Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 8, 2023

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

RE: CCN: 245187
Cycle Start Date: July 14, 2023

Dear Administrator:

On July 14, 2023, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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:

Nathan Schreier, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: nate.schreier@state.mn.us
Office: (651) 201-4348 Mobile (651) 392-2726

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 October 14, 2023 (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 January 14, 2024 (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
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245187	A. BUILDING _____ B. WING _____	C 07/14/2023

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 7/10/23 - 7/14/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) 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 7/10/23 - 7/14/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was or NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed The following complaints were reviewed with no deficiency issued. H51873610C (MN84786), H51873608C (MN87704), H51873606C (MN88710), H51873607C (MN90011), H51873609C (MN94925), H51873611C (MN94797), H51873612C (MN95058), H51878381C (MN89251), H51873464C (MN93520), H51873463C (MN93617, MN93649), H51878383C (MN89945), H51873532C (MN89064),	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/16/2023

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

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F 000	Continued From page 1 H51873613C (MN95205), H51873326C (MN94779), H51873503C (MN91103) AND The following complaints were reviewed. H51878382C (MN89224) with a deficiency issued at F580, F610, and F689 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 553 SS=E	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the	F 553		9/12/23

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F 553	Continued From page 2 plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide an opportunity to participate in care planning for 4 of 4 residents (R21, R29, R73, R56) reviewed for care conferences. Findings include: R21 R21's quarterly Minimum Data Set (MDS) dated 6/20/23, indicated she was cognitively intact, independent with bed mobility, transfers, and toileting, and had diagnoses of heart failure, diabetes, lung disease, anxiety, and depression. The MDS indicated there was not an active discharge plan in place for her to return to the community.	F 553	1.R21, R29, R73,R56 plan of care reviewed, scheduled care conference completed per policy. 2.All residents have the potential to be affected by the deficient practice and plan of care will be reviewed. 3.Education will be provided to nursing staff related to care planning and scheduling care conferences per policy. 4.Audits will be completed by the Administrator 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	

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F 553	Continued From page 3 R21's care plan discharge focus updated 7/20/22, indicated she wished to discharge to the community to live with her mother, and instructed staff to discuss discharge goals and status with resident regularly and update on progress. R21's MHM IDT Care Conference Form V-3 dated 2/9/23, indicated she was working with a relocation worker for transitional service with a goal to discharge back to the community and live with her mother. R21's medical record lacked evidence of additional care conferences. During interview on 7/12/23 at 8:51 a.m., R21 stated she had not had a care conference for a long time and was trying to discharge to be with her mother. R29 R29's quarterly MDS dated 5/26/23, indicated he was cognitively intact, independent with bed mobility, transfers, and toilet use, and had a diagnosis of lung disease. The MDS indicated he had an active discharge plan in place to return to the community. R29's care plan discharge focus updated 5/16/22, indicated he did not want to discharge to the community. R29's MHM IDT Care Conference Form V-3 dated 2/20/23, indicated he was a long-term resident at the facility and had no active discharge planning at that time.	F 553	needed.	

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F 553	Continued From page 4 R29's medical record lacked evidence of additional care conferences. During interview on 7/10/23 at 11:09 a.m., R29 stated he had not been invited to attend any care conferences for a several months. R73 R73's quarterly MDS dated 5/11/23, indicated he was moderately cognitively impaired, required extensive assistance of two staff for bed mobility, transfers, and toilet use, with a diagnosis of lung disease. The MDS indicated he had an active discharge plan in place to return to the community. R73's care plan dated 7/20/22, indicated he wished to return to home with his spouse and children, and instructed staff to discuss discharge status regularly with resident and family and update on progress. R73's MHM IDT Care Conference Form V-3 dated 1/31/23, indicated R73's family member (FM)-A attended the care conference, and R73 planned to discharge to home after therapy goals were met. R73's medical record lacked evidence of additional care conferences. During interview on 7/11/23 at 4:52 p.m., R73 stated he was unhappy at the facility and wanted to be discharged. He stated he did not recall his last care conference and wanted to be kept informed.	F 553		

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F 553	Continued From page 5 During interview on 7/12/23 at 10:41 a.m., R73's family member (FM)-A stated she and R73 were not happy at the facility and wanted to be discharged elsewhere but the facility was not helping them with discharge planning. She stated she attended a care conference in January, but the facility no longer had a social worker and she had not been invited to once since. As R73's spouse and emergency contact she expected to be invited and updated regarding his care. R56 R56's quarterly minimum data set (MDS) dated 5/14/23, indicated R56 was cognitively intact and did not exhibit behaviors. R56's diagnoses included debility (weakness), cardiorespiratory conditions, and renal conditions. R56 received dialysis. R56's MHM IDT Care Conference Form V-3 dated 2/3/23, indicated the form as "In Progress" but was not complete. The MHM IDT Care Conference Form V-3 dated 1/9/23, indicated the form as "Complete". During an interview on 7/10/23 at 11:04 a.m., R56 stated the facility no longer held meetings with him to discuss his cares or concerns. R56 stated the facility had recently removed a personal fan from his room, had concerns about call light times, food preferences, timing of receiving food trays, application of edema wraps, and weight loss. R56 had informed other staff about some of his concerns but did not attend a care conference to discuss his personal concerns. During interview on 7/13/23 at 12:31 p.m., social services representative (SSR) stated the facility	F 553		

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F 553	Continued From page 6 did not have a current social worker, and the new admissions coordinator (AC) was helping her cover the role. She stated she had been in the position for two weeks, was not a social worker, had five days of training, and social services was 'brand new' to her. She stated there was a list of residents who were overdue for quarterly care conferences, and they were behind in coordinating resident discharges. Upon review of their medical records, SSR confirmed R21's last care conference was on 2/9/23, R29's last care conference was on 2/20/23, R56's last care conference was 2/3/23, and R73's last care conference was on 1/31/23. SSR stated they all should have had another care conference in May 2023, and did not. She stated it was important to have care conferences to make sure the residents were getting the care they needed and could talk about issues, specifically surrounding discharge. During interview on 7/13/23 at 12:44 p.m., admissions coordinator (AC) stated when he met with residents to complete assessments, he asked them about when they were available for care conference and if they wanted family or guardian invited, but he did not schedule the meetings himself. He stated there was a list of residents who needed care conferences, but he did not add names to the list. He thought SSR scheduled the meetings, and care conference schedules were discussed in daily morning meetings. During interview on 7/13/23 at 12:54 p.m., director of nursing (DON) stated she expected care conferences to be completed per facility policy and federal regulations, on admission, quarterly, annually, and as needed to ensure	F 553		

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F 553	Continued From page 7 residents were aware of what was happening with their care, allow them to make decisions, and provide an opportunity to inform staff of their preferences. In an email dated 7/14/23 at 1:38 p.m., DON stated the facility did not have a care conference policy.	F 553		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to	F 565		9/12/23

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F 565	Continued From page 8 participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure resident council concerns were addressed or followed-up on in a timely manner. This had the potential to affect 12 residents who attended the resident council meetings in the previous six months. Findings include: Resident Council notes dated 1/27/23, indicated the following concerns: -The evening shift taking 45 minutes to an hour to answer call lights. -Building not clean. Resident Council notes dated 2/24/23, indicated the following concerns: -Residents waiting too long for medications. -Staff on personal phones while call lights are activated. -Gnats and bugs in the facility. Resident Council notes dated 3/31/23, indicated the following concerns: -Long wait times for meals. -Want educational-style activities that are learning based. -Call light times remain long. -Staff continue to talk on their personal phones.	F 565	1. Resident council agenda reviewed and new concern process implemented for follow up and resolution. 2. All residents have the potential to be affected by the deficient practice and resident council concerns will be documented and followed up on 3. Education will be provided to Therapeutic Recreation Director regarding following up with resident council concerns in a timely manner. 4. Audits will be completed by the Administrator and/or designee resident council concerns: 3 concerns weekly for 4 weeks and then 3 concerns twice a month for 1 month and then 3 concerns once 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 565	Continued From page 9 Resident Council notes dated 4/28/23, indicate the following concerns: -Call light wait times. -Ants in the second-floor dining room. -Dirty windows and floors. Resident Council notes dated 5/26/23, indicated the following concerns: -Gnats in the dining rooms and throughout the facility. -Dirty windows. -Light bulbs out in resident rooms and throughout the facility. -Call light times. -Staff on personal phones while cares are being done. Resident Council notes dated 6/23/23, indicated the following concerns: -Light bulbs out. -Long call light times. During a meeting with members of the resident council on 7/13/23 at 1:47 p.m., residents stated they met every month, and the director of therapeutic recreation (TRD) was always present as requested by the committee. The residents stated there were ongoing concerns regarding call light wait times, staff on their personal phones during working hours, various maintenance concerns including pests and burned-out light bulbs, the review of residents rights, and age and cognitively appropriate activities not being available. Residents stated there was no official process or follow up regarding the concerns they brought up during their monthly meetings. The TRD stated she did not consistently review resident rights during the resident council meetings and was unaware that should have	F 565		

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(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 565	Continued From page 10 been included in the meetings. The TRD stated she would occasionally discuss concerns brought up during the resident council meetings during the monthly Quality Assessment and Performance Improvement (QAPI) meetings, however, she was unaware of an official process for how the concerns were to be processed and addressed. The TRD further stated department heads may be notified verbally of concerns; however, there was no documentation to indicate resident council concerns were acknowledged or being addressed by the appropriate and corresponding departments. During an interview on 7/13/23 at 3:10 p.m., the director of nursing (DON) states concerns brought up during resident council may be discussed during the monthly QAPI meetings; however, that was not the official process for the concerns to be addressed. The DON further stated the TRD should notify the department responsible for the concern so it can be addressed properly. The DON stated she should have been notified of long call light times being a concern; however, she was unaware that was a concern. The DON further stated concerns brought up during resident council were not automatically treated as a grievance, depending on the type of concern it was, although the DON was unable to give examples of a concern that would be a grievance. The DON also stated staff on their personal phones was an ongoing issue; however, she did not have a plan for correcting it, nor had she conducted any audits to address the concern as she did not realize it was a "big problem." The facility Resident Council Bylaws undated, indicated the intent of the resident council was to	F 565		

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F 565	Continued From page 11 provide residents participation in suggesting improvements and assisting administration to provide better programs, surroundings, and services within the facility. The bylaws indicated concern forms were to be read and approved prior to each meeting, resident concerns were to be discussed and resident rights were to be reviewed. The facility Complaint and Grievance Procedure dated 12/22, indicated a grievance form was to be completed when a complaint had been expressed to any staff member, including when the concern was immediately addressed to show documentation the concern was resolved to the satisfaction of the person filing the complaint.	F 565		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in	F 580		9/12/23

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F 580	Continued From page 12 §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify resident representatives and/or a provider for 3 of 3 residents (R27, R39, R238) who had a change in condition and/or were involved in incidents resulting in potential or actual harm. Findings include:	F 580	1. R27, R39, and R238 plan of care reviewed, resident representative and provider updated regarding change in condition. 2. All residents with a change in condition have the potential to be affected by the deficient practice. Resident representatives and providers will be updated with changes in condition.	

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F 580	Continued From page 13 R27 R27's quarterly Minimum Data Set (MDS) dated 5/14/23, indicated R27 had severe cognitive deficits and was independent with eating. R27 had diagnoses that included high blood pressure, viral hepatitis C, dementia, behavioral and psychotic disturbance, anxiety, and paranoid schizophrenia. R27's Care Area Assessment (CAA) dated 8/11/22, indicated R27 triggered for cognitive loss/dementia, psychotropic drug use, pressure ulcers, and nutrition. R27's care plan dated 7/20/22, indicated R27 had severely impaired thought processes and needed assistance and supervision with all decision making. Interventions included communicating with R27's family/caregivers regarding R27's capabilities and needs. R27 also had a psychosocial well-being problem related to anxiety, schizophrenia, and borderline intellectual functioning. Interventions included increased communication with R27's family/caregivers regarding R27's care, including condition, and all changes and providing opportunities for R27's family/caregivers to participate in her care. R27 also had a communication problem with interventions that included discussing concerns with R27's family. R27's physician orders dated 4/4/23, indicated R27 was placed on a controlled carbohydrate (pre-diabetic) and no added sodium diet (to decrease/maintain blood pressure and/or fluid retention). R27's weight summary log indicated R27 had	F 580	3. Education will be provided to nursing staff related use updating resident representatives and providers with change of conditions. 4. Audits will be completed by the DON and/or designee related to residents who have change in condition. 3 audits will completed weekly for 4 weeks, 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.	

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F 580	Continued From page 14 maintained a weight between 138.1 pounds (lbs) and 142.6 lbs from 9/15/22 to 11/28/22. The weight summary further indicated the following weight changes in pounds (lbs): -11/28/22, 138.1 -12/1/22, 146.8 (a 6.3% gain 3 days) -12/2/22, 146.8 -1/4/23, 143.0 -2/1/23, 159.6 -2/4/23, 159.6 -3/1/23, 161.0 (a 16.58% gain in three months) -4/1/23, 162.8 -5/1/23, 166.8 -6/1/23, 173.6 (a 25.71% gain in six months) -7/1/23, 173.8 During an interview on 7/13/23 at 11:39 a.m., R27's family member (FM)-B stated she was unaware R27 had gained weight until she visited her recently. FM-B stated R27 had never weighed more than 105 lbs and she was concerned about R27's health. FM-B further stated no one from the facility had contact R27's family to discuss goals and/or interventions regarding R27's continued weight gain or notified them R27's had new orders for a pre-diabetic and a no added sodium diet. During an interview on 7/12/23 at 12:53 p.m., the registered dietician (RD) stated weight gain was a desirable goal for residents with a diagnosis of dementia and although R27 had a sudden weight gain in December 2022, that had steadily continued, resulting in R27 having current BMI of 29.8 (borderline obese), RD was not concerned and had not discussed R27's weight gain with R27's family or provider. The RD further stated she did not have a goal weight for R27.	F 580		

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F 580	Continued From page 15 During an interview on 7/12/23 at 3:11 p.m., nurse practitioner (NP)-A stated it was concerning that R27 continued to gain weight and the RD should have notified R27's family and worked with them to ensure R27 maintained a healthy weight. R39 A Nursing Home Incident Report (NHIR) dated 2/13/23, indicated R39 was seen holding hands with a male resident and entering his room. Upon entering the room, staff witnessed the male resident with his pants down, exposing himself to R39. R39's annual MDS dated 6/11/23, indicated R39 had severe cognitive deficits with diagnoses that included Alzheimer's disease, a cognitive communication deficit, and dementia with behavioral disturbances. R39's CAA dated 6/11/23, indicated R39 triggered for cognitive loss/dementia, communication, behaviors, and psychotropic drug use. R39's care plan dated 3/20/23, indicated R39 was dependent of staff for cognitive stimulation, social interaction, and well-being related to cognitive deficits and Alzheimer's disease. R39 was also at risk for alterations in behavior related to past trauma as reported by her son. Interventions included utilizing family for support and notify R39's responsible party of any changes in neurological status. During an interview on 7/11/23 at 12:28 p.m., family member (FM)-C stated he had not been notified of the incident between R39 and the male resident. FM-C stated he was concerned the	F 580		

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F 580	Continued From page 16 facility was not communicating concerns regarding R39's behavior, safety, and care to him, and would have wanted to be notified of the incident when it happened. R238 R238's discharge MDS dated 9/17/22, indicated R238 had intact cognition and required limited assistance of one staff for all activities of daily living (ADLs). R238's diagnoses included stomach cancer, cognitive communication deficit, and anarthria (a motor speech disorder causing a lack of control of the muscles used for speaking), muscle weakness, and difficulty walking. R238's care plan dated 9/16/23, indicated R238 was at a high risk for falls and had an actual fall on 9/16/23. Interventions included monitoring, documenting, and reporting any signs or symptoms of bruises or pain. R238's CAA dated 9/17/22, indicated R238 triggered for ADL function and falls. R238's physician orders dated 9/16/22, indicated R238 was on 2 milligrams (mg) of coumadin (a blood thinner). R238's progress note dated 9/16/23 at 5:56 p.m., indicated R238 had a witnessed fall at the front door of his room. R238 had no injuries and denied pain. R238's progress note dated 9/16/23 at 6:20 p.m., indicated R238 had developed a hematoma to the back of his head. The progress note lacked the provider or family had been updated regarding the change in R238's condition.	F 580		

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F 580	Continued From page 17 During an interview on 7/13/23 at 9:17 a.m., R238's family member (FM)-D stated she was unaware R238 had fallen while he was in the facility until after she brought R238 home against medical advice (AMA) less than 48 hours after his admission due to concerns over his care, and R238 told her. FM-D stated although the facility had called her to inquire about R238's whereabouts and if he was going to be returning to the facility, more than 8 hours after R238 had left, the facility still had not notified her that R238 had a fall, nor that he had developed a hematoma to the back of his head. During an interview on 7/13/23 at 10:47 a.m., nurse practitioner (NP)-B stated she had not been notified of R238's fall or that he had later developed a hematoma to the back of his head as a result of the fall. NP-B stated there were no notes to indicate any provider had been notified of R238's fall and NP-B would have expected the staff to update the provider any time a resident fell, especially if the resident struck their head and was on a blood thinner. During an interview on 7/14/23 at 9:30 a.m., the director of nursing (DON) stated she would expect resident family and/or representatives to be notified when an allegation of abuse was made and when a resident had a significant weight change. The DON also stated the provider and resident's family/representative should have been notified after a resident fell and updated immediately if the resident developed an injury as a result of the fall, especially if the resident was on a blood thinner. The facility Change in a Resident's Condition or	F 580		

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F 580	Continued From page 18 Status policy, undated, indicated staff were to notify a provider when there was an accident or incident involving a resident. The staff were also to notify the resident's representative within 24 hours of a resident who had an accident or incident that resulted in an injury.	F 580		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to minimize verbal resident-to-resident abuse for 1 of 1 resident (R30) reviewed who was verbally abused by another resident (R58) . Findings include: R30's significant change Minimum Data Set (MDS) assessment dated 4/12/23, indicated R30 was mildly cognitively impaired and identified diagnoses including stroke, depression,	F 600	1. R30 has been moved to a different room and is no longer roommates with R58. R30 currently feels safe in the facility and is happy with new placement. 2. All residents have the potential to be affected by the deficient practice. All reports of verbal abuse will be investigated and reported to the state agency to prevent ongoing abuse. 3. Education will be provided to employees on abuse prevention and reporting policy.	9/12/23

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F 600	Continued From page 19 post-traumatic stress disorder (PTSD), schizoaffective disorder (a mental health disorder characterized by a combination of symptoms including mood alterations), and anxiety. The MDS also identified R30 as "Black or African American" and R30 was dependent on staff for transfers, utilized a wheelchair but was unable to self-propel the chair. R30's care plan dated 4/21/23, identified R30 as a vulnerable adult and was at risk for abuse and/ or neglect. The plan directed staff to observed R30 for signs and symptoms of abuse and neglect and report to the facility social services or supervisor for appropriate follow up. R58's quarterly MDS assessment dated 6/29/23, identified a diagnosis of adjustment disorder with no mood or behaviors identified. R58 required extensive assistance with bed mobility and transfers and was unable to ambulate. The MDS assessment indicated R58 refused the cognitive evaluation but was able to independently make decisions. R58's care plan dated 3/8/21, indicated R58 had a history of yelling and swearing at staff as well as making racially inappropriate comments to staff since 2021. The plan directed staff to allow R58 to express feelings, however, the plan did not direct the staff as to appropriate interventions when verbal aggression was directed towards others. During observation on 7/10/23 at 9:50 a.m., R30, R58 and nursing assistant (NA)-F were in the shared room of R30 and R58. R58 directed NA-F to "Take [R30] somewhere else, get him out of here." NA-F assisted R30 out of the room and	F 600	4. Audits will be completed by the DON and/or designee regarding abuse allegations. 3 residents will be audited weekly for 4 weeks, 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 600	Continued From page 20 into a lounge by the nurse's station. During an interview on 7/10/23 at 11:07 a.m., R30 stated his roommate (R58) is "always talking about [R30's] black skin." R30 further indicated that R58 did not like "blacks" and R30 stated he was "upset" by R58's comments about skin color. During observation on 7/10/23 at 11:44 a.m., R30 was seated in the activity room. R30 was observed to cry with tears rolling on his face and informed activity aide (AA)-A he wanted to leave the facility. AA-A encouraged R30 to participate in the activity, however, AA-A did not discuss with R30 the events which were causing R30 to cry. Review of R30's clinical record included an Associated Clinic of Psychology progress note from a psychotherapy session with licensed social worker (LSW)-A dated 4/17/23, indicated R30 had expressed concerns regarding racial slurs directed at R30 by R58. LSW-A indicated R30 may benefit from a room change. A second Associated Clinical of Psychology progress note by LSW-A dated 5/22/23, indicated R30 continued to report racial slurs directed at R30 by R58 and identified R30 may benefit from a room change. During an interview on 7/12/23 at 1:00 p.m., LSW-A stated R30 had expressed concerns regarding racial slurs being directed toward R30 by R58. LSW-A had recommended to separate R30 and R58, however, the facility had not acted upon the recommendations. On 7/12/23 at 1:10 p.m., the facility administrator stated she was unaware of concerns related to	F 600		

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F 600	Continued From page 21 R58 racial slurs towards R30 and would investigate immediately. During an interview on 7/12/23 at 1:29 p.m., NA-A stated R58 often got upset and made frequent racial slurs towards people of color. During an interview on 7/12/23 at 1:32 p.m., licensed practical nurse (LPN)-A stated R58 voiced racial slurs towards people of color. LPN-A stated R58 frequently voiced racial remarks in the presence of R30, who would tell R58 to stop. During observation on 7/12/23, at approximately 2:00 p.m. staff were observed moving R58 's belongings out of R30's room and into a new room. During an interview on 7/13/23 at 10:14 a.m., registered nurse (RN)-A stated R58 had a history of making racial slurs in the presence of people of color. RN-A confirmed R58 made racial remarks in R30's presence. At times R30 would appear unbothered, but other times R30 would "get upset and try to intervene." RN-A indicated the facility licensed social worker (LSW-B), a former employee, reviewed notes from psychotherapists and followed up with any recommendations. RN-A was aware LSW-A had recommended a room change for R30 and RN-A had offered a room change. However, R30 declined a room change. Upon review of R30's medical record, RN-A confirmed the clinical record lacked documentation related to declination of a room change. During an interview on 7/13/23 at 1:49 p.m., the director of nursing (DON) stated R58 had a history of being verbally abusive towards others.	F 600		

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F 600	Continued From page 22 The DON was unaware R58's racial remarks were affecting R30. R30's response to R58's comments should have been reported to the State Agency and investigated. The DON was also unaware of the Associated Clinic of Psychology recommendation to move R30 out of R58's room. This information should have been discussed by the management team (interdisciplinary team). In addition, if R30 had been offered a room change and declined, this should have been documented in the clinical record. In order to minimize verbal abuse towards R30, the DON confirmed R58 was moved out of R30's room on 7/12/23. The Abuse Prevention/Vulnerable Adult Plan dated 2/2/23, indicated the facility was to ensure residents were not subjected to abuse from other residents and that the facility would identify and remedy any abusive situations.	F 600		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State	F 610		9/12/23

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	245187	A. BUILDING _____ B. WING _____	C 07/14/2023

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 610	Continued From page 23 Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to thoroughly investigate an allegation of resident-to-resident sexual abuse for 1 of 1 residents (R39). Findings include: A Nursing Home Incident Report (NHIR) dated 2/13/23, indicated R39 was seen holding hands with a male resident and entered his room. Upon entering the room, staff witnessed the male resident with his pants down, exposing himself to R39. An Investigation Report dated 2/13/23, indicated staff witnessed R39 and R55 holding hands as they walked down the hall and into R55's room. Upon entry to R55's room, staff saw R55 with his pants down, exposing his genitals to R39. The report indicated R39 was not interviewable. The report indicated R55 reported he was in his bathroom and when he came out, R39 was in his room, although staff witnessed them walk down the hall and into his room together. R55 was placed on a 1:1 for monitoring, although R55 had been on a 1:1 at the time of the occurrence related to previous inappropriate behaviors. The report indicated an investigation was initiated and ongoing. Review of an interview on 2/13/23 at 2:16 p.m., by licensed practical nurse (LPN)-C, who was also the unit coordinator, indicated when R39 was asked if she felt safe, R39 responded "sometimes." The interview also indicated when	F 610	1.R39 and R55 do not recall have no recollection of the events. Both residents have been referred to ACP for psych services. R55 has been moved off of the memory care unit and placed in a private room. R55 has a wandergaurd bracelet and current 1:1 continues. Moving R55 off of the memory care unit will minimize risk of others wandering into his room. Discharge planning is ongoing. 2.All residents have the potential to be affected by the deficient practice. All allegations of sexual abuse will be thoroughly investigated and interventions put into place. 3.Education will be provided to IDT related to investigation an allegation of resident-to-resident. 4.Audits will be completed by Administrator and/or designee related to investigations of allegations and interviews are completed thoroughly. 6 residents will be audited weekly for 4 weeks, 6 residents twice a month for 1 month, and then 6 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 610	Continued From page 24 R39 was asked if she felt scared, R39 responded "sometimes," and when asked how she was feeling, R39 responded "alright I guess." No further information or intervention was documented regarding R39's responses. R39 R39's annual MDS dated 6/11/23, indicated R39 had severe cognitive deficits with diagnoses that included Alzheimer's disease, a cognitive communication deficit, and dementia with behavioral disturbances. R39's CAA dated 6/11/23, indicated R39 triggered for cognitive loss/dementia, communication, behaviors, and psychotropic drug use. R39's care plan dated 3/20/23, indicated R39 was dependent of staff for cognitive stimulation, social interaction, and well-being related to cognitive deficits and Alzheimer's disease. R39 was also at risk for alterations in behavior related to past trauma as reported by her son. Interventions included utilizing family for support and notify R39's responsible party of any changes in neurological status. R39's care plan lacked documentation referencing the incident with R55 or possible interventions to ensure it did not reoccur and R39 felt safe. R55 R55's quarterly Minimum Data Set (MDS) dated 5/27/23, indicated R55 had severe cognitive deficits and a Patient Health Questionnaire (PHQ-9) score of 19, indicating R55 had major depression that was moderately severe. The MDS also indicated R55 was independent with all activities of daily living (ADLs). R55 had diagnoses that included major depression,	F 610		

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F 610	Continued From page 25 dementia without behavioral disturbance, cognitive communication deficit, and adjustment disorder with mixed anxiety. R55's Care Area Assessment (CAA) dated 2/24/23, indicated R55 triggered for delirium, cognitive loss/dementia, communication, and psychotropic drug use. R55's care plan dated 2/13/23, indicated R55 exposed himself to a female resident (R39). Updated interventions indicated resident was on a 1:1. During an interview on 7/14/23 at 8:11 a.m., nursing assistant (NA)-F stated he was sitting with a nurse at the nurse's station on 2/13/23, when he saw R55 and R39 walk into R55's room, at the end of the hallway, together. NA-F stated R55 was on a 1:1 for previous inappropriate behavior; however, NA-F did not know where the staff member was and could not recall who was supposed to be monitoring R55 at the time. NA-F stated he alerted the nurse and together they went to R55's room. NA-F stated upon entering R55's room, R55 had his pants down and his penis was erect, while he was attempting to pull R39's pants down. NA-F stated R39 appeared to be an active participant and did not appear frightened. NA-F stated he and the nurse then separated the residents and reported the incident to LPN-C. NA-F further stated R55 remained on a 1:1 and no new interventions were implemented. During an interview on 7/14/23 at 8:26 a.m., LPN-B stated although she was not working at the time, she was aware of the incident between R55 and R39. LPN-B further stated R55 had been on a 1:1 when the incident occurred, and no	F 610		

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F 610	Continued From page 26 other interventions were implemented after the incident. During an interview on 7/11/23 at 12:28 p.m., family member (FM)-C stated he had not been notified of the incident between R39 and R55. FM-C stated he was concerned the facility was not communicating concerns regarding R39's behavior, safety, and care to him, and would have wanted to be notified of the incident when it happened. During an interview on 7/12/23 at 10:27 a.m., the psychiatrist (PMD) stated although he had seen R55 since the incident had occurred between R55 and R39, the staff had not notified him of the incident or requested a referral for him to speak with R55 or R39. During an interview on 7/14/23 at 9:09 a.m., the director of nursing (DON) stated R55 had been on a 1:1 since before she started working at the facility in November 2022, and didn't know what else to do to decrease his behaviors. The DON stated she was aware R55 had occasionally refused his medications but was unaware of a pattern or reason for the refusals, although that could have influenced his negative behaviors. The DON further stated because R55 was on a 1:1 at the time of the incident between he and R39, she would have expected the staff member assigned to monitor him, to be with R55 at all times and intervene immediately if R55 was displaying possibly inappropriate behaviors. The DON stated she did not know where the staff assigned to monitor R55 was at the time of the incident and could not recall who was assigned to him at that time the incident occurred.	F 610		

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F 610	Continued From page 27 Although staff who were working at the time of the incident were interviewed, no other residents were interviewed regarding their feelings of safety, if they had similar experiences or had witnessed the incident or similar incidents from R55. Although R55 was on a 1:1 at the time of the incident, there was no investigation into where the staff member was who was supposed to be monitoring R55 on the 1:1. No new interventions were implemented and R39's care plan was not updated to reflect the incident or possible interventions to ensure similar incidents did not recur. The investigation also lacked indication of the staff regarding abuse and/or abuse prevention. The facility Abuse Prevention/Vulnerable Adult Plan policy dated 2/2/23, indicated the physician and family were to be notified of an allegation of abuse and an ongoing investigation. The investigation Team (including but not limited to the administrator, DON, nurse manager, and social worker) were to review all incident reports no later than the next working day following the incident. An investigation was to begin immediately, and staff were to take immediate actions to prevent further abuse and ensure resident safety. A summary identifying trends was to be submitted to QAPI (Quality Assurance and Performance Improvement) committee at least quarterly. Staff were to provide ongoing support and counseling to the resident and family as needed and ensure proper follow-up communication to practitioners and family as applicable. The Interdisciplinary Team (IDT) was to review residents requiring behavior interventions and develop individualized care plans to ensure residents were not subjected to aggressive incidents.	F 610		

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F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after	F 645		9/12/23

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F 645	Continued From page 29 being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure a level I Pre-Admission Screening and Resident Review (PASRR) level I was completed and accurate prior to admission to the facility for 1 of 1 residents (R27). Findings include: R27's quarterly Minimum Data Set (MDS) dated 5/14/23, indicated R27 had severe cognitive	F 645	1. R27 PASRR level I and resident review has been uploaded to resident□s medical record. 2. All residents who are residing at facility have the potential to be affected by the deficient practice. All residents will have a PASRR level I and resident review uploaded into their medical record. 3. Education will be provided to social services related to PASRR requirements	

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F 645	Continued From page 30 deficits with diagnoses that included borderline intellectual functioning, behavioral and psychotic disturbance, and paranoid schizophrenia. R27's hospital discharge summary dated 7/14/22, indicated R27 had the following diagnoses: -6/13/07, paranoid schizophrenia -5/14/07, schizoaffective disorder R27's PASRR dated 7/14/22, indicated "the PAS [PASRR] was not final until the lead agency sends the documentation to the nursing facility." In addition, the results indicated R27 did not have a current diagnosis of a mental illness and lacked indication R27 had a diagnosis with paranoid schizophrenia. During an interview on 7/13/23 at 3:30 p.m., the social services representative (SSR) stated she was filling in as a social worker (SW) because the previous SW left the facility in June 2023. The SSR stated when a resident admitted to the facility, admissions would scan in the resident's PASRR. The SSR would then review the PASRR to determine if any further action was necessary. The SSR stated she did not realize R27's PASRR was not complete and was not sure what the process was to fix the error. The facility Pre-Admission Screening (PASRR) policy dated 6/23/23, indicated social services would check for a PASRR and ensure the resident qualified for long-term care according to medical assistance (MA) standards, prior to the admission of the resident to the facility. The initial screening would be completed by the referring agency and the Senior Linkage Line would send a letter indicating the resident met the requirements for admission to the facility.	F 645	upon admission. 4. Audits will be completed by the social service and/or designee for admission PASRR level I and review. 3 residents will be audited weekly for 4 weeks, 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 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess, update, and implements a care plan for 1 of 1 resident (R55) who continued to have behaviors with no new interventions. Findings include:	F 657	1. R55□s care plan has been updated with new interventions. R55 is sees ACP for psych services. R55 has been moved off of the memory care unit and placed in a private room. R55 has a wandergaurd bracelet and current 1:1 continues. Moving R55 off of the memory care unit will minimize risk of him leading others or	9/12/23

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F 657	Continued From page 32 R55's quarterly Minimum Data Set (MDS) dated 5/27/23, indicated R55 had severe cognitive deficits and a Patient Health Questionnaire (PHQ-9) score of 19, indicating R55 had major depression that was moderately severe. The MDS also indicated R55 was independent with all activities of daily living (ADLs). R55 had diagnoses that included major depression, dementia without behavioral disturbance, cognitive communication deficit, and adjustment disorder with mixed anxiety. R55's Care Area Assessment (CAA) dated 2/24/23, indicated R55 triggered for delirium, cognitive loss/dementia, communication, and psychotropic drug use. R55's care plan dated 2/13/23, indicated the following behaviors: -12/1/2022: R55 was found with a female resident (R31) in his bed. R55 was already on a 1:1 and no new interventions were initiated. -12/10/22: R55 had verbal and physical aggression towards a male resident. Updated interventions indicated educating staff. -1/13/23: R55 had a physical altercation with another resident. No injuries noted. Updated interventions indicated physically guiding R55 when re-directing. -1/28/23: R55 had a physical altercation with a male resident. No injuries noted. Updated interventions indicated moving other resident's chair out of the high-trafficked area, removing R55 from the area, 1:1 support as needed, encouraging R55 to verbally express his emotions and deep breathing. -2/13/2023 R55 exposed himself to a female resident (R39). Updated interventions indicated resident was on a 1:1; although R55 had been on	F 657	others wandering into his room. Discharge planning is ongoing. 2. All new admissions and residents have the potential to be affected by the deficient practice. Residents who have behaviors will be comprehensively assessed and have care plans updated and interventions implemented. 3. Education will be provided to IDT related to comprehensively assesseing, updating care plans and implementing intervention for those with ongoing behaviors. 4. Audits will be completed by the Administrator and/or designee related to assesseing, updating care plans and implementing intervention for those with ongoing behaviors. 3 residents will be audited weekly for 4 weeks, 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 657	Continued From page 33 a 1:1 since at least November 2022, prior to the listed behaviors occurring. During an interview on 7/11/23 at 5:19 p.m., nursing assistant (NA)-F stated R31 had walked into R55's room that morning and when NA-F who was on a 1:1 with R55, attempted to intervene, R55 became angry saying she [R31] was his "lady" and pushed NA-F against the wall. A maintenance worker intervened and NA-F was unharmed. During an interview on 7/14/23 at 8:11 a.m., NA-F stated although R55 had "always" been on a 1:1, he continued to have behaviors including inappropriate sexual behaviors with female residents and aggression towards male residents. NA-F stated he was at the nurse's station when he witnessed R55 walk into his room with R39 on 2/13/23. NA-F stated although R55 was on a 1:1, NA-F noticed there were no staff accompaning R55. NA-F went to R55's room and saw his standing, holding his erect penis and attempting to help R39 pull her pants down. NA-F further stated the only intervention to decrease R55's behaviors had "just been the 1:1", and no other interventions had been implemented to decrease R55's behaviors. During an interview on 7/14/23 at 8:26 a.m., licensed practical nurse (LPN)-B stated R55 would become aggressive with male residents and was "into the women." LPN-B stated R55 had been on a 1:1 for a "long time" and there were no other interventions in place regarding his behaviors. LPN-B further stated, although the female residents sought out R55 and appeared to enjoy his company, R55 would become aggressive toward staff when they attempted to	F 657		

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F 657	Continued From page 34 redirect the female residents, calling them his ladies. LPN-B stated when she has asked what the long-term plan was for R55, management told her they are "working on it" but nothing changes and R55 continues to have inappropriate behaviors with no new interventions other than a 1:1. During an interview on 7/14/23 at 9:09 a.m., the director of nursing (DON) stated R55 had been on a 1:1 since before she started working at the facility in November 2022, and didn't know what else to do to decrease his behaviors. The DON stated she was aware R55 had occasionally refused his medications but was unaware of a pattern or reason for the refusals, although that could have influenced his negative behaviors. The facility Care Planning policy dated 1/6/22, indicated the facility will develop and implement a comprehensive individualized care plan. The personalized care plan will identify problem areas and their causes and, develop interventions that are targeted and meaningful to the resident. The policy further indicated the care plan was to be modified and updated as the resident's condition and care needs changed.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely	F 677	1. R25 care plan reviewed related to toileting plan. R25 is being toileted per his	9/12/23

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THE VILLAS AT THE CEDARS	7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426

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F 677	Continued From page 35 assistance with incontinence cares for 1 of 3 residents (R25) who were dependent upon staff for incontinence cares. Findings include: R25's significant change Minimum Data Set (MDS) assessment dated 4/15/23, indicated R25 had significant cognitive impairment and diagnoses including encephalopathy (brain damage) and hemiparesis (weakness of one side of the body). The MDS indicated R25 required extensive assistance of two staff for bed mobility, transfers, toileting and was unable to ambulate. R25 was always incontinent of bowel and bladder. R25's care plan directed staff to assist R25 to the toilet after a meal for a bowel program as well as to check and change incontinent brief before and after meals and as needed to prevent skin breakdown. An undated, nursing care assignment sheet indicated R25 was to be assisted with toileting every 2-3 hours. The care plan further indicated R25 was on a bowel program that directed staff to assist resident to the toilet after meals to promote continent bowel movements. During a continuous observation on 7/12/23 from 7:19 a.m. to 11:06 a.m. (3 hours and 40 minutes) the following observations were conducted: At 7:19 a.m., R25 was sitting in a wheelchair in front of a television in the common area. At 8:20 a.m., R25 was wheeled to the dining room and assisted with breakfast.	F 677	care plan. 2. All Residents who have a toileting plan have the potential to be affected by the deficient practice. All residents with toileting plan were reviewed. All residents are being toileted per their care plan. 3. Education will be provided to IDT, Nurses and TMAs, and NARs related to following toileting and incontinence care plans. 4. Audits will be completed by the DON and/or designee related to following toileting plan and incontinence cares. 3 audits will be completed weekly for 4 weeks, 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.	

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F 677	Continued From page 36 At 9:24 a.m., R25 was assisted from the dining room by nursing assistant (NA)-C and placed back in front of the television in the common area. At 10:57 a.m., NA-B stated the last time R25 was toileted was when R25 was assisted out of bed this morning. NA-B could not recall the time R25 was assisted out of bed. At 11:06 a.m. NA-B and NA-E transferred R25 to bed. At 11:09 a.m., NA-B and NA-E removed R25's incontinent brief. The brief was saturated with urine and feces. At 11:15 a.m., NA-E stated R25 was to be assisted with incontinence cares every 2-3 hours and was to be assisted to the toilet after meals to promote bowel movements. NA-E confirmed R25 had last been assisted when R25 was assisted out of bed prior to 7:19 a.m. a total of greater than 3 hours and 40 minutes earlier. During an interview on 7/12/23 at 11:30 a.m., registered nurse (RN)-A stated for a resident with a care planned 2-3-hour toileting plan, over three hours without toileting assistance was too long. RN-A also stated R25 should have been toileted as soon as possible after a meal to allow R25 to evacuate bowels. During an interview on 7/13/23 at 1:40 p.m., the director of nursing (DON) stated R25 was to receive assistance with incontinence cares every 2-3 hours and assisted to the toilet after each meal to stimulate bowel movements as directed	F 677		

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F 677	Continued From page 37 by the care plan. The Activities of Daily Living (ADLs)/Maintain Abilities Policy dated 3/31/23, directed staff to ensure residents are given the appropriate treatment and services to maintain or improve his or her ability to carry out activities of daily living. The policy further indicated the facility would provide care and services that included elimination/toileting assistance.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess, develop, and implement meaningful and engaging activities for 2 of 2 residents (R27, R39) in the memory care unit. This had the potential to affect all 20 residents residing in the memory care unit. Findings include: R27's annual Minimum Data Set (MDS) dated 6/11/23, indicated R27 had severe cognitive	F 679	1. R27 and R39 were assessed and care plans were developed to provide meaningful activities. 2. All residents in memory care unit have the potential to be affected by the deficient practice. All residents were assessed and care plans updated with activity preferences. Activities to provide activities based on care plans. 3. Education will be provided to TRD and staff related to assessing, care planning and implementing activities meaningful to	9/12/23

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F 679	Continued From page 38 deficits, was independent with eating, required extensive assistance with all other activities of daily living (ADLs) and was independent with walking. R27's Care Area Assessment (CAA) dated 6/11/23, indicated R27 triggered for cognitive loss/dementia, communication, behaviors, psychotropic drug use, and falls. R27's Customary Routine and Activities assessment dated 7/20/22, indicated it was "very important" to R27 to listen to music, be around animals, do her favorite activities, go outside, and to participate in religious activities. It was "somewhat important" for R27 to do activities in groups. The assessment further indicated, although R27 had severe cognitive deficits, R27's family was not included in the assessment. R27's care plan dated 12/13/22, indicated R27 used yelling and physical behaviors to communicate feelings. Interventions included offering R27 an independent activity such as coloring. The care plan also indicated R27 had an activity deficit related to dementia and was involved in weekly activities. Interventions included ensuring activities were compatible with R27's physical and mental capabilities, and known interests and preferences, and were age appropriate. Interventions also indicated providing activities of interest that empowered R27 by allowing choice, discussion and self-expression. R27 also had an ADL deficit related to dementia and paranoid schizophrenia. Interventions included conversing with R27 during cares and to stop and talk with R27 as staff pass by her. R27 also had impaired cognitive function related to impulsive wandering. Interventions included	F 679	each resident. 4. Audits will be completed by the TRD and/or designee related to individual activity preferences. 3 residents will be audited weekly for 4 weeks, 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 679	Continued From page 39 asking family about past lifestyle, capabilities, and needs. R27 also had a potential for psychotropic drug adverse drug reaction (ADR). Interventions included providing R27's favorite activity. R27's Activity Participation Review dated 2/10/23, indicated R27 was involved in scheduled activities and sensory groups and enjoyed music and faith-based groups. No further comments, goals or interventions were documented. R27's physician orders dated 7/14/22, indicated R27 could participate in activities as tolerated. During an interview on 7/13/23 at 11:39 a.m. family member (FM)-B stated staff had "never" asked what kinds of activities R27 would enjoy and thought keeping R27 active and engaged in activities would help decrease some of R27's inappropriate and/or unhealthy behaviors. R39 R39's annual Minimum Data Set (MDS) dated 6/11/23, indicated R39 had severe cognitive deficits, was independent with eating, required extensive assistance for all other activities of daily living (ADLs) and although not steady, walked independently. An activity assessment was not completed. R39's Customary Routine and Activities assessment dated 6/10/22, indicated it was "very important" to R39 to listen to music, be around animals, do her favorite activities, and go outside. It was "somewhat important" to do activities in groups and to participate in religious activities. The assessment further indicated, although R39 had severe cognitive deficits, R39's family was	F 679		

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F 679	Continued From page 40 not included in the assessment. No further activity assessment was documented. R39's Care Area Assessment (CAA) dated 6/11/23, indicated R39 triggered for cognitive loss/dementia, communication, behaviors, psychotropic drug use, and falls. R39 care plan dated 3/13/23, indicated R39 was dependent on staff for activities, cognitive stimulation, social interaction, and well-being. Interventions included ensuring activities were compatible with R39's physical and mental capabilities, and known interests and preferences, and were age appropriate. Interventions also included activities that do not involve overly demanding cognitive tasks. The care plan also indicated R39 had an alteration in behaviors related to Alzheimer's disease. Interventions included staff offering positive interactions and attention with R39, stopping to talk with R39 as passing by and redirecting R39 to activities of interest. R39's Activity Participation Review dated 6/13/23, indicated R39 was dependent on staff for activities. R39 walked the unit and would observe activities. No further comments, goals or interventions were documented. R39's physician orders dated 5/24/22, indicated R39 could do activities as tolerated. During an interview on 7/12/23 at 10:06 a.m., FM-C stated although he was R39's family representative, he had never been asked what R39's interests were or what activities she may enjoy.	F 679		

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F 679	Continued From page 41 During a continuous observation on 7/10/23 from 9:52 a.m. to 10:18 a.m., R27 was sitting in a chair in the dining room with a baseball hat pulled down, her head on her arm, appeared to be sleeping. At 10:15 a.m., activities assistant (AA)-B took some residents outside; however, no activities, music, TV, or other stimulation was provided for the residents who remained in the dining room, including R27 and R39. During a continuous observation on 7/11/23 from 4:49 p.m. to 5:24 p.m., multiple residents, including R27, were sitting in the dining room at cleared off tables, staff started a movie with random cats playing and a light music background. No staff interaction with residents and no other tactile or sensory activities available. At 5:24 p.m., staff put a children's Walt Disney movie on. Staff continue to stand against the wall without interacting with residents or offering other activities. During an observation on 7/12/23 at 7:45 a.m., multiple residents including R27 and R39 were sitting in the dining room at cleared off tables, jazz/blues music playing, no other tactile or sensory activities available for residents. Staff standing against the wall, no interaction with residents. During a continuous observation on 7/13/23 from 7:12 a.m. to 8:25 a.m., more than eight residents sitting in the dining room at cleared off tables waiting for breakfast. Nursing assistant (NA)-F was standing against a wall holding a clipboard. No music was playing, the TV was not on, and staff were not interacting with the residents including R39. At 7:14 a.m., licensed practical nurse (LPN)-C who was also the unit manager,	F 679		

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F 679	Continued From page 42 turned on the radio. No other activities, stimulation, or interaction was provided to the residents. At 8:25 a.m., some towels in a bucket, and a stuffed animal was placed on the tables in front of some residents; however, staff did not interact with the residents or ask them if that was what interested them. During an interview on 7/14/23 at 8:26 a.m., LPN-B stated "once in a while" there was an activity staff on the unit but it was not daily. LPN-B stated "usually" only the radio or the TV was on for stimulation but the residents were not "kept busy" like LPN-B had seen at other facilities and thought more activities would help to decrease some of the residents' behaviors. LPN-B was not aware of activity assessments and did not know what each resident's interests or preferences were. During an interview on 7/12/23 at 12:11 p.m., AA-B stated she worked mostly in the memory care unit. AA-B stated she was responsible for transporting all of the residents to and from scheduled activities; therefore, the activity may get started late and be cut short. AA-B was also concerned about bringing residents outside because nursing staff did not go outside to assist her and therefore, she could not include residents who walk and wander, although they would enjoy the activity. AA-B stated "most of the day" the residents just watch TV and there was no other interaction or stimulus for the residents in the memory care unit. During an interview on 7/12/23 at 11:21 a.m., the therapeutic recreation director (TRD) stated activity assessments should have been completed quarterly or when a resident had a	F 679		

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F 679	Continued From page 43 significant change. The TRD also stated if a resident was unable to answer the questions on the assessment, staff should have contacted the resident's family/representative to find out what activities the resident would be interested in. The TRD further stated the facility focused on sensory based activities such as music and food. The TRD also expected staff to interact with the residents when no group activities were scheduled and to offer residents items or activities of interest as it may help decrease aggressive or inappropriate behaviors. During an interview on 7/14/23 at 8:54 a.m., the director of nursing (DON) stated she expected staff to interact with the residents and offer the residents activities and other sensory stimulating objects when organized activities were not being done. The DON also stated staff should be assessing the resident and asking their family/representative to find out what their interests were and individualizing activities. The DON further stated more interaction and activities may help to decrease aggressive behavior and engage residents who wander to "stave off the boredom." The DON also stated it was important to offer activities, movies, and music that was age appropriate and culturally based. During an interview on 7/12/23 at 10:27 a.m. psychiatrist (PMD) stated he had not seen activities being done in the locked memory care unit and believed offering activities to the residents in the memory care unit would "definitely be helpful" to increase resident mood and possibly decrease negative behaviors. During an interview on 7/12/23 at 3:11 p.m. nurse practitioner (NP)-A stated staff should be offering	F 679		

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F 679	Continued From page 44 residents activities and interaction throughout the day and nursing staff should be assisting to bring residents to activities to ensure their safe transport and ability to participate and keep to the activity schedule, especially in the memory care unit. The facility Activity Program policy dated 6/18, indicated activities were provided to support the well-being of residents and to encourage independence and community interaction. Activities were to be based on comprehensive assessments and individual resident preferences.	F 679		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete a comprehensive fall analysis to determine root cause, develop and implement resident-centric interventions, and monitor for post-fall complications following a fall for 1 of 1 residents (R73) reviewed for falls. In addition, the facility failed to ensure the environment was free from hazards to prevent falls and accidents for 4 of 4 residents (R39, R27, R31, R55) in the locked, memory care unit.	F 689	1. R73□s fall was root caused and care plan updated new interventions. For R39, R27, R31, and R55 the fan/environmental hazard was removed from the hallway. 2. All residents have the potential to be affected. All falls will be root caused, care planned, and interventions put into place. All residents will be monitored post fall for complications. Hallways will be kept free of unnecessary environmental hazards. 3. Education will be provided to IDT and nursing staff regarding root causing falls,	9/12/23

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F 689	Continued From page 45 Findings include: R73's quarterly MDS dated 5/11/23, indicated he was moderately cognitively impaired, required extensive assistance of two staff for bed mobility, transfers, and toilet use, was always continent of urine, frequently incontinent of bowel, and not on a toileting program. He had a diagnosis of lung disease. The MDS indicated he did not have any falls since admission or most recent assessment. R73's Medical Diagnosis list included diabetes, weakness, and bilateral below-the-knee leg amputations (BKA). R73's Falls Care Area Assessment dated 4/3/23, indicated he was at risk for falls due to changes in mobility and medications, and included interventions of encourage to wear non-skid shoes, ensure call light is in reach, and keep area free of clutter. The Villas at the Cedars Incidents by Incident Type report dated 7/12/23, indicated R73 had falls on 3/21/23, 4/3/23, 6/21/23, 6/28/23. A progress note dated 3/3/23, indicated R73 had an unwitnessed fall after attempting to self-transfer. A progress note dated 4/3/23, indicated R73 had an unwitnessed fall and slipped out of bed onto the floor. A progress note dated 6/21/23, indicated R73 was found on the floor between the wheelchair and bed after attempting to self-transfer. A progress note dated 6/28/23, indicated R73	F 689	updating care plans and implementing interventions. They will also be educated on monitoring for post fall complications. All staff will be educated on keeping hallways clear of unnecessary environmental hazards that may contribute to falls. 4. Audits will be completed by the DON and/or designee related to root causing, updating care plans, implementing interventions, and monitoring for post fall complications. 3 resident audits to be completed weekly for 4 weeks, then 3 residnts twice a month for 1 month, and then 3 residents 1x for 1 month. 3 audits will also be completed weekly for 4 weeks, then 3 audits twice a month for one month, and then 3 audits once a month for one month to ensure hallways are free of unnecessary environmental hazards that may contribute to falls. 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 689	Continued From page 46 was found sitting on the ground in the front parking lot after one wheel on his wheelchair rolled off the curb as he was waiting for transportation. R73's falls care plan updated 6/28/23, indicated he was at risk for falls due to generalized weakness and BKA, and had a history of attempting to self-transfer without staff assistance. A progress note dated 7/9/23, indicated staff responded to R73's bathroom call light and found him with his knees on the pedals of his wheelchair and hanging onto bathroom wall grab bars. R73 reported hitting his head on the wall and new tingling in his fingers. R73 was sent to the hospital for evaluation. R73's hospital Emergency Center Note dated 7/9/23, indicated R73 had a fall, hit his head on the wall, and had a persistent headache, neck pain, and numbing and tingling in his fingers. Radiology notes indicated he had moderate-severe head trauma. R73's medical record lacked a post-fall analysis, additional fall prevention interventions, and post-fall skin assessment documenting bruising after his fall on 7/9/23. During interview on 7/10/23 at 1:17 p.m., R73 stated he was in the bathroom the previous day and put the call light on, but nobody came to help. He stated he tried to transfer himself, fell, and hit his head on the wall as his arms struck the wheelchair. R73 was transported to the hospital for evaluation. He stated his head really hurt and felt like his eyes were "popping out". R73 had	F 689		

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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

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F 689	Continued From page 47 numerous large bruises on both arms and hands with a small bandage on his left hand where he stated he was bleeding. During observation and interview on 7/11/23 at 4:51 p.m., R73 was in his wheelchair toward the nursing desk. He stated his head was throbbing and his eyes hurt, and he wanted to get something for pain. During interview on 7/12/23 at 10:41 a.m., with R73 and family member (FM)-A, FM-A stated R73 used his call light to get to the bathroom and "held it" as long as he could, but if nobody came, he got himself there because "who wants to poop their pants?" R73 stated it could be up to 30 minutes for a call light response, so he transferred himself and sometimes fell. FM-A stated he had a recent fall and ended up in the hospital and had a follow up appointment scheduled with a neurosurgeon due to concussion, new tingling in his hands, and a continuous headache from bumping his head. During interview on 7/13/23 at 8:37 a.m., nursing assistant (NA)-E stated if a resident was at risk for falls it was identified on the care plan, or she found out in report or by seeing mats on the floor. During interview on 7/14/23 at 9:49 a.m., NA-B stated she knew who was at risk for falls by looking in the care plan. She stated R73 would tell them when he needed to use the toilet, so staff made sure to help him when he asked. She stated she heard R73 fell but was unaware of any new interventions. During interview on 7/14/23 at 9:57 a.m., registered nurse (RN)-D stated she was informed	F 689		

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F 689	Continued From page 48 of residents who were at higher risk for falls through verbal report. She stated she kept an eye on those who had dementia or could not do anything for themselves and checked on them every hour or two to make sure they were safe. If someone fell, she completed a risk management form and wrote a progress note but did not update the care plan. During interview on 7/14/23 at 10:02 a.m., RN-A stated nurses completed fall risk assessments on admission, quarterly, and annually, and implemented interventions to keep residents safe. She stated if a resident had a fall the nurses were supposed to complete a risk management form to present the scene and to identify the immediate intervention put in place to prevent the resident form falling again. The IDT team met Monday through Friday and reviewed the details to identify the cause of the fall and adjusted interventions as needed based on the situation. She stated she expected a new intervention after each fall depending on why they fell to try to prevent future falls. RN-A stated R73 was impulsive, and he refused to follow most of the interventions. She confirmed there had not been any follow-up on the fall of 7/9/23, no new interventions were added to the care plan, and the risk management form was not complete. During interview on 7/14/23 at 10:29 a.m., director of nursing (DON) stated fall risk assessments were completed quarterly and as needed, and interventions were put in placed based upon risk. She stated after a resident fell, the nurse completed a risk management form and put an immediate intervention in place to attempt to prevent additional falls. The interdisciplinary team (IDT) reviewed the fall	F 689		

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F 689	Continued From page 49 within the next day or two and completed a root-cause analysis to ensure the interventions were appropriate. She stated not everyone knew how to complete the risk management forms correctly, so sometimes the associated note did not pull over to the progress notes, but it was important to add and communicate the new intervention to keep the resident safe and ensure follow-up. During an observation on 7/10/23 at 9:09 a.m., upon entering the locked memory care unit, a large, blue, industrial floor drying fan was on the floor near the dining room and facing down the hallway toward the resident rooms. The fan was approximately six to eight inches from the wall and plugged in with an industrial, yellow cord that was more than six feet long. The fan was on; however, the floor did not appear wet and there was no caution sign to indicate it was. R39 R39's annual MDS dated 6/11/23, indicated R39 had severe cognitive deficits, was independent with eating, required extensive assistance for all other activities of daily living (ADLs) and although not steady, walked independently. R39's diagnoses included osteoarthritis (a degenerative joint disease), Alzheimer's disease, muscle weakness, reduced mobility, seizures, weakness, and dementia with behavioral disturbances. R39's Care Area Assessment (CAA) dated 6/11/23, indicated R39 triggered for cognitive loss/dementia, communication, behaviors, psychotropic drug use, and falls. R39's care plan dated 12/16/22, indicated R39	F 689		

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F 689	Continued From page 50 was dependent on staff for activities, cognitive stimulation, and social interaction. R39 had an alteration in behaviors related to wandering into rooms and taking items. Interventions included staff intervening as needed to protect the rights and safety of others, to divert R39's attention and remove her from an unsafe situation or area. R39 was at low risk for falls related to an unsteady gait and a preference to walk barefoot. Interventions included ensuring R39 wore appropriate footwear while walking and providing a safe environment free from clutter. R39's Fall Review Evaluation dated 6/10/23, indicated R27 was totally incontinent and unable to independently come to a standing position. Interventions included R27 wearing "grippy" socks. During an observation on 7/10/23 from 9:44 a.m., to R39 walked from the dining room down the hallway, past the fan that was plugged in and running. At 9:49 a.m., R39 walked back down the hallway to the dining room, past the fan on the floor. During an observation on 7/11/23 at 4:40 p.m., R39 walked from the end of the hallway to the fan which was plugged in and running. R39 picked up the industrial fan cord that was over six feet long and began to wrap the cord around the hall railing various times. R39 attempted to pick up the fan but was unable to lift it, so she pushed it with her barefoot against the wall. At 4:43 p.m., R39 entered the unoccupied resident room next to the fan and closed the door behind her; no staff were present or witnessed R39 enter the room. At 4:46 p.m., licensed practical nurse (LPN)-C was notified of R39's whereabouts. LPN-C removed	F 689		

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F 689	Continued From page 51 R39 from the empty room and walked her to her room, passing the fan. At 4:54 p.m., R39 returned to the fan in the hallway and began playing with the cord again, draping it over the fan and wrapping in around the railing while the fan was plugged in and turned on. No staff witnessed or intervened. R27 R27's annual Minimum Data Set (MDS) dated 6/11/23, indicated R27 had severe cognitive deficits, was independent with eating, required extensive assistance with all other activities of daily living (ADLs) and was independent with walking. R27's diagnoses included dementia, paranoid schizophrenia, cataracts, anxiety, repeated falls, muscle weakness, cognitive communication deficits, osteoarthritis (a degenerative joint disease), seizures, abnormality of gait, and unsteadiness on her feet. R27's Care Area Assessment (CAA) dated 6/11/23, indicated R27 triggered for cognitive loss/dementia, communication, behaviors, psychotropic drug use, and falls. R27's care plan dated 7/20/22, indicated R27 had severe cognitive impairment as evidenced by impulsively wandering in and out of resident rooms and sitting self on the floor. R27 was also at moderate risk for falls and had four falls in six weeks between 5/7/23 and 6/18/23. Interventions included anticipating R27's needs, offering a walker, and escorting R27 from the dining room after meals. R27 also used an antidepressant with interventions that included monitoring for increased sleepiness and walking with R27 in the hallway.	F 689		

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F 689	Continued From page 52 During a continuous observation on 7/13/23 at 7:20 a.m. to 8:05 a.m., R27 walked from her room down the hallway, past the fan on the floor, to sit in the dining room. At 8:00 a.m., R27 went back down the hall to visit with R55 at the end of the hallway, past the fan on the floor. At 8:04 a.m., R27 returned to the dining room, walking past the fan on the floor. The fan was plugged in but not on. R31 R31's quarterly MDS dated 4/16/23, indicated R31 had moderate cognitive deficits, was independent with bed mobility, transfers, and eating, was steady at times while walking independently, and required extensive assistance for all other ADLs. R31's diagnoses included seizures, Alzheimer's disease, osteoarthritis, weakness, difficulty walking, rheumatoid arthritis (an autoimmune disorder causing pain and inflammation to the joints and damage to eyes, skin, and organs), traumatic brain injury, and unsteadiness with an abnormal gait. R31's CAA dated 1/14/23, indicated R31 triggered for delirium, cognitive loss/dementia, communication, behaviors, falls, psychotropic drug use, and pain. R31's care plan dated 9/29/22, indicated R31 had limited mobility due to rheumatoid arthritis with a goal to remain free from fall related injuries. R31 was also a moderate to high risk for falls due to poor safety judgement. Interventions included providing a safe environment free from clutter. R31's Fall Review Evaluation dated 4/14/23,	F 689		

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F 689	Continued From page 53 indicated R31 had a lurching, swaying, or slapping gait and used short discontinuous or shuffling steps. During an observation on 7/10/23 at 9:30 a.m., R31 wandered continuously from the dining room, down the hallway passing the fan on the floor multiple times. The fan was plugged in and running although the floor did not appear to be wet and there was no caution sign present. During an observation on 7/11/23 at 4:31 p.m., R31 walked from the dining room, down the hallway, past the fan that was plugged in and running although the floor was dry. R31 turned around and walked back down the hallway, holding onto the railing, leaning to walk around the fan while still holding onto the railing, and returned to the dining room. R55 R55's quarterly MDS dated 5/27/23, indicated R55 had severe cognitive deficits and was independent with all ADLs. R55 walked independently using a walker although R55 was seen using only a cane to ambulate. R55's diagnoses included dementia, left-sided weakness due to a stroke, low back pain, cognitive communication deficit, difficulty walking with unsteadiness, muscle weakness, and anxiety. R55's CAA dated 2/24/23, indicated R55 triggered for delirium, cognitive loss/dementia, communication, psychotropic drug use, and falls. R55's care plan dated 3/11/22, indicated R55 was at risk for falls related to poor safety judgement.	F 689		

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F 689	Continued From page 54 Interventions included providing a safe environment with floors free from spills and clutter. R55's Fall Review Evaluation dated 5/24/23, indicated R55's vision was impaired and was occasionally oriented to person and place. During an observation on 7/13/23 at 7:25 a.m., R55 walked down the hallway using his cane, from his room, past the fan on the floor, to the dining room. At 7:25 a.m., R55 and R39 walked back down the hallway together, past the fan. During an interview on 7/14/23 at 9:03 a.m., the director of nursing (DON) stated she did not know why the fan was in the hallway and stated it was a fall hazard for the residents who walked in the unit and a safety hazard for R39 who was playing with the cord. The DON further stated if the floors weren't wet, the fan should have been removed to avoid residents from falling or incurring any other injuries. The Fall Prevention and Management policy dated 2/2021, indicated facility staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. Nursing staff complete an incident review and analysis and observe for delayed complications of fall for 72 hours, including symptoms of pain, swelling, bruising and note their presence.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance	F 692		9/12/23

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F 692	Continued From page 55 CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to comprehensively assess, develop, and implement interventions for ongoing and unplanned weight gain for 1 of 1 residents (R27) who had sudden and continued weight gain. Findings include: The Centers for Disease Control and Prevention (CDC) "About Adult BMI" article dated 6/3/22, indicated a body mass index (BMI) for adults (over the age of 20 years) of 25.0 to 29.9 was categorized as overweight, and a BMI of 30.0 and above was obese. The article also indicated	F 692	1. R27 was comprehensively assessed and interventions were developed and care planned related to weight. 2. All residents who have ongoing and unplanned weight gain have the potential to be affected. Residents with unplanned weight gain were assessed and intervention implemented and care planned. 4. Education will be provided to IDT related to ongoing and unplanned weight gain and need for assessment, care planning and intervention implementation. 5. Audits will be completed by the DON	

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F 692	Continued From page 56 people who were obese were at an increased risk for many disease and health conditions including but not limited to: death, high blood pressure, diabetes, heart disease, stroke, osteoarthritis (a degenerative joint disease), mental illnesses (depression, anxiety) and a low quality of life. R27's quarterly Minimum Data Set (MDS) dated 5/14/23, indicated R27 had severe cognitive deficits and was independent with eating. R27 had diagnoses that included viral hepatitis C, dementia, anxiety, high blood pressure, depression, borderline intellectual functioning, osteoarthritis, behavioral and psychotic disturbance, anxiety, and paranoid schizophrenia. R27's Care Area Assessment (CAA) dated 8/11/22, indicated R27 triggered for cognitive loss/dementia, psychotropic drug use, pressure ulcers, and nutrition. R27's care plan dated 7/14/22, indicated R27 had severely impaired thought processes and needed assistance and supervision with all decision making. Interventions included communicating with R27's family/caregivers regarding R27's capabilities and needs. R27 also had a psychosocial well-being problem related to anxiety, schizophrenia, and borderline intellectual functioning. Interventions included increased communication with R27's family/caregivers regarding R27's care, including condition, and all changes and providing opportunities for R27's family/caregivers to participate in her care. R27 also had a communication problem with interventions that included discussing concerns with R27's family. The care plan further indicated R27 had a potential nutritional risk related to chewing/swallowing difficulties. Interventions	F 692	and/or designee related to unplanned weight gain and assessment, care planning, and implementation of interventions. 3 residents will be audited weekly for 4 weeks, 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 692	Continued From page 57 included monitoring food intake and monthly weights. R27's weight summary log indicated R27 had maintained a weight between 138.1 pounds (lbs) and 142.6 lbs from 9/15/22 to 11/28/22. The weight summary further indicated the following weight changes in pounds (lbs): -11/28/22, 138.1 -12/1/22, 146.8 (a 6.3% gain 3 days) -12/2/22, 146.8 -1/4/23, 143.0 -2/1/23, 159.6 -2/4/23, 159.6 -3/1/23, 161.0 (a 16.58% gain in three months) -4/1/23, 162.8 -5/1/23, 166.8 -6/1/23, 173.6 (a 25.71% gain in six months) -7/1/23, 173.8 R27's dietary progress notes were as follows: -1/6/23, R27 triggered for an excessive weight gain. Interventions included discontinuing R27's supplemental shake from twice a day to once a day. -5/25/23, R27 triggered for excessive weight gain. Weight gain desirable due to the potential for weight loss related to a diagnosis of dementia. No signs or symptoms (s/s) of edema. No new interventions documented. -6/13/23, R27 triggered for excessive weight gain. No s/s of edema. R27 was at risk for weight loss as disease progresses. Weight is above IBW (ideal body weight) of 124 lbs. No new interventions documented. -7/6/23 R7 triggered for excessive weight gain. UBW (usual body weight) had been 130 lbs with an IBW of 120lbs. R27 is overweight as evidenced by her BMI; however, R27 appears at	F 692		

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F 692	Continued From page 58 an appropriate weight for her height and age. Honor food choices. No new recommendations. R27's physician orders dated 4/4/23, indicated R27 was placed on a controlled carbohydrate (pre-diabetic) and no added sodium diet (to decrease/maintain blood pressure and/or fluid retention). R27's Associated Clinic of Psychology (ACP) note dated 6/14/23, indicated R27 had "gained a substantial amount of weight" while at the facility. During an interview on 7/13/23 at 11:39 a.m., R27's family member (FM)-B stated she was unaware R27 had gained weight until she visited her recently. FM-B stated R27 had "never" weighed more than 105 lbs and she was concerned about R27's health. FM-B further stated no one from the facility had contact R27's family to discuss goals or interventions regarding R27's continued weight gain or that R27 had been placed on a pre-diabetic and a no added sodium diet. During an interview on 7/12/23 at 12:53 p.m., the registered dietician (RD) stated weight gain was a desirable goal for residents with a diagnosis of dementia and although R27 had a sudden weight gain on 12/1/22, that steadily continued, resulting in R27 having a current BMI of 29.8 (borderline obese), RD was not concerned and had not discussed R27's weight gain with R27's family or provider. The RD further stated neither the family or provider had voiced concerns regarding R27's weight gain to her although the provider had ordered a no added sodium and controlled carbohydrate (with a diagnosis of pre-diabetes) diet on 4/4/23. The RD further stated there was	F 692		

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(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 692	Continued From page 59 no goal weight for R27 and was unable to determine how much more weight R27 would gain before it became a concern. During an interview on 7/12/23 at 11:50 a.m., the culinary director (CD) stated he was unaware of R27's recent weight gain. During an interview on 7/12/23 at 10:47 a.m., the psychiatrist (PMD) stated he had noticed R27 had gained a "substantial amount of weight" recently and he had decreased her Remeron medication as that can cause appetite stimulation. The PMD further stated, although R27 had been on the medication upon admission to the facility on 7/14/22, and her weight gain didn't occur until months later, he was trying to see if there was anything he could do to cease the weight gain. The PMD also stated, although discontinuing the medication could help stop or slow the weight gain, it would not necessarily result in weight loss and, would have been more beneficial to have discontinued it when R27 was at a healthier weight, around 150 lbs. During an interview on 7/12/23 at 3:11 p.m., nurse practitioner (NP)-A, the supervisor for R27's NP who was unavailable for interview, stated R27's continued weight gain was concerning, and the RD should have notified R27's family and worked with them to ensure R27 maintained a healthy weight. NP-A stated although R27 had been on a feeding tube and had previous concerns for low weight, gaining too much weight and becoming obese would result in additional health concerns including diabetes and joint issues, adding, a high BMI was "not good for anyone." NP-A further stated she was aware R27 liked to eat and when she asked for snacks, staff would give them to	F 692		

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	245187	A. BUILDING _____ B. WING _____	C 07/14/2023

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

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F 692	Continued From page 60 her, but because of R27's cognitive deficits, staff should have been offering R27 healthier snacks and/or activities to help her maintain a healthy weight and continue to be able to ambulate independently. The facility Weight Protocol policy dated 10/12, indicated weight changes of +/- 3 lbs warranted a re-weight within 24 hours. Residents were to be weighed monthly; however, at the discretion of the nursing staff in conjunction with the culinary director, provider, and registered dietician, residents at high risk for nutritional compromise may be weighed more frequently. Residents at high risk included: unintended weight gain of more than 5% in one month; 7.5% in three months; 10% in six months. A resident's physician and responsible party were to be notified of any unintended weight gain as soon as the staff was made aware. KEY ELEMENTS OF NONCOMPLIANCE To cite deficient practice at F692, the surveyor's investigation will generally show that the facility failed to do one or more of the following: o Accurately and consistently assess a resident's nutritional status on admission and as needed thereafter; o Identify a resident at nutritional risk and address risk factors for impaired nutritional status, to the extent possible; o Identify, implement, monitor, and modify interventions (as appropriate), consistent with the resident's assessed needs, choices, preferences, goals, and current professional standards of practice, to maintain acceptable parameters of nutritional status;	F 692		

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THE VILLAS AT THE CEDARS	7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426

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F 692	Continued From page 61 o Notify the physician as appropriate in evaluating and managing causes of the resident's nutritional risks and impaired nutritional status; o Identify and apply relevant approaches to maintain acceptable parameters of residents' nutritional status, including fluids; o Provide a therapeutic diet when ordered; o Offer sufficient fluid intake to maintain proper hydration and health.	F 692		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to adequately maintain	F 700	1. R73□s bed has been switched out and bedrails have been readjusted and	9/12/23

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F 700	Continued From page 62 bed rails to minimize the risk of entrapment for 1 of 1 resident (R73) reviewed who had bed rails attached to their bed. Findings include: R73's quarterly MDS dated 5/11/23, indicated he was moderately cognitively impaired and required extensive assistance of two staff for bed mobility, transfers, and toilet use. The MDS indicated he did not use bed rails. R73's safety device care plan focus dated 10/7/23, indicated he had bilateral amputation of both legs below the knee and used right and left grab bars (bed rails). It instructed staff to evaluate safety device use quarterly and as needed, including risk/benefits, alternatives, need for ongoing use, and reason for safety device. R73's MHM Bed Mobility Device Evaluation dated 5/12/23, indicated R73 requested bed rails and had ¼ rails in upright position used as grab bars to assist with transfers to maintain independence. A progress note dated 4/3/23, indicated R73 slid off the bed on to the floor and got up by himself. A progress note dated 6/21/23, indicated R73 was found on the floor between his wheelchair and the bed, and R73 stated he tried to transfer himself but forgot to lock the wheelchair. During interview and observation on 7/10/23 at 1:17 p.m., R73 stated his bed rails were loose, and if he leaned on the left one it would "come down". He stated they were not helpful and asked many people to have them fixed, but with all the agency staff it was not relayed to the right people.	F 700	tightened by maintenance. 2. All residents who use grab bars have the potential to be affected by the deficient practice. All bedrails/grab bars have been reviewed to ensure they are in compliance and being properly maintained on the bed. 3. Education will be provided to maintenance staff related to maintaining grab bars/bedrails and also to nursing staff regarding reporting any bedrail issues to maintenance. 4. Audits will be completed by the Maintenance Director and/or designee to ensure grab bars/bedrails are properly installed and maintained. 3 rail audits completed weekly for 4 weeks, then 3 bedsd twice a month for 1 month, and then 3 beds 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 700	Continued From page 63 During observation on 7/12/23 at 7:56 a.m., both of R73's bed rails were loose and easily moved forward and backward, and left to right. Colored stickers were on both the bed frame and the rails to identify where they should be placed. The bed rail brackets were attached on the frame approximately six inches further toward the head of the bed than the stickers indicated. The right rail was approximately an inch from the bed frame, while the left was approximately four inches from the frame. During interview on 7/12/23 at 11:25 a.m., nursing assistant (NA)-B stated residents needed an order for side rails, and if they needed to be tightened or fixed they put an order into their computer system for maintenance. She stated she had not noticed R73's bed rails were loose. During interview on 7/12/23 at 11:27 a.m., NA-C stated if she noticed something needed to be repaired, she placed a request in the computer system and let the nurse or supervisor know. She did not know R73's bed rails were loose. During observation and interview on 7/12/23 at 11:31 a.m., registered nurse (RN)-B stated if a resident requested bed rails she completed an assessment, updated the nurse manager, and notified maintenance via telephone or computer so they could install the rails. She stated it was important to ensure they were installed correctly to avoid harm. RN-B evaluated R73's bed rails and stated the were "not looking correct at all". She stated the were too "slack" and "very wobbly", and the left one was not against the bed frame. She stated he needed to use them to get up and to encourage independence, and it was	F 700		

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F 700	Continued From page 64 important to ensure they were not loose to prevent him from falling or getting caught up in them. RN-B stated maintenance installed the rails, but staff should have followed up to make sure they were on correctly, and then physically reassessed and tested the rails with the resident at bedside quarterly. On 7/12/23 at 11:40 a.m., registered nurse (RN)-A stated bed rails were installed per therapy recommendation or resident request. She stated a provider order was obtained, resident needs and safety were assessed, and a work order was placed for maintenance to add them to the bed. She stated she checked the function and safety of the rails when she completed the quarterly assessment and placed a work order to get them fixed if needed. RN-A tested R73's bed rails and confirmed they were both loose. She stated she would ask maintenance to tighten them up and was unsure if maintenance regularly tested the bed rails. She stated they needed to be installed correctly and securely for resident safety and to ensure residents could not fall through and cause damage to the residentd head/neck or even death. During interview on 7/123/23 at 12:57 p.m., director of nursing (DON) stated if bed rails were requested for bed mobility nursing completed an assessment for need and safety and discussed the risks and benefits with the resident prior to installation of bed rails. She stated staff should be checking bed equipment for functionality regularly. During interview on 7/12/23 at 12:33 p.m., regional director of maintenance (RDM) stated nurses placed a work order to have bedrails	F 700		

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F 700	Continued From page 65 installed and maintenance staff installed the rails appropriate to the type of bed. He stated they did not have a guide to determine which rails went with which bed, but some only went on one type, and he was unsure if different manufacturers rails could be put on other beds, or if they were all bed specific based on method of attachment. He stated the director of maintenance (DM) performed a monthly inspection of bed rails to ensure nothing was wrong with them, and if staff noticed something was wrong, they should inform maintenance. Upon review of R73's bed rails RDM stated they were a little loose, and the bed style was very old, and "that's how these [bed rails] have always been". RMD stated the facility did not have manufacturer's instructions and specifications for the bed, confirmed the bed rails were approximately six inches further toward the head of the bed than the stickers identified, and the left rail was further away from the frame than the right rail. During interview on 7/12/23 at 12:48 p.m., DM stated R73's bed rails were loose, and stated he put them further back toward the head on the bed frame because there was a nut and bolt in the way preventing him from placing them where the sticker was. The facility Logbook Documentation dated 7/12/23, instructed maintenance to inspect connectors on rails and tighten as necessary, and tighten, adjust, or replace any parts that are loose, show signs of wear, or are missing. The Work History Report dated 7/12/23, indicated the monthly facility bed rail inspections were completed on 6/25/23, 4/8/23, 3/24/23, and 1/30/23.	F 700		

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F 700	Continued From page 66 In an email dated 7/14/23 at 1:38 p.m., DON stated the facility did not have a bed rail policy.	F 700		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a safe, functional environment for 1 of 1 resident (R73) reviewed whose bed did not lock and bed controller did not work. R73's quarterly MDS dated 5/11/23, indicated he was moderately cognitively impaired, required extensive assistance of two staff for bed mobility, transfers, and toilet use. The MDS indicated he did not have any falls since the most recent assessment. R73's Medical Diagnosis list included bilateral below-the-knee leg amputations (BKA), diabetes, weakness, and lung disease. R73's Falls Care Area Assessment dated 4/3/23, indicated he was at risk for falls due to changes in mobility and medications. A progress note dated 3/3/23, indicated R73 had an unwitnessed fall after attempting to self-transfer. A progress note dated 4/3/23, indicated R73 had	F 921	1. R73 bed was removed and replaced with another working bed. 2. All residents have the potential to be affected by the deficient practice. All beds have working controllers and wheels that lock properly. All resident beds that lock are properly assessed, inspected, and assured the locking mechanism is working appropriately. 3. Education will be provided to maintenance staff and IDT related to proper maintenance of beds. Education provided to I staff regarding process to notify maintenance of beds that are not working properly. 4. Audits will be completed by the Maintenance Director and/or designee related to ensure resident beds are working properly. 3 beds will be audited weekly for 4 weeks, then 3 beds twice a month for 1 month, and then 3 beds 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	9/12/23

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F 921	Continued From page 67 an unwitnessed fall and slipped out of bed onto the floor. A progress note dated 4/5/23, indicated R73's fall was reviewed by the interdisciplinary team, and included maintenance notified to assess function of resident's bed. A progress note dated 6/21/23, indicated R73 was found on the floor between the wheelchair and bed after attempting to self-transfer. During observation and interview on 7/10/23 at 1:17 p.m., R73 stated he had fallen from the bed while trying to self-transfer in the past. During observation on 7/12/23 at 7:56 a.m., and 10:38 a.m., R73's bed was easily moveable, and the bed locking feet were elevated approximately one inch from the ground. The wheel locks were in the locked position. During interview on 7/12/23 at 11:25 a.m., nursing assistant (NA)-B stated staff entered maintenance requests into the computer system if something required fixing. She stated NAs normally locked resident beds when they were not actively working with a resident, but she did not notice R73's bed was not locked. During interview on 7/12/23 at 11:27 a.m., NA-C stated beds remained locked, and if something wasn't working, she let the nurse a supervisor know. She was not aware R73's bed did not lock. During interview on 7/12/23 at 11:31 a.m., registered nurse (RN)-B stated beds should be locked when staff are not working with the resident, and she put maintenance requests into	F 921	needed.	

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F 921	Continued From page 68 the computer or notified the manager if repairs were needed. RN-B verified R73's bed was not locked and moved easily by hand across the floor. She stated it was important to ensure the bed was locked to prevent falls. During interview on 7/12/23 at 11:40 am., RN-A stated resident beds should be locked in place. Upon review of R73 bed, she verified the locking feet were not all the way to the ground and she was able to move the bed. RN-A attempted to use the bed controller, but it did not function, and the locks on the wheels were not working to prevent movement. She stated she needed to get maintenance to come to fix it or get a different bed for R73's safety since he had a history of falls. During interview on 7/13/23 at 12:57 p.m., director of nursing (DON) stated beds should be locked for resident safety, especially if a resident got out of bed independently. She stated staff should be identifying equipment for lack of functionality and reporting it to get it fixed. During interview on 7/12/23 at 12:33 p.m., with regions director of maintenance (RDM) and director of maintenance (DM), RDM stated all the nursing staff had access to the computer to enter maintenance requests, and if they noticed anything wrong, they were supposed to enter it into the system. RDM and DM both observed R73's bed and confirmed it moved and could not be locked. They observed the control box and verified a six-inch section of the cord was partially stripped of its outer protective sheath exposing the colored wires underneath. The red wire was severed, rendering the box dysfunctional. RDM stated the beds were inspected monthly by DM to	F 921		

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F 921	Continued From page 69 ensure they were in good working and identified R73's bed was "so old they don't make parts for them". He stated the bed was taken out of service for resident safety. A policy regarding bed maintenance was requested but not provided.	F 921		

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	245187	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/12/2023**

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THE VILLAS AT THE CEDARS	**7900 WEST 28TH STREET** **SAINT LOUIS PARK, MN 55426**

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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 07/12/2023. 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 | 08/17/2023

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

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

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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
K 000	Continued From page 2 The facility has a capacity of 112 beds and had a census of 86 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain clear path of egress per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, 19.2.3.4, and 7.1.10.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/12/2023 at 11:20 AM, it was revealed by observation that there was a bed frame stored in the exit corridor near resident room 229. An interview with the Administrator, the Maintenance Director, and two Regional Maintenance Directors verified this deficient finding at the time of discovery.	K 211	Bed frame removed from hallway. All residents have the potential to be affected by the deficient practice. All hallways have been audited to ensure a clear path of egress. Education will be provided to maintenance staff related to remove non-medical equipment from the hallway. Audits will be completed by the Maintenance Director and/or designee related to hallway clearance. 3 bed audits will be completed weekly for 4 weeks and then 3 bed audits twice a month for 1 month and then 3 hallway clearance 1x for	9/12/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245187	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/12/2023**

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K 211	Continued From page 3	K 211	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 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)	K 321		9/12/23

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	245187	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/12/2023**

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K 321	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous storage rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3 and 7.2.1.8.1. This deficient findings could have an isolated impact on the residents within the facility. Findings include: On 07/12/2023 at 10:39 AM, it was revealed by observation that resident room 27 was re-purposed as a storage room and the door did not have a self-closing device installed on it. An interview with the Administrator, the Maintenance Director, and two Regional Maintenance Directors verified this deficient finding at the time of discovery.	K 321	Self-closing device was installed on storage room door. All residents have the potential to be affected by the deficient practice. All doors have been audited to ensure self-closing device is fully functional on doors. Education will be provided to maintenance staff related to self-closing devices on doors. Audits will be completed by the Maintenance Director and/or designee related to self-closing devices are fully functional on doors to shut and latch. 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 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed	K 341		9/12/23

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	245187	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/12/2023**

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K 341	Continued From page 5 at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to install the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1 and 9.6.1.3, and NFPA 72 (2010 edition), The National Fire Alarm and Signaling Code, section 17.14.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/12/2023 between 09:30 AM and 12:00 PM, it was revealed by observation that all of the manual pull stations for the fire alarm system in the facility are mounted higher than the maximum 48". An interview with the Administrator, the Maintenance Director, and two Regional Maintenance Directors verified this deficient finding at the time of discovery.	K 341	The manual pull stations for the fire alarm system were removed and 1 pull station was added to each nurse□s station between 42 and 48. All residents have the potential to be affected by the deficient practice. Education will be provided to maintenance staff related to fire alarm pull station Audits will not be necessary after installation of pull stations as pull stations are fixed permanently to the wall.	
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING	K 372		9/12/23

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K 372	Continued From page 6 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 an isolated impact on the residents within the facility. Findings include: 1. On 07/12/2023 at 10:32 AM, it was revealed by observation that there was a penetration in the smoke barrier above the smoke barrier doors near room 3 caused by low-voltage wires. 2. On 07/12/2023 at 10:33 AM, it was revealed by observation that there was a penetration in the smoke barrier above the smoke barrier doors near room 21 caused by low-voltage wires. An interview with the Administrator, the Maintenance Director, and two Regional Maintenance Directors verified these deficient findings at the time of discovery.	K 372	The smoke barriers were caulked to seal the penetrations. All residents have the potential to be affected by the deficient practice. All smoke barriers in the facility were inspected for penetration. Education will be provided to maintenance staff regarding smoke barriers. Audits will be completed by the Maintenance Director and/or designee related to smoke barriers. 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.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 26, 2023

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

RE: CCN: 245187
Cycle Start Date: July 14, 2023

Dear Administrator:

On September 14, 2023, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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