Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 17, 2025

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

RE: CCN: 245187
Cycle Start Date: April 3, 2025

Dear Administrator:

On May 28, 2025, we notified you a remedy was imposed. On June 11, 2025 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of June 9, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 3, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of May 28, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 3, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on June 9, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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

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June 17, 2025

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

Re: Reinspection Results
Event ID: GI4612

Dear Administrator:

On May 16, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 3, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 23, 2025

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

RE: CCN: 245187
Cycle Start Date: April 3, 2025

Dear Administrator:

On April 3, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 July 3, 2025 (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 October 3, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the

same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

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

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Electronically delivered
April 23, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: GI4611

Dear Administrator:

The above facility was surveyed on April 2, 2025 through April 3, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

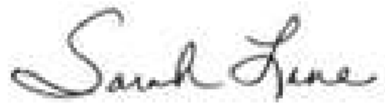
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting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

Lisa Krebs, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00144	A. BUILDING: _____ B. WING _____	C 04/03/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/2/25, and 4/3/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed: H51872124C (MN00111548) with licensing orders issued at 1390. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

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2 000	Continued From page 2 state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control.	21390		5/13/25

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21390	Continued From page 3 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to follow infection control protocols to ensure proper handwashing was implemented for 2 of 4 residents (R1, R2); failed to ensure proper enhanced barrier precautions (EBP) were utilized appropriately for 2 of 2 residents (R1, R3); and failed to disinfect vital sign machine after use for 1 of 1 residents (R1). Findings include Enhanced barrier precautions: refer to an infection control intervention designed to reduce transmission of multi-drug-resistant organism that employs targeted gown and glove use during high contact resident care activities. Gowns and gloves are used as personal protective equipment (PPE). R1 R1's face sheet dated 4/3/25, identified diagnoses of sequelae of cerebral infarction. R1's admission Minimum Data Set (MDS) dated 3/20/25, identified some cognitive impairment. Used intravenous (IV) medication of antibiotic. R1's care plan dated 2/25/25, EBP related to peripherally inserted central catheter (PICC) line. Staff to follow EBP, use appropriate communication to follow EBP, explain reason for use of EBP, staff to put on and take off PPE per EBP when providing high contact cares. Additionally, on 3/4/25, identified a current infection related to acute bacterial endocarditis (serious infection of the heart lining and valves).	21390	Corrected.	

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21390	Continued From page 4 During an observation on 4/2/25 at 2:05 p.m., R1 did not have signage on the door that indicated EBP precautions, nor a container around the area of the room for staff to apply personal protective equipment (PPE) for the EBP. During an observation and interview on 4/3/25 at 8:21 a.m., R1 was lying in bed, PICC line was on right arm. Licensed practical nurse (LPN)-A came into R1's room holding R1's IV medication. LPN-A was wearing gloves and a mask when she entered. LPN-A was not wearing a gown. Removed cap on PICC, rubbed an alcohol wipe on insertion site, screwed on antibiotic. During an observation on 4/3/25 at 8:46 a.m., an EBP sign was on the front of the door to R1's room. No container for EBP PPE was at location or in room. During an observation and interview on 4/3/25 at 9:29 a.m., R1 stated she had never seen staff wearing gowns when working with her. LPN-A brought medications to R1. LPN-A was wearing a mask but no gloves or gown. LPN-A left room and returned with a vital sign machine. LPN-A obtained blood pressure on R1. LPN-A applied gloves to administer nasal spray, removed blood pressure cuff. Removed gloves. Did not sanitize hands. Left room and returned. Did not apply gown or gloves. LPN-A applied new gloves to assist with nasal cannula. Removed gloves. Picked up garbage and grabbed vital sign machine and went to the nurse's cart. Threw away garbage and sanitized hands. Did not sanitize vital sign machine. During an observation on 4/3/25 at 10:33 a.m., nursing assistant (NA)-B was completing morning cares on R1. NA-B was wearing gloves. NA-B did	21390		

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21390	Continued From page 5 not wear a gown. NA-B needed more gloves to complete cares. Removed gloves, left room, returned without wearing PPE, applied new gloves. NA-A was assisting R2 with cares and NA-B asked NA-A to come to R1's side of the room. NA-A entered wearing gloves, no gown. Did not remove gloves between helping R2 to help R1. NA-B removed gloves and applied a new pair. NA-A left room to get more supplies. NA-A returned without wearing PPE. NA-B left room to get supplies and returned with no PPE on. NA-A applied gloves and began to clean bowel movement from rectal area. NA-B removed one glove and reapplied the new glove while touching the new glove with the old one. NA-B finished task, removed gloves, did not perform hand hygiene then applied new gloves. NA-B then left the room to get more gloves. NA-A removed gloves. NA-B returned without wearing PPE. NA-A and NA-B applied gloves, completed care, removed gloves. NA-B washed hands in bathroom sink. NA-A did not perform hand hygiene before both the NA's left the room. During an observation on 4/3/25 at 12:10 p.m., LPN-A went into R1's room. LPN-A was not wearing PPE. LPN-A applied gloves. Took saline and one alcohol wipe from pink basin at R1's window and unscrewed antibiotic. LPN-A used an alcohol wipe and wiped the opening of the PICC line. Screwed in the saline and pushed the fluid through the PICC. Removed the saline, opened a new cap for the PICC and screwed it on, removed gloves. During an observation on 4/3/25 at 12:20 p.m., physical therapist (PT)-A was in R1's room providing care. No PPE was used. R2	21390		

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21390	Continued From page 6 R2's face sheet dated 4/3/25, identified diagnoses of stress fracture (break) left tibia (main long bone of lower leg), obesity (excessive body fat). R2's admission Minimum Data Set (MDS) dated 2/5/25, identified R2 was cognitively intact. During an observation on 4/3/25 at 10:07 a.m., NA-B went to room to answer call light, applied gloves. NA-B removed gloves and left room. NA-B returned with hands full of laundry and applied gloves. R2 had a visible, red rash on upper thigh, abdomen, breast area. NA-B placed walker in front of R2, picked up discarded hospital gown from floor, assisted with pulling up R2's pants and stripped the bed. Removed gloves and left room. No hand hygiene was performed. R3 R3's face sheet dated 4/3/25, identified a diagnosis of end stage renal disease. R3's care plan dated 3/25/25, identified EBP precautions related to dialysis access site. During an observation on 4/3/25 at 9:45 a.m., LPN-A applied PPE and entered R3's room with medication. At 9:50 a.m., LPN-A exited R3's room and draped gown outside residents' room on a handrail and walked away. LPN-A returned and reapplied gown and entered R3's room. LPN-A left room and applied hand sanitizer. During an interview on 4/3/25 at 12:01 p.m., NA-A stated handwashing would be completed after touching a resident's body. EBP would be used if the resident had an infection or open wounds.	21390		

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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) COMPLETE DATE
21390	Continued From page 7 NA-A stated if a resident required EBP there would be signs and containers or supplies hanging on the door. If unsure, could ask the nurse if EBP was required. During an interview on 4/3/25 at 12:06 p.m., NA-B stated handwashing is done before and after providing care to residents, and before and after glove wearing. EBP is used when providing cares to residents. NA-B did not wear EBP PPE when caring for R1 or wash hands before and after glove use and should have. During an interview on 4/3/25 at 12:15 p.m., LPN-A stated EBP PPE should be put on before you go in a room and R1 was on EBP. LPN-A did not wear PPE because she did not see any supply of PPE nearby. If the supplies are there, LPN-A will use them but the majority of the time there are no supplies. The vital sign machine should be disinfected each time it is used, and it was not done after R1. Therapy should wear PPE for EBP, everyone that goes in the room should wear it. During an interview on 4/3/25 at 12:20 p.m., PT-A stated initially when R1 was at the facility they were to wear EBP PPE but currently it was not required. During an interview on 4/3/25 at 1:32 p.m., registered nurse (RN)-A stated EBP signs are used on doors with what to put on for PPE. Anything that involves high contact care with the resident would need EBP PPE such as if a resident has a wound, catheter, infectious disease. Handwashing should be completed before entering and upon exiting rooms, if gloves are removed handwashing should be done before putting a new pair on.	21390		

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	00144	A. BUILDING: _____ B. WING _____	C 04/03/2025

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21390	Continued From page 8 During an interview on 4/3/25 at 3:12 p.m., DON stated staff were trained in EBP when it was first introduced in April 2024, yearly in the facility online education. EBP PPE is used for wound care, multi-drug-resistant organisms, catheters, any kind of IV dressings, PICC line, and basically anything that has an opening in the skin that infections could enter. Vital sign equipment should be disinfected after use. It was the expectation of the DON that staff would follow handwashing guidelines, disinfectant guidelines, and infection control protocols. The facility Enhanced Barrier Precautions policy dated 4/1/24, identified the facility would implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Referred to the use of gown and gloves for use during high contact resident care activities for residents known to be colonized or infected with multidrug resistant organisms as well as those at increased risk of multidrug resistant organism acquisition. Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions. Make gown and gloves available. Ensure access to alcohol based hand rub in every resident room, position a trash can inside the resident room for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room. High contact care activities included: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assistance with toileting, device care or use, wound care, working with residents in the therapy gym, specifically when anticipating close contact. The facility Handwashing policy undated,	21390		

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21390	Continued From page 9 identified proper handwashing techniques should be used to protect the spread of infection. Handwashing shall be completed before applying gloves and after removing gloves. The facility Infection Prevention and Control program dated 11/2024, identified the program was designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infections. The facility Infection Prevention and Control program dated 11/2024, identified the program was designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infections. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program to mitigate transmission of potential infections. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21390		

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F 000	INITIAL COMMENTS On 4/2/25, and 4/3/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H51872124C (MN00111548) , with deficiencies cited at F694 and F880. 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 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a peripherally inserted central catheter (PICC) was appropriately managed based on professional	F 694	R1 PICC is patent and works properly. R1 PICC line care is being completed per facility policy.	5/13/25

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

Electronically Signed | 05/01/2025

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

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F 694	Continued From page 1 standards of practice and in accordance with physician orders for 1 of 1 resident (R1) reviewed for intravenous (IV) medications. Findings include: R1's face sheet dated 4/3/25, identified diagnoses of cerebral vascular accident (stroke), sequelae of cerebral infarction (complications of stroke on brain and body). R1's hospital discharge summary dated 2/25/25, identified R1 had diagnoses that included bacterial endocarditis. Treatment of Ceftriaxone (antibiotic) via PICC. Discharge order for Ceftriaxone 2-gram solution daily. R1's admission Minimum Data Set (MDS) dated 3/20/25, identified moderate cognitive impairment. R1 was administered IV antibiotic medication. R1's care plan dated 3/4/25, identified a current infection related to acute bacterial endocarditis (serious infection of the heart lining and valves). Give medications as ordered, update medical doctor on changes, vital signs as ordered/facility protocol. During an observation and interview on 4/3/25 at 8:21 a.m., R1 was lying in bed, R1's PICC line was located on R1's right arm. Licensed practical nurse (LPN)-A came into R1's room holding R1's IV medication. LPN-A was wearing gloves and a mask when she entered. LPN-A removed the cap of the PICC, disinfected the insertion site with an alcohol wipe, and then attached the antibiotic bulb to the line. LPN-A told R1 she would return in 15-minutes, then left the room. LPN-A did not	F 694	All residents with a PICC line have the potential to be affected by the deficient practice and their PICC line care will be flushed per policy. Like residents with PICC line access were assessed for signs and symptoms of infection and found to be working properly without indication of infection. Education will be provided to nursing staff related to proper PICC line care per policy. Education will be provided by DON and/or designee. Visual audits of nurses will be completed three times a week for four weeks to ensure flushing PICC line is being completed per policy. Audits will be completed by the DON and/or designee. Audit results will be reviewed at QAPI monthly to determine if any trends are identified, and or recommendations for adjustments to the audit schedule is needed.	

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F 694	Continued From page 2 check R1's PICC for patency - flush the PICC prior to the administration of the antibiotic. During an observation on 4/3/25 at 9:29 a.m., LPN-A returned to R1's room with oral medications but did not check the status of infusion of the antibiotic. At 10:07 a.m. R1 stated the antibiotic was done. The balloon holding the medication was deflated. At 10:52 a.m., nursing assistant (NA)-B told R1 she would tell LPN-A that the antibiotic was finished. During an interview on 4/3/25 at 12:06 p.m., NA-B confirmed R1's antibiotic bulb was still connected to R1's PICC line. NA-B explained she forgot to tell LPN-A when she finished R1's cares. During an observation on 4/3/25 at 12:10 p.m., LPN-A went in to R1's room to disconnect the antibiotic. LPN-A applied gloves, disconnected the antibiotic bulb, and used an alcohol wipe to disinfect the PICC cap. LPN-A then flushed the line with saline. During an interview on 4/3/25 at 12:15 p.m., LPN-A stated the PICC line should be flushed before and after medication administration. LPN-A verified R1's PICC line was not flushed prior to medication administration "I thought about it but did not want to do so much flushing." During an interview on 4/3/25 at 3:12 p.m., director of nursing (DON) stated there are batched orders that are put in the system for PICC lines that include flushing before and after medication administration. Staff should also use an alcohol wipe before and after each thing they do with the PICC line. Staff are educated yearly on PICC care during a skills fair each September.	F 694		

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F 694	Continued From page 3 The facility PICC use, flushing, dressing change, administering medications, IV infusion, obtaining a blood sample, and removing procedure undated, identified to perform a vigorous mechanical scrub of the needleless connector for at least 5 seconds using antiseptic pad and allow to dry completely. While maintaining the sterility of the tip, attach a prefilled 10 milliliter (mL) syringe containing normal saline to the needleless connector. Slowly aspirate for blood return. If blood returned, slowly inject the solution into the catheter. Remove and discard the syringe. Perform a vigorous mechanical scrub of the needleless connector for at least 5 seconds using antiseptic pad. Allow to dry completely. Connect IV tubing to cap on end of PICC. Repeat the process when the IV medication process is completed.	F 694		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880		5/13/25

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F 880	Continued From page 4 and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880	Continued From page 5 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to follow infection control protocols to ensure proper handwashing was implemented for 2 of 4 residents (R1, R2); failed to ensure proper enhanced barrier precautions (EBP) were utilized appropriately for 2 of 2 residents (R1, R3); and failed to disinfect vital sign machine after use for 1 of 1 residents (R1). Findings include Enhanced barrier precautions: refer to an infection control intervention designed to reduce transmission of multi-drug-resistant organism that employs targeted gown and glove use during high contact resident care activities. Gowns and gloves are used as personal protective equipment (PPE). R1 R1's face sheet dated 4/3/25, identified diagnoses of sequelae of cerebral infarction. R1's admission Minimum Data Set (MDS) dated 3/20/25, identified some cognitive impairment. Used intravenous (IV) medication of antibiotic. R1's care plan dated 2/25/25, EBP related to	F 880	R1, R2, and R3 are at baseline and no new infection was noted. Enhanced barrier precautions, disinfecting vital sign machine between use, and handwashing are being followed per facility policy. All like residents were reviewed and care plans updated. All residents with Enhanced Barrier Precautions (EBP) have the potential to be affected by the deficient practice and PPE will be worn when working directly with the resident. Handwashing will be completed before applying gloves and after removing gloves, and vital sign machine will be disinfected in between use. Education will be provided to all staff related to wearing proper PPE while working with EBP resident, handwashing before applying gloves and after removing gloves, and disinfecting vital machine after use. Audits will be completed by the DON and/or designee for all affected residents: 2 times weekly audits for 4 weeks of any staff for all affected residents: then twice	

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F 880	Continued From page 6 peripherally inserted central catheter (PICC) line. Staff to follow EBP, use appropriate communication to follow EBP, explain reason for use of EBP, staff to put on and take off PPE per EBP when providing high contact cares. Additionally, on 3/4/25, identified a current infection related to acute bacterial endocarditis (serious infection of the heart lining and valves). During an observation on 4/2/25 at 2:05 p.m., R1 did not have signage on the door that indicated EBP precautions, nor a container around the area of the room for staff to apply personal protective equipment (PPE) for the EBP. During an observation and interview on 4/3/25 at 8:21 a.m., R1 was lying in bed, PICC line was on right arm. Licensed practical nurse (LPN)-A came into R1's room holding R1's IV medication. LPN-A was wearing gloves and a mask when she entered. LPN-A was not wearing a gown. Removed cap on PICC, rubbed an alcohol wipe on insertion site, screwed on antibiotic. During an observation on 4/3/25 at 8:46 a.m., an EBP sign was on the front of the door to R1's room. No container for EBP PPE was at location or in room. During an observation and interview on 4/3/25 at 9:29 a.m., R1 stated she had never seen staff wearing gowns when working with her. LPN-A brought medications to R1. LPN-A was wearing a mask but no gloves or gown. LPN-A left room and returned with a vital sign machine. LPN-A obtained blood pressure on R1. LPN-A applied gloves to administer nasal spray, removed blood pressure cuff. Removed gloves. Did not sanitize hands. Left room and returned. Did not apply	F 880	a month for 1 month and then 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule is needed.	

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F 880	Continued From page 7 gown or gloves. LPN-A applied new gloves to assist with nasal cannula. Removed gloves. Picked up garbage and grabbed vital sign machine and went to the nurse's cart. Threw away garbage and sanitized hands. Did not sanitize vital sign machine. During an observation on 4/3/25 at 10:33 a.m., nursing assistant (NA)-B was completing morning cares on R1. NA-B was wearing gloves. NA-B did not wear a gown. NA-B needed more gloves to complete cares. Removed gloves, left room, returned without wearing PPE, applied new gloves. NA-A was assisting R2 with cares and NA-B asked NA-A to come to R1's side of the room. NA-A entered wearing gloves, no gown. Did not remove gloves between helping R2 to help R1. NA-B removed gloves and applied a new pair. NA-A left room to get more supplies. NA-A returned without wearing PPE. NA-B left room to get supplies and returned with no PPE on. NA-A applied gloves and began to clean bowel movement from rectal area. NA-B removed one glove and reapplied the new glove while touching the new glove with the old one. NA-B finished task, removed gloves, did not perform hand hygiene then applied new gloves. NA-B then left the room to get more gloves. NA-A removed gloves. NA-B returned without wearing PPE. NA-A and NA-B applied gloves, completed care, removed gloves. NA-B washed hands in bathroom sink. NA-A did not perform hand hygiene before both the NA's left the room. During an observation on 4/3/25 at 12:10 p.m., LPN-A went into R1's room. LPN-A was not wearing PPE. LPN-A applied gloves. Took saline and one alcohol wipe from pink basin at R1's window and unscrewed antibiotic. LPN-A used an	F 880		

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F 880	Continued From page 8 alcohol wipe and wiped the opening of the PICC line. Screwed in the saline and pushed the fluid through the PICC. Removed the saline, opened a new cap for the PICC and screwed it on, removed gloves. During an observation on 4/3/25 at 12:20 p.m., physical therapist (PT)-A was in R1's room providing care. No PPE was used. R2 R2's face sheet dated 4/3/25, identified diagnoses of stress fracture (break) left tibia (main long bone of lower leg), obesity (excessive body fat). R2's admission Minimum Data Set (MDS) dated 2/5/25, identified R2 was cognitively intact. During an observation on 4/3/25 at 10:07 a.m., NA-B went to room to answer call light, applied gloves. NA-B removed gloves and left room. NA-B returned with hands full of laundry and applied gloves. R2 had a visible, red rash on upper thigh, abdomen, breast area. NA-B placed walker in front of R2, picked up discarded hospital gown from floor, assisted with pulling up R2's pants and stripped the bed. Removed gloves and left room. No hand hygiene was performed. R3 R3's face sheet dated 4/3/25, identified a diagnosis of end stage renal disease. R3's care plan dated 3/25/25, identified EBP precautions related to dialysis access site.	F 880		

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F 880	Continued From page 9 During an observation on 4/3/25 at 9:45 a.m., LPN-A applied PPE and entered R3's room with medication. At 9:50 a.m., LPN-A exited R3's room and draped gown outside residents' room on a handrail and walked away. LPN-A returned and reapplied gown and entered R3's room. LPN-A left room and applied hand sanitizer. During an interview on 4/3/25 at 12:01 p.m., NA-A stated handwashing would be completed after touching a resident's body. EBP would be used if the resident had an infection or open wounds. NA-A stated if a resident required EBP there would be signs and containers or supplies hanging on the door. If unsure, could ask the nurse if EBP was required. During an interview on 4/3/25 at 12:06 p.m., NA-B stated handwashing is done before and after providing care to residents, and before and after glove wearing. EBP is used when providing cares to residents. NA-B did not wear EBP PPE when caring for R1 or wash hands before and after glove use and should have. During an interview on 4/3/25 at 12:15 p.m., LPN-A stated EBP PPE should be put on before you go in a room and R1 was on EBP. LPN-A did not wear PPE because she did not see any supply of PPE nearby. If the supplies are there, LPN-A will use them but the majority of the time there are no supplies. The vital sign machine should be disinfected each time it is used, and it was not done after R1. Therapy should wear PPE for EBP, everyone that goes in the room should wear it. During an interview on 4/3/25 at 12:20 p.m., PT-A stated initially when R1 was at the facility they	F 880		

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 04/03/2025

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F 880	Continued From page 10 were to wear EBP PPE but currently it was not required. During an interview on 4/3/25 at 1:32 p.m., registered nurse (RN)-A stated EBP signs are used on doors with what to put on for PPE. Anything that involves high contact care with the resident would need EBP PPE such as if a resident has a wound, catheter, infectious disease. Handwashing should be completed before entering and upon exiting rooms, if gloves are removed handwashing should be done before putting a new pair on. During an interview on 4/3/25 at 3:12 p.m., DON stated staff were trained in EBP when it was first introduced in April 2024, yearly in the facility online education. EBP PPE is used for wound care, multi-drug-resistant organisms, catheters, any kind of IV dressings, PICC line, and basically anything that has an opening in the skin that infections could enter. Vital sign equipment should be disinfected after use. It was the expectation of the DON that staff would follow handwashing guidelines, disinfectant guidelines, and infection control protocols. The facility Enhanced Barrier Precautions policy dated 4/1/24, identified the facility would implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Referred to the use of gown and gloves for use during high contact resident care activities for residents known to be colonized or infected with multidrug resistant organisms as well as those at increased risk of multidrug resistant organism acquisition. Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions.	F 880		

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F 880	Continued From page 11 Make gown and gloves available. Ensure access to alcohol based hand rub in every resident room, position a trash can inside the resident room for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room. High contact care activities included: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assistance with toileting, device care or use, wound care, working with residents in the therapy gym, specifically when anticipating close contact. The facility Handwashing policy undated, identified proper handwashing techniques should be used to protect the spread of infection. Handwashing shall be completed before applying gloves and after removing gloves. The facility Infection Prevention and Control program dated 11/2024, identified the program was designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infections. The facility Infection Prevention and Control program dated 11/2024, identified the program was designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infections.	F 880		