Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 27, 2026

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

RE: CCN: 245187
Cycle Start Date: January 27, 2026

Dear Administrator:

On February 6, 2026, we notified you a remedy was imposed. On February 18, 2026 the Minnesota Departments 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 February 11, 2026.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective April 27, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of February 6, 2026, 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 April 27, 2026 due to denial of payment for new admissions. Since your facility attained substantial compliance on February 11, 202, 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 Therefore, the NATCEP prohibition is rescinded.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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

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February 27, 2026

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

Re: Reinspection Results
Event ID: 1E1AF7-H1

Dear Administrator:

On February 18, 2026 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 January 27, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
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February 6, 2026

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

RE: CCN: 245187

Cycle Start Date: January 27, 2026

Dear Administrator:

On January 27, 2026, 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 immediate jeopardy (Level J), The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found other 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), whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On January 20, 2026, the situation of immediate jeopardy to potential health and safety cited at F760 was removed.

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)).

REMEDIES

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

• Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 27, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 27, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 27, 2026.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

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

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective April 27, 2026. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Supervisor, Federal Rapid Response
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

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.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 27, 2026 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at 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.

APPEAL RIGHTS

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

tamika.brown@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

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February 6, 2026

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

Re: State Nursing Home Licensing Orders
Event ID: 1E1AF7-H1

Dear Administrator:

The above facility survey was completed on January 27, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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 Supervisor, Federal Rapid Response
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,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245187**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **01/27/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT THE CEDARS	**7900 WEST 28TH STREET , SAINT LOUIS PARK, Minnesota, 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
F0000	INITIAL COMMENTS On 1/21/26 through 1/22/26 and 1/26/26 through 1/27/26, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H51874221C (2722492 and 2723420) with citation issued at F760 PAST NON-COMPLIANCE H51873943C (2720026) with citation issued at F657. H51874382C (2710257) H51874080C (2721175) H51874100C (2721730) 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.	F0000		02/10/2026
F0657 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.	F0657	R2's care plan was updated to reflect current verbal altercation and interventions put in place to prevent the altercation from occurring again. R2 has been referred to ACP for an evaluation for any future psychosocial distress. Facility reviewed any resident-to-resident altercations occurring in the last 60 days, and care plans and care sheets were updated to reflect current interventions. The interdisciplinary team was re-educated on care plan updates, timing, and revision. All care plans must be developed within 7 days after completion of a comprehensive assessment and must be prepared by the interdisciplinary team and reviewed/revised by the IDT team after each assessment. Care plans to be revised	02/11/2026

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245187**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **01/27/2026**

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

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F0657 SS = D	Continued from page 1 (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 interview and record review, the facility failed to review and revise the comprehensive care plan in a timely manner following a verbal altercation for 1 of 3 residents (R2) reviewed for abuse. This failure placed R2 at risk for psychosocial distress and potential recurrence of resident-to-resident conflict. Findings include: R2's hospital discharge summary dated 8/30/25, identified R2 diagnoses included severe recurrent major depression (MDD) and neurocognitive deficits. R2's associated clinic of psychology note dated 12/22/25, identified R2 diagnoses included posttraumatic stress disorder and major depressive disorder, recurrent episode, moderate. R2's activity of daily living (ADLs) care plan dated 3/7/25 indicated R2 was at risk for decreased cognitive related to PTSD (post traumatic syndrome disorder) and MDD. ADLs care plan dated 3/10/25 directed staff to monitor for signs of emotional distress or mood and behavior changes and safety monitoring will be implemented as needed to ensure residents safety. ADls care plan dated 3/10/25 directed staff to utilize trauma informed care when working with the resident. The care plan dated 3/10/25 identified triggers as unannounced visitors and no male attendees, nightmares, and flashbacks. Incident	F0657	Continued from page 1 and updated promptly following an incident with any new interventions. The director of nursing or designee will audit all resident-to -resident altercations x4 weeks to ensure proper interventions are put into place, and care plans are updated with current interventions. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue audits. date of compliance 2/11/26.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245187	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/27/2026

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

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F0657 SS = D	Continued from page 2 Review of an alleged incident report dated 1/16/26 outlined R2 was involved in a verbal altercation with another resident (R3). The report indicated R3 became visibly upset, raised his voice, and R2 asked him to leave the room. R3 continued yelling in the hallway toward the nursing station, requiring staff intervention. Review of R2's care plan showed no evidence the facility reviewed R1's comprehensive care plan following the altercation, no documentation of updated interventions addressing triggers, supervision needs, conflict-prevention strategies, or psychosocial follow up. No documentation of a care plan meeting or interdisciplinary review since the incident on 1/16/26. During an interview on 1/21/26 at 4:30 p.m., R2 stated she did not feel safe in the facility because people continued entering her room without knocking. R2 reported on 1/16/26, R3 entered her room and displayed aggressive behavior by putting his fingers in her face, which triggered her PTDS and caused fear for her safety. During an interview on 1/22/26 at 2:38 p.m., R3 stated on 1/16/26, he knocked before entering R2's room to visit her roommate. R3 reported R2 became rude and threatened to call the police. R3 stated he became upset and left the room. R3 denied being aggressive toward R2 and reported he continued to knock and open the door slightly so his friend could come out for smoke break after the incident. During an interview on 1/21/26 at 3:50 p.m., a nursing assistant (NA)-A stated she did not recall receiving an education recently on trauma-informed care. NA-A explained she was not aware of an incident between R2 and R3 but realized R2 stayed in her room for the most part. Staff typically separate residents and initiate 15-minute safety checks after altercations. NA-A asserted she was not aware of any recent review of R2's care plan. During an interview on 1/22/26 at 1:26 p.m., a registered nurse (RN)-B, the unit manager stated when staff made her aware of the altercation between R2 and R3 on 1/16/26, she went in the unit while R3 was still yelling in the hallway. RN-B explained R2 reported R3 put his fingers in her face, invading her personal space. RN-B stated R3 reported R2 was the aggressor, being rude and wanted to call the police on him which R2's roommate confirmed. RN-B explained she instructed R3 not to return to the room and to call his friend	F0657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245187	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/27/2026

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

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F0657 SS = D	Continued from page 3 instead for smoke break. RN-B stated she did not update R2's care plan with new interventions addressing triggers, supervision needs, conflict -prevention strategies, or psychosocial follow-up following the altercation. During an interview on 1/27/26 at 1:17 p.m., the director of nursing (DON) explained the care plan should have been reviewed and revised after an altercation incident to address triggers, supervision needs, and other safety measures. The DON stated he did not recall any care plan meeting or interdisciplinary (IDT) review following the altercation. The facility Trauma Informed care policy dated 2/24/23 showed staff were required to add goals and interventions to the care plan for the residents with a history of trauma to address potential triggers and approaches to minimize or eliminate their effects. The policy directed the interdisciplinary team (IDT) to monitor the effectiveness of interventions and update the care plan as needed.	F0657		
F0760 SS = SQC-J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a medication was available for administration for 1 of 3 residents (R1) reviewed for medication errors. This resulted in immediate jeopardy (IJ) when R1 was not administered physician prescribed anti-seizure medication which resulted in hospital intensive care unit (ICU) admission for medical management and treatment. The IJ began on 1/17/26 when the facility failed to ensure R1 received scheduled dose Lacosamide (anti-seizure medication) on 1/17/26, 1/18/26, and 1/19/2026 (six doses) and an additional dose not administered on morning of 1/20/26 this caused R1 to have 3 seizures over the span of 7 minutes resulting in hospital ICU admission where R1 remains. The administrator, the director of nursing, and the regional director of operations were notified of the IJ on 1/27/26 at 4:40 p.m. The facility had implemented actions to prevent recurrence prior to the survey	F0760	"Past Noncompliance - no plan of correction required"	02/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245187	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/27/2026

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

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F0760 SS = SQC-J	Continued from page 4 therefore, the citation was issued at past non-compliance (PNC). Findings include: R1’s admission record dated 4/26/24, identified R1’s diagnoses included encephalopathy (any dysfunction of the brain that alters mental state, causing symptoms like confusion), seizure disorder, and generalized weakness. R1’s hospital discharge summary dated 6/17/25, identified R1’s primary admitting diagnoses included status epilepticus, seizure disorder, alcoholic dementia, and metabolic encephalopathy. R1’s quarterly Minimum Data Set (MDS) dated 11/6/25, indicated R1 had moderate cognitive impairment, administered anti-seizure medication and was independent for toileting, transfer, and mobility. R1’s activity of daily living (ADLs) care plan dated 2/12/25, indicated R1 required anti-seizure medication to be administered as ordered by the provider. Additionally, it directed staff to ensure a position to prevent injury during seizure activity, open airway, and document characteristics. ADLs care plan dated 2/12/25, directed staff to monitor neurological status after any activity for residual impairment and notify the provider of any seizure activity. R1 Physician orders included: -Lacosamide Oral tablet 200 mg. Give 1 tablet by mouth two times a day for uncontrolled seizures (start date 6/17/25.) -Monitor for seizure activity: unusual smells, tastes, sounds, or sensations, Nausea, intense fear and panic, sensation in certain parts of your body, jerky movement in of the arm, leg, or body, weakness and falling to the ground: Every shift (start date 6/16/25) January 2026 Medication Administration Record (MAR) identified R1 did not receive either scheduled dose of Lacosamide oral 200 mg on 1/17/26, 1/18/26, and 1/19/26 (six doses) with notations the medication was not available. Additionally, on 1/20/26 the 8:00 a.m. dose was also not administered. The record identified three different nurses did not administer the doses. In review of R1’s record between 1/16/26 through 1/20/26, there was no indication R1’s physician was notified nor evident the pharmacy was notified the doses were not administered and/or none available to administer	F0760		

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F0760 SS = SQC-J	Continued from page 5 according to the physician order. January 2026 Treatment Administration Record (TAR) identified the physician order to monitor for seizure activity with corresponding checked mark boxes with nurses' initials indicating the task was complete. Review of R1's record which included progress notes did not include the results of the monitoring associated with this task nor was it evident of increased monitoring for signs and symptoms of seizure activity after the prescribed doses of Lacosamide were missed. R1's progress note dated 1/20/26 at 11:31 a.m., indicated when R1 was non-responsive and tremoring, the provider onsite ordered her to be sent to the hospital. R1's hospital admission notes dated 1/20/26 identified R1 was admitted to the intensive care unit (ICU) at the hospital with seizures activity and concern for status epilepticus, requiring intubation on ventilator for airway protection. The note further indicated R1 had been out of Lacosamide (an anti-seizure medication) for the past three days as it had not been available. R1's head computed tomography (CT) scan identified R1 was found to have a thin subdural hemorrhage versus dural thickening along the left cerebral convexity R1's late entry progress note dated 1/20/26 at 1:33 p.m. for 1/16/26 at 1:31 p.m., indicated licensed practical nurse (LPN)-A noticed R1's seizure medication was low so she called and left a voicemail to the provider but did not hear back from the provider before the end of her shift. R1's late entry progress note dated 1/20/26 at 1:30 p.m. for 1/17/26 at 1:31p.m. indicated R1's seizure medication was not delivered, LPN-A called and left a voicemail to the provider. R1's late entry progress note dated 1/20/26 at 1:30 p.m. for 1/19/26, indicated LPN-A left two messages for the provider and did not get a return call back. R1's late entry progress note dated 1/20/26 at 2:15 p.m. for 1/19/26 at 3:58 p.m., indicated staff called the pharmacy to reorder R1's seizure medication which would be delivered on the first run. Attempts were made to interview LPN-A on 1/26/26 at 3:30 pm and again on 1/27/26 at 11:50 a.m., which were not answered, no return phone call was received. During an interview on 1/26/26 at 3:38 p.m., LPN-B stated he cared for R1 the evening shifts of 1/17/26	F0760		

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F0760 SS = SQC-J	Continued from page 6 and 1/18/26. LPN-B stated R1 was supposed to get her seizure medication (Lacosamide 200 mg) two times a day. He could not find the medication in the cart, so he did not give the evening scheduled dose on 1/17/26 and 1/18/26. LPN-B did not notify the pharmacy or the provider or the nurse manager for further directions. LPN-B explained he should have called the pharmacy and the provider but was busy and forgot. LPN-B asserted he did not give any report to the night nurse to follow up and monitor R1 for seizure episodes. Additionally, LPN-B was suspended on 1/20/26 pending the investigation and received re-education regarding medication administration. During an interview on 1/27/26 at 11:04 a.m., LPN-C stated after getting a report on 1/19/26 about anti-seizure medication not available from the day shift nurse, she called the pharmacy to reorder the medication, and the pharmacy confirmed its delivery for that night. LPN-C stated anti-seizure medication arrived as she was leaving the facility. She did not give any report to the night nurse regarding R1 and did not notify the provider, so the anti-seizure medication was not given on 1/19/26. She was terminated on 1/25/26. A packing slip summary dated 1/19/26 indicated R1's Lacosamide 200 mg was delivered on 1/19/26 at 9:00 p.m. During an interview on 1/27/26 at 12:03 p.m., a registered nurse (RN)-A stated she cared for R1 on 1/20/26 in the morning and found R1 very sleepy, difficult to arouse so she determined it was not safe to administer medications which included the anti-seizure medication. RN-A notified the provider onsite of R1's change in condition. RN-A explained she had not been informed R1 had missed three days of anti-seizure medication. During an interview on 1/27/26 at 12:46 p.m., RN-B, unit manager, stated LPN-C shared with her on 1/20/26 about R1 missing anti-seizure medication for three days. After R1 was sent to the hospital, RN-B found 10 anti-seizure tablets (Lacosamide 200 mg) in the medication cart. RN-B expected nurses to contact the pharmacy when a medication was unavailable and notify the provider as well as the nurse manager if doses were not administered; these procedures were not followed in this case. During an interview on 1/26/26 at 3:03 p.m., a pharmacist (PH-A) stated she could not find any electronic request for the seizure medication (Lacosamide 200mg) on 1/17/26 and 1/18/26. The pharmacy	F0760		

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F0760 SS = SQC-J	Continued from page 7 had a prescription on file to supply the facility upon request, so there was no need for new script from the provider. PH-A explained that residents who missed an anti-seizure medication should be monitored for seizure episodes to prevent complications such cardiac issues and even stroke. During an interview on 1/27/26 at 10:05 a.m., a nurse practitioner (NP-A) stated she did not have any record about the facility notification regarding the seizure medication not available nor a refill request. NP-A stated on 1/20/26, RN-A alerted her R1 was having change in condition and when she went to the room to evaluate R1, she found R1 actively seizing. NP-A observed three seizures episodes within seven minutes before the emergency medical services (EMS) arrived to transport her to the hospital. NP-A explained the complication for R1 not having her seizure medication could result in brain injury or even death. She expected nursing staff to notify the medical team regarding any seizure medication not available. During an interview on 1/27/26 at 1:17 p.m., the director of nursing (DON) stated when he got the report about anti-seizure medications not administered, the interdisciplinary team initiated an incident investigation. The facility identified R1 missed three days (6 doses) of prescribed seizure medication (Lacosamide 200 mg). R1 experienced a change of condition and was sent to the hospital on 1/20/26. The DON explained staff failed to obtain the medication from the pharmacy resulting in missed doses, did not update the provider when doses were missed. Additionally, nurses did not follow re-order procedure of medications and follow up was not completed to ensure timely delivery of medication. The DON reported they had identified three nurses involved, interviewed, and suspended them pending the investigation. All residents receiving anticonvulsant medications for seizure disorder were identified and reviewed for any missed doses and full house medication administration re-education for nurses and the TMAs (trained medication aide) was initiated Medication Ordering/Medication Not Available policy dated January 2026 required all nurses and TMAs (Trained Medication Aide) to follow the medication ordering procedure when a medication is running out and/or unavailable. If the medication is down to 3 days or less, the nurse should verify that the medication has been reordered. Medication and treatment orders' policy indicated orders for medication and treatments will be consistent	F0760		

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F0760 SS = SQC-J	Continued from page 8 with principles of safe and effective order writing. The facility put the following corrective measures in place and was verified as completed: -LPN-A, LPN-B and LPN-C were suspended pending investigation and re-education was provided on 1/20/26. -The facility reviews their policy and procedure for safe medication and developed a plan to ensure a sufficient supply of medications for residents for timely administration on 1/20/26. -All residents with seizure medications were reassessed to ensure their safety on 1/20/26. -The facility began re-education and competencies test to nursing staff to ensure compliance of medication administration on 1/20/26 On 1/26/26 through 1/27/27 staff were interviewed and were able to articulate the ordering procedure when a medication is running out and /or unavailable. This deficient practice is being cited at past Non-compliance.	F0760		

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20000	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 1/21/26 through 1/22/26 and 1/26/26 through 1/27/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT compliance with the MN State Licensure.The following complaint was reviewed: H51873943C (2720026) with a licensing orders were issued at (0570).	20000		02/11/2026

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

Minnesota State Department of Health

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20000	Continued from page 1 H51874221C (2722492 and 2723420) H51874382C (2710257) H51874080C (2721175) H51874100C (2721730) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		
20570	Comprehensive Plan of Care; Revision CFR(s): MN Rule 4658.0405 Subp. 4 Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to review and revise the comprehensive care plan in a timely manner following a verbal altercation for 1 of 3 residents (R2) reviewed for abuse. This failure placed R2 at risk for psychosocial distress and potential recurrence of resident-to-resident conflict. Findings include: R2's hospital discharge summary dated 8/30/25, identified R2 diagnoses included severe recurrent major depression (MDD) and neurocognitive deficits. R2's associated clinic of psychology note dated 12/22/25, identified R2 diagnoses included posttraumatic stress disorder and major depressive disorder, recurrent episode, moderate.	20570	R2's care plan was updated to reflect current verbal altercation and interventions put in place to prevent the altercation from occurring again. R2 has been referred to ACP for an evaluation for any future psychosocial distress. Facility reviewed any resident-to-resident altercations occurring in the last 60 days, and care plans and care sheets were updated to reflect current interventions. The interdisciplinary team was re-educated on care plan updates, timing, and revision. All care plans must be developed within 7 days after completion of a comprehensive assessment and must be prepared by the interdisciplinary team and reviewed/revised by the IDT team after each assessment. Care plans to be revised and updated promptly following an incident with any new interventions. The director of nursing or designee will audit all resident-to-resident altercations x4 weeks to ensure proper interventions are put into place and care plans are updated with current interventions. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Date of compliance 2/11/26.	02/11/2026

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20570	Continued from page 2 R2's activity of daily living (ADLs) care plan dated 3/7/25 indicated R2 was at risk for decreased cognitive related to PTSD (post traumatic syndrome disorder) and MDD. ADLs care plan dated 3/10/25 directed staff to monitor for signs of emotional distress or mood and behavior changes and safety monitoring will be implemented as needed to ensure residents safety. ADls care plan dated 3/10/25 directed staff to utilize trauma informed care when working with the resident. The care plan dated 3/10/25 identified triggers as unannounced visitors and no male attendees, nightmares, and flashbacks. Incident Review of an alleged incident report dated 1/16/26 outlined R2 was involved in a verbal altercation with another resident (R3). The report indicated R3 became visibly upset, raised his voice, and R2 asked him to leave the room. R3 continued yelling in the hallway toward the nursing station, requiring staff intervention. Review of R2's care plan showed no evidence the facility reviewed R1's comprehensive care plan following the altercation, no documentation of updated interventions addressing triggers, supervision needs, conflict-prevention strategies, or psychosocial follow up. No documentation of a care plan meeting or interdisciplinary review since the incident on 1/16/26. During an interview on 1/21/26 at 4:30 p.m., R2 stated she did not feel safe in the facility because people continued entering her room without knocking. R2 reported on 1/16/26, R3 entered her room and displayed aggressive behavior by putting his fingers in her face, which triggered her PTDS and caused fear for her safety. During an interview on 1/22/26 at 2:38 p.m., R3 stated on 1/16/26, he knocked before entering R2's room to visit her roommate. R3 reported R2 became rude and threatened to call the police. R3 stated he became upset and left the room. R3 denied being aggressive toward R2 and reported he continued to knock and open the door slightly so his friend could come out for smoke break after the incident. During an interview on 1/21/26 at 3:50 p.m., a nursing assistant (NA)-A stated she did not recall receiving an education recently on trauma-informed care. NA-A explained she was not aware of an incident between R2 and R3 but realized R2 stayed in her room for the most part. Staff typically separate residents and initiate	20570		

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20570	Continued from page 3 15-minute safety checks after altercations. NA-A asserted she was not aware of any recent review of R2's care plan. During an interview on 1/22/26 at 1:26 p.m., a registered nurse (RN)-B, the unit manager stated when staff made her aware of the altercation between R2 and R3 on 1/16/26, she went in the unit while R3 was still yelling in the hallway. RN-B explained R2 reported R3 put his fingers in her face, invading her personal space. RN-B stated R3 reported R2 was the aggressor, being rude and wanted to call the police on him which R2's roommate confirmed. RN-B explained she instructed R3 not to return to the room and to call his friend instead for smoke break. RN-B stated she did not update R2's care plan with new interventions addressing triggers, supervision needs, conflict -prevention strategies, or psychosocial follow-up following the altercation. During an interview on 1/27/26 at 1:17 p.m., the director of nursing (DON) explained the care plan should have been reviewed and revised after an altercation incident to address triggers, supervision needs, and other safety measures. The DON stated he did not recall any care plan meeting or interdisciplinary (IDT) review following the altercation. The facility Trauma Informed care policy dated 2/24/23 showed staff were required to add goals and interventions to the care plan for the residents with a history of trauma to address potential triggers and approaches to minimize or eliminate their effects. The policy directed the interdisciplinary team (IDT) to monitor the effectiveness of interventions and update the care plan as needed. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop and implement measure to ensure timely review and revision of the care plan. The DON or designee could update policies and procedures, educate staff on these changes, and audit periodically to ensure goals and interventions adressing the needs of resident(s) are maintained. The DON or designee could perform measurable audits and report the findings of those audits to the Quality Assessment and Performance Improvement (QAPI) committee to ensure compliance and determine the need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20570		