT recommended hand splint program. R14's Treatment Administration Record (TAR) dated 6/1/24 through 8/31/24, identified an order with start date of 11/23/23, to place brace (splint) after moving hand and all fingers within resident's tolerance of movement. The order was check marked as having been completed daily by nursing before being discontinued on 8/26/24. R14's order discontinuation summary dated 8/26/24, identified the above brace order from the TAR was discontinued and the section for reason for discontinuation was left blank. There was no rationale for stopping the splint. R14's care conferences dated 8/9/24 and 10/8/24, lacked a discussion about the hand splint or contracture. During an observation and interview on 10/21/24 at 6:54 p.m., R14 was in bed. A hand roll splint was on top of his bedside table. When asked about the splint, R14 stated his right hand could not be opened anymore. R14 used his left hand to uncover his right hand from the sheet, his right hand was observed to be contracted in a fist position. There was also an unpleasant odor to his right hand. R14 said the hand roll splint was for his right hand but it was too painful to wear. During an observation on 10/22/24 at 8:11 a.m., R14 was in bed without the splint on. During an interview on 10/22/24 at 1:38 p.m., nursing assistant (NA)-A stated therapy would tell the staff if a resident had a splint program. NA-A stated she had worked at the facility for a year and was not aware of R14's splint program. NA-A agreed R14's hand was contracted into a fist position. During an interview on 10/22/24 at 1:40 p.m., trained medication assistant (TMA)-A stated R14 used to have a splint, but he had not seen it. TMA-A reviewed the orders and said there were no current orders for it. If the order was active it would show up for nursing to check off upon the order's completion. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/22/24 at 1:43 p.m., the certified occupational therapist assistant (COTA) reviewed R14's therapy medical record and stated he was seen for right hand contracture last year from 7/2023 until 10/26/23. Therapy worked with him on ROM (range of motion) and slow stretch to make donning of palm guard easier. R14 was discharged from therapy with orders for scheduled hand roll splint 4-6 hours daily to prevent further contracture, teach nurses and update care plan and upon discharge teaching, staff were able to demonstrate the don and doff process. The COTA stated therapy was not updated the hand roll splint was no longer implemented as intended and would expect nursing to follow up so they could reassess as that process was usually part of the training provided to nurses when a splint program was implemented. The COTA stated there were not measurements of the contracture on file, so she was unable to determine if the contracture had worsened without the splint program implementation. Additionally, contractures could cause pain and contribute to skin breakdown, especially in the palm due to moisture and pressure. During an interview on 10/22/24 at 1:55 p.m., registered nurse (RN)-B stated if a resident had a splint, there should be an order in place. RN-B stated if splint interventions were in the care plan they should be implemented, if the resident was not using the splint, therapy should be updated so a reassessment could be started. During a follow up interview on 10/23/24 at 1:30 p.m., R14 was sitting up in his wheelchair. There was no odor to his hand. He stated staff have not offered the hand splint and he said he probably could not tolerate it due to the discomfort. During an interview on 10/22/24 at 2:07 p.m., the director of nursing (DON) reviewed R14's splint care plan and agreed the last update coinciding with the MDS was on 10/10/24, so the care plan was up to date. The DON stated the care plan identified he refused the splint, however, was not able to answer when asked if therapy followed up in accordance with the care plan. During a follow up interview on 10/24/24 at 11:34 a.m., with the DON and administrator together, the DON stated contractures posed a risk for skin breakdown and pain and after reviewing the medical record did not see a rationale why R14's splint was discontinued on 8/26/24. The DON stated the checkmarks after the order on the TAR identified the program was carried out as ordered up until it's discontinuation date. The administrator stated R14 was cognitively intact and could speak for himself and had refused the splint. When asked for documentation of refusals, or a conversation with R14 on risks of not wearing a splint and the options of a reassessment with therapy, none was provided. During a follow up observation and interview with R14 on 10/24/24 at 11:59 a.m., he stated nursing staff put a rolled-up washcloth in his hand today as they were worried his fingernails would cut into his palm, he also stated his skin can get iffy since his hand was stuck closed, and he did not want more problems. The DON walked by R14's room and was called in to observe the washcloth and R14 stated it felt good, he had it on for about one hour now without pain. An assistive device and/or splint program policy was requested and not provided. The facility policy titled Activities of Daily Living (ADLs)/Maintain Abilities dated 3/31/23, identified based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility would provide the necessary care and services to ensure that a resident's abilities in activities of daily living did not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable.

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	245083	A. Building B. Wing	10/24/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on observation, interview, and document review, the facility failed to implement fall interventions for 1 of 2 residents (R40) reviewed with a history of falls. Findings include: R40's admission Minimum Data Set (MDS) dated [DATE], indicated R40 had intact cognition, did not reject cares, had a walker, required partial to moderate assist with toileting, showering and lower body dressing, required supervision for transfers from chair to bed, required partial to moderate assist with toilet transfers, and did not have a history of falls. R40's Medical Diagnosis form undated, indicated the following diagnoses: heart failure, muscle weakness, difficulty in walking, neoplasm of unspecified behavior of brain, malignant neoplasm of unspecified part of the right bronchus or lung, and metabolic encephalopathy (a change in how the brain works). R40's physician orders indicated the following order: 10/11/24, apixaban (an anticoagulant) oral tablet 5 milligram (MG) give 1 tablet by mouth two times a day related to atrial fibrillation (irregular, fast heart beat). R40's care plan dated 9/3/24, indicated R40 was at risk for falls due to osteoarthritis and had the following interventions in place: physical therapy (PT) per physician orders, follow PT and occupational therapy (OT) instructions for mobility function, low bed, keep room clean and free of clutter, keep call-light in reach, and monitor and document on safety. Review information on past falls and attempt to determine the cause of falls, record possible root causes, alter or remove any potential causes if possible, educate the resident, family, caregivers, and interdisciplinary team (IDT) as to causes. The care plan lacked interventions for applying non-slip tape to R40's room. Further, R40's care plan indicated R40 required assist of one for ambulation. R40's care guide indicated R40 was assist of one with activities of daily living (ADLs) and required stand by assist with ambulation. The care guide lacked information for fall prevention interventions. R40's nursing progress note dated 10/3/24 at 7:42 a.m., indicated R40 was found on the floor around 5:45 a.m., on her left side and R40 stated she was trying to go to the bathroom and slipped. R40's interdisciplinary team (IDT) note dated 10/3/24 at 4:10 p.m., indicated R40's fall was reviewed by the IDT and indicated upon return from the hospital, R40 would have gripper socks at nighttime, and non-slip tape on the bedroom floor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R40's Fall Review Evaluation Updated form dated 10/3/24 at 4:18 p.m., indicated R40 had a recent fall, and under a heading, Summary/Interventions indicated R40 was sent to the hospital for further evaluation and upon return would be encouraged to wear gripper socks at night and would have non-slip tape placed on the floor in R40's room. R40's IDT note dated 10/23/24 at 12:20 p.m., indicated IDT reviewed R40's fall interventions and universal fall precautions remained in place, R40 was stable with gripper sock intervention following recent fall and planned to resolve non-skid tape on R40's floor. R40's history and physical dated 10/3/24 at 5:43 p.m., indicated R40 had a history of Alzheimer's disease, small cell lung cancer (SCLC) that progressed to a stage four with brain metastasis in February 2023, ischemic cardiomyopathy, and coronary artery disease and was unable to identify when she fell , or provide a history. The history and physical further indicated R40 fell on [DATE] at 5:00 a.m., and hit the left side of her head and her left hip. During observation on 10/21/24 at 2:09 p.m., R40 had a faded bruise located on R40's left cheekbone. R40 had a walker at the bedside with two hand rails on the bed. During observation on 10/22/24 at 9:47 a.m., R40's floor lacked non-slip tape. During observation on 10/23/24 at 10:40 a.m., R40's floor lacked non-slip tape. During interview on 10/23/24 at 11:01 a.m., nursing assistant (NA)-A stated R40 went to the bathroom independently and added R40 didn't bother them and thought R40's family member put R40's clothes out. During interview on 10/23/24 at 11:16 a.m., registered nurse (RN)-A stated they looked at the care plan and a Kardex to know what kind of cares a resident required and stated R40 would walk in the room independently. R40 repeated the same questions, asking how she wore her compression stockings. RN-A stated an intervention for non-slip tape was documented in the progress notes and RN-A verified R40's room lacked non-slip tape and stated it was important to have the intervention in place to reduce the risk of R40 falling. During interview on 10/23/24 at 11:39 a.m., the director of nursing (DON) stated NA's documented in the electronic medical records (EMR) and used care guides to know what cares a resident required. The DON further stated every resident had universal fall precautions in place including occupational therapy (OT), physical therapy (PT), keep the call light in reach, low bed, keep the room free of clutter, and were in place prior to R40's fall and they monitored for bruising because R40 was on an anticoagulant. The DON viewed R40's note dated 10/3/24, that indicated R40 would have non-slip tape on the bedroom floor and stated it was a double intervention, R40 was forgetful and not always compliant and stated tape would be a further intervention. A policy, Fall Prevention and Management, dated February 2024, indicated the facility identified residents at risk for falls, implemented fall prevention interventions, provided guidelines for assessing a resident after a fall and assisted staff in identifying causes of the fall. Staff may also identify and implement relevant interventions to try to minimize serious consequences of falling. Staff will clarify the details of a fall and the IDT will review falls at a.m. meetings and document interventions, first aid, or treatment, and care plans will be updated to reflect fall interventions.

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	245083	A. Building B. Wing	10/24/2024

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The Villas at the Park	4415 West 36 1/2 Street Saint Louis Park, MN 55416

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42579 Based on observation, interview, and document review, the facility failed to ensure staff utilized enhanced barrier precautions (EBP) during wound care and failed to ensure current standards of infection control practice for catheter care was followed for 1 of 2 residents (R30) observed for wound care and catheter care. Findings include: EBP R30's quarterly Minimum Data Set (MDS) dated [DATE], identified she had intact cognition, and no behaviors or rejection of care occurred in the lookback period. Diagnoses included stress incontinence and neurogenic bladder. Currently, two unstageable pressure injuries presenting as deep tissue injury were present and R30 had an indwelling catheter. R30 required extensive assist of two staff for bed mobility, transfers, and toilet use. R30's care plan dated 9/11/24, identified EBP were in place due to foley catheter. Interventions included to follow EBP and don/doff PPE (personal protective equipment) when high contact cares were required. The care plan lacked EBP for wound care. R30's undated banner from the front page of the electronic medical record (EMR) identified Special Instructions: Staff to follow enhanced barrier precautions R/T (related to) indwelling catheter and wounds. During an observation on 10/21/24 at 5:17 p.m., R30's bedroom door had an EBP sign on it and PPE bin directly outside the room entrance, containing gowns, gloves, and masks. The EBP sign directed staff to wear gloves and a gown for the following high contact resident care activities: dressing, bathing, transfer, hygiene, changing incontinence products, and device care including line care, catheter care, tubes, tracheostomy, and wound care. During an observation and interview on 10/22/24 at 10:24 a.m., registered nurse (RN)-B and RN-C walked past the PPE bin, entered R30's room, used hand sanitizer, and put gloves on. RN-B leaned over with scrub top touching R30's bed linens, removed the blanket off R30's right foot, unwrapped and removed dried bloody gauze wrap from the right foot pressure ulcer and right lower leg abrasion and disposed the dressing in the garbage can. The wounds were now open to air. RN-B changed gloves and started to spray wound cleaner on new gauze to clean the wounds. At this point surveyor asked RN-B if PPE was required. RN-B said, yes, she removed gloves, exited, got a gown out of the bin outside the room, donned the correct PPE and RN-C did the same. During a follow up interview on 10/22/24 at 1:55 p.m., RN-B stated she should have had a gown on during wound cares to prevent the spread of any germs before starting direct resident care for wound dressing changes but forgot. Catheter Care (continued on next page)

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	245083	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at the Park	4415 West 36 1/2 Street Saint Louis Park, MN 55416

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Minnesota State Health Force Center of Excellence; Nursing Assistant Skill Video number 57 dated 9/26/19, identified to empty a urinary catheter drainage bag the following critical steps must be completed correctly: place a barrier on the floor, place a urine collection container on top of the barrier, remove the drainage outlet from the bottom of the bag, open the outlet and drain the catheter bag contents into the container, close the outlet and wipe the end of the tube and tube holder with an alcohol wipe. R30's care plan dated 8/9/24, identified the following interventions for catheter care: position catheter bag and tubing below the level of the bladder and away from entrance, monitor and document intake and output as per facility policy, monitor for s/sx (signs and symptoms) of discomfort on urination and frequency, monitor/document for pain/discomfort due to catheter, and monitor/record/report to MD (medical doctor) for s/sx UTI (urinary tract infection): pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. The care plan lacked infection control measures during emptying the catheter. R30's nurse practitioner (NP) progress note dated 10/16/24, identified a history of UTI. During an observation on 10/23/24 at 10:35 a.m., nursing assistant (NA)-A, with gloves and gown on, placed a urinal on the floor, opened the bottom outlet of the catheter bag, emptied 1,000 milliliters (mL) into a urinal, closed the outlet, walked to the room's bathroom, emptied the urinal in the toilet, returned and reopened bottom outlet, drained another 250 mL, closed the outlet, walked to the bathroom, emptied the urine in the toilet. NA-A had not placed a barrier on the floor under the urinal and had not used an alcohol wipe to clean the bottom drainage outlet after draining. During a follow up interview on 10/23/24 at 10:55 a.m., NA-A stated she was not prepared to empty the catheter and should have used a barrier on the ground for urine drips and alcohol wipe to clean. R30's room lacked the needed supplies. During an interview on 10/23/24 at 11:50 a.m., NA-D stated when emptying a catheter, a barrier should be used on the floor and then clean the drainage outlet with alcohol wipe for infection control. During an interview on 10/24/24 at 11:11 a.m., the director of nursing (DON) stated she would expect staff to wear the required EBP PPE prior to active wound care and expected standards of practice to be followed during foley catheter care. The facility policy EBP dated 4/1/24, identified EBP referred to the use of gown and gloves for use during high contact resident care activities for residents known to be colonized or infected with a MDRO (multidrug resistant organisms) as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). High-contact resident care activities included: a. Dressing b. Bathing c. Transferring (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Providing hygiene e. Changing linens f. Changing briefs or assisting with toileting g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes h. Wound care: any skin opening requiring a dressing. The facility policy Indwelling Catheter Care Procedure dated 7/21/23, identified when emptying the catheter bag, don new gloves, uncap bottom outlet of bag, drain urine into measuring container, cleanse outlet with alcohol swab and recap the outlet. Measure urine and dispose of it in toilet. Remove gloves and wash hands. The facility policy lacked instruction to place a barrier on the floor under the measuring container.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on observation, interview, and document review, the facility failed to conduct regular inspections of hospital bed rails as part of a regular maintenance program. Findings include: R204's admission Minimum Data Set (MDS) dated [DATE], indicated R204 had intact cognition, required partial to moderate assistance with bed mobility, was always incontinent of bowel and bladder, required substantial assistance with dressing, did not have an impairment in range of motion to upper extremities, and did not use bed rails. R204's Medical Diagnosis form undated, indicated the following diagnoses: dementia, urinary tract infection, ulcerative pancolitis (a type of inflammatory bowel disease) with unspecified complications, diarrhea, and Alzheimer's disease. R204's physician orders dated 10/22/24, indicated R204 could have bilateral grab bars. R204's care plan dated 9/28/24, indicated R204 was at risk for falls and interventions included monitoring and documenting on safety, and remove any potential causes if possible. Further, R204 had an alteration in mobility due to Alzheimer's dementia and the goal was R204 would move safely within her environment. An intervention dated 10/22/24, indicated R204 required grab bars to the bed to aid in bed mobility. R204's Bed Mobility Device Evaluation dated 10/21/24, indicated R204 required bilateral grab bars to assist with repositioning in bed. R204's nursing progress notes dated 10/21/24 at 11:54 p.m, 10/22/24 at 1:08 a.m., 10/23/24 at 1:43 p.m., indicated R204 was turned and repositioned frequently. During interview and observation on 10/22/24 at 8:06 a.m., R204's hand rail on R204's left side swung out and was not secured to the bed. R204 stated she used the rail. The hand rail on R204's right side was steady. During observation on 10/23/24 at 7:34 a.m., R204's left sided bed rail was still loose. During interview and observation on 10/23/24 between 10:16 a.m., and 10:36 a.m., nursing assistant (NA)-A and NA-D stated R204 was not able to turn herself in bed. At 10:17 a.m., NA-D stated he was going to assist R204 with cares. At 10:19 a.m., NA-D raised the head of the bed. At 10:20 a.m., R204's hand rails were up on both sides of the bed. At 10:21 a.m., the head of the bed was lowered down. At 10:23 a.m., NA-A and NA-D assisted to turn R204 towards her left side and R204 grabbed the bed rail on the left. At 10:26 a.m., R204 was assisted to turn towards R204's left side and grabbed the bed rail and the rail moved outward. At 10:34 a.m., NA-D raised the foot and head of the bed and at 10:35 a.m. NA-D lowered the bed. At 10:36 a.m. the left hand rail appeared to be missing a part to prevent the rail from moving outward. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 10/23/24 at 1:47 p.m., registered nurse (RN)-A stated the nurse manager or director of nursing (DON) was notified if bed rails were needed and would contact maintenance to have them installed. RN-A stated everyone checked the rails, and maintenance double checked rails. RN-A stated the nurses checked the rails as often as they could when they went into the room to make sure everything was ok and when in contact with the resident, since things changed on a daily basis. RN-A stated they touched the bed rails, however, may not check all residents' bed rails, and stated it should be completed frequently on a day to day basis. During interview on 10/23/24 at 1:58 p.m., NA-D stated there were no issues with bed rails. During interview on 10/23/24 at 1:58 p.m., licensed practical nurse (LPN)-A stated maintenance checked bed rails for sturdiness and for repairs and if a resident was deemed appropriate for bed rails, therapy and nursing would obtain orders. LPN-A further stated the NAs or residents using the bed rails made sure they were sturdy. LPN-A stated she had not seen whether maintenance completed any recheck on bed rails for sturdiness. During interview on 10/23/24 between 2:24 p.m., and 2:31 p.m., the maintenance director (M) stated a physician's order was needed prior to installing bed rails and further stated bed rails were not placed on the bed until the order was obtained. M further stated he checked to make sure bed rails were in working order and staff notified him if a rail was loose, and stated staff were in residents' rooms working with them and checked to make sure bed rails were in working order. M stated bed rails were checked everyday adding he walked through the building to check the rooms and looked to see if something looked loose and would shake the rails. M further stated he had not been informed of loose rails. At 2:31 p.m., M verified R204's left bed rail was missing a lock. During interview on 10/24/24 at 10:10 a.m., the administrator stated she expected maintenance to check bed rails on rounds, nursing staff to complete checks, and stated she expected maintenance to get to it on weekly rounds if not daily. A policy was requested as well as a log of when bed rail checks were completed. A maintenance log dated 10/10/24, indicated a bed rail inspection was completed. No other documentation was provided for the bed rail for R204's bed that was ordered on 10/22/24. An email from the administrator dated 10/24/24 at 10:22 a.m., indicated the facility did monthly bed rail inspections, and they were trying to locate a relevant policy, however a policy was not provided.