DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 6, 2026

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

RE: CCN: 245187
Cycle Start Date: December 2, 2025

Dear Administrator:

On December 23, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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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December 2, 2025

Administrator
THE VILLAS AT THE CEDARS

7900 WEST 28TH STREET
SAINT LOUIS PARK, MN 55426

RE: CCN:245187
Cycle Start Date: December 2, 2025

Dear Administrator:

On December 2, 2025, a survey was completed at your facility by the Minnesota Departments 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:

Annette Winters, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 March 2, 2026(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 June 2, 2026(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.

Kamala Fiske-Downing

Compliance Analyst | Federal Enforcement

Health Regulation Division

Minnesota Department of Health

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Administrator
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7900 WEST 28TH STREET
SAINT LOUIS PARK, MN 55426

Re: Event ID: 1D8402-H1

Dear Administrator:

The above facility survey was completed on December 2, 2025 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 no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any 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

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 12/02/2025

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 9/29/25 – 10/1/25 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 complaints were reviewed: H51875186C / 2628280 H51875166C / 2628627 with deficiencies issued at F684 A deficient practice was identified related to incidental findings at F679 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.	F0000		12/22/2025
F0679 SS = D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is NOT MET as evidenced by:	F0679	R1 activity preferences were reviewed by TR and updated care plan to reflect preferences. All resident have the potential to be affected by the deficient practice. Residents were interviewed regarding their activity preferences, and care plans were updated to match. Education will be provided to TR on ensuring resident preferences are met and documented. Audits will be completed by the NHA and/or designee for all affected residents: weekly for 4 weeks and then twice a month for 1 month and then 1x for 1 month. Audit results will be reviewed at Quality Assurance	12/22/2025

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 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 12/02/2025

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F0679 SS = D	Continued from page 1 Based on observation, interview, and record review, the facility failed to support the facility-sponsored and individual activities for residents' preference to support their physical, mental, and psychosocial well-being for 2 of 3 residents (R1 & R2) who were dependent on staff for activities. Findings include: R1's care plan dated 6/10/25 indicated R1 had little or no activity involvement and wished not to participate. R1's goal was that he would express satisfaction with the type of activities and the level of activity involvement when asked. R1's interventions was staff was to respect his right to decline involvement in group activities. The care plan did not indicate any self-guided activities offered to R1 or how the facility encouraged the support and development of his interests, hobbies, and skills. R1's Evaluation and Social History Assessment dated 6/10/25 indicated R1 was oriented to self, person, place, and time. He had visual deficits, but no hearing deficits to impact activity participation. R1 liked arts and crafts such as metal working, sports and exercising, going for walks, music, reading, writing, and watching television. He enjoyed one-to-one activity, large group and or small group, for leisure he was given a handheld radio for music. R1's admission Minimum Data Set dated 6/12/25 indicated R1 had a Brief Inventory of Mental of Status (BIMS) score of 12 indicating R1 had moderate cognitive impairment. R1 used a wheelchair for mobility. R1 required moderate/partial assistance with showering, upper and lower body dressing, personal hygiene, sitting to standing, chair/bed-to-chair transfer, toilet transfer, tub, or shower transfer. R1 was not assessed for walking due to a medical condition or safety concerns. R1's diagnoses were Type 2 Diabates Mellitus with foot ulcer, non-pressure chronic ulcer, adult failure to thrive, tobacco use and dependence on renal dialysis, heart failure. R1 was not at risk for pressure ulcers/injuries and did not have an unhealed pressure ulcer. R1 had a diabetic foot ulcer. R1's activity report indicated: 6/9/25 the activity was smoking.	F0679	Continued from page 1 Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule is needed.	

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F0679 SS = D	Continued from page 2 6/23/25 the activity was a community event where R1 spent 2.5 hours. 7/13/25 the activity was a music event where R1 spent 1.25 hours. 7/27/25 the activity was Bingo and Bible study where R1 spent 2 hours. 7/28/25 the activity was smoking. 8/3/25 the activity was Bingo where R1 spent 1 hour. 8/10/25 the activity was Music where R1 spent 1.25 hours, and the other activity was smoking. 8/11/25 the activity was Bingo, and the note indicated was R1 was not available, yet time spent was 1 hour. 8/13/25 the activity was Bingo where R1 spent 1 hour. 8/14/25 the activity was movie and television the time spent was non-applicable and the other activity was smoking. 8/15/24 the activity was Bingo where R1 spent 1 hour, and the other activity was smoking. 8/24/25 the activity was Bingo where R1 spent 1.25 hours. 8/27/25 the activity was Bingo where R1 spent 1 hour at, and the other activity was smoking. 8/28/25 the activity was Trivia R1 refused yet the time spent was 45 minutes the other activity was smoking. 9/2/25 the activity was “other” the note indicated R1 was not available, yet time spent was 1 hour. 9/3/25 the activity was “other” the note indicated R1 was not available, yet time spent was 1 hour. 9/4/25 the activity was Bingo where R1 spent 1 hour. Bible study he refused yet the time spent was 45 minutes and smoking were the other activity. 9/5/25 the activity was a pop-in visit the note indicated R1 was not available. 9/6/25 the activity was a pop-in visit the note indicated R1 was not available. 9/7/25 the activity was bingo, and the note indicated	F0679		

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F0679 SS = D	Continued from page 3 R1 was not available, yet time spent was 1 hour and R1 was not available for smoking. 9/8/25 the activity was smoking and “other” the note indicated R1 was not available. 9/14/25 the activity was reminiscing and the note indicated R1 was not available, yet the time spent was 30 minutes. 9/16/25 the activity was a virtual event, and the note indicated R1 was not available, yet time spent was 1 hour. The other event was smoking. 9/19/25 the activity was physical therapy and reminiscing R1 refused. 9/21/25 the activities were Bingo and reminiscing, the note indicated R1 was not available, and the time spent was 1.5 hours. 9/22/25 the activities were trivia, games and Reminiscing R1 refused. Upon observation and interview on 9/29/25 at 12:01 p.m. during R1’s wound cares the licensed practical nurse (LPN)-B mentioned R1’s smoking to him. After the LPN-B left the room R1 stated if he had something other to do maybe he would not go out and smoke so much. He stated he had attempted Bingo a few times and would continue, but he had been asking staff “over and over” to get a remote control for his television so he could watch news, sit coms, and sports. He denied having a hand-held radio to use as identified on his assessment. He complained that the activities were all the same, reminiscing, games, and Bingo he would like some more self-guided activities for his room and some group activities that would take place outside. R2’s admission MDS dated 3/11/25 indicated R2 had a BIMS score of 15 indicating she was cognitively intact. R2 was dependent on staff for toileting, showering, lower body dressing, and transferring from chair to bed. R2 required moderate assistance with upper body dressing and required set-up for personal hygiene. R2 was frequently incontinent of bowl and bladder. R2’s pertinent diagnoses were coronary artery disease, congestive heart failure, diabetes, displaced fracture of the lateral malleolus (outside portion of the ankle). R2 was at risk for pressure ulcers and had a surgical wound.	F0679		

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F0679 SS = D	Continued from page 4 R2's Activity evaluation and Social History assessment dated 3/15/25 indicated R2 was oriented to self, person, place, and time. She had no visual or hearing deficits. R2 enjoyed watching television, spending days at the park, playing cards and games (chess and checkers), arts and crafts, spiritual activities, music, and readings. She loved conversation in both large and small group activities. She was at ease with self-initiated activities and was willing to try activities. She was uninterested and refused most structural activities. R2's care plan dated 3/11/25 indicated R2 had an alteration in socialization; establishes her own goal, prefers independent leisure activities in her room however was willing to schedule group activities. R2 was alert and oriented and communicated her leisure needs. R2's goal was to state satisfaction with the currently level of independent activity through the next review date, (there was not a review date identified). R2's interventions were to be provided with an activities calendar and to notify R2 to any changes of the activities. Respect R2's choice of independent activities. The care plan did not indicate any self-guided activities offered to R1 or how the facility encouraged the support and development of his interests, hobbies, and skills. R2's activity report indicated: 3/18/25 The type of activity was an independent activity with a high engagement level that was not independent. The time spent was not applicable. No other details about the activity were documented or if R2 completed. 4/1/25 The type of activity was a pop in visit. The time spent was not applicable. No other details about activity were documented. 4/22/25 The type of activity was arts and crafts the note indicated R2 was not available, yet the time spent was 1 hour. 5/27/25 the type of activity was cooking and baking the note indicated R2 was not available, yet the time spent was 45 minutes.	F0679		

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F0679 SS = D	Continued from page 5 5/29/25 the type of activity was trivia, and the note indicated R2 was not available, yet the time spent was 45 minutes. 6/5/25 the type of activity was trivia, and the note indicated R2 was not available, and the time spent was 45 minutes. Cooking and baking were an activity that R2 was available for, and no time was spent. 6/24/25 the type of activity was Bible study, and the note indicated R2 was not available, and the time spent was 45 minutes. 7/1/25 the type of activity was board games the note indicated R2 was not available, yet the time spent was 45 minutes. 7/3/25 the type of activity was a pop in visit with R2 and the time spent was non-applicable. 7/4/25 the type of activity was social time spent was non-applicable. 7/7/25 the type of activity was sensory stimulation, yet the time spent with R2 was 45 minutes. 7/10/25 the type of activity was Trivia, the note indicated R2 was not available, yet the time spent was 45 minutes. 7/16/25 the type of activity was Bingo the note indicated R2 was not available, yet the time spent was 1 hour. 7/17/25 the activity was health and fitness the note indicated R2 was not available, yet the time spent was 30 minutes. 7/21/25 the activity was social time the note indicated R2 was not available, yet the time spent was 45 minutes. 7/23/25 the activity was bingo, and the note indicated R2 was not available, yet the time spent was 1 hour. 7/31/25 the activity was trivia the note indicted R2 was not available, yet the time spent was 45 minutes she also was not available for the snack activity on 7/31/25. 8/10/25 the activity was Bible study the note indicated R2 was not available, yet the time spent was 45 minutes.	F0679		

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F0679 SS = D	Continued from page 6 8/11/25 the activity was social time and time spent was 45 minutes. 8/13/25 the activity was arts and crafts, and the note indicated R2 was not available, yet the time spent was 2 hours and 15 minutes. 8/19/25 the activity was documented as “other” and the time spent was non-applicable. 8/25/25 the activity was social time, and the note indicated R2 was not available the time spent was non-applicable. 8/26/25 the activity was documented as other and the note indicated R2 was not available, yet the time spent was 45 minutes. 8/27/25 the activity was Bingo, and the note indicated R2 was not available, yet the time spent was 1 hour. 8/28/25 the activity was health and fitness, and the note indicated R2 was not available, yet the time spent was 30 minutes on the same date the activity was cooking and baking and R2 refused yet the time spent was 45 minutes. 9/2/25 the activity was documented as “other” and the note indicated R2 was not available, yet the time spent was 1 hour. 9/3/25 the activity was a movie and television, time spent was non-applicable. Also on 9/3 was Bible study and the note indicated R2 was not available, yet the time spent was 30 minutes. 9/5/25 the activity was Trivia and word games the note indicated R2 was not available, yet the time spent was 2 hours. 9/8/25 the activity was telephone, and no time spent was non-applicable. 9/8/25 the activity was a virtual event, and the note indicated R2 was not available, yet the time spent was 45 minutes. 9/17/25 the activity was Bible study, and the note indicated R2 was not available, yet the time spent was 45 minutes. 9/18/25 the activity was health and fitness, and the note indicated R2 was not available, yet the time spent was 30 minutes. R2 did have a pop in visit and the time	F0679		

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

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F0679 SS = D	Continued from page 7 spent was non-applicable. 9/21/25 the activity was Bible study, and the note indicated R2 was not available, yet the time spent was 45 minutes. 9/23/25 the activity was arts and crafts, and the note indicated R2 was not available, yet the time spent was 1 hour. There was also cognitive games R2 was not available, yet the time spent was 1 hour. 9/24/25 the activity was movie and television, the time spent was non-applicable. Upon observation and interview on 9/30/25 at 11:30 a.m. R2 was an obese lady sitting up in her bed on her phone attempting to call her son. She chuckled and stated that she was sure her son was ignoring her because she calls him multiple times a day due to getting borderline depressed and bored at the facility. She stated she attended dialysis 3 times a week and that was mainly her activity. She stated staff will inform her of an activity but will not get her up in time to attend the group activities because she used a mechanical lift for transfers and that was time consuming. She stated she received one-to-one visits about once a month for 10 minutes and had been able to attend Bingo a few times. She was thankful for her phone and her television. She would like to be offered books, puzzles or games she could do to pass time in her room. She stated she was available for activities except when she was at dialysis, which was on the first floor of the facility. Upon interview on 9/30/25 at 2:08 p.m. registered nurse, RN-A stated R2 spent most of her time in her calling family members. She heard R2 state she would like to go to activities, but then never witnessed her going to them. She was not certain of the reason. Upon interview on 10/1/25 at 10:56 a.m. licensed practical nurse, LPN-B stated she had only seen R2 out of her bed when she is going to dialysis. R2 had not asked her to assist her to an activity. She stated R1 spent most of his day wheeling himself in his chair outside to smoke. She was not aware that R1's television did not work or that he would like to be able to watch television. Upon interview on 10/1/25 at 12:09 p.m. activity aid	F0679		

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F0679 SS = D	Continued from page 8 stated she was aware that both R1 and R2 liked to stay in their rooms. She had not offered R1 or R2 independent activities in their rooms. She stated R1 and R2 were both welcome to join group activities whenever they wanted. She was not aware that R2 wanted to attend activities however staff was not getting her ready on time. She was not aware that R1's television as not working, she could get him a new remote and that will fix the problem. She stated when R1 was on the transitional care unit (TCU) he did watch television in his room but when he moved to long term care (LTC) she did not realize the television was a concern. Upon interview on 10/1/25 at 12:35 the activity director (AD) stated it is the residents' rights to refuse activities as documented in R1 and R2's care plans. She stated R2 did receive one-to-one visits in her room monthly by activity staff. R1 refused most activity related ideas presented to him. She was not aware R1's television was not working; she stated that would be taken care of immediately. Upon interview on 10/1/25 at 12:55 p.m. LPN-A stated that televisions were provided to the residents on the TCU. On LTC the residents were to provide their own television unless one was left behind or the facility had an extra one. She asked if R1's television was his own or the facilities. An activities policy was requested; however, an Activities of Daily Living Policy was received instead.	F0679		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to ensure a resident received treatment and care professional standards of practice for 1 of 3	F0684	R1's wound treatment orders were immediately reviewed and reconciled with the outpatient wound clinic to ensure the correct, current plan of care was followed. A complete wound assessment was performed, including measurement, staging, evaluation for infection, and photo documentation. A wound culture and podiatry imaging referral were ordered. Residents who receive outside wound care have the potential to be affected by the deficient practice. Residents with wound care were audited to ensure treatment orders are accurate for measurements, stating, and infection status. Education will be provided to nursing staff related to wound care treatment per policy.	12/22/2025

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F0684 SS = D	Continued from page 9 residents (R1) reviewed for quality of care. R1 received treatments that were not ordered and R1 was simultaneously seeing an outpatient wound clinic and the facilities inhouse wound care team who both prescribed different wound care orders leading to inconsistent treatment for R1's wound including missed treatments and inaccurate assessments. Based on observation, interview, and record review the facility failed to ensure a resident received treatment and care professional standards of practice for 1 of 3 residents (R1) reviewed for quality of care. R1 received treatments that were not ordered and R1 was simultaneously seeing an outpatient wound clinic and the facilities inhouse wound care team who both prescribed different wound care orders leading to inconsistent treatment for R1's wound including missed treatments and inaccurate assessments. Findings include: Upon observation and interview on 9/29/25 at 12:01 p.m. R1 was observed wheeling himself back from Dialysis in his wheelchair. He was using his feet to scoot along the floor. His left foot was wrapped in an ace wrap, the wrap was soiled with dirt and a yellowish/red discharge. R1 stated he had been at the facility for four months. He had a surgery on his ankle and was aware he had a small diabetic foot ulcer upon admission. He stated received services from both outpatient and inhouse wound care providers. He was not certain why he saw both. He stated the and the facility did not follow the orders given from outpatient therapy. The facility did not perform his dressing changes daily, sometimes it was left for a few days. R1 had returned from the hospital about two weeks ago. He stated he had a blood infection throughout his body from his foot wound and had part of his heel cut off. Upon observation on 9/29/25 at 12:01 Licensed Practical Nurse (LPN)-B was asked to complete R1's dressing change as his ace bandage was saturated with reddish/yellowish drainage. R1's ace wrap was removed, the drainage had bled through a tubular stretch stocking (a seamless elastic tube-shaped bandage used to secure dressings in place), kerlix wrap (cotton wrap to assist with a fast-wicking absorbent) and the ace wrap. R1 was actively bleeding from the open surgical wound on his heel. The wound measured approximately 8-centimeters (cm) in Length (L), 6 cm in Width (W). The wound depth could not be identified due to the	F0684	Continued from page 9 Audits will be completed by the DON and/or designee: 3 residents weekly for 4 weeks and then 3 residents twice a month for 1 month and then 3 residents 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule is needed.	

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F0684 SS = D	Continued from page 10 bleeding. What appeared to be a blood clot or skin tag measuring approximately 3-centimeter (cm) (L), 2 cm (W) was dangling from the wound. LPN-B applied pressure with the soiled Kerlix to the active bleeding from the wound for 4 minutes. LPN-B did not have new dressing supplies in R1's room. She came back into the room with the new supplies, placed them on R1's bed. LPN-B cleansed the wound with betadine solution (a brownish-yellow antiseptic). LPN-B saturated the same gauze she used to cleanse the wound, formed it into a ball and placed it inside the wound. She covered the wound with an ABD pad (absorbent pad), cut the soiled portion of R1's tubular stocking off and placed the cut tubular stocking over R1's foot and wrapped his foot in the same ace bandage she had removed from R1 and secured it with the same tape she had taken off the ace wraps. R1's orders dated 6/8/25 – 10/1/25 did not include any orders for betadine to be used for R1's wound care. R1's facility Admission Skin and Wound Evaluation dated 6/2/25 indicated R1 had a diabetic wound on his left middle heel that was present on admission. -How long the wound was present – No documentation was completed -The wound was not staged -Wound measurements - an area was of 4x4 centimeters squared (cm2), 3.4 centimeters (cm) in length (L), 2.0 cm in width (W), and 5.6 cm in depth (D). -Wound bed was 100% granulated -Evidence of infection – no documentation was completed - Heavy serosanguinous/bloody -No odor -Peri-wound – attached: edge appears flush with wound bed or as a sloping edge -Surrounding tissue – was macerated (softening or breakdown of the skin resulting from prolonged exposure to moisture): wet, white, waterlogged tissue -Induration – no documentation was completed. -Edema – no documentation was completed,	F0684		

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F0684 SS = D	Continued from page 11 -Pain – no documentation was completed. -Orders – goals of care- wound slow to heel, wound healing is slow or stalled but stable, little or no deterioration, -Dressing appearance – saturated. -Cleansing solution – normal saline. -Debridement – no documentation completed. -Primary dressing – Iodoform packed and compression wrap. -Additional care – no documentation completed i.e., air flow pad, compression, cushion, customized show ear, foam mattress, foot cradle, heel suspension/protective device, incontinence management, mattress with pump, mobility aid, moisture barrier, moisture control, dietary, padded rails/chair, repositioning devices, turning or repositioning. -Progress – stalled R1's Treatment Administration Record (TAR) dated 6/1/25 – 6/30/25 indicated on 6/3/25 R1 was ordered wound care to his left heel ulcer to cleanse the wound with normal saline, apply Santyl lotion (antimicrobial) to the wound bed and cover with a foam border dressing. This treatment was completed on 6/4/25 and 6/5/25. The treatment was not completed on 6/3/25 and 6/6/25. R1's TAR dated 6/1/25 – 6/30/25 indicated on 6/9/25 R1's treatment for wound care to the left heel, cleanse wound with moist 4x4 gauze, apply Medi-honey to the wound bed, cover with polymem (a multifunctional wound dressing that work to cleanse, fill, absorb and moisten wounds while helping to relieve pain) or foam border dressing every evening shift for the left heel until heeled. This treatment was completed on 6/11/25. 6/12/25, 6/14/25, 6/15/25, 6/15/25, 6/16/25, 6/17/25, 6/18/25, 6/19/25, 6/20/25, 6/21/25, 6/22/25, 6/23/25, 6/24/25, 6/25/25, 6/26/25, 6/27/25, 6/28/25, 6/29/25 ad 6/30/25. This treatment was not completed on 6/9/25 and 6/13/25. R1's providers note dated 6/2/25 completed by the Nurse Practitioner (NP)-B indicated R1 had a dressing on his left foot that was changed. He will be followed by the	F0684		

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F0684 SS = D	Continued from page 12 inhouse wound team. R1 had a left foot ulcer with necrotic tissue, some blood drainage (no other wound details identified). MRI of R1's foot 5/17/25 indicated superficial soft tissue ulceration along the plantar aspect of the heel without evident of underlying osteomyelitis (bone infection). R1's hospital discharge note dated 6/8/25 indicated R1 admitted to the hospital on 6/3/25 with a complicated medical history. R1 had a history of congestive heart failure, diabetes mellitus 2, chronic kidney disease with dialysis, hypertension, and a recent status post vascular catheter placement on 6/1/25. R1 presented to the hospital two times that day – once with shortness of breath and another after a fall. MRI identified left occipital lobe lesion possible subacute stroke or mass. R1 had a diabetic ulcer on his left heel. R1 was recently at the hospital from 5/8/25 to 6/1/25, which the hospital was treating R1 for fluid management with dialysis and a left leg/heel abscess, sepsis, and diabetic foot infection, was on vancomycin and Zosyn (antibiotics) initially and transitioned to oral Augmentin and clindamycin (antibiotics). Diagnosis at discharge included left diabetic mellitus heel wound, peripheral artery disease, left occipital stroke, end stage renal disease with dialysis, chronic hypoxic respiratory failure/chronic obstructive pulmonary disease, recent elevated troponins, acute diastolic congestive heart failure, diabetes mellitus 2, anxiety, and cognitive impairment. Transitional Care Unit at facility to ensure follow-up with wound care for left heel wound, follow up with cardiology, assist with health care directives, monitor blood sugar closely. R1's inhouse wound care note dated 6/11/25 indicated R1 had an unstageable wound on the left heel. R1's wound was 3.9 centimeters in (L) x 4.1 cm (W) x 0.1 cm (D). The tissue was 100% eschar (dead tissue in a wound) with a small amount of serous exudate (clear water fluid) and the peri-wound was moist. R1's order was to clean the wound with normal saline, pat dry. Apply Iodosorb (an antimicrobial ointment to the wound bed, cover with an ABD pad and secure with Kerlix every other day. Instructed patient to use his surgical shoe and stay off the heel wound. R1's admission Minimum Data Set dated 6/12/25 indicated R1 had a Brief Inventory of Mental of Status (BIMS) score of 12 indicating R1 had moderate cognitive impairment. R1 used a wheelchair for mobility. R1 required moderate/partial assistance with showering,	F0684		

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F0684 SS = D	Continued from page 13 upper and lower body dressing, personal hygiene, sitting to standing, chair/bed-to-chair transfer, toilet transfer, tub, or shower transfer. R1 was not assessed for walking due to a medical condition or safety concerns. R1's diagnoses were Type 2 Diabetes Mellitus with foot ulcer, non-pressure chronic ulcer, adult failure to thrive, tobacco use and dependence on renal dialysis, heart failure. R1 had a diabetic foot ulcer. R1's TAR dated 6/1/25 – 6/30/25 indicated on 6/12/25 – 6/26/25 R1 was ordered to cleanse the left heel wound with wound cleanser and pat dry. Apply Calmoseptine to the peri-wound, Iodosorb to the wound bed, cover with an ABD pad, gauze roll to be changed every other day. This treatment was completed on 6/12/25, 6/14/25, 6/16/25, 6/18/25, 6/20/25, 6/22/25, 6/24/25 and 6/26/25. R1's weekly skin assessment dated 6/17/25 indicated no new skin issues, an old wound on the left heel was noted. R1 did not have any weekly skin assessments completed the weeks of 6/24/25, 6/31/25 or 7/6/25. R1's inhouse wound care note dated 6/20/25 indicated R1's wound had deteriorated this week. No other complaints. R1's treatment plan was updated, which included applying Santyl cream to the wound bed and calcium alginate (a gel forming wound dressing) and cover with border form every day and as needed. R1's wound was 5.6 cm (L) x 5.8 cm (W) x 0.1 D R1 had moderate serosanguinous exudate (clear and bloody fluid) with 100% slough (dead tissue that forms in a wound) of the tissue with no signs and symptoms of infection. R1's care plan dated 6/22/25 indicated R1 had Type 2 Diabetes with a foot ulcer. There were no goals indicated. R1's interventions were to monitor/document/report to the Medical Doctor as needed for any signs or symptoms of infection to any open areas, redness, pain, heat swelling or pus. Refer to podiatrist/foot care nurse to monitor/document foot care needs and to cut long nails. R1's care plan did not indicate skin assessments, dressing changes, orders to off load his foot, non-weightbearing status, or any information regarding his inhouse and outpatient providers.	F0684		

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F0684 SS = D	Continued from page 14 R1's outpatient wound care note dated 6/23/25 indicated R1 was seen for left heel wound care his measurements were 7.4 cm (L) x 8.5 cm (W) and 0.5 cm (D) R1 was to continue Medi-honey dressing gel dressing and return to clinic weekly. R1's inhouse wound care note dated 6/24/25 indicated R1's wound measured 6.5 cm (L) x 6.4 cm (W) x 0.1 cm (D) 100% slough (dead tissue that forms inside a wound) with moderate serosanguinous exudate (a water fluid mixed with blood). His treatment orders were to cleanse with Vashe (wound solution) or normal saline, pat dry. Skin prep to the peri-wound. Apply Santyl (nickel thickness) and calcium alginate daily and as needed. If wound was dry apply Vashe or normal saline moistened gauze over Santyl to help activate. R1's TAR dated 7/1/25 – 7/31/25 indicated on 7/1/25 – 7/31/25 R1 was ordered to have his left heel wound cleansed with a moist 4x4 gauze, apply Medi honey to the wound bed and cover with polymem or foam border dressing every evening. This was completed on 7/1/25, 7/2/25, 7/3/25, 7/4/25, 7/5/25, 7/6/25, 7/7/25, 7/8/25, 7/9/25, 7/10/25, 7/11/25, 7/12/25, 7/13/25, 7/14/25, 7/15/25, 7/16/25, 7/17/25, 7/18/25, 7/19/25, 7/21/25, 7/22/25, 7/23/25, 7/24/25, 7/25/25, 7/26/25, 7/27/25, 7/28/25, 7/29/25 and 7/30/25. This treatment was not completed on 7/20/25 and 7/31/25. R1's TAR dated 7/1/25 – 7/31/25 indicated on 7/1/25 – 7/9/25 R1 was ordered to have his left heel wound cleansed with Vashe or normal saline, pat dry. Skin prep (a topical product used to prepare the skin for adhesives) around the peri-wound. Apply Santyl (nickel thickness) and calcium alginate daily and as needed. If the wound was dry apply Vashe or normal saline moistened gauze over Santyl to help activate onetime every other day for the wound. This ordered indicated both a daily treatment and every other day treatment. The treatment was performed on 7/1/25, 7/3/25, 7/5/25, 7/7/25 and 7/9/25. The treatment was not completed on 7/2/25, 7/4/25, 7/6/25 and 7/8/25. R1's inhouse wound care note dated 7/2/25 indicated R1 was seen, his wounds were improving and no changes to his treatment plan. R1's outpatient wound care note dated 7/9/25 indicated there were two sets of wound care orders in the order	F0684		

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F0684 SS = D	Continued from page 15 set. The outpatient wound clinic requested the facility stop Santyl as it is only fibrionolase and not a collagenase. Just apply Medihoney gel or equivalent. R1 only had a Vaseline gauze on today, please ensure he is getting the right dressing. Much of the wound necrosis was debrided, wound needs more offloading especially in bed at night, ensure patient has heel lift boot. The outpatient wanted to the facility to make sure they schedule R1 for appointments weekly. The facility acknowledged the note on 7/9/25. R1's weekly skin assessment dated 7/12/25 indicated R1 had an old wound on his left heel. Skin was clean, dry, and intact. No new skin issues noted on that shift. R1's outpatient wound care note dated 7/16/25 indicated improvement in the wound. The wound was debrided with moderate amount of necrotic tissue from the left heel. Dressing remains the same with Medi-Honey, polymem foam, ABD, and tape. Emphasized the importance to off load the heel especially at night. R1's great toe was assessed due to a new wound. The toenail was loosely attached, so it was removed today. Dressed Mepilex and Medipor tape. R1's weekly skin assessment dated 7/21/25 indicated R1 had a healing wound noted on the left heel. R1's TAR dated 7/1/25 – 7/31/25 indicated R1 on 7/12/25 – 7/22/25 R1 was ordered to have his left heel wound cleansed with Vashe wash or normal saline, pat dry. Apply skin prep to the peri-wound. Apply Medi-honey gel and calcium alginate daily and as needed. If wound is dry apply Vashe or normal saline moistened gauze over the Medi-honey every evening. This treatment was completed on 7/12/25, 7/13/25, 7/14/25, 7/15/25, 7/16/25, 7/17/25, 7/18/25 and 7/19/25. This treatment was not performed on 7/20/25. R1's outpatient wound clinic note dated 7/22/25 indicated R1 asked for a prescription for the Medi-honey gel and other supplies because he stated the staff was not using what the outpatient wound clinic uses. He also indicted concerns that the facility was not providing daily dressing changes. He stated the dressing was not changed on 7/21/25 but was changed right before he went to the appointment on 7/22/25. Upon arrival to his appointment R1 did not have Medi-honey gel or foam, just xeroform under his gauze	F0684		

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F0684 SS = D	Continued from page 16 roll. The order indicated to please ensure daily Medi-honey gel, Polymem or other plan foam, 4x4s, ABD, Kerlix and paper tape dressing changes. R1's inhouse wound clinic note dated 7/23/25 indicated R1 had no changes to his plan. His wound measurements were 5.1 cm (L) x 2.6 cm (W) x 0.1 cm (D) with heavy serosanguinous drainage tissue type was 70% slough, 20% granulation (new cells), 10% eschar (scab)The wound was fragile. R1's weekly skin assessment dated 7/28/25 indicated R1 had an old wound on his left heel. Skin clean, dry, and intact. No new skin issues noted on that shift. R1 did not have a skin assessment completed on the week of 8/5/25. R1's outpatient wound clinic note dated 7/29/25 indicated wound appeared better with Medi-honey and the wound was debrided. The facility was to continue with Medi-honey, Polymem, ABD pad, Kerlix and tape. Continue to keep dry and daily dressing changes. Continue with weekly wound care appointments to assist with wound closure. R1's inhouse wound care note dated 7/30/25 indicated R1 was to maintain the current treatment plan as the wound was improving. R1's wound was 4 cm (L) x 4 cm (W) x 0.1 cm D. R1 had heavy seropurulent (wound drainage of clear water drainage and pus) exudate with a mild odor the tissue was 40% epithelial, 30% granulation, 10% slough, and 20% eschar. His peri wound was moist, no signs of infection. R1's TAR dated 8/1/25 – 8/31/25 indicated wound treatment orders for R1 on 8/3/25 – 8/26/25 were to cleanse the wound with normal saline, pat dry. Apply nickel thickness Santyl to the wound bed. If the wound was dry apply normal saline moistened gauze over Santyl to help activate every evening. This was completed on 8/3/25, 8/4/25, 8/5/25, 8/6/25, 8/9/25, 8/10/20, 8/11/25, 8/12/25. 8/13/25, 8/14/25, 8/15/25, 8/16/25. 8/17/25, 8/18/25, 8/19/25, 8/20/25. 8/21/25, 8/22/25, 8/23/25. 8/24/25, 8/25/25, The treatment was not charted as completed on 8/7/25, 8/8/25 and 8/26/25. R1's inhouse wound care note dated 8/6/25 indicated R1's wound was improving, no signs of infection. The	F0684		

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F0684 SS = D	Continued from page 17 wound measured 4 cm (L) x 4.2 cm (W) x 0.1 cm (D). He had moderate serosanguinous exudate with a mild odor. The peri-wound was moist the tissue type had 10% eschar, 20% slough and 70% granulation. R1's weekly skin assessment dated 8/11/25 indicated R1 stated he had a skin inspection with a shower the prior day. He refused a skin assessment. R1's inhouse wound care note dated 8/13/25 indicated R1's wound was improving with no changes in his orders. His measurements were 3.8 cm (L) x 2.6 cm (W) x 0.1 cm (D) he had moderate serosanguinous exudate with a mild odor no signs of infection. His tissue type was 30% slough and 70% granulation. No signs or symptoms of infection. R1's weekly skin inspection dated 8/18/25 indicated R1 had no skin issues noted. R1's TAR dated 8/1/25 – 8/31/25 indicated on 8/26/25 R1's wound care order to left heel was to cleanse the wound with moist 4x4 gauze, apply Medi-honey to the wound bed, cover with polymemor or foam border dressing. Tubi-grip (tubular stretch stocking) every evening shift until heeled. This was completed on 8/27/25, 8/28/25, 8/29/25. 8/30/25 and 8/31/25. R1's inhouse wound care note dated 8/27/25 indicated R1's wound continued to heal. The treatment plan was updated to clean the left heel ulcer with Vashe or normal saline, pat dry. Skin prep to the peri-wound. Apply Santyl (nickel thickness) and calcium alginate cover with superabsorbent dressing daily and as needed. If wound is dry, apply Vashe or normal saline moistened gauze over Santyl to help activate. R1's measurements were 2.9 cm (L), 3 cm (W) x 0.1 cm (D). R1 had heavy serosanguinous exudate with no odor. His tissue type had 10% slough, 80% granulation and 10% dermis. His peri-wound was moist with maceration (softening and breakdown of the skin due to prolonged exposure to excessive moisture). R1's weekly skin inspection dated 9/1/25 indicated R1 had no new skin issues an old wound on his left heel was noted.	F0684		

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F0684 SS = D	Continued from page 18 R1's outpatient wound clinic note dated 9/2/25 indicated R1 showed signs of infection on his left heel on the side where the wound probed to the rough bone. R1 was not showing systemic signs of illness, it was not indicated that he be sent to the emergency department; however, wound cultures were ordered a visit with his podiatric surgeon for imaging of the bone on a more urgent basis. The wound culture was ordered because of a very foul smell. R1's order was to stop the med-honey gel and start either daily saline moistened hydro Fera blue dressing or daily Vashe moistened gauze changes for an antimicrobial effect. R1's physician orders dated 9/2/25 – 10/1/25 did not indicate the facility ordered wound cultures or set-up a podiatric surgeon visit for imaging of the bone on an urgent basis. R1's progress notes dated 9/2/25 – 10/1/25 did not indicate the facility ordered wound cultures or set-up a podiatric surgeon visit for imaging of the bone on an urgent basis. R1's inhouse wound care note dated 9/3/25 indicated R1's wound was stable, and the treatment was updated [SIC] no orders added. R1's measurements were 5.1 (L) 3.1 (W) 0.2 cm (D). R1 had light serous exudate with no odor the tissue type had 50% slough and 50% granulation. The peri-wound was moist and macerated (the softening or breakdown of skin resulting in prolonged moisture exposure). R1's nursing progress notes dated 9/5/25 indicated R1 was transferred to the hospital for three episodes of emesis/vomiting yellow colored mixed with previous food. Suspected dehydration. R1's hospital discharge summary dated 9/15/25 indicated R1 was admitted on 9/5/25 with nausea, vomiting and diarrhea. His history included hypertension, hyperlipidemia, insulin dependent type 2 diabetes mellitus, left diabetic foot ulcer, peripheral artery disease with vascular catheter placement June 2025, chronic hypoxic respiratory failure on nocturnal 2-liter supplemental oxygen, end stage renal disease on dialysis. He was found to have Klebsiella oxytoca (bacteria) and Proteus mirabilis bacteria and left calcaneal osteomyelitis (inflammation of the bone caused by an infection) and underwent a partial	F0684		

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F0684 SS = D	Continued from page 19 calcanectomy, removing bone from the heel. R1's wound evaluation from 9/2/25 indicated a concern of probing to the bone (clinical technique used to diagnose osteomyelitis. He was febrile (had a fever) on presentation. R1's facility nursing progress note dated 9/15/25 indicated R1 returned to the facility. R1's providers order dated 9/15/25 indicated R1 was to have every other day dressing changes for his surgical incision. The wound was to be cleansed with saline and pat dry with sterile gauze, apply zero form (a petroleum-based foam dressing) to the surgical incision then dry gauze, ABD pad (absorbent pad), gauze roll and secure with a 4-inch ace wrap. R1's nursing progress note dated 9/16/25 indicated R1 was re-admitted to the facility following hospitalization for nausea and vomiting. He was found to have sepsis the likely source was a foot wound, osteomyelitis. R1 had a partial calcanectomy and debridement on 9/9/25. R1's nursing progress note dated 9/29/25 at 12:49 p.m. by LPN-B indicated R1's dressing was changed and reapplied to pack with gauze soaked in betadine, covered with gauze to hold in place, wrapped in kerlix, sleeve placed and ace wrap to keep pressure over the heel. Upon observation and interview on 9/29/25 at 1:35 p.m. the director of nurse, DON was asked to change R1's dressing. The DON undressed the dressing LPN-B had placed on him which revealed R1 had a statured ball of betadine in his wound. The DON stated, she was not certain if using a ball of betadine from a former order R1 had or if LPN-B had performed the services on the wrong resident. The DON properly completed R1's dressing change. R1's nursing progress note dated 9/29/25 at 2:20 p.m. LPN-B indicated she reviewed R1's orders and went to reapply the dressing with dry gauze per the provider orders and the DON was already in R1's room reapplying his dressing with the correct order. Upon interview on 9/29/25 at 1:35 p.m. the director of	F0684		

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F0684 SS = D	Continued from page 20 nursing (DON) stated she was not certain if R1 was going to outpatient therapy or seeing the inhouse provider. R1 was on the transitional care unit (TCU) and that nurse manager no longer worked at the facility and she oversaw his wound care. She was going to review his medical records. Upon interview 9/30/25 at 12:15 p.m. R1's outpatient wound care specialist physical therapist (PT)- A stated R1's sepsis and calcanectomy were avoidable. R1 started with outpatient therapy in 6/2025 where pictures were documented that he had enough tissue on his heel where they could debride the necrotic tissue off. R1 did complain that the dressings were not being completed at the facility the way the outpatient provider ordered. The outpatient provider sent notes to the facility after each visit with the orders and calls were placed to the facility. Medi-honey was used to soften and clean out the dead tissue, so the provider could debride the wound. The hope was that the necrotic tissue did not reach his bone. R1 would arrive at his appointments with the wrong dressing. He would show-up with a Vaseline gauze or sometimes a hydrogel (gauze composed of a water polymer to provide a moist environment) gauze and soiled ace wraps. She empowered R1 to watch and know what goes on at the facility with his cares. PT-A stated prior to the interview she did review R1's chart. When he was admitted to the hospital on 9/5/25 the infection was inoculation (reached) his bone and this could have been prevented if the facility followed the treatment orders and scheduled dressing changes. R1 ended was a partial calcanectomy, part of the bone cut off due to bone infection. Per his vascular note it was not due inadequate flow he had had adequate blood flow. PT-A stated this was avoidable it was bound to become infected with the facilities practice. "How bad and the stinky the dressing was, I do think it was neglectful." He got a lot of germ load by sitting in that dead tissue. If the facility would have followed the outpatient orders the necrotic tissue would have softened and the debridement could have occurred, and the wound would have closed. Upon interview on 9/30/25 at 2:08 p.m. registered nurse (RN)-A stated she worked with R1 when he was on the TCU. She stated she did not recall any Medi-honey orders. She stated if there was a conflict in the orders the nurses should report it to the nurse manager or call the provider. She stated the facility is supposed to follow the outpatient providers orders and the inhouse should not be writing orders. If inhouse wanted a change they should be reaching out in	F0684		

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F0684 SS = D	Continued from page 21 collaboration with the outpatient provider. She was not aware of any nurse who provided both the orders to R1 in the same day. Upon interview on 9/30/25 at 3:45 p.m. licensed practical nurse (LPN)-A nurse manager stated she had only worked with R1 since he returned from the hospital on 9/15/25 and was not aware of his inpatient and outpatient services any or conflicting orders. She stated a resident should not have simultaneous order going on the chart. When a new order was started an old one should be discontinued Upon interview on 10/1/25 at 10:19 a.m. nurse practitioner (NP)-A the inhouse wound nurse stated she was not aware that R1 had been seeing outpatient patient therapy. Her role when outpatient therapy was involved was to support the staff with the dressing changes and make recommendations between the outpatient visits. She would not change an order. She stated the facility should have told her he was seeing the outpatient wound provider as well as her for consistency of orders. NP-A collaborated through the facility on her weekly wound care rounds and did not review R1's medical chart at the facility where R1's outpatient wound orders were. On a follow-up interview on 10/1/25 at 12:30 p.m. the DON stated R1 provided cares by both outpatient and inpatient wound care services. If a resident was seeing both providers, the facility was to follow the outpatient wound cares orders and the inhouse team was for support. She stated she believed the staff was performing R1's orders correctly. She recalled a time where the facility could not get Medi-honey but could not recall exactly when or it pertained to R1. She was not aware if the facility reached out to the outpatient provider to notify them if Medi-honey was unavailable and thought maybe that was part of the conflicting orders. The DON stated she had not audited R1's TARs and was not aware if the staff were providing both treatments on the same day, one of the treatments on the same day or no treatment at all. Staff had not mentioned conflicting orders to her. Upon interview on 10/1/25 at 11:01 R1's PCP stated upon R1's admission he ordered the inhouse wound care. He was also aware R1 was going to the outpatient clinic. He did not recall seeing any conflict in orders because the facility did not notify him. He allowed wound care	F0684		

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F0684 SS = D	Continued from page 22 team to take over the treatment plans with the facility. He stated the facility should have been following the outpatient wound orders. He did not recall receiving a message or signing an order for wound cultures prior to R1's hospitalization. His team gave orders to send R1 to the Emergency Department for nausea and vomiting on 9/5/25. He stated if the outpatient provider ordered R1 to see a podiatric surgeon on an emergency basis the facility should have taken care of that. Upon interview on 10/3/25 at 11:38 a.m. the facilities Medical Director stated the facility had informed him about the complaint allegations with R1s wound. His expectations were that the facility follow providers orders and question if there are conflicting orders. He stated he believed the facility should follow the inhouse providers wound care orders because that practitioner see's the patient weekly and the outpatient was for extra precautions. He stated he did not review R1's entire chart, however felt since the facility was treating R1 with two providers his calcanectomy may have been unavoidable. A facility policy titled Skin Assessment and Wound Management with a revision date of 2/2025 indicated guidelines for assessing and managing wounds. 1. A pressure ulcer risk assessment (Braden Scale) will be completed per the facilities assessment Schedule/Grid. 2. Implement appropriate preventative skin measures. Examples include, but are not limited to-nutritional interventions, mobility and repositioning plan, pressure redistribution plan. 3. Skin Evaluation and Skin Risk Factors Form is completed before initial MDS, annually, and upon significant change. 4. Staff will perform routine skin inspections (with daily care). 5. Nurses are to be notified if skin changes are identified.	F0684		

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F0684 SS = D	Continued from page 23 6. A weekly skin inspection will be completed by licensed staff.	F0684		
F0880 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 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	F0880	R1 received wound care dressing change using Enhanced Barrier Precautions. R1's wound care ordered were reviewed in-house and outpatient providers to ensure alignment with current wound care treatment. R1 was assessed for any signs/symptoms of infection. No new infection was identified at the time of reassessment All residents on EBP or receiving wound care have the potential to be affected by the deficient practice. A facility wide audit of all residents on EBP was completed to verify proper signage, PPE availability, staff compliance with gown and glove use during high-contact care, and hygiene compliance. A wound-care audit was completed for all residents with active wounds to ensure correct cleansing agents, correct supplies, no reuse of supplies, and documentation matches provider orders. Education will be provided to nursing staff related to EBP and PPE use and wound care infection control standards. Audits will be completed by the DON and/or designee related to resident with EBP and wound care treatments. 3 residents will be audited for 4 weeks and then 3 residents twice a month for 1 month and then 3 residents 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule is needed.	12/22/2025

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F0880 SS = D	Continued from page 24 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to follow enhanced barrier precautions (an infection control intervention designed to reduce transmission of multidrug-resident organisms that employs targeted gown and glove use during high contact resident activities) for 1 of 3 residents reviewed (R1). In addition, during a wound care dressing change staff failed to follow proper infection control protocol. Findings include: Upon observation on 9/29/25 at 11:50 a.m. R1 had an enhanced barrier precaution (EBP) sign posted outside his room. The sign indicated everyone must: clean their hands, including before entering and leaving the room. Providers must also wear gloves and a gown for the following high contact resident care activities: -Dressing	F0880		

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F0880 SS = D	Continued from page 25 -Bathing/Showering -Transferring -Changing linens -Providing hygiene -Changing brief or assisting with toileting -Device care use, central line, urinary catheter, feeding tube and tracheostomy -Wound care – any skin opening requiring a dressing. R1's admission Minimum Data Set dated 6/12/25 indicated R1 had a Brief Inventory of Mental of Status (BIMS) score of 12 indicating R1 had moderate cognitive impairment. R1 used a wheelchair for mobility. R1 required moderate/partial assistance with showering, upper and lower body dressing, personal hygiene, sitting to standing, chair/bed-to-chair transfer, toilet transfer, tub, or shower transfer. R1 was not assessed for walking due to a medical condition or safety concerns. R1's diagnoses were Type 2 Diabates Mellitus with foot ulcer, non-pressure chronic ulcer, adult failure to thrive, tobacco use and dependence on renal dialysis, heart failure. R1 was not at risk for pressure ulcers/injuries and did not have an unhealed pressure ulcer. R1 had a diabetic foot ulcer. R1's providers order dated 9/15/25 indicated R1 was to have every other day dressing change for his surgical incision. The wound was to be cleansed with saline and pat dry with sterile gauze, apply zero form (a petroleum-based foam dressing) to the surgical incision then dry gauze, ABD pad (absorbent pad), gauze roll and secure with a 4-inch ace wrap. Upon observation on 9/29/25 at 12:01 p.m. R1 was wheeling himself in his wheelchair down the hall using his feet to propel. His left foot was wrapped in an ace wrap with visible dirt and reddish yellow drainage. Licensed Practical Nurse (LPN)-B was asked to complete his dressing change. She entered the room and washed her hands in the bathroom sink. She did not set-up a sterile field for the dressing supplies. R1's ace wrap was removed, the drainage had bled through a tubular stretch stocking (a seamless elastic tube-shaped bandage used to secure dressings in place), kerlix wrap	F0880		

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F0880 SS = D	Continued from page 26 (cotton wrap to assist with a fast-wicking absorbent) and the ace wrap. R1 was actively bleeding from the open surgical wound on his heel. The wound measured approximately 8-centimeters (cm) in Length (L), 6 cm in Width (W). The wound depth could not be identified due to the bleeding. What appeared to be a blood clot or skin tag measuring approximately 3-centimeter (cm) (L), 2 cm (W) was dangling from the wound. LPN-B applied to pressure with the soiled Kerlix to the active bleeding of the wound for 4 minutes. LPN-B did not have new dressing supplies in R1's room. She wrapped the soiled kerlix around the wound and left the room to gather supplies. She doffed her soiled gloves, did not sanitize her hands. She came back into the room with the new supplies, placed them on R1's bed, went in the bathroom washed her hands and donned clean gloves. LPN-B cleansed the wound with betadine solution (a brownish-yellow antiseptic). LPN-B saturated the gauze she used to cleanse the wound, formed it into a ball and placed it inside the wound. She covered the wound with an ABD pad (absorbent pad), took R1's soiled tubular stocking, cut it in half with the same scissors, without sanitizing, she had used to remove R1's dressing. LPN-B placed the cut tubular stocking over R1's foot and wrapped his foot in the same soiled ace bandage she had removed from R1 and used the same tape she removed from his dressing to secure the ace wrap. LPN-B placed the soiled dressing supplies in R1's garbage can and left in the room. Upon observation and interview on 9/29/25 at 1:35 p.m. the director of nurse, DON was asked to change R1's dressing along with an interview. The DON had donned a gown, gloves, and a face mask per the EBP guidelines. She gathered supplies, sanitized the bedside table to place the new supplies. She undressed the dressing using proper technique and completed the dressing change per the provider's current order. As she was undressing the wound she stated betadine was not part of R1's order as she removed the ball of betadine gauze from the wound. The DON cleansed the wound with saline, pat dry. She used pressure from the saline syringe and the questionable skin tag vs. a blood clot separated from the wound and the DON identified it as a blood clot and discarded. She donned clean gloves and sanitized her hands prior to placing the zero-form dressing in the wound. R1's wound was covered with an ABD pad, wrapped in kerlix. A tubular stocking was placed over the kerlix and then wrapped with an ace bandage. The DON used all clean supplies and removed the discarded supplies from LPN-B's dressing change and her own from R1's room. The DON stated was not certain why LPN-A used betadine on the wound. Her expectations	F0880		

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 12/02/2025

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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F0880 SS = D	Continued from page 27 were that all supplies are brought into the room prior to the dressing change. A surface is sanitized for the clean supplies. EBP PPE should have been followed so LPN-A should have gowned, masked, and gloved. Any equipment used during a dressing change must be sanitized and soiled dressings are not re-used. Soiled dressing was not to be left in the resident rooms. Upon interview on 9/29/25 at 2:05 p.m. LPN-B stated she was aware that she should have worn a gown and a mask when she completed R1's wound care. She stated EBP is meant for a resident with any type of "opening" and R1's wound was open. She expected R1's wound supplies to be in his room, she changed his dressing over the weekend and his supplies were in his drawer, so she was able to remove them drawer as she was changing the dressing. Upon interview on 10/2/25 at 11:38 a.m. the facilities Medical Director stated he expected staff to always follow all infection control precautions when providing care. A facility policy titled Infection Prevention and Control dated with a revision date of 11/2024 under the title Prevention of Infection indicated: Important facets of infection prevention include: a. identifying possible infections or potential complications of existing infections. b. instituting measures to avoid complications or dissemination. c. educating staff and ensuring that they adhere to proper techniques and procedures. d. enhancing screening for possible significant pathogens. e. immunizing residents and staff to try to prevent illness. f. implementing appropriate isolation precautions when necessary; and g. following established general and disease-specific guidelines such as those of the Centers for Disease Control (CDC).	F0880		

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F0880 SS = D	Continued from page 28 A Center for Disease Control website https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.html?CDC_AAref_Val=https://www.cdc.gov/hai/containment/PPE-Nursing-Homes.html titled Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resident Organisms (MDROs) dated 4/2/2025 reviewed on 10/1/25 indicated: 1. Multidrug-resistant organism (MDRO) transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. 2. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. 3. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: • Wounds or indwelling medical devices, regardless of MDRO colonization status • Infection or colonization with an MDRO. 4. Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care. 5. Standard Precautions, which are a group of infection prevention practices, continue to apply to the care of all residents, regardless of suspected or confirmed infection or colonization status. A Minnesota Department of Health website https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/woundcare.pdf titled Wound Care Infection Prevention Recommendations for Long-Term Care Facilities dated 11/30/22 reviewed on 10/1/25 indicated: Wound care equipment and supplies %ª Any reusable equipment (e.g., bandage scissor, flashlight, mirror) and supplies that come in contact with non-intact skin, mucous membranes, or any bodily fluids or drainage, including fluids on bedding or gloved health care workers hands, are considered semi-critical instruments. Either: 1. Perform high-level disinfection (HLD) before use on	F0880		

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F0880 SS = D	Continued from page 29 another resident OR 2. Discard wound care equipment or products when no longer needed for an individual resident. %ª When HLD (or sterilization) is not available and dedicated equipment is used for each resident, it is important to clean and disinfect each piece of equipment after each use on the same resident to reduce bio load per manufacturer's instructions for use, 3 %ª Dispose of dedicated equipment (if disposable equipment is used) or arrange to have dedicated equipment appropriately processed after no longer needed for care of the designated resident. %ª Dedicate tape, sprays, creams, and all wound care products to an individual resident and do not store used sprays with clean wound care supplies. %ª If fresh bandages are cut for the resident, it should be done with clean scissors, not with scissors used to cut off soiled bandages. %ª Wound care dressings can be disposed of in the regular trash unless they are dripping or saturated with blood or other regulated body fluids. Clean and disinfect the surface (e.g., over bed table) where wound care supplies will be placed prior to setting down wound care supplies in resident room. %ª Store wound care supplies in a clean area of resident room	F0880		

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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 9/29/25 to 10/1/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure The following complaints were reviewed during the survey.	20000		12/22/2025

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 H51875186C / 2628280 H51875166C / 2628627 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		