Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 07, 2025

Administrator
The Villas At The Cedars
7900 West 28th Street
Saint Louis Park, MN 55426

RE: CCN: 245187
Cycle Start Date: September 19, 2024

Dear Administrator:

On November 6, 2024, we notified you a remedy was imposed. On December 23, 2024 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 18, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 19, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 6, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 19, 2024. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

An equal opportunity employer.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 7, 2025

Administrator
The Villas At The Cedars
7900 West 28th Street
Saint Louis Park, MN 55426

Re: Reinspection Results
Event ID: 755G12

Dear Administrator:

On November 1, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 19, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 6, 2024

Administrator
The Villas At The Cedars
7900 West 28th Street
Saint Louis Park, MN 55426

RE: CCN: 245187
Cycle Start Date: September 19, 2024

Dear Administrator:

On October 1, 2024, we informed you that we may impose enforcement remedies.

On October 30, 2024, the Minnesota Department of Public Safety completed a revisit and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for no more than minimal harm (Level C), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

The deficiency(ies) not corrected is/are as follows:

K345 - Fire AlarmSystem - Testing And Maintenance

REMEDIES

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

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 19, 2024

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 19, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 19, 2024.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial

compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $12,924, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by December 19, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Villas At The Cedars will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 19, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 19, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

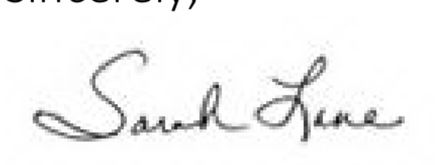
A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process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

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

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

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 1, 2024

Administrator
The Villas At The Cedars
7900 West 28th Street
Saint Louis Park, MN 55426

RE: CCN: 245187
Cycle Start Date: September 19, 2024

Dear Administrator:

On September 19, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by December 19, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 19, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

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

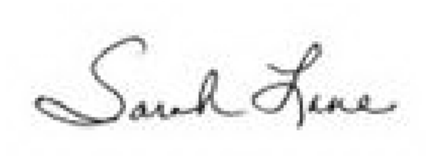
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

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

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 1, 2024

Administrator
The Villas At The Cedars
7900 West 28th Street
Saint Louis Park, MN 55426

Re: State Nursing Home Licensing Orders
Event ID: 755G11

Dear Administrator:

The above facility was surveyed on September 16, 2024 through September 19, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

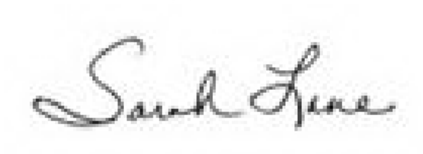
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting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

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245187	A. BUILDING _____ B. WING _____	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT THE CEDARS	7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 9/16/24 - 9/19/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 9/16/24 - 9/19/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H51878221C (MN100645). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)	F 550		10/24/24

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

Electronically Signed | 10/10/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245187	A. BUILDING _____ B. WING _____	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT THE CEDARS	7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 1 §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245187	A. BUILDING _____ B. WING _____	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT THE CEDARS	7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain resident privacy and dignity 2 of 3 residents (R46, R11) reviewed for dignity. R46 R46's admission (MDS) dated 6/20/24, indicated R46 had moderate cognitive impairment and required substantial and/or maximal assistance with most activities of daily living (ADLs), such as hygiene, dressing, and transfers. During observation on 9/18/24 at 7:30 a.m., R46 had their call light on. At 7:32 a.m., the social services designee (SS)-A knocked on R46's door and stated they would let them [the staff] know as they walked out of R46's room. At 7:34 a.m., SS-A stated loudly down the hall to nursing assistant (NA)-A R46 needed a "check and change." During interview on 9/18/24 at 8:48 a.m., NA-A stated SS-A "always" does "that" when questioned about SS-A's statement in the hall. NA-A stated SS-A should come to staff and tell them what residents' need with a quieter voice. NA-A stated residents needed privacy and did not want other residents to think "what is going on" by hearing voices in the hallway. During interview on 9/19/24 at 11:52 a.m., SS-A stated nursing staff spoke with them afterwards and speaking more privately about residents' needs was important for residents' dignity and	F 550	1. R46 was reassured that staff are getting education on HIPPA and privacy. R46 acknowledged and on board with the process. R11's family was contacted regarding clothing preferences and care plan updated with preferences. R11's room was rearranged to provide dignity with privacy curtain. 2. All residents have the potential to be affected by the deficient practice. 3. Education will be provided to nursing staff related to HIPPA and resident privacy per policy. 4. Audits will be completed by the DON and/or designee for all affected residents: weekly for 4 weeks and then twice a month for 1 month and then 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule is needed.	

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	245187	A. BUILDING _____ B. WING _____	C 09/19/2024

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F 550	Continued From page 3 HIPPA (Health Insurance Portability and Accountability Act; law to protect the privacy and security of health information). During interview on 9/19/24 at 11:58 a.m., R46 stated "that's part of being here" when asked how they would feel about a staff member stating they needed a "check and change" by name in the hallway, then asked his family member (FM)-B if such an incident would bother her. FM-B stated the incident would bother her, and R46 agreed he would be bothered too. During interview on 9/19/24 at 3:10 p.m., DON expected staff to pull a staff member aside or talk in a different room to share information about other residents to provide resident privacy and maintain dignity. R11 R11's annual Minimum Data Set (MDS) dated 8/26/24, indicated R11 was in a persistent vegetative state and/or had no discernible consciousness. R11 was dependent on staff for activities of daily living, such as oral and toileting hygiene, dressing, mobility, and transfers, and had impairment on both sides of upper and lower extremities. R11 had diagnoses of quadriplegia (severe or complete loss of motor function in all four limbs) and epilepsy (brain condition which causes recurring burst of uncontrolled electrical activity and changes in behavior, movements, feelings, and levels of consciousness). During observation and interview on 9/18/24 at 9:32 a.m., nursing assistant (NA)-C and NA-E assisted R11 with morning cares, which included a bed bath, oral and toileting hygiene, and	F 550		

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F 550	Continued From page 4 dressed R11 with a clean gown. Throughout all cares, including when R11 was exposed during incontinence cares, the privacy curtain was partially closed, and there was a clear view from R11 to R30's side of the room. R30 sat facing away from R11 in his electric wheelchair which he used independently and was awake or with eyes closed throughout R11's cares. NA-C left the room after cares were completed and stated R11 wore a gown all the time and thought he preferred to be in a gown. NA-C stated some care plans indicated resident or family preferences for dressing. NA-C stated they always pulled the privacy curtain when assisting residents and verified they did not pull the privacy curtain for R11. R11's care plan dated 9/7/24, indicated R11 was dependent on staff for dressing and did not specify if R11 wanted to dress in a gown or personal clothes during the day time. During interview on 9/18/24 at 10:33 a.m., NA-E verified R11's privacy curtain was not pulled during cares and stated the room was "tight" for transferring R11 when pulled, and R30 went through R11's side of the room to get out the bedroom door regardless of the privacy curtain being pulled during cares. NA-E stated the curtains were important to provide resident privacy. During interview on 9/18/24 at 4:38 p.m., family member (FM)-A stated R11 would want privacy and not to be cleaned where another resident could see. FM-A stated R11 was a "smart" and "clean" person who took care of himself and not normal for him to be in a gown throughout the day.	F 550		

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F 550	Continued From page 5 During observation on 9/19/24 at 10:50 a.m., R11 had a gown on and laid in bed. During interview on 9/19/24 at 10:58 a.m., nursing assistant (NA)-B stated family preferences were in the care plan or the nurse manager communicated preferences to staff after care conferences. During observation on 9/19/24 at 11:45 a.m., R11 still had a gown on and laid in bed. During interview on 9/19/24 at 12:01 p.m., NA-C stated R11 was repositioned, but his morning cares were not completed. NA-C stated they were going to assist R11 with another staff member next. During interview on 9/19/24 at 12:13 p.m., NA-D stated residents' care plan, assistance needs, and functional maintenance programs were on their computer and a sheet in a binder, and staff documented cares completed in POC (Point of Care). NA-D stated R11 wore a gown all day and was not sure of family preferences. During observation on 9/19/24 at 2:29 p.m., R11 was in a gown and sat in wheelchair in room. During interview on 9/19/24 at 3:10 p.m., the director of nursing (DON) expected privacy curtain use when staff completed resident cares and was important to maintain the dignity of R11. DON stated family preferences were verbalized and care planned. DON reviewed R11's care plan, NA sheet, and NA tasks and did not see an intervention specific to whether to dress R11 in a gown or personal clothes. DON expected	F 550		

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F 550	Continued From page 6 residents to be dressed in day clothes, unless care planned, to maintain resident dignity. The facility was asked for a policy related to resident dignity and stated they did not have a policy on dignity.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a self-administration of medications (SAM) assessment was completed to allow 1 of 1 resident (R30) to safely administer their own non-oral medications. Findings include: R30's annual Minimum Data Set (MDS) dated 8/27/24, indicated R30 was cognitively intact and had diagnoses of paraplegia (loss of muscle function in lower half of the body), cataracts (clouding of the lens of the eye), diabetes mellitus (condition which affects how body uses blood sugar), hypertension (high blood pressure), and renal failure (chronic kidney disease; loss of kidney function). R30 required substantial and/or maximal to dependent assistance with activities of daily living (ADLs) such as dressing, toileting hygiene, and rolling left and right and was independent with ADLs such as eating and use of motorized wheelchair.	F 554	1. R30 self-administration of medications assessment was completed with non-oral medications. 2. All residents identified to be appropriate to self-administer medications have the potential to be affected by the deficient practice and SAM assessments will be reviewed and updated as needed. 3. Education will be provided to nursing staff related to self-administration medication assessment per policy. 4. Audits will be completed by the DON and/or designee: 3 residents weekly for 4 weeks and then 3 residents twice a month for 1 month and then 3 residents 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule is needed.	10/24/24

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F 554	Continued From page 7 R30's care plan dated 9/12/24, indicated R30 desired to self-administer TUMs (chewable antacid which treats symptoms cause by too much stomach acid) and 650 milligrams (mg) of acetaminophen and keep at bedside and all other oral medications after nurse setup. The care plan directed staff to perform a self-administration assessment to evaluate ability to self-administer. R30's physician orders included: -Fluticasone propionate nasal suspension 50 mcg/act (micrograms per actuation) one spray in both nostrils one time a day related to other seasonal allergic rhinitis with start date of 9/23/23. -Biofreeze external gel 4% apply to right upper extremity and/or hand topically every day and evening shift for arthritic pain with further directions which indicated unsupervised self-administration okay to use home supply and leave at bedside with start date of 2/29/24. -May self-administer TUMs and Tylenol (acetaminophen) and keep at bedside and all other oral medications after nurse set-up with start date of 5/17/24. R49's most recent Self-Administration (SAM) Assessment dated 8/27/24, indicated R30 was able to self-administer oral medications after nurse setup and keep TUMs and Tylenol at bedside per order. Opthalmic, nasal and/or aural and topical medication/treatment were not selected as medications R30 was capable of self-administering. R49's SAM assessement dated 2/27/24, indicated R30 was able to self-administer oral medications after nurse setup and opthalmic and	F 554		

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F 554	Continued From page 8 nasal medications and keep TUMs at bedside. Topical medication and/or treatment was not included. R49's SAM assessment dated 11/27/23, indicated R30 was able to self-administer oral medications, nasal spray, and eye drops after nurse set up and keep TUMs at bedside. Topical medication and/or treatment was not included. R49's SAM assessment dated 5/24/23, indicated R30 was able to self-administer oral medications, topical medication and/or treatment, opthalmic, nasal, and inhalation medication after nurse setup and keep TUMs at bedside. During observation and interview on 9/16/24 at 1:10 p.m., R30 sat in his motorized wheelchair in his room and had a fluticasone nose spray with a prescription label, Clear Eyes Triple Relief eye drops, and Biofreeze on his rolling bedside table. R30 stated he kept the medications in his room and used the Flonase once a day to "unplug" his right nostril and the eye drops three to four times a day for his dry eyes. During interview on 9/16/24 at 1:21 p.m., licensed practical nurse (LPN)-B, stated a self-administration assessment and doctor's order were required before residents administered their own medications and/or kept medications in their room. LPN-B reviewed R30's physician orders and medication administration record (MAR). LPN-B verified R30 did not have an order for self-administration of the nasal spray and no order for the eye drops. LPN-B stated R30 ordered some medications himself, such as eye drops.	F 554		

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F 554	Continued From page 9 During observation and interview on 9/16/24 at 1:42 p.m., registered nurse (RN)-A verified the fluticasone, eye drops, and Biofreeze were in R30's room, and R30 stated to leave the medications in his room where they were kept for "years". During interview on 9/19/24 at 3:10 p.m., DON expected nursing to compete self-administration assessment upon admission or when residents had a change in cognition. DON reviewed R30's Self-Administration Assessment dated 8/27/24 and verified the assessment did not include non-oral medications, such as eye drops, Biofreeze, or Flonase. DON stated R30 was at risk of using the non-oral medications improperly without having an assessment for the non-oral medications. A facility policy titled Self-Administration of Medications dated 2/24, directed staff to assess each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident and document in the medical record and care plan if a resident was deemed safe and appropriate to self-administer medications.	F 554		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by:	F 558		10/24/24

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F 558	Continued From page 10 Based on observation, interview, and document review, the facility failed to ensure resident use of shared toilet for 1 of 1 resident (R62) reviewed for accommodation of needs. Findings include: R62's quarterly Minimum Data Set (MDS) dated 8/16/24, indicated R62 had intact cognition and no behaviors or rejection of cares. R62 had limb prosthesis and used a wheelchair. R62 required partial and/or moderate assistance for toileting hygiene and toilet transfers and supervision and/or touching assistance for chair and/or bed-to-chair transfers and walking. The MDS indicated R62 was frequently incontinent of bowel and bladder. R62's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) Worksheet dated 6/14/24, was triggered due to assist needed with activities of daily living (ADLs), such as dressing, hygiene, sitting to standing, and transfers. R62's care plan dated 9/10/24, directed staff to provide R62 with supervision for non-weight bearing transfers, and R62 washed hands and held grab bars but needed assistance with adjusting clothes and wiping during toilet use. During interview on 9/16/24 at 2:08 p.m., R62 stated he used a bathroom and toilet down the hall because his shared bathroom smelled and had a tube which drained into the toilet. R62 stated he had spoken with staff previously, but they stated it was only body fluids. During observation and interview on 9/16/24 at 7:18 p.m., RN-A set up overnight peritoneal	F 558	1. R49 care plan was reviewed, and peritoneal dialysis drain tube was changed to a drain bag. 2. All residents with peritoneal dialysis have the potential to be affected by the deficient practice and will have a drain bag if they have a shared bathroom. 3. Education will be provided to nursing staff related to the use of peritoneal dialysis and drain bags. 4. Audits will be completed by the DON and/or designee related to resident with peritoneal dialysis. 3 residents will be audited for 4 weeks and then 3 residents twice a month for 1 month and then 3 residents 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule is needed.	

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F 558	Continued From page 11 dialysis for a resident who shared the bathroom with R62 and lined the drain to the shared toilet. RN-A stated other residents did not use the bathroom, since they used urinals and bed pans. The bathroom and toilet was shared between two rooms with two males in each room. During observation on 9/18/24 at 7:13 a.m., R62 sat in his wheelchair with prosthetics on in the television area of the floor and was already dressed. During observation on 9/18/24 at 7:22 a.m., the peritoneal dialysis tube was still lined to the toilet. During interview on 9/19/24 at 10:58 a.m., nursing assistant (NA)-B stated R62 used the bathroom down the hallway and not in his room and was not sure why. During interview on 9/19/24 at 12:25 p.m., licensed practical nurse (LPN)-A stated peritoneal dialysis drain tubes were usually attached to a drain bag and not to the toilet. LPN-A stated the residents of the shared bathroom usually used urinals and had not heard concerns about residents using the shared bathroom. During interview on 9/19/24 at 2:31 p.m., NA-D stated they tried to clean the bathroom whenever R62 told them the bathroom was soiled, knew R62 used a bathroom down the hall, and had not told anyone about R62's concerns. During interview on 9/19/24 at 3:10 p.m., DON stated dialysis contents may be drained into the toilet or into drain bags when multiple residents used the bathroom. DON was not aware R62 used the bathroom down the hall instead of the	F 558		

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F 558	Continued From page 12 shared bathroom connected to his room. DON stated R62 had a bedside urinal but used a bathroom for bowel movements, and they would get a drain bag for the resident with peritoneal dialysis, so R62 could use the shared bathroom. No policy provided.	F 558		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		10/24/24

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F 584	Continued From page 13 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure an enteral feeding pump, tube feeding pole, and supporting legs were cleaned and in sanitary condition for 1 of 2 residents (R11) reviewed for tube feeding. Furthermore, the facility failed to keep the building clean for 1 of 1 bathroom with an unclean exhaust fan and 1 of 1 room with an unclean wall vent and ceiling tiles. Also, the facility failed to keep furniture in good condition for 1 of 2 residents (R30) who had an extended table from a dresser in their room. Findings include: TUBE FEEDING EQUIPEMENT R11's annual Minimum Data Set (MDS) dated 8/26/24, indicated R11 was in a persistent vegetative state and/or had no discernible consciousness. R11 was dependent on staff for activities of daily living, such as oral and toileting hygiene, dressing, mobility, and transfers, and had impairment on both sides of upper and lower extremities. R11 had diagnoses of quadriplegia (severe or complete loss of motor function in all	F 584	1. R11's tube feeding pump, pole, and supporting legs were cleaned. R11's order for cleaning of tube feeding pole and machine was added to TAR. R11 and R30's bathroom exhaust fans, wall vents, and ceiling tiles were either cleaned or replaced. R30's table was replaced with a new table. Housekeeping will have a routine in cleaning the vents during their scheduled cleanings. 2. All residents have the potential to be affected by this deficient practice. 3. Education will be provided to housekeeping related to room cleaning. Nursing will be educated on cleaning tube feeding pole and machine on NOC shift. 4. Audits will be completed by the Administrator and/or designee related to tube feeding pump, pole, supporting legs, exhaust fans, wall vents, and ceiling tiles. 3 rooms will be audited weekly for 4 weeks and then 3 rooms twice a month for 1 month and then 3 rooms 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are	

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F 584	Continued From page 14 four limbs) and epilepsy (brain condition which causes recurring burst of uncontrolled electrical activity and changes in behavior, movements, feelings, and levels of consciousness). The MDS indicated R11 had a feeding tube through which they received more than 50% of their nutrition. R11's medication and treatment administration record July 2024, directed the night shift to clean the tube feeding pole with a start date of 4/4/24. The tube feeding pole was recorded as cleaned every night shift until a discontinued date of 7/12/24. The rest of July 2024 lacked documentation of tube feeding pole cleaning, as well as the MAR and TAR for August and September of 2024. During observation on 9/16/24 at 1:15 p.m., R11's enteral feeding pump had splatters of tan splotches, tube feeding pole had dusky, cloudy appearance throughout, and supporting legs had grayish splatters. During observation on 9/17/24 at 3:26 p.m., the enteral feeding pump, tube feeding pole, and supporting leg conditions were unchanged. During observation on 9/18/24 at 7:53 a.m., the enteral feeding pump, tube feeding pole, and supporting leg conditions were unchanged. During observation and interview on 9/18/24 at 9:14 a.m., licensed practical nurse (LPN)-B stated they cleaned tube feeding equipment when they saw a spill and housekeeping also cleaned regularly or when nursing notified them. LPN-B did not know if there was a schedule to clean the tube feeding equipment or where the cleaning was documented. LPN-B stated tube feeding	F 584	identified, and recommendations for adjustments to the audit schedule are needed.	

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F 584	Continued From page 15 equipment were kept clean for R11's dignity and infection control purposes. LPN-B wiped the enteral feeding pump and pole with a disinfectant wipe and stated they would let housekeeping know to clean the supporting legs. The splatters came off the enteral feeding pump, and the pole had a shiny appearance. During interview on 9/19/24 at 3:10 p.m., DON expected tube feeding poles to be cleaned and documented regularly and when visibly soiled. DON reviewed R11's orders and did not see an active order or documentation for cleaning R11's tube feeding pole. DON stated a clean tube feeding pole was important for infection control. A facility policy Maintaining Patency of a Feeding Tube (Flushing) dated 3/23/23, directed staff to clean reusable equipment used for opening a clogged feeding tube according to manufacturer's instructions but did not include enteral feed pump, tube feeding pole, and supporting legs. Facility policies Isolation Room Cleaning Procedures, Daily Cleaning Procedures, and Deep Clean Procedures undated, did not include cleaning of enteral feeding pump, tube feeding pole, or supporting legs. EXHAUST FANS, WALL VENTS, AND LINING OF FLAT SURFACE Findings include: R11's annual Minimum Data Set (MDS) dated 8/26/24, indicated R11 was in a persistent vegetative state and/or had no discernible consciousness. R11 was dependent on staff for activities of daily living (ADLs), such as oral and toileting hygiene, dressing, mobility, and	F 584		

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F 584	Continued From page 16 transfers. R30's annual MDS dated 8/27/24, indicated R30 was cognitively intact and required substantial and/or maximal to dependent assistance with ADLs such as dressing, toileting hygiene, and rolling left and right and was independent with ADLs such as eating and use of motorized wheelchair. R49's quarterly MDS dated 9/4/24, indicated was cognitively intact and independent with most ADLs, such as walking, hygiene, and transfers. R62's quarterly MDS dated 8/16/24, indicated R62 had intact cognition and required partial and/or moderate assistance for toileting hygiene, and putting on and/or taking off footwear, supervision and/or touching assistance for chair and/or bed-to-chair transfers and walking. R69's quarterly MDS dated 8/6/24, indicated R69 had intact cognition and required assistance for most ADLs. R70's quarterly MDS dated 7/15/24, indicated R70 was cognitively intact and required assistance for most ADLs. The facility's Closed Work Orders report dated 4/18/24 through 9/17/24, lacked requests to clean exhaust fan for the shard bathroom and the wall vent and ceiling tile in R11 and R30's room. The report also lacked request to fix the lining of the furniture item in R11 and R30's room. A TELS (platform to track maintenance tasks) Report Builder dated 9/17/24, indicated exhaust fans, including those in the bathroom, had been	F 584		

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F 584	Continued From page 17 marked "done on-time" twice a month March 2024 through August 2024, and the last task completion was 9/9/24. Exhaust fan checks included ensuring air flow was sufficient enough to hold a piece of paper to the vent when operating and cleaning vents with a vacuum and air compressor, when needed to remove all dust. During observation on 9/16/24 at 1:15 p.m., a wall vent near the ceiling in R11 and R30's room had grayish particles and ceiling tile had brownish colored streaks which started narrower near the wall vent then expanded out. During observation on 9/16/24 at 2:08 p.m., a shared bathroom between R49, R62, R69, and R70 had a square shaped ceiling exhaust fan with gray particles plugging every other row of smaller squares. During interview on 9/18/24 at 8:21 a.m., trained medication assistant (TMA)-A stated they put requests for maintenance into TELS. During observation on 9/18/24 at 9:14 a.m., licensed practical nurse (LPN)-B cleaned a tube feeding pole of R11 who shared a room with R30. LPN-B went to bathroom to doff personal protective equipment and washed hands and upon exiting the bathroom brushed against the side lining of an extended table of a dresser. R30 stated he had told someone to fix that, and LPN-B did not reply. During observation and interview on 9/19/24 at 2:35 p.m., the maintenance director (DOM), corporate maintenance (CM), and regional maintenance director (RM) stated fans and vents were checked daily by housekeeping. DOM, CM,	F 584		

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F 584	Continued From page 18 and RM observed the exhaust fan in the shared bathroom and stated the exhaust fan looked "pretty plugged" and needed to be vacuumed out. DOM, CM, and RM observed the wall vent near the ceiling by R11's bed and verified needed cleaning. DOM verified the loose lining of the extended dresser in R11 and R30's room and was not aware it needed fixing and expected staff to place in a TELS (platform to track maintenance tasks) request when maintenance needed to fix an item. During interview on 9/19/24 at 4:57 p.m., the administrator expected housekeeping to clean vents and exhaust fans during general daily and deep cleaning, and the exhaust fans and vents should be free of dust. The facility was asked for a policy related to maintenance and fixing resident room items and/or furniture and stated they did not have such policy. A facility policy Daily Cleaning Procedures undated, directed staff to work clockwise around the room and dust all high surfaces, which included vents. The policy also directed staff to dust vents in the restroom. A facility policy Deep Clean Procedures undated, directed staff to use a high duster to clean vents.	F 584		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	F 656		10/24/24

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F 656	Continued From page 19 resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive	F 656		

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F 656	Continued From page 20 care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and observation, the facility failed to ensure a comprehensive and individualized care plan was developed for 1 of 1 resident (R49) reviewed for constipation. Findings include: R49's quarterly Minimum Data Set (MDS) dated 9/4/24, indicated was cognitively intact, had verbal behaviors and rejection of care, used a walker, and was independent with most activities of daily living (ADLs), such as walking, hygiene, and transfers. R49 was occasionally incontinent of bladder and frequently incontinent of bowel. The MDS indicated R49 had end stage renal disease (medical condition in which a person's kidneys stop functioning on a permanent basis) and diabetes mellitus (condition which affects how body uses blood sugar). R49's care plan dated 9/16/24, lacked information about bowel and bladder incontinence, toileting, or constipation. R49's nursing progress notes indicated the following: -On 8/26/24 at 00:20 [12:20 a.m.], R49 called ambulance for stomach pain and constipation. -On 8/26/24 at 03:09 [3:09 a.m.], R49 returned to the facility and senna-docusate sodium was ordered as needed. -On 8/27/24 at 23:23 [11:23 p.m.], R49 called ambulance for discomfort and constipation and went to the University of Minnesota Fairview.	F 656	1. R49 care plan was updated to include bowel and bladder incontinence, toileting, and constipation. 2. All residents have the potential to be affected by the deficient practice. 3. Education will be provided to nurse managers related to updating care plans including elimination. 4. Audits will be completed by Administrator and/or designee related to care plans including elimination. 3 residents will be audited weekly for 4 weeks and then 3 residents twice a month for 1 month and then 3 residents 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule is needed.	

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F 656	Continued From page 21 During interview on 9/19/24 at 10:58 a.m., nursing assistant (NA)-B stated staff looked at residents' care plans to know what kind of assistance residents required for eating, toileting, and other activities of daily living (ADLs). NA-B stated staff asked R49 whether he had bowel movements or not, and R49 spoke with the nurses when he had concerns about bowel movements. During interview on 9/19/24 at 11:14 a.m., licensed practical nurse (LPN)-A stated staff referred to physician orders, medication and treatment administration records, and resident care plan to know how to care for a resident. During interview on 9/19/24 at 3:10 p.m., the director of nursing (DON) stated R49 had history of constipation, refusing suppositories, and hospitalization related to abdominal pain. DON expected staff to monitor and follow facility protocol for constipation. DON reviewed R49's care plan and verified R49's care plan did not have information about bowel or bladder continence, constipation, or toileting needs. DON expected resident care plans to be resident-specific so staff knew how to assist them. A facility policy Care Planning- Interdisciplinary Team dated 7/21/23, indicated care plans were based on resident's comprehensive assessment and developed by a care planning and/or interdisciplinary team. A facility policy Care Planning dated 1/6/22, indicated would be developed based on resident's daily care routines and utilized by staff personnel for the purposes of providing care or services,	F 656		

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F 656	Continued From page 22 and the care plan was modified and updated as the condition and care needs of the resident changed.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and monitor non-pressure related skin conditions for 1 of 1 resident (R49) reviewed for skin concerns. Findings include: R49's quarterly Minimum Data Set (MDS) dated 9/4/24, indicated was cognitively intact, had verbal behaviors and rejection of care, used a walker, and was independent with most activities of daily living (ADLs), such as walking, hygiene, and transfers. R49 was occasionally incontinent of bladder and frequently incontinent of bowel. The MDS indicated R49 had end stage renal disease (medical condition in which a person's kidneys stop functioning on a permanent basis) and diabetes mellitus (condition which affects how body uses blood sugar). The MDS did not indicate any behavioral symptoms not directed	F 684	1. R49 skin concern was assess and monitoring orders were added for papular eczema. R49's care plan was updated with skin concern. 2. All residents who are residing at the facility have the potential to be affected by the deficient practice and weekly skin inspections with skin impairments will be reviewed and care plans will be updated as needed. 3. Education will be provided to nursing related to skin inspections including adding in monitoring for skin impairments. 4. Audits will be completed by the DON and/or designee for skin inspections: 3 residents weekly for 4 weeks and then 3 residents twice a month for 1 month and then 1 resident 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and	10/24/24

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F 684	Continued From page 23 towards others, such as scratching self. R49 had diabetic foot ulcer, dressings to feet, and nonsurgical dressings to areas other than to feet. R49's care plan dated 9/16/24, direct staff to monitor R49's skin integrity daily during cares and weekly inspection by nurse, monitor skin breakdown for signs and/or symptoms of infection and report to provider, document on skin condition and keep provider informed of changes. These interventions were initiated 5/9/24. The care plan lacked information about papular eczema, rashes, and itching and/or scratching. R49's Medication Administration Record (MAR) dated 8/1/24 through 8/31/24, indicated an order for triamcinolone acetonide external cream 0.1% topical to affected areas on arms and neck twice a day for papular eczema (type of eczema which causes red bumps that look similar to acne to appear on your skin). The MAR indicated R49 received 22 applications, refused twice, and was hospitalized three times when cream was supposed to be applied before the order was discontinued on 8/29/24. Four times at the beginning of the treatment staff indicated to see notes but the progress notes lacked text to further describe whether the cream was applied or not. R49's Weekly Skin Inspection indicated the following: -On 8/3/24 at 15:43 [3:43 p.m.], R49 had "no visible bruising, swelling, redness or open areas to facial region, arms" and declined for staff to assess other body parts. -On 8/10/24 at 14:51 [2:51 p.m.], R49 refused shower and skin check. -On 8/17/24 at 15:26 [3:26 p.m.], R49 had a wound to right foot and no visible "bruising,	F 684	recommendations for adjustments to the audit schedule are needed.	

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F 684	Continued From page 24 swelling, redness or open areas to facial region, arms" and declined for staff to assess other body parts. -On 8/24/24 at 13:42 [1:42 p.m.], R49 refused skin assessment and had wound to right foot. -On 9/7/24 at 14:45 [2:45 p.m.], R49 had "no new skin issues". -On 9/14/24 at 15:37 [3:37 p.m.], R49 had a wound to right foot and "no visible bruising, swelling, redness or open areas to facial region, arms" and declined for staff to assess other body parts. An Acute encounter note [provider progress note] dated 8/13/24 at 00:00 [midnight], indicated R49 had "bumps on bilateral arms, nape of neck and hairline. Many papular, red bumps at varying stages" ....."No drainage. No pain. Arms are generally itchy, skin is dry and flakey. Will trial topical corticosteroid, if no improvement I recommend referral to dermatology." The note directed for an order for triamcinolone cream 0.1% for arms, neck, and upper back for papular eczema twice daily for 14 days. The note indicated R49 believed the papular eczema was slowly worsening over one week and had the raised areas previously. A History and Physical encounter note [provider progress note] dated 8/15/24 and 8/27/24 at 00:00 [midnight], indicated no new information about R49's papular eczema. R49's nursing progress notes dated 8/5/24 at 11:16 [11:16 a.m.], indicated R49 had an order for dry itchy area twice daily but did not specify what was applied or where. R49's nursing progress notes dated 8/3/24 to 9/18/24, identified R49's skin was "warm/dry" but no further description	F 684		

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F 684	Continued From page 25 related to bumps on arms. During observation and interview on 9/16/24 at 6:23 p.m., R49 had multiple raised, circular areas on both upper extremities. R49 stated he had the raised areas on his arms for "a while" and discussed with his provider about seeing a dermatologist (medical doctor who specializes in conditions which affect the skin, hair, and nails). R49 stated he had an itching problem, used ointment, was not sure what helped his skin, and thought the raised areas were improving. During interview on 9/19/24 at 10:58 a.m., nursing assistant (NA)-B stated they report skin concerns to the nurse "right away" and the nurse documented about residents' skin. During interview on 9/19/24 at 11:14 a.m., licensed practical nurse (LPN)-A stated they notified the nurse manager, provider, and responsible party when a resident had a new skin concern, and the provider would let them know of any recommendations. LPN-A stated staff monitored skin conditions during daily treatments and weekly skin assessments and documented in progress notes or skin assessments. LPN-A stated they would update the provider if they were not seeing an improvement in skin condition or if a concern persisted after treatment completed. LPN-A stated they worked with R49 previously and knew about the raised areas on R49's upper extremities but would have to look in R49's chart to know if the raised areas were improving or not. LPN-A stated R49 was alert and oriented and would let staff know if he had concerns. During interview on 9/19/24 at 11:27 a.m., registered nurse (RN)-B stated they noticed the	F 684		

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F 684	Continued From page 26 raised areas on R49's arms and thought the raised areas were present the last time they worked with R49. RN-B stated they did not apply any treatment to R49's arms during the morning and would have to look at R49's chart to know if the raised areas were improving or not. RN-B did not see any current treatments or progress notes about the raised areas on R49's arms. RN-B reviewed the four most recent skin assessments. RN-B stated there were no specific notes about R49's arms, and R49's arms were visible to staff even when R49 refused skin assessments. During interview on 9/19/24 at 3:10 p.m., the director of nursing (DON) expected new skin concerns to be monitored every shift until healed and/or noted in weekly skin assessments. DON reviewed R49's skin assessment, progress notes, and MAR and verified no documentation on if R49's skin was improving or not and so no dermatology appointment had been set up. DON stated resident was hospitalized when the 14 days of triamcinolone cream application ended. DON stated documentation was important for following up on skin conditions. A facility policy Skin Assessment and Wound Management dated 3/24, expected staff to notify provider and treatment ordered, notify resident representative, complete education with resident/representative, initiate skin and wound evaluation, notify nurse manager, referral to dietary or therapy if appropriate, review and update care plan including interventions and risks for skin breakdown, and update resident care lists for new skin concerns. The policy directed staff to update provider and resident and/or representative as needed and update care plan as needed.	F 684		

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F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide routine range of motion for 1 of 2 residents (R11) reviewed for range of motion (ROM). Further, the facility failed to implement a walking program for 1 of 1 resident (R62) reviewed for walking program. Findings include: R11 R11's annual Minimum Data Set (MDS) dated 8/26/24, indicated R11 was in a persistent vegetative state and/or had no discernible consciousness. R11 was dependent on staff for activities of daily living, such as oral and toileting hygiene, dressing, mobility, and transfers, and	F 688	1. R11 ROM was added to care sheet and point of care charting for aides. R62 walking program was added to care sheet and point of care charting for aides. 2. All residents with ROM and walking programs have the potential to be affected by the deficient practice and care plans, care sheets, and point of care charting will be reviewed. 3. Education will be provided to nursing related to ROM and walking programs. 4. Audits will be completed by the Administrator and/or designee related to ROM and walking programs: 3 residents weekly for 4 weeks and then 3 residents twice a month for 1 month and then 1 resident 1x for 1 month. Audit results will	10/24/24

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F 688	Continued From page 28 had impairment on both sides of upper and lower extremities. R11 had diagnoses of quadriplegia (severe or complete loss of motor function in all four limbs) and epilepsy (brain condition which causes recurring burst of uncontrolled electrical activity and changes in behavior, movements, feelings, and levels of consciousness). The MDS indicated R11 had a feeding tube and no range of motion (for at least 15 minutes a day) in the last seven calendar days of the MDS period. R11's face sheet dated 9/20/24, indicated R11 had additional diagnoses of contractures (permanent tightening of the muscles, tendons, skin, and nearby tissues which causes the joints to shorten and become stiff) to both ankles, right wrist, elbow, and shoulder. R11's care plan dated 9/7/24, directed staff to perform passive range of motion with "am/pm" (before noon or midday/after noon or midday) cares daily. R11's Functional Maintenance Program dated 4/18/21, directed staff to perform daily passive range of motion to bilateral lower extremities. R11's Occupational Therapy Evaluation and Plan of Treatment revised 6/11/24, indicated nursing was managing R11's contracture impairment. R11's Occupational Therapy Progress Report signed 6/25/24, indicated R11 was seen five days during the 6/7/24 to 6/24/24 progress period. The report indicated R11 had significant tone and contracture. The report included short and long-term goals related to developing a range of motion program for staff to continue after therapy discharge.	F 688	be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule is needed.	

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F 688	Continued From page 29 R11's Physical Therapy Evaluation and Plan of Treatment signed 6/14/24, the report indicated R11 had impaired left and right lower extremity range of motion and a caregiver goal to establish a range of motion program to prevent worsening of contractures and skin breakdown. R11's Physical Therapy Treatment Encounter Notes signed 6/25/24, indicated passive range of motion to bilateral lower extremities completed to increase mobility and prevent the risk of contractures and education to nursing assistant on bed and body positioning to prevent contractures. R11's medication and treatment administration record dated 7/1/24 through 9/19/24, lacked documentation on range of motion. R11's progress notes dated 6/28/24 to 9/19/24, lacked documentation on range of motion. R11's Documentation Survey Report (nursing assistant charting on tasks) dated 7/1/24 to 9/19/24, lacked documentation on range of motion. During observation and interview on 9/18/24 at 9:32 a.m., nursing assistant (NA)-C and NA-E assisted R11 with morning cares, which included a bed bath, oral and toileting hygiene, and dressed R11 with a clean gown. R11's right wrist and elbow and left fingers were curled. NA-C and NA-E used a mechanical lift to assist R11 into his wheelchair and applied pillow boots to both feet. NA-C and NA-E left R11's room, and NA-C returned and covered R11 with a sheet and started remaking R11's bed with clean linen.	F 688		

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F 688	Continued From page 30 NA-C left R11's room and stated they were going to get more linen. NA-C stated R11's morning cares were completed, and R11 would be repositioned throughout the shift. NA-C completed ROM on residents to assist with stiffness, pain, and circulation of blood. NA-C stated they looked at residents' schedule or charting to know who needed ROM. NA-C stated they did not perform ROM with R11 during morning cares but was going to later. During interview on 9/18/24 at 10:33 a.m., NA-E stated they looked at residents' care plans to know who needed ROM and charted ROM when completed. NA-E stated they did not assist R11 with ROM, and therapy had not told tell them R11 needed ROM. During interview on 9/19/24 at 12:34 p.m., the director of rehab (DOR) stated nursing received a form after therapy which described residents' functional maintenance program. DOR stated R11 had a stretching program, and R11's range of motion was difficult to maintain due to hospitalizations and chronic contractures. During interview on 9/19/24 at 2:51 p.m., RN-B stated some walking programs or other functional maintenance programs, like ROM and/or stretching, were in the MAR or TAR (medication or treatment administration record), and NAs assisted the residents with the programs. During interview on 9/19/24 at 3:10 p.m., the director of nursing (DON) expected ROM and strengthening exercises to be in care plans and documented in tasks or nursing notes. DON reviewed R11's ROM intervention in care plan and did not see ROM in the NA tasks or other	F 688		

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F 688	Continued From page 31 areas of R11's chart. DON stated ROM exercises were important to improve R11's pain and positioning and prevent further contractures. R62 R62's quarterly Minimum Data Set (MDS) dated 8/16/24, indicated R62 had intact cognition and no behaviors or rejection of cares. R62 had no impairment to upper or lower extremities, limb prosthesis, and wheelchair, and lacked identification of use of walker. R62 required partial and/or moderate assistance for toileting hygiene, toilet transfers, and putting on and/or taking off footwear, and supervision and/or touching assistance for chair and/or bed-to-chair transfers and walking. The MDS indicated R62 had zero days of training and skill practice in walking in the last seven days of the MDS look back period. R62's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) Worksheet dated 6/14/24, was triggered due to assist needed with activities of daily living (ADLs), such as dressing, hygiene, sitting to standing, and transfers. R62's care plan dated 9/10/24, directed staff to provide R62 with supervision for non-weight bearing transfers. The care plan lacked information on walking or ambulation. R62's physician order with start date of 6/5/24, directed staff to provide R62 with non-pharmacological interventions, such as ambulation, if target behavior observed. R62's therapy communication form dated 8/1/24, indicated R62 should be ambulated to and/or	F 688		

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F 688	Continued From page 32 from all meals and to the bathroom with staff supervision and/or stand-by assistance with "FWW" (four wheeled walker). R62's Associated Clinic of Psychology (ACP) Progress Note dated 8/12/24, directed staff to help R62 focus on interventions to help him feel he was making progress, such as working on walking. R62's treatment administration record (TAR) dated 7/1/24 to 7/31/24, indicated R62 ambulated twice on 7/4/24 in response to target behavior but no other days. R62's TAR dated 8/1/24 to 8/31/24, indicated R62 had target behaviors and non-pharmacological interventions were completed other than ambulation. R62's TAR dated 9/1/24 to 9/19/24, indicated R62 did not have a target behavior which required a non-pharmacological intervention. R62's Documentation Survey Report (nursing assistant charting on tasks) dated 6/1/24 through 9/19/24, identified walking in corridor (hallway) occurred at the following frequency: 6/1/24 through 6/30/24: 11 out of 30 mornings, and six out of 30 evenings. 7/1/24 through 7/31/24: three out of 31 mornings, and seven out of 31 evenings. 8/1/24 through 8/31/24: 14 out of 31 mornings, and nine out of 31 evenings. 9/1/24 through 9/19/24: five out of 19 mornings, and seven out of 19 mornings. R62's Documentation Survey Report (nursing assistant charting on tasks) dated 6/1/24 through 9/19/24, identified "NA" (Not Applicable) or lacked documentation at the following frequency for walking in corridor:	F 688		

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F 688	Continued From page 33 6/1/24 through 6/30/24: 19 out of 30 mornings, and 24 out of 30 evenings. 7/1/24 through 7/31/24: 28 out of 31 mornings, and 24 out of 31 evenings. 8/1/24 through 8/31/24: 17 out of 31 mornings, and 22 out of 31 evenings. 9/1/24 through 9/19/24: 14 out of 19 mornings, and 12 out of 19 evenings. R62's Documentation Survey Report (nursing assistant charting on tasks) dated 6/1/24 through 9/19/24, identified walking in the room occurred at the following frequency: 6/1/24 through 6/30/24: 10 out of 30 mornings, and four out of 30 evenings. One morning out of 30 was marked as "RX" (Resident not available). 7/1/24 through 7/31/24: three out of 31 mornings, and six out of 31 evenings. 8/1/24 through 8/31/24: 16 out of 31 mornings, and eight out of 31 evenings. 9/1/24 through 9/19/24: six out of 19 mornings, and five out of 19 evenings. R62's Documentation Survey Report (nursing assistant charting on tasks) dated 6/1/24 through 9/19/24, identified "NA" (Not Applicable) or lacked documentation at the following frequency for walking in room: 6/1/24 through 6/30/24: 19 out of 30 mornings, and 26 out of 30 evenings. 7/1/24 through 7/31/24: 28 out of 31 mornings, and 25 out of 31 evenings. 8/1/24 through 8/31/24: 15 out of 31 mornings, 23 out of 31 evenings. 9/1/24 through 9/19/24: 13 out of 19 mornings, and 14 out of 19 evenings. During interview on 9/16/24 at 1:56 p.m., R62 sat in a wheelchair with bilateral leg prosthetics. R62	F 688		

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F 688	Continued From page 34 stated he was supposed to walk every day but could not get assistance. R62 stated staff were aware and spoke with staff about walking but getting walking assistance was still a "hit or miss". Unknown staff person approached resident with a walker and gait belt, but R62 stated he wanted to continue interview and assistance afterwards. During observation on 9/18/24 at 7:13 a.m., R62 sat in his wheelchair with prosthetics on in the television area of the floor. During observation on 9/18/24 at 8:46 a.m., R62 wheeled himself down the hallway. During interview on 9/18/24 at 12:28 p.m., R62 sat in his wheelchair in his room and stated the staff did not return to walk with him on 9/16/24 and today (9/18/24) was the first time he walked with staff in a "long time". During interview on 9/19/24 at 10:58 a.m., nursing assistant (NA)-B stated staff looked at residents' care plans to know which residents have range of motion exercises, walking programs, and what assistance was required for eating, toileting, and other activities of daily living (ADLs). NA-B stated R62 ambulated, and R62 should have a walking program although NA-B was not as familiar with the hallway R62 was on. During interview on 9/19/24 at 12:13 p.m., NA-D stated residents' care plan, assistance needs, and functional maintenance programs were on their computer and a sheet in a binder, and staff documented cares completed in POC (Point of Care). NA-D was not sure if R62 had a walking program and stated R62 was in his wheelchair most of the time.	F 688		

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F 688	Continued From page 35 During interview on 9/19/24 at 12:34 p.m., the director of rehab (DOR) stated nursing received a form after therapy which described residents' functional maintenance program. DOR stated R62 had a double amputation and prosthetics. R62 walked 300 feet with a walker and supervision assistance. DOR stated R62 had a walking program but preferred to walk with certain NAs over others. DOR expected NAs to ask R62 to walk once or twice a week and document refusals, even if they were not R62's preferred NA. During interview on 9/19/24 at 2:51 p.m., RN-B stated some walking programs or other functional maintenance programs, like ROM and/or stretching, were in the MAR or TAR (medication or treatment administration record), and NAs assisted the residents with the programs. RN-B stated they had seen a staff walking with R62 during their morning shift. R62's Documentation Survey Report dated 9/19/24, indicated "NA" (Not Applicable) for walking in room and corridor for the morning shift. During interview on 9/19/24 at 3:10 p.m., DON stated nursing received a sheet from therapy for walking programs and then entered the program into the care plan and/or into the NA tasks. DON reviewed R62's care plan and tasks and did not find a walking program description for R62. DON reviewed therapy communication form and ACP note. DON stated R62's walking program was important to give R62 a feeling of independence and control, strengthen R62, and get used to his prosthetic legs.	F 688		

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F 688	Continued From page 36 A facility policy Activities of Daily Living (ADLs)/Maintain Abilities Policy dated 3/31/23, directed staff to provide care and services for ADLs, such as ambulation, to ensure a resident's ability with ADLs maintained or improved unless resident had an unavoidable clinical condition. The policy did not address resident range of motion.	F 688		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		10/24/24

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F 880	Continued From page 37 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 880	1. PPE was provided to laundry to use	

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F 880	Continued From page 38 review the facility failed to ensure personal protection equipment (PPE) was used when sorting dirty laundry. This had the potential to impact all 82 residents who reside in the facility. Findings include: During observation and interview on 9/19/24 at 10.24 a.m., Environmental Service Director (ESD) indicated the laundry aide would take the dirty laundry from the red chute in the laundry room and sort it. He indicated the staff was to wear a gown and gloves when handling dirty laundry. He indicated the gowns are to be hung on the wall in the dirty laundry room. He verified there were no gowns on the wall. Interview with laundry aide (LA) -A and LA- B at 10:35 a.m. they indicated there were no gowns, and there had not been for around a month. LA-B indicated she wears gloves when sorting dirty laundry, but no gowns have been available. Review of undated Contaminated Laundry policy indicated: Employers must ensure that employees who have contact with contaminated laundry wear appropriate PPE as discussed in the Bloodborne Pathogen Standard 29 CFR 1910.1030(d)(4)(iv)(B) when handling and/or sorting contaminated laundry. Employers must ensure employee wear appropriate PPE such as gloves, gowns, face shields, and masks when sorting contaminated laundry.	F 880	when sorting dirty laundry. 2. All residents have the potential to be affected by the deficient practice. The laundry aide will use PPE when sorting dirty laundry. 3. Education will be provided to laundry staff regarding sorting dirty laundry. 4. Audits will be completed by the Housekeeping Manager and/or designee related to sorting dirty laundry. Sorting dirty laundry will be audited weekly for 4 weeks and then twice a month for 1 month and then 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule are needed.	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal	F 883		10/24/24

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT THE CEDARS	7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 39 immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;	F 883		

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F 883	Continued From page 40 (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure the current pneumococcal vaccination was offered for 1 of 5 residents (R47) reviewed for immunizations. Findings include: Review of R47 record indicated R47 was admitted on 1/22/24, with diagnosis including metabolic encephalopathy(brain dysfunction caused by a chemical imbalance in the blood that affect the brain) , and dementia Review of R47 record indicated R47's family gave written consent on 3/4/24, for R47 to receive the pneumococcal vaccine per PCP (Primary care provider) order and CDC (Center for Disease Control) guideline. R47's medical record lacked evidence R47 was offered or received the current pneumococcal vaccination. Interview on 9/19/24 at 4:40 p.m., the Director of Nursing (DON) indicated if the consent was signed by the family, the physician would be	F 883	1. R47 consent was received by the provider and facility ordered the vaccine and administered to the resident. 2. All residents have the potential to be affected by the deficient practice. Residents will be offered pneumococcal vaccination and administered if consent is signed. 3. Education will be provided to Nursing related to pneumococcal vaccination. 4. Audits will be completed by the DON and/or designee related to pneumococcal vaccination. 3 resident audits will be completed weekly for 4 weeks and then 3 residents twice a month for 1 month and then 3 residents 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule is needed.	

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F 883	Continued From page 41 notified, orders received, and the vaccination would be added to the medical record. The DON verified no orders were received from the physician. The DON indicated she would verify with R47's son and get an order from the physician.	F 883		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/16/24 - 9/19/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed with no deficiencies cited: H51878221C (MN100645). Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,	2 000		

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2 000	Continued From page 2 "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and observation, the facility failed to ensure a comprehensive and individualized care plan was developed for 1 of 1 resident (R49) reviewed for constipation. Findings include: R49's quarterly Minimum Data Set (MDS) dated 9/4/24, indicated was cognitively intact, had verbal behaviors and rejection of care, used a walker, and was independent with most activities of daily living (ADLs), such as walking, hygiene, and transfers. R49 was occasionally incontinent of bladder and frequently incontinent of bowel. The MDS indicated R49 had end stage renal disease (medical condition in which a person's kidneys stop functioning on a permanent basis) and diabetes mellitus (condition which affects how body uses blood sugar).	2 565	Corrected	10/24/24

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2 565	Continued From page 3 R49's care plan dated 9/16/24, lacked information about bowel and bladder incontinence, toileting, or constipation. R49's nursing progress notes indicated the following: -On 8/26/24 at 00:20 [12:20 a.m.], R49 called ambulance for stomach pain and constipation. -On 8/26/24 at 03:09 [3:09 a.m.], R49 returned to the facility and senna-docusate sodium was ordered as needed. -On 8/27/24 at 23:23 [11:23 p.m.], R49 called ambulance for discomfort and constipation and went to the University of Minnesota Fairview. During interview on 9/19/24 at 10:58 a.m., nursing assistant (NA)-B stated staff looked at residents' care plans to know what kind of assistance residents required for eating, toileting, and other activities of daily living (ADLs). NA-B stated staff asked R49 whether he had bowel movements or not, and R49 spoke with the nurses when he had concerns about bowel movements. During interview on 9/19/24 at 11:14 a.m., licensed practical nurse (LPN)-A stated staff referred to physician orders, medication and treatment administration records, and resident care plan to know how to care for a resident. During interview on 9/19/24 at 3:10 p.m., the director of nursing (DON) stated R49 had history of constipation, refusing suppositories, and hospitalization related to abdominal pain. DON expected staff to monitor and follow facility protocol for constipation. DON reviewed R49's care plan and verified R49's care plan did not have information about bowel or bladder continence, constipation, or toileting needs. DON	2 565		

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2 565	Continued From page 4 expected resident care plans to be resident-specific so staff knew how to assist them. A facility policy Care Planning- Interdisciplinary Team dated 7/21/23, indicated care plans were based on resident's comprehensive assessment and developed by a care planning and/or interdisciplinary team. A facility policy Care Planning dated 1/6/22, indicated would be developed based on resident's daily care routines and utilized by staff personnel for the purposes of providing care or services, and the care plan was modified and updated as the condition and care needs of the resident changed. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is comprehensive and followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure comprehensive care plans and staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be	2 895		10/24/24

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2 895	Continued From page 5 implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide routine range of motion for 1 of 2 residents (R11) reviewed for range of motion (ROM). Further, the facility failed to implement a walking program for 1 of 1 resident (R62) reviewed for walking program. Findings include: R11 R11's annual Minimum Data Set (MDS) dated 8/26/24, indicated R11 was in a persistent vegetative state and/or had no discernible consciousness. R11 was dependent on staff for activities of daily living, such as oral and toileting hygiene, dressing, mobility, and transfers, and had impairment on both sides of upper and lower extremities. R11 had diagnoses of quadriplegia (severe or complete loss of motor function in all four limbs) and epilepsy (brain condition which causes recurring burst of uncontrolled electrical activity and changes in behavior, movements, feelings, and levels of consciousness). The MDS indicated R11 had a feeding tube and no range of motion (for at least 15 minutes a day) in the last	2 895	Corrected	

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2 895	Continued From page 6 seven calendar days of the MDS period. R11's face sheet dated 9/20/24, indicated R11 had additional diagnoses of contractures (permanent tightening of the muscles, tendons, skin, and nearby tissues which causes the joints to shorten and become stiff) to both ankles, right wrist, elbow, and shoulder. R11's care plan dated 9/7/24, directed staff to perform passive range of motion with "am/pm" (before noon or midday/after noon or midday) cares daily. R11's Functional Maintenance Program dated 4/18/21, directed staff to perform daily passive range of motion to bilateral lower extremities. R11's Occupational Therapy Evaluation and Plan of Treatment revised 6/11/24, indicated nursing was managing R11's contracture impairment. R11's Occupational Therapy Progress Report signed 6/25/24, indicated R11 was seen five days during the 6/7/24 to 6/24/24 progress period. The report indicated R11 had significant tone and contracture. The report included short and long-term goals related to developing a range of motion program for staff to continue after therapy discharge. R11's Physical Therapy Evaluation and Plan of Treatment signed 6/14/24, the report indicated R11 had impaired left and right lower extremity range of motion and a caregiver goal to establish a range of motion program to prevent worsening of contractures and skin breakdown. R11's Physical Therapy Treatment Encounter Notes signed 6/25/24, indicated passive range of	2 895		

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2 895	Continued From page 7 motion to bilateral lower extremities completed to increase mobility and prevent the risk of contractures and education to nursing assistant on bed and body positioning to prevent contractures. R11's medication and treatment administration record dated 7/1/24 through 9/19/24, lacked documentation on range of motion. R11's progress notes dated 6/28/24 to 9/19/24, lacked documentation on range of motion. R11's Documentation Survey Report (nursing assistant charting on tasks) dated 7/1/24 to 9/19/24, lacked documentation on range of motion. During observation and interview on 9/18/24 at 9:32 a.m., nursing assistant (NA)-C and NA-E assisted R11 with morning cares, which included a bed bath, oral and toileting hygiene, and dressed R11 with a clean gown. R11's right wrist and elbow and left fingers were curled. NA-C and NA-E used a mechanical lift to assist R11 into his wheelchair and applied pillow boots to both feet. NA-C and NA-E left R11's room, and NA-C returned and covered R11 with a sheet and started remaking R11's bed with clean linen. NA-C left R11's room and stated they were going to get more linen. NA-C stated R11's morning cares were completed, and R11 would be repositioned throughout the shift. NA-C completed ROM on residents to assist with stiffness, pain, and circulation of blood. NA-C stated they looked at residents' schedule or charting to know who needed ROM. NA-C stated they did not perform ROM with R11 during morning cares but was going to later.	2 895		

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2 895	Continued From page 8 During interview on 9/18/24 at 10:33 a.m., NA-E stated they looked at residents' care plans to know who needed ROM and charted ROM when completed. NA-E stated they did not assist R11 with ROM, and therapy had not told tell them R11 needed ROM. During interview on 9/19/24 at 12:34 p.m., the director of rehab (DOR) stated nursing received a form after therapy which described residents' functional maintenance program. DOR stated R11 had a stretching program, and R11's range of motion was difficult to maintain due to hospitalizations and chronic contractures. During interview on 9/19/24 at 2:51 p.m., RN-B stated some walking programs or other functional maintenance programs, like ROM and/or stretching, were in the MAR or TAR (medication or treatment administration record), and NAs assisted the residents with the programs. During interview on 9/19/24 at 3:10 p.m., the director of nursing (DON) expected ROM and strengthening exercises to be in care plans and documented in tasks or nursing notes. DON reviewed R11's ROM intervention in care plan and did not see ROM in the NA tasks or other areas of R11's chart. DON stated ROM exercises were important to improve R11's pain and positioning and prevent further contractures. R62 R62's quarterly Minimum Data Set (MDS) dated 8/16/24, indicated R62 had intact cognition and no behaviors or rejection of cares. R62 had no impairment to upper or lower extremities, limb prosthesis, and wheelchair, and lacked identification of use of walker. R62 required	2 895		

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2 895	Continued From page 9 partial and/or moderate assistance for toileting hygiene, toilet transfers, and putting on and/or taking off footwear, and supervision and/or touching assistance for chair and/or bed-to-chair transfers and walking. The MDS indicated R62 had zero days of training and skill practice in walking in the last seven days of the MDS look back period. R62's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) Worksheet dated 6/14/24, was triggered due to assist needed with activities of daily living (ADLs), such as dressing, hygiene, sitting to standing, and transfers. R62's care plan dated 9/10/24, directed staff to provide R62 with supervision for non-weight bearing transfers. The care plan lacked information on walking or ambulation. R62's physician order with start date of 6/5/24, directed staff to provide R62 with non-pharmacological interventions, such as ambulation, if target behavior observed. R62's therapy communication form dated 8/1/24, indicated R62 should be ambulated to and/or from all meals and to the bathroom with staff supervision and/or stand-by assistance with "FWW" (four wheeled walker). R62's Associated Clinic of Psychology (ACP) Progress Note dated 8/12/24, directed staff to help R62 focus on interventions to help him feel he was making progress, such as working on walking. R62's treatment administration record (TAR) dated 7/1/24 to 7/31/24, indicated R62 ambulated twice on 7/4/24 in response to target behavior but	2 895		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT THE CEDARS	7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 895	Continued From page 10 no other days. R62's TAR dated 8/1/24 to 8/31/24, indicated R62 had target behaviors and non-pharmacological interventions were completed other than ambulation. R62's TAR dated 9/1/24 to 9/19/24, indicated R62 did not have a target behavior which required a non-pharmacological intervention. R62's Documentation Survey Report (nursing assistant charting on tasks) dated 6/1/24 through 9/19/24, identified walking in corridor (hallway) occurred at the following frequency: 6/1/24 through 6/30/24: 11 out of 30 mornings, and six out of 30 evenings. 7/1/24 through 7/31/24: three out of 31 mornings, and seven out of 31 evenings. 8/1/24 through 8/31/24: 14 out of 31 mornings, and nine out of 31 evenings. 9/1/24 through 9/19/24: five out of 19 mornings, and seven out of 19 mornings. R62's Documentation Survey Report (nursing assistant charting on tasks) dated 6/1/24 through 9/19/24, identified "NA" (Not Applicable) or lacked documentation at the following frequency for walking in corridor: 6/1/24 through 6/30/24: 19 out of 30 mornings, and 24 out of 30 evenings. 7/1/24 through 7/31/24: 28 out of 31 mornings, and 24 out of 31 evenings. 8/1/24 through 8/31/24: 17 out of 31 mornings, and 22 out of 31 evenings. 9/1/24 through 9/19/24: 14 out of 19 mornings, and 12 out of 19 evenings. R62's Documentation Survey Report (nursing assistant charting on tasks) dated 6/1/24 through 9/19/24, identified walking in the room occurred at the following frequency: 6/1/24 through 6/30/24: 10 out of 30 mornings,	2 895		

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2 895	Continued From page 11 and four out of 30 evenings. One morning out of 30 was marked as "RX" (Resident not available). 7/1/24 through 7/31/24: three out of 31 mornings, and six out of 31 evenings. 8/1/24 through 8/31/24: 16 out of 31 mornings, and eight out of 31 evenings. 9/1/24 through 9/19/24: six out of 19 mornings, and five out of 19 evenings. R62's Documentation Survey Report (nursing assistant charting on tasks) dated 6/1/24 through 9/19/24, identified "NA" (Not Applicable) or lacked documentation at the following frequency for walking in room: 6/1/24 through 6/30/24: 19 out of 30 mornings, and 26 out of 30 evenings. 7/1/24 through 7/31/24: 28 out of 31 mornings, and 25 out of 31 evenings. 8/1/24 through 8/31/24: 15 out of 31 mornings, 23 out of 31 evenings. 9/1/24 through 9/19/24: 13 out of 19 mornings, and 14 out of 19 evenings. During interview on 9/16/24 at 1:56 p.m., R62 sat in a wheelchair with bilateral leg prosthetics. R62 stated he was supposed to walk every day but could not get assistance. R62 stated staff were aware and spoke with staff about walking but getting walking assistance was still a "hit or miss". Unknown staff person approached resident with a walker and gait belt, but R62 stated he wanted to continue interview and assistance afterwards. During observation on 9/18/24 at 7:13 a.m., R62 sat in his wheelchair with prosthetics on in the television area of the floor. During observation on 9/18/24 at 8:46 a.m., R62 wheeled himself down the hallway.	2 895		

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2 895	Continued From page 12 During interview on 9/18/24 at 12:28 p.m., R62 sat in his wheelchair in his room and stated the staff did not return to walk with him on 9/16/24 and today (9/18/24) was the first time he walked with staff in a "long time". During interview on 9/19/24 at 10:58 a.m., nursing assistant (NA)-B stated staff looked at residents' care plans to know which residents have range of motion exercises, walking programs, and what assistance was required for eating, toileting, and other activities of daily living (ADLs). NA-B stated R62 ambulated, and R62 should have a walking program although NA-B was not as familiar with the hallway R62 was on. During interview on 9/19/24 at 12:13 p.m., NA-D stated residents' care plan, assistance needs, and functional maintenance programs were on their computer and a sheet in a binder, and staff documented cares completed in POC (Point of Care). NA-D was not sure if R62 had a walking program and stated R62 was in his wheelchair most of the time. During interview on 9/19/24 at 12:34 p.m., the director of rehab (DOR) stated nursing received a form after therapy which described residents' functional maintenance program. DOR stated R62 had a double amputation and prosthetics. R62 walked 300 feet with a walker and supervision assistance. DOR stated R62 had a walking program but preferred to walk with certain NAs over others. DOR expected NAs to ask R62 to walk once or twice a week and document refusals, even if they were not R62's preferred NA. During interview on 9/19/24 at 2:51 p.m., RN-B stated some walking programs or other functional	2 895		

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2 895	Continued From page 13 maintenance programs, like ROM and/or stretching, were in the MAR or TAR (medication or treatment administration record), and NAs assisted the residents with the programs. RN-B stated they had seen a staff walking with R62 during their morning shift. R62's Documentation Survey Report dated 9/19/24, indicated "NA" (Not Applicable) for walking in room and corridor for the morning shift. During interview on 9/19/24 at 3:10 p.m., DON stated nursing received a sheet from therapy for walking programs and then entered the program into the care plan and/or into the NA tasks. DON reviewed R62's care plan and tasks and did not find a walking program description for R62. DON reviewed therapy communication form and ACP note. DON stated R62's walking program was important to give R62 a feeling of independence and control, strengthen R62, and get used to his prosthetic legs. A facility policy Activities of Daily Living (ADLs)/Maintain Abilities Policy dated 3/31/23, directed staff to provide care and services for ADLs, such as ambulation, to ensure a resident's ability with ADLs maintained or improved unless resident had an unavoidable clinical condition. The policy did not address resident range of motion. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for limited range of motion/ambulation to assure they are receiving the necessary treatment/services to prevent further limitation in range of motion. The director of nursing or designee, could conduct random	2 895		

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2 895	Continued From page 14 audits of the delivery of care to ensure appropriate care and services are implemented. The results of the audits could be brought to the quality assurance committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a tuberculosis skin test (TST), TB blood test or chest X-rays were	21426	Corrected	10/24/24

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21426	Continued From page 15 conducted and the results documented for 2 of 5 new employees (nursing assistant (NA) D and culinary aide (CA) A) reviewed for tuberculosis (TB) screening as directed by the Centers for Disease Control and Prevention. Findings include: NA-D's hire date was 4/1/24 and no Baseline TB Screening Tool for Health Care Workers was located since hire. CA-A's hire date was 8/26/24 and no Baseline TB Screening Tool for Health Care Workers was located. Interview on 9/19/24 at 4:02 p.m., the administrator indicated she was unable to find any Mantoux information for NA-D and CA-A. The facility tuberculosis Risk Assessment Instructions and Worksheet dated 6/2024 indicated: Baseline TB screening is required at the time of hire for all health care personnel in Minnesota Baseline TB screening includes 1. Assessing for current systems of active TB disease 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either an two-step tuberculin skin test or single TB blood test. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could monitor to assure tuberculin testing procedures were developed and implemented to ensure staff was free of tuberculosis prior to working with	21426		

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21426	Continued From page 16 residents. The DON, or designee, could conduct audits to ensure TB testing was conducted. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21675	MN Rule 4658.1410 Linen Nursing home staff must handle, store, process, and transport linens so as to prevent the spread of infection according to the infection control program and policies as required by part 4658.0800. These laundering policies must comply with the manufacturer's instructions for the laundering equipment and products and include a wash formula addressing the time, temperature, water hardness, bleach, and final pH. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure personal protection equipment (PPE) was used when sorting dirty laundry. This had the potential to impact all 82 residents who reside in the facility. Findings include: During observation and interview on 9/19/24 at 10.24 a.m., Environmental Service Director (ESD) indicated the laundry aide would take the dirty laundry from the red chute in the laundry room and sort it. He indicated the staff was to wear a gown and gloves when handling dirty laundry. He indicated the gowns are to be hung on the wall in the dirty laundry room. He verified there were no	21675	Corrected	10/24/24

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21675	Continued From page 17 gowns on the wall. Interview with laundry aide (LA) -A and LA- B at 10:35 a.m. they indicated there were no gowns, and there had not been for around a month. LA-B indicated she wears gloves when sorting dirty laundry, but no gowns have been available. Review of undated Contaminated Laundry policy indicated: Employers must ensure that employees who have contact with contaminated laundry wear appropriate PPE as discussed in the Bloodborne Pathogen Standard 29 CFR 1910.1030(d)(4)(iv)(B) when handling and/or sorting contaminated laundry. Employers must ensure employee wear appropriate PPE such as gloves, gowns, face shields, and masks when sorting contaminated laundry. SUGGESTED METHOD OF CORRECTION: The environmental Service Director or designee, could ensure policies regarding proper personal protective equipment (PPE) were developed and implemented in laundry. The Environmental Service Director, or designee, could conduct audits to ensure PPE was correctly being used in the laundry. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21675		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors,	21695		10/24/24

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21695	Continued From page 18 ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure an enteral feeding pump, tube feeding pole, and supporting legs were cleaned and in sanitary condition for 1 of 2 residents (R11) reviewed for tube feeding. Furthermore, the facility failed to keep the building clean for 1 of 1 bathroom with an unclean exhaust fan and 1 of 1 room with an unclean wall vent and ceiling tiles. Also, the facility failed to keep furniture in good condition for 1 of 2 residents (R30) who had an extended table from a dresser in their room. Findings include: TUBE FEEDING EQUIPEMENT R11's annual Minimum Data Set (MDS) dated 8/26/24, indicated R11 was in a persistent vegetative state and/or had no discernible consciousness. R11 was dependent on staff for activities of daily living, such as oral and toileting hygiene, dressing, mobility, and transfers, and had impairment on both sides of upper and lower extremities. R11 had diagnoses of quadriplegia (severe or complete loss of motor function in all four limbs) and epilepsy (brain condition which causes recurring burst of uncontrolled electrical activity and changes in behavior, movements, feelings, and levels of consciousness). The MDS indicated R11 had a feeding tube through which they received more than 50% of their nutrition. R11's medication and treatment administration	21695	Corrected	

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21695	Continued From page 19 record July 2024, directed the night shift to clean the tube feeding pole with a start date of 4/4/24. The tube feeding pole was recorded as cleaned every night shift until a discontinued date of 7/12/24. The rest of July 2024 lacked documentation of tube feeding pole cleaning, as well as the MAR and TAR for August and September of 2024. During observation on 9/16/24 at 1:15 p.m., R11's enteral feeding pump had splatters of tan splotches, tube feeding pole had dusky, cloudy appearance throughout, and supporting legs had grayish splatters. During observation on 9/17/24 at 3:26 p.m., the enteral feeding pump, tube feeding pole, and supporting leg conditions were unchanged. During observation on 9/18/24 at 7:53 a.m., the enteral feeding pump, tube feeding pole, and supporting leg conditions were unchanged. During observation and interview on 9/18/24 at 9:14 a.m., licensed practical nurse (LPN)-B stated they cleaned tube feeding equipment when they saw a spill and housekeeping also cleaned regularly or when nursing notified them. LPN-B did not know if there was a schedule to clean the tube feeding equipment or where the cleaning was documented. LPN-B stated tube feeding equipment were kept clean for R11's dignity and infection control purposes. LPN-B wiped the enteral feeding pump and pole with a disinfectant wipe and stated they would let housekeeping know to clean the supporting legs. The splatters came off the enteral feeding pump, and the pole had a shiny appearance. During interview on 9/19/24 at 3:10 p.m., DON	21695		

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21695	Continued From page 20 expected tube feeding poles to be cleaned and documented regularly and when visibly soiled. DON reviewed R11's orders and did not see an active order or documentation for cleaning R11's tube feeding pole. DON stated a clean tube feeding pole was important for infection control. A facility policy Maintaining Patency of a Feeding Tube (Flushing) dated 3/23/23, directed staff to clean reusable equipment used for opening a clogged feeding tube according to manufacturer's instructions but did not include enteral feed pump, tube feeding pole, and supporting legs. Facility policies Isolation Room Cleaning Procedures, Daily Cleaning Procedures, and Deep Clean Procedures undated, did not include cleaning of enteral feeding pump, tube feeding pole, or supporting legs. EXHAUST FANS, WALL VENTS, AND LINING OF FLAT SURFACE Findings include: R11's annual Minimum Data Set (MDS) dated 8/26/24, indicated R11 was in a persistent vegetative state and/or had no discernible consciousness. R11 was dependent on staff for activities of daily living (ADLs), such as oral and toileting hygiene, dressing, mobility, and transfers. R30's annual MDS dated 8/27/24, indicated R30 was cognitively intact and required substantial and/or maximal to dependent assistance with ADLs such as dressing, toileting hygiene, and rolling left and right and was independent with ADLs such as eating and use of motorized wheelchair.	21695		

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21695	Continued From page 21 R49's quarterly MDS dated 9/4/24, indicated was cognitively intact and independent with most ADLs, such as walking, hygiene, and transfers. R62's quarterly MDS dated 8/16/24, indicated R62 had intact cognition and required partial and/or moderate assistance for toileting hygiene, and putting on and/or taking off footwear, supervision and/or touching assistance for chair and/or bed-to-chair transfers and walking. R69's quarterly MDS dated 8/6/24, indicated R69 had intact cognition and required assistance for most ADLs. R70's quarterly MDS dated 7/15/24, indicated R70 was cognitively intact and required assistance for most ADLs. The facility's Closed Work Orders report dated 4/18/24 through 9/17/24, lacked requests to clean exhaust fan for the shard bathroom and the wall vent and ceiling tile in R11 and R30's room. The report also lacked request to fix the lining of the furniture item in R11 and R30's room. A TELS (platform to track maintenance tasks) Report Builder dated 9/17/24, indicated exhaust fans, including those in the bathroom, had been marked "done on-time" twice a month March 2024 through August 2024, and the last task completion was 9/9/24. Exhaust fan checks included ensuring air flow was sufficient enough to hold a piece of paper to the vent when operating and cleaning vents with a vacuum and air compressor, when needed to remove all dust. During observation on 9/16/24 at 1:15 p.m., a wall vent near the ceiling in R11 and R30's room had grayish particles and ceiling tile had brownish	21695		

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21695	Continued From page 22 colored streaks which started narrower near the wall vent then expanded out. During observation on 9/16/24 at 2:08 p.m., a shared bathroom between R49, R62, R69, and R70 had a square shaped ceiling exhaust fan with gray particles plugging every other row of smaller squares. During interview on 9/18/24 at 8:21 a.m., trained medication assistant (TMA)-A stated they put requests for maintenance into TELS. During observation on 9/18/24 at 9:14 a.m., licensed practical nurse (LPN)-B cleaned a tube feeding pole of R11 who shared a room with R30. LPN-B went to bathroom to doff personal protective equipment and washed hands and upon exiting the bathroom brushed against the side lining of an extended table of a dresser. R30 stated he had told someone to fix that, and LPN-B did not reply. During observation and interview on 9/19/24 at 2:35 p.m., the maintenance director (DOM), corporate maintenance (CM), and regional maintenance director (RM) stated fans and vents were checked daily by housekeeping. DOM, CM, and RM observed the exhaust fan in the shared bathroom and stated the exhaust fan looked "pretty plugged" and needed to be vacuumed out. DOM, CM, and RM observed the wall vent near the ceiling by R11's bed and verified needed cleaning. DOM verified the loose lining of the extended dresser in R11 and R30's room and was not aware it needed fixing and expected staff to place in a TELS (platform to track maintenance tasks) request when maintenance needed to fix an item.	21695		

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21695	Continued From page 23 During interview on 9/19/24 at 4:57 p.m., the administrator expected housekeeping to clean vents and exhaust fans during general daily and deep cleaning, and the exhaust fans and vents should be free of dust. The facility was asked for a policy related to maintenance and fixing resident room items and/or furniture and stated they did not have such policy. A facility policy Daily Cleaning Procedures undated, directed staff to work clockwise around the room and dust all high surfaces, which included vents. The policy also directed staff to dust vents in the restroom. A facility policy Deep Clean Procedures undated, directed staff to use a high duster to clean vents. SUGGESTED METHOD OF CORRECTION: The administrator, maintenance supervisor, or designee could ensure a preventative maintenance program was developed to accurately reflect ongoing preventative maintenance scheduled or needed in the facility on a routine basis. The facility could create policies and procedures, educate staff on these changes and perform environmental rounds/audits periodically to ensure preventative maintenance is adequately completed. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		

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	00144	A. BUILDING: _____ B. WING _____	C 09/19/2024

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21805	Continued From page 24	21805		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain resident privacy and dignity 2 of 3 residents (R46, R11) reviewed for dignity. R46 R46's admission (MDS) dated 6/20/24, indicated R46 had moderate cognitive impairment and required substantial and/or maximal assistance with most activities of daily living (ADLs), such as hygiene, dressing, and transfers. During observation on 9/18/24 at 7:30 a.m., R46 had their call light on. At 7:32 a.m., the social services designee (SS)-A knocked on R46's door and stated they would let them [the staff] know as they walked out of R46's room. At 7:34 a.m., SS-A stated loudly down the hall to nursing assistant (NA)-A R46 needed a "check and change." During interview on 9/18/24 at 8:48 a.m., NA-A stated SS-A "always" does "that" when questioned about SS-A's statement in the hall. NA-A stated SS-A should come to staff and tell them what residents' need with a quieter voice.	21805	Corrected	10/24/24

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21805	Continued From page 25 NA-A stated residents needed privacy and did not want other residents to think "what is going on" by hearing voices in the hallway. During interview on 9/19/24 at 11:52 a.m., SS-A stated nursing staff spoke with them afterwards and speaking more privately about residents' needs was important for residents' dignity and HIPPA (Health Insurance Portability and Accountability Act; law to protect the privacy and security of health information). During interview on 9/19/24 at 11:58 a.m., R46 stated "that's part of being here" when asked how they would feel about a staff member stating they needed a "check and change" by name in the hallway, then asked his family member (FM)-B if such an incident would bother her. FM-B stated the incident would bother her, and R46 agreed he would be bothered too. During interview on 9/19/24 at 3:10 p.m., DON expected staff to pull a staff member aside or talk in a different room to share information about other residents to provide resident privacy and maintain dignity. R11 R11's annual Minimum Data Set (MDS) dated 8/26/24, indicated R11 was in a persistent vegetative state and/or had no discernible consciousness. R11 was dependent on staff for activities of daily living, such as oral and toileting hygiene, dressing, mobility, and transfers, and had impairment on both sides of upper and lower extremities. R11 had diagnoses of quadriplegia (severe or complete loss of motor function in all four limbs) and epilepsy (brain condition which causes recurring burst of uncontrolled electrical	21805		

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21805	Continued From page 26 activity and changes in behavior, movements, feelings, and levels of consciousness). During observation and interview on 9/18/24 at 9:32 a.m., nursing assistant (NA)-C and NA-E assisted R11 with morning cares, which included a bed bath, oral and toileting hygiene, and dressed R11 with a clean gown. Throughout all cares, including when R11 was exposed during incontinence cares, the privacy curtain was partially closed, and there was a clear view from R11 to R30's side of the room. R30 sat facing away from R11 in his electric wheelchair which he used independently and was awake or with eyes closed throughout R11's cares. NA-C left the room after cares were completed and stated R11 wore a gown all the time and thought he preferred to be in a gown. NA-C stated some care plans indicated resident or family preferences for dressing. NA-C stated they always pulled the privacy curtain when assisting residents and verified they did not pull the privacy curtain for R11. R11's care plan dated 9/7/24, indicated R11 was dependent on staff for dressing and did not specify if R11 wanted to dress in a gown or personal clothes during the day time. During interview on 9/18/24 at 10:33 a.m., NA-E verified R11's privacy curtain was not pulled during cares and stated the room was "tight" for transferring R11 when pulled, and R30 went through R11's side of the room to get out the bedroom door regardless of the privacy curtain being pulled during cares. NA-E stated the curtains were important to provide resident privacy. During interview on 9/18/24 at 4:38 p.m., family	21805		

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21805	Continued From page 27 member (FM)-A stated R11 would want privacy and not to be cleaned where another resident could see. FM-A stated R11 was a "smart" and "clean" person who took care of himself and not normal for him to be in a gown throughout the day. During observation on 9/19/24 at 10:50 a.m., R11 had a gown on and laid in bed. During interview on 9/19/24 at 10:58 a.m., nursing assistant (NA)-B stated family preferences were in the care plan or the nurse manager communicated preferences to staff after care conferences. During observation on 9/19/24 at 11:45 a.m., R11 still had a gown on and laid in bed. During interview on 9/19/24 at 12:01 p.m., NA-C stated R11 was repositioned, but his morning cares were not completed. NA-C stated they were going to assist R11 with another staff member next. During interview on 9/19/24 at 12:13 p.m., NA-D stated residents' care plan, assistance needs, and functional maintenance programs were on their computer and a sheet in a binder, and staff documented cares completed in POC (Point of Care). NA-D stated R11 wore a gown all day and was not sure of family preferences. During observation on 9/19/24 at 2:29 p.m., R11 was in a gown and sat in wheelchair in room. During interview on 9/19/24 at 3:10 p.m., the director of nursing (DON) expected privacy curtain use when staff completed resident cares and was important to maintain the dignity of R11.	21805		

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21805	Continued From page 28 DON stated family preferences were verbalized and care planned. DON reviewed R11's care plan, NA sheet, and NA tasks and did not see an intervention specific to whether to dress R11 in a gown or personal clothes. DON expected residents to be dressed in day clothes, unless care planned, to maintain resident dignity. The facility was asked for a policy related to resident dignity and stated they did not have a policy on dignity. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to accurately reflect the individual need of each resident discussed above. It could also address other residents that may be at risk for the same concern. The facility could update policies and procedures, educate staff on these changes, and audit periodically to ensure the needs of resident(s) are maintained. Random audits for an amount of time determined by the quality assessment and performance improvement (QAPI) committee could ensure compliance. The administrator, DON, or designee could then take that information back to QAPI to assess need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 09/19/2024. At the time of this survey, The Villas At the Cedars was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 10/04/2024

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

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K 000	Continued From page 1	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

The Villas At The Cedars is a 3-story building with no basement. The original building was constructed in 1972 and was determined to be of Type I(332) Construction. In 1995 an addition was constructed to the west, and it was determined to be of TYPE I(332) Construction. This facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the

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K 000	Continued From page 2 corridors that is monitored for automatic fire department notification. The facility has a capacity of 107 beds and had a census of 79 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised	K 222		10/24/24

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K 222	Continued From page 3 automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install the delayed egress system per NFPA 101 (2012 edition), Life Safety Code sections 19.2.1 and 7.2.1.6.1.1 (4). This deficient finding could have an isolated impact on the	K 222	1. Delayed egress signage posted. 2. All residents have the potential to be affected by the deficient practice. All doors have a delayed egress sign posted on the door.	

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K 222	Continued From page 4 residents within the facility. Findings include: On 09/19/2024 at 11:00 AM, it was revealed by observation that the stairwell door near resident room 212 has a delayed egress system installed on it, but there is no signage posted on the door. An interview with the Administrator, two Regional Maintenance Directors, and the Facility Maintenance Director verified this deficient finding at the time of discovery.	K 222	3. Education will be provided to maintenance staff related to signage on delayed egress doors. 4. Audits will be completed by the Maintenance Director and/or designee related to signage on delayed egress doorways. Delayed egress door audits will be completed weekly for 4 weeks and then delayed egress door audits twice a month for 1 month and then 3 delayed egress door audits 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule are needed.	
K 345 SS=C	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 9.6.1.3, and NFPA 70, (2011 edition), National Electrical Code, sections 760.24, 760.53, and 300.4. This deficient finding could have a widespread impact on the residents within the facility.	K 345	1. Fire alarm wire going to the OS&Y valve was installed in conduit and protected. 2. All residents have the potential to be affected by the deficient practice. The fire alarm wires will be inspected to ensure they are in conduit or protected. 3. Education will be provided to	10/24/24

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K 345	Continued From page 5 Findings include: On 09/19/2024 at 11:26 AM, it was revealed by observation that the fire alarm wire going to the OS&Y valve for the sprinkler riser was not installed in conduit or protected. An interview with the Administrator, two Regional Maintenance Directors, and the Facility Maintenance Director verified this deficient finding at the time of discovery.	K 345	maintenance staff related to fire alarm wires being installed in conduit or protected. 4. Audits are not needed as the fire alarm wire was protected.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of	K 363		10/24/24

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K 363	Continued From page 6 unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5 and 19.3.6.3.10. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 09/19/2024 at 11:03 AM, it was revealed by observation that the door to resident room 221 was difficult to close and would not latch. Maintenance repaired the door during the survey. 2. On 09/19/2024 at 11:11 AM, it was revealed by observation that the door to the linen closet on the first floor near the spa would not latch and stay latched when closed. 3. On 09/19/2024 at 11:18 AM, it was revealed by observation that the door to resident room 101 would not latch due to a nurse cart in the hallway	K 363	1. 221's door was repaired so it would latch and stay latched. 2nd floor linen closet door was replaced so it would latch and stay latched. An outlet was installed on the outside of room 101 so staff could utilize the outlet to charge their laptops. 2. All residents have the potential to be affected by the deficient practice. 3. Education will be provided to maintenance staff related to doors properly latching and staying latched. 4. Audits will be completed by the Maintenance Director and/or designee related to doors latching and staying latched. 3 door audits will be completed weekly for 4 weeks and then 3 door audits twice a month for 1 month and then 3 door audits 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule is	

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K 363	Continued From page 7 being plugged into an outlet in the resident room and the cord was blocking the door. An interview with the Administrator, two Regional Maintenance Directors, and the Facility Maintenance Director verified these deficient findings at the time of discovery.	K 363	needed.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 09/19/2024 at 10:30 AM, it was revealed by observation that the smoke barrier wall on the second floor in the day room had holes in it above the T.V.	K 372	1. The smoke barriers were caulked to seal the holes above the ceiling on each unit. 2. All residents have the potential to be affected by the deficient practice. All smoke barriers in the facility were inspected for holes. 3. Education will be provided to maintenance staff regarding smoke barriers. 4. Audits will be completed by the Maintenance Director and/or designee related to smoke barriers. 3 audits will be	10/24/24

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K 372	Continued From page 8 2. On 09/19/2024 at 10:37 AM, it was revealed by observation that the smoke barrier on the first floor on the east side of the day room had large holes in it above the ceiling. 3. On 09/19/2024 at 10:40 AM, it was revealed by observation that the smoke barrier on the first floor on the south side of the day room had multiple large holes in it above the ceiling. 4. On 09/19/2024 at 10:44 AM, it was revealed by observation that the smoke barrier on the lower level on the east side of the day room had large holes in it above the ceiling. 5. On 09/19/2024 at 10:46 AM, it was revealed by observation that the smoke barrier on the lower level above the ceiling in the lounge on the south side had large holes in it. An interview with the Administrator, two Regional Maintenance Directors, and the Facility Maintenance Director verified these deficient findings at the time of discovery.	K 372	completed weekly for 4 weeks and then 3 audits twice a month for 1 month and then 3 audits 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule is needed.	
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do	K 374		10/24/24

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K 374	Continued From page 9 not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8 and 8.5.4.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 09/19/2024 at 11:09 AM, it was revealed by observation that the smoke barrier doors near resident room 120 did not fully close when testing the self-closing device. An interview with the Administrator, two Regional Maintenance Directors, and the Facility Maintenance Director verified this deficient finding at the time of discovery.	K 374	1. The smoke barrier door near room 120 was repaired. 2. All residents have the potential to be affected by the deficient practice. All smoke barrier doors were inspected to ensure they are in proper working condition. 3. Education will be provided to maintenance staff regarding smoke barrier doors and ensure the self-closing devise is fully functional. 4. Audits will be completed by the Maintenance Director and/or designee related to smoke barrier doors and the self-closing devise is fully functional. 3 audits will be completed weekly for 4 weeks and then 3 audits twice a month for 1 month and then 3 audits 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule is needed.	
K 711 SS=C	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept	K 711		10/24/24

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K 711	Continued From page 10 informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire safety plan per NFPA 101 (2012 edition), Life Safety Code, section 19.7.2.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/19/2024 between 09:30 AM and 12:00 PM, it was revealed by a review of available documentation that the fire safety plan that was provided at the time of the survey did not include the Transmission of the fire alarms to the fire department. An interview with the Administrator, two Regional Maintenance Directors, and the Facility Maintenance Director verified this deficient finding at the time of discovery.	K 711	1. The transmission of the fire alarms report was added to the fire safety plan. 2. All residents have the potential to be affected by the deficient practice. The transmission of the fire alarms report was added to the fire safety plan. 3. Education will be provided to maintenance staff regarding the fire safety plan. 4. Audits are not needed as the transmission of the fire alarms to the fire department was added to the fire safety plan binder.	
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected	K 712		10/24/24

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K 712	Continued From page 11 times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/19/2024 between 09:30 AM and 12:00 PM, it was revealed by a review of available documentation that the facility was not completing fire drills at varied times. Fire drills during first shift were conducted on 01/24/2024 at 10:00 AM, 04/11/2024 12:00 PM, 07/02/2024 at 10:00 AM, and 10/25/2023 at 01:45 PM. Second shift fire drills were conducted at 02/22/2024 at 05:00 PM, 05/11/2024 at 02:00 PM, 08/16/2024 at 04:00 PM, and 11/29/2023 at 02:00 PM. Two drills were conducted at 10:00 AM and three drills were conducted around 2:00 PM. An interview with the Administrator, two Regional Maintenance Directors, and the Facility Maintenance Director verified this deficient finding at the time of discovery.	K 712	1. A fire drill schedule was completed for the next year related to times of fire drills. 2. All residents have the potential to be affected by the deficient practice. A schedule was completed to ensure fire drills are conducted under varied times and conditions. 3. Education will be provided to maintenance staff regarding the timing of fire drills. 4. Audits will be completed by the Administrator and/or designee related to the timing of fire drills. 1 audits will be completed monthly for 3 months as fire drills are conducted on a monthly basis. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule is needed.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101	K 920		10/24/24

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K 920	Continued From page 12 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include:	K 920	1. The power strip was removed from the vending machine and the vending machine was plugged directly into the outlet. 2. All residents have the potential to be affected by the deficient practice. The vending machine was plugged directly into the outlet. 3. Education will be provided to maintenance staff regarding the usage of electrical adaptive devices. 4. Audits will be completed by the Maintenance Director and/or designee	

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K 920	Continued From page 13 On 09/19/2024 at 11:47 AM, it was revealed by observation the vending machines near the kitchen were plugged into a power strip. An interview with the Administrator, two Regional Maintenance Directors, and the Facility Maintenance Director verified this deficient finding at the time of discovery.	K 920	related to the usage of electrical adaptive devices. 3 audits will be completed weekly for 4 weeks and then 3 audits twice a month for 1 month and then 3 audits 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule is needed.	