DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 21, 2026

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

RE: CCN: 245187
Cycle Start Date: March 3, 2026

Dear Administrator:

On April 10, 2026, 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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Re: Reinspection Results
Event ID: 1F1AFE-H2

Dear Administrator:

On April 10, 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 March 3, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
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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 03/03/2026

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 1/26/26, 1/27/26, and 3/3/26, 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: H51876981C (2788115), H51876981C (2785632), and H51875985 (2704838) with deficiencies issued at F697 and F760. As a result of the investigation deficiencies were cited at F580 and F684. 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		04/07/2026
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a	F0580	Resident no longer resides in the facility All residents with respiratory conditions have the potential to be affected by the deficient practice. An audit of current residents was conducted to identify: Any significant changes in condition (last 30 days) in relation to abnormal vital signs, Documentation of provider and family notification. Education will be provided to nursing staff related to notification requirements related to change of conditions, when to notify provider and family, and documentation expectations.	04/07/2026

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

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F0580 SS = D	Continued from page 1 deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to report a change in condition to the provider and family for 1 of 3 residents (R2) when R2 had an acute episode of hypoxemia (low levels of oxygen in the blood characterized by symptoms that may include shortness of breath and bluish lips) during a combined	F0580	Continued from page 1 Audits will be completed by the DON and/or designee weekly x4 weeks and then monthly x2 months then 1x for 1 month for all affected residents related to any significant changes in condition, documentation of provider and family notification, and documentation of completeness. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule are needed.	

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F0580 SS = D	Continued from page 2 physical and occupational therapy assessment. Findings include: R2's admission Minimum Data Set (MDS) dated 2/2/26 indicated intact cognition, R2 did not require oxygen or respiratory assistive devices, and had diagnoses that included chronic lung disease. R2's Admission Data Collection (nursing assessment) dated 1/28/26 at 3:45 p.m., indicated R2's oxygen saturation rate on 1/28/26 at 2:26 p.m., was 96% on room air with a respiration rate of 18 breaths per minute, normal respirations, and R2 used a continuous positive airway pressure (CPAP) machine (used to treat sleep apnea - a condition where breathing repeatedly stops and starts during sleep). R2's provider orders dated 1/28/26, indicated CPAP machine on at night and for oxygen at 2 liters per nasal cannula to maintain oxygen saturation above 90%. R2's baseline care plan dated 1/28/26, indicated intact cognition and alteration in oxygen/gas exchange with interventions to monitor oxygen saturations as ordered and as needed (PRN), monitor for cyanosis (bluish or discoloration of lips caused by lack of oxygen), monitor and document on respiratory status, administer oxygen as ordered, and keep doctor informed of changes. R2's physical therapy (PT) assessment dated 1/29/26, and signed at 6:05 p.m., indicated R2 demonstrated signs of respiratory distress, the registered nurse (RN) was immediately informed, and R2 was placed on CPAP. R2's occupational therapy (OT) assessment 1/29/26, signed at 8:13 p.m., indicated R2's oxygen saturations fluctuated significantly with his lips turning blue during the evaluation, nursing was notified, and R2 was placed on CPAP. R2's progress notes from 1/29/26 at 11:52 a.m., to 1/30/26 at 9:17 a.m., lacked indication R2's provider or family were notified of the hypoxic incident.	F0580		

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F0580 SS = D	Continued from page 3 During an interview on 2/26/26 at 11:29 a.m., R2 stated on his second day at the facility (1/29/26), during therapy, he had a hard time breathing, a nurse assessed his oxygen saturation rate, and it was 66%, and the nurse put the CPAP on him as there was no oxygen in the room. During an interview on 2/26/26 at 2:46 p.m., family member (FM)-B stated when she visited R2 the evening of 1/29/26, R2 stated a nurse was in his room earlier because his lips were turning blue. The FM-B asked if nursing checked his oxygen again later, and R2 stated staff had not checked it again. A nurse went to assess R2's vital signs (VS) and stated the oxygen was low, at 89%, but not as low as earlier in the day. FM-B further stated the facility staff had not informed her of the hypoxic event, R2 did. During an interview on 2/27/26 at 11:47 a.m., licensed practical nurse (LPN)-B stated if R2's oxygen rate was at 66%, or 89%, the oxygen rate was low. The nurse should have documented the rate and notified the provider. LPN-B acknowledged the medical record lacked indication the provider was notified. During an interview on 2/27/26 at 2:13 p.m., registered nurse (RN)-B stated if a nurse intervened for a resident's low oxygen rate, the nurse should have notified the provider and the family. During an interview on 3/3/26 at 10:09 a.m., RM-D stated if a resident had a sudden low oxygen saturation, that was considered a change in condition, and a provider and family should have been notified. During an interview on 2/27/26 at 10:38 a.m., the nurse practitioner (NP)-A stated if R2 had an episode of O2 saturations of 66% she would have liked to be notified, and the family should have been notified. During an interview on 3/3/26 at 11:53 a.m., the director of nursing (DON) stated she would have expected the nurse to notify R2's provider and family of the change. The Notification of Changes policy dated 3/2024 indicated it is the policy of this facility that changes in a resident's condition or treatment be	F0580		

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F0580 SS = D	Continued from page 4 shared with the resident and/or the resident representative, according to their authority, and reported to the attending physician or delegate (hereafter designated as the physician).	F0580		
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 interviews and document review, the facility failed to assess and monitor 1 of 3 residents (R2) per the provider orders on admission and failed to comprehensively assess and monitor 1 of 3 residents (R2) after a change in condition when R2 participated in therapy, his lips turned blue and had a significant decrease in oxygen saturation rate. Findings include: R2's admission Minimum Data Set (MDS) dated 2/2/26 indicated R2 had intact cognition, required no oxygen or respiratory assistive devices, and had diagnoses that included chronic lung disease. R2's baseline care plan dated 1/28/26 indicated intact cognition and an alteration in oxygen/gas exchange with interventions to monitor oxygen saturations as ordered and as needed (PRN), monitor for cyanosis (bluish or discoloration of lips caused by lack of oxygen), monitor and document on respiratory status, administer oxygen as ordered, and keep doctor informed of changes. R2's provider orders indicated the following:Starting 1/28/26 at 3:00 p.m., monitor vital signs every 4 hours for 24 hours for one day through 2/17/26 at 2:15 p.m. Starting 1/28/26 at 3:00 p.m., monitor for pain every shift through 2/17/26 at 2:15 p.m. Starting 1/28/26 at 3:00 p.m., chart the resident's condition in nurse's notes every shift for seven days Starting 1/28/26 at	F0684	Resident no longer resides in the facility All residents with respiratory conditions have the potential to be affected by the deficient practice. An audit of current residents with respiratory diagnosis, 02 use, or recent therapy evaluations or change of condition admitted within the last 30 days in relation to abnormal vital signs was completed to ensure: Vital signs were completed per provider orders, Oxygen saturation monitoring was completed as ordered, Skilled notes and nursing documentation were completed per order Education will be provided to nursing staff related to requirements related to following provider orders without omission, required actions after a change in condition, and proper documentation of assessments, vital signs, and oxygen saturation. Audits will be completed by the DON and/or designee weekly x4 weeks and then monthly x2 months then 1x for 1 month for all affected residents related to following provider orders without omission, required actions after a change in condition, and proper documentation of assessments, vital signs, and oxygen saturation. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule are needed.	04/07/2026

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F0684 SS = D	Continued from page 5 3:00 p.m., check oxygen saturation levels every shift through 2/17/26 at 2:15 p.m. Starting 1/28/26 at 11:00 p.m., complete a Daily Skilled Note every night shift on Wednesdays and Sundays through 2/17/26 at 2:15 p.m. Starting 1/29/26 at 3:00 p.m., complete a Daily Skilled Note every evening shift on Tuesday, Thursday, and Saturday through 2/17/26 at 2:25 p.m. Starting 1/30/26 at 7:00 a.m., complete a Daily Skilled Note everyday shift on Monday, Wednesday, Friday through 2/17/26 at 2:15 p.m. R2's physical therapy (PT) assessment dated 1/29/26, and signed at 6:05 p.m., indicated R2 demonstrated signs of respiratory distress, the registered nurse (RN) was immediately informed, and R2 was given the CPAP (continuous positive airway pressure -used to keep the airway open during sleep). R2's occupational therapy (OT) assessment 1/29/26, signed at 8:13 p.m., indicated R2's oxygen saturations fluctuated significantly with lips turning blue during the evaluation, nursing was notified, and R2 was placed on CPAP. R2's oxygen saturation levels were documented in the electronic health record (EHR) as follows:1/28/26 at 2:26 p.m. at 96% on room air (RA)1/28/26 from 3-11 p.m., oxygen saturation levels were not assessed/recorded1/29/26 at 12:42 a.m. at 97% on CPAP 1/29/26 at 4:03 a.m. 93% on RA1/29/26 at 9:51 a.m., 91% per nasal cannula (NC)1/29/26 at 9:53 a.m., 93% on RA1/29/26 at 8:41 p.m., 91% on CPAP1/30/26 at 3:03 a.m., 94% on CPAPR2's oxygen saturation level documentation lacked indication of a decreased saturation level, reported during PT and OT assessments. Further, the record lacked indication of vital signs, which include oxygen saturation rates, were monitored every 4 hours, for 24 hours after admission, as ordered. R2's vital signs records indicated blood pressure, pulse, respirations, and temperature were assessed:1/28/26 at 2:26 p.m.1/29/26 at 12:42 a.m.1/29/26 at 4:03 a.m.1/29/26 at 9:51 a.m. R2's vital sign records indicated R2's pulse and respirations were also assessed on 1/29/26 at 2:28 p.m., but lacked evidence of temperature and blood pressure, or oxygen saturation rate. The records also lacked indication vital signs were assessed every four hours for 24 hours as ordered.	F0684		

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F0684 SS = D	Continued from page 6 R2's January 2026 Treatment Administration Record (TAR) lacked indication of the following:Daily Skilled Notes were completed as ordered on evening shift 1/31/26.Vital signs were entered on the TAR on 1/28/26 at 4:00 p.m. and 8:00 p.m. R2's progress notes R2's progress notes from 1/28/26 at 2:45 p.m., to 9:17 a.m., lacked indication any additional oxygen saturation rates were assessed, and lacked Daily Skilled Notes and nursing assessments on 1/30/26 and 1/31/26. R2's February 2026 TAR lacked indication of the following:Pain assessments every shift as ordered. Staff charted the resident's condition in nurse's notes every shift for seven days (through 2/3/26) as orderedOxygen saturation levels were checked every shift as orderedDaily Skilled Notes were completed as ordered During an interview on 2/26/26 at 11:29 a.m., R2 stated on his second date at the facility, 1/29/26, during therapy, he had a hard time breathing, a nurse assessed his oxygen saturation rate, and it was 66%, and the nurse put the CPAP on him. During an interview on 2/26/26 at 2:46 p.m., FM-B stated when she visited R2 the evening of 1/29/26, R2 indicated a nurse was in his room earlier because his lips were turning blue and FM-B asked if nursing checked his oxygen again later, and R2 stated staff had not checked it again. FM-B went to the nurse's desk to ask for staff to check R2's vital signs, and no one came for about 45 minutes, and then went to ask again, but was told the nurse was on a meal break. A nurse manager went to assess R2's vital signs (VS) and stated the oxygen was low, at 89%, but not as low as earlier in the day. FM-B could not recall who the nurse was who checked R2's VS. FM-B further stated there was no oxygen in R2's room on 1/29/26; it came on 1/30/26. During an interview on 2/27/26 at 11:47 a.m., licensed practical nurse (LPN)-B stated if R2's oxygen rate was at 66%, or 89%, the oxygen rate was low and the nurse who assessed him should have documented the low rate in the progress notes and notified the provider. LPN-B acknowledged the medical record lacked indication the event happened or the provider was notified. LPN-B further acknowledged R2's vital signs were not	F0684		

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F0684 SS = D	Continued from page 7 monitored as ordered, and oxygen saturation levels were not checked as ordered, and daily charting was not completed as ordered. During an interview on 2/27/26 at 2:13 p.m., RN-B stated R2 did not have daily skilled notes for 1/30/26 and 1/31/26, should have had progress notes charted every shift, but did not, and R2's vital signs and oxygen assessments were not performed as ordered. If the resident was not assessed, the resident and family would be concerned about his care. RN-B stated she was not aware R2 had a low oxygen saturation during therapy, but if a nurse intervened because of low oxygen, it should have been charted, and R2 should have had more frequent assessments afterwards, and acknowledged the incident and more frequent assessments were not documented. During an interview on 2/27/26 at 10:38 a.m., the nurse practitioner (NP)-A stated if R2 had an episode of O2 saturations of 66% she would have liked to be notified, and the family should have been notified. The NP-A stated the episode should have been documented if it was not. During an interview on 3/3/26 at 11:53 a.m., the director of nursing (DON) acknowledged R2's medical record lacked documentation of R2's hypoxic event and the nurse's interventions. The DON stated after R2's change in condition nursing staff should have completed an assessment, provided care as needed, called the provider and family, and would have expected further assessment and monitoring but there was no record that occurred. Further, the DON stated she would have expected orders were followed, and care provided per the provider orders. Polices for assessment and monitoring and for following orders as prescribed were requested but not provided.	F0684		
F0697 SS = D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by:	F0697	Resident no longer resides in the facility All residents with active pain diagnosis or receiving PRN pain medications have the potential to be affected by the deficient practice. An audit of current residents was conducted to ensure: Pain assessments are completed per policy and with any report of pain, PRN pain medications are followed by timely reassessment, Scheduled pain medications are administered as ordered, and Non-pharmacological interventions are documented. Licensed nurses (RN/LPN) completed mandatory education	04/07/2026

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F0697 SS = D	Continued from page 8 Based on interview and document review the facility failed to sufficiently manage pain for 1 of 3 residents (R2) when R2 reported severe pain and was not provided with pain medications until more than 24 hours later. Findings include: R2's admission Minimum Data Set (MDS) dated 2/2/26 indicated intact cognition and a diagnosis that included spinal stenosis (narrowing of the spaces within the spine which puts pressure on the nerves and spinal cord) of the cervical (neck) region and required active care at the facility for aftercare for surgery that involved fusion of the spinal bones. R2 received opioid pain medications as needed (PRN), and pain occasionally interfered with activities. R2's baseline care plan dated 1/28/26, indicated intact cognition, pain/comfort issues, with a goal for adequate pain relief, and interventions that included non-medicinal forms of pain relief such as position, rest, and massage, and included pain medications as ordered by the physician. R'2s provider orders dated indicated the following:Dated 1/28/26 at 3:00 p.m., monitor for pain daily, every shift through 2/17/26 at 2:15 p.m.Dated 1/28/26 at 11:30 a.m., acetaminophen 325 milligrams (mg), 2 tablets by mouth every 4 hours as needed for mild painDated 1/28/26 at 11:30 a.m., oxycodone HCl (narcotic pain medication administered for moderate to severe pain), 5 mg, 1 tablet buy mouth every 4 hours as needed for painDated 1/28/26 at 3:00 p.m., use non-pharmacological pain interventions including ice, heated blankets, massage, repositioning, music, essential oils, food/drink, and relaxing/breathing. Document interventions used.R2's January 2026 Medication Administration Record (MAR) indicated the following:acetaminophen was not administered in January, although the progress notes on 1/29/26 at 9:47 p.m., indicated it was administered.Oxycodone was administered for the first time on 1/29/26 at 8:59 p.m. for pain rated as 7/10 and twice on 1/30/26 and 1/31/26 for pain rated between 7-10/10. [The January 2026 MAR indicated R2's pain was rated as 0/10 on 1/30/26 at 9:10 a.m., but during an interview on 2/27/26 at 4:36 p.m., registered nurse (RN)-A stated the pain rating was entered incorrectly and should have been entered as 10/10.]The MAR lacked indication oxycodone was administered again on 1/29/26 at 9:47 p.m., but the progress notes at that time indicated it was	F0697	Continued from page 8 on: Pain assessment and reassessment expectations, Proper documentation of pain management, and Use of pain scales. Audits will be completed by the DON and/or designee weekly x4 weeks and then monthly x2 months then 1x for 1 month for all affected residents related to pain assessments and timely reassessments, PRN pain medication documentation, and proper documentation of pain management. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule are needed.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT THE CEDARS	7900 WEST 28TH STREET , SAINT LOUIS PARK, 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
F0697 SS = D	Continued from page 9 administered. R2's January 2026 Treatment Administration Record (TAR) indicated R2's pain was rated as follows:1/28/26 during the 11-7 p.m. shift rated as 7/101/30/26 during the 7-3 a.m. shift rated as 2/10All other shifts through the 11-7 p.m. shift indicated pain was rated as 0/10.The TAR further indicated the only non-medicinal pain intervention offered on 1/28/26 for pain rated as 7/10 was food and drink. R2's January 2026 pain assessment log indicated pain ratings as follows:1/29/26 at 2:41 p.m. rated as 7/101/29/26 at 8:59 p.m. rated as 7/10 R2's progress notes indicated the following:1/28/26 progress notes lacked documentation about pain assessments1/29/26 at 7:53 p.m., indicated a family member was at the nursing desk requesting pain medications for R2. Family reported R2's pain level was rated as 7/10, which meant from experience, it was really meant 9/10 because R2 had, "Learned to live through pain." A nurse assessed R2's pain, which R2 rated as 7/10, and the nurse then called the on-call provider to request an oxycodone prescription be sent to the pharmacy so the nurse may pull the medication from the facility's medication bank.1/29/26 at 8:59 p.m., indicated oxycodone 5 mg was retrieved from the mediation bank and administered to R2 for pain.1/29/26 at 9:47 p.m., oxycodone 5 mg was retrieved from the medication bank and administered with acetaminophen and Flexeril (muscle relaxer).1/30/26 at 2:04 a.m., oxycodone 5 mg During an interview on 2/26/26 at 11:29 a.m., with R2 and family member (FM)-A, R2 stated when he arrived at the facility his pain was constant, and would get "harder" at times, rated as an 8/10 or 9/10. "It would get pretty damn hard." During an interview on 2/26/26 at 11:29 a.m., FM-A stated R2 came to the facility after surgery for fused spinal discs, and when R2 arrived, the facility did not have R2's pain medication, oxycodone 5 mg, that was ordered. FM-A stated during a visit with R2 on 1/29/26 around 6:00 p.m., the R2 was shouldn't have had to wait for oxycodone. He was hurting so much R2. FM-A added, he had a terrible ride to the facility, and the facility did not have pain medication to help with the pain when he arrived. During an interview on 2/26/26 at 1:31 p.m., licensed practical nurse (LPN)-A stated when a resident was	F0697		

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F0697 SS = D	Continued from page 10 newly admitted, the admitting nurse completed a form for the pharmacy to request medications, faxed the form with any required prescriptions to the pharmacy, and then the nurse calls the pharmacy to ensure the pharmacy received the fax. The LPN-A stated the pharmacy delivers medications to the facility twice a day. Additionally, the LPN-A stated residents should not have to wait for pain medications because nurses can get narcotic pain medications from the facility medication bank with an access code provided by a pharmacist and a witness and did not know why R2 waited so long to get pain medication. During an interview on 2/26/26 at 2:47 p.m., FM-B stated when she visited on 1/29/26, R2 had not had pain medications, and a nurse was trying to get them for him. He admitted 1/28/26 and didn't have pain relief or medication available. FM-B stated R2 reported pain at a rating of 9/10, or 10/10, and didn't want to move around or eat due to the severe pain and had pressed his call light an hour prior to the arrival of family to request pain medications but hadn't gotten them as of the time of the family visit. During an interview on 2/27/26 at 2:13 p.m., RN-B stated she saw R2's FM-A at the nurse's desk on 1/29/26 but didn't normally work at that station. RN-B went with the FM-A and assessed R2's pain, and the FM-A was adamant R2 was uncomfortable and the pain was usually more than R2 stated. R2 rated his pain as 7/10, in his head not his neck, and RN-B told the FM-A she would check to see what R2 had ordered for pain medications. RN-B stated R2's oxycodone was not in the facility because of a miscommunication about the prescription but was able to order the medication from pharmacy. RN-B stated she instructed the unit nurse (she didn't recall who), R2 could have acetaminophen and Flexeril. RN-B stated with pain rated as 7/10, she would not offer non-pharmacological relief first and further stated R2 should have gotten pain relief on 1/28/26 and should not have had to wait until 1/29/26. RN-B did not recall giving another dose previously without charting it. Additionally, RN-B stated when R2 had unmanaged pain, he could have required rehospitalization. The process for obtaining a narcotic prescription was for a nurse to check for the prescription upon admission, and if it is not present, or is not complete, the nurse would call the hospital or the on-call provider to get a prescription. If the resident was not being assessed, or the pain was not managed, the resident and family would be concerned about his care. During an interview on 2/27/26 at 10:38 a.m., the nurse practitioner (NP)-A stated if R2 had pain rated as 7/10	F0697		

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F0697 SS = D	Continued from page 11 or higher, he would have had pain medications and would not have comfortable. NP-A stated the nurse could have called the pain team for a one-time dose, waiting over 24 hours for pain relief was too long, and NP-A thought oxycodone 5 mg was available in the facility medication bank. NP-A stated she was not notified that the staff couldn't get the pain medication. During an interview on 3/3/26 at 11:53 a.m., during an interview the director of nursing (DON) stated when residents were admitted, they typically came with orders, the facility admitting nurse reviewed the orders, and if pain medications were required but not ordered, the nurse would get an order from the provider. The DON acknowledged there was a disruption in the process for R2 to get pain medications timely, and there continues to be gaps in the process the facility nurses are not following. The DON stated nurses had education about the process, but still had a medication error afterwards, so were still not following the process. The Pain Management protocol dated 3/23/23, indicated a review of each resident's diagnoses and conditions was conducted that commonly cause or predispose to pain, with a review of individual pain upon admission. The staff and provider will identify the location, intensity, frequency, pattern and severity of pain, and observe the resident during rest and movement for evidence of pain. Nursing staff would identify situations or interventions where an increase in pain may be anticipated. The resident's care plan would reflect the pain management needs. If the prescribed medications were not available or there was a delay in obtaining the medication, the provider will be notified, and alternative medications or interventions would be obtained to meet the resident's pain management needs.	F0697		
F0760 SS = D	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 verify and accurately transcribe orders for 1 of 3 residents (R1) when a blood pressure medication with conflicting dose and types were prescribed for R1	F0760	R1 and R2 no longer reside in the facility All residents have the potential to be affected by deficient practice. An audit of medication administration records (MARs) for the past 14 days was completed to identify: Missed doses, Wrong dose/time/route errors, and Documentation discrepancies Licensed nurses completed mandatory re-education on: Medication order transcription, administration safety, Prevention of significant medication errors, and Proper documentation and reporting of errors	04/07/2026

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F0760 SS = D	Continued from page 12 and then then transcribed incorrectly. Additionally, the facility failed to timely administer prescribed pain medication for 1 of 3 residents (R2) who was admitted post-surgically after a cervical (neck) spinal fusion. Findings include: R1's admission Minimum Data Set (MDS) dated 12/5/25, indicated intact cognition, with diagnoses that included heart failure, orthostatic hypotension (blood pressure that drops significantly when first sitting up or standing up), and stroke. R1's hospital discharge summary dated 12/12/25 indicated R2 was prescribed metoprolol succinate (long-acting type) 50 milligrams (mg) twice daily, in the morning and bedtime. R1's facility orders indicated the following:Metoprolol succinate ER (extended release) 50 mg, give 1 tablet daily by mouth 12/13/25 to 1/16/25 at 8:00 a.m. Metoprolol succinate ER (extended release or long-acting), give 50 mg 1 tablet daily by mouth from 12/12/25 to 1/15/26 at 8:00 p.m. R1's December 2025 Medication Administration Records (MAR) indicated the following:Metoprolol succinate ER 50 mg was administered daily at 8:00 a.m., and at bedtime from 12/12/25 to 12/31/25, with one dose omitted 12/14/25 at bedtime with no reason for the omission documented. R1's cardiology provider note dated 1/15/26, indicated R1 entered the appointment prescribed metoprolol succinate 50 mg once daily and recommendations after the appointment included increasing the metoprolol succinate to 75 mg daily. R1's cardiology provider order from the cardiology clinic dated 1/15/26 indicated increase metoprolol succinate to 75 mg twice daily (BID), contrary to the dose recommended in the cardiology Provider Note. R1's facility orders indicated the following:Metoprolol succinate ER 24 hour sprinkles 25 mg, give 3 tablets by mouth two times a day 1/16/26 to 2/4/26. The progress notes lacked indication facility staff clarified the conflicting cardiology order and cariology provider note from the same visit, or clarified with the	F0760	Continued from page 12 Audits will be completed by the DON and/or designee weekly x4 weeks and then monthly x2 months then 1x for 1 month for all affected residents related to Missed/late medications and Documentation accuracy. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule are needed.	

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F0760 SS = D	Continued from page 13 cardiologist the discrepancy in dosing with the admitting order from the hospital. R1's provider orders sent from the facility pharmacy to the facility dated 1/30/26 indicated metoprolol succinate ER 50 mg, take 1 tablet once daily. R1's facility orders indicated:Metoprolol succinate ER 24 hour sprinkles 25 mg, give 3 tablets by mouth two times a day 1/16/26 to 2/4/26 Metoprolol tartrate 50 mg, give 1 tablet by mouth daily 1/30/26 to 2/2/26 instead of metoprolol succinateMetoprolol tartrate 50 mg, give 1 tablet by mouth daily 2/3/26 to 2/5/26 The facility orders were clarified and corrected on 2/6/26 to:Metoprolol tartrate 50 mg, give 1 tablet by mouth daily 2/6/26 , instead of metoprolol succinate that was prescribed The progress notes lacked indication nursing staff clarified the conflicting and duplicate orders. R1's January and February MARs indicated both metoprolol succinate 75 mg BID and metoprolol tartrate 50 mg daily were given from 1/30/26 to 2/4/26, and doses of metoprolol succinate were given twice daily from 1/15/26 to 2/4/26 without clarifying the conflicting order of once daily versus twice daily. R1's January 2026 MAR indicated the following:Metoprolol succinate ER 50 mg was administered daily at 8:00 a.m., from 1/1/26 to 1/15/26.Metoprolol succinate ER 50 mg was administered daily at 8:00 p.m., from 1/1/26 to 1/14/26. Metoprolol succinate ER Sprinkle 25 mg, 3 tablets were administered daily at 8:00 a.m., and 4:00 p.m., except one dose was omitted on 1/30/26 at 4:00 p.m. Metoprolol tartrate [wrong form or metoprolol] 50 mg was administered one time at 6 p.m., on 1/30/26. R1's February 2026 MAR indicated the following:Metoprolol tartrate 50 mg was administered at 12:00 p.m. on 2/3/26 and refused on 2/4/26. Metoprolol tartrate 50 mg was administered at 6:00 p.m. on 2/1/26 and 2/2/26. Metoprolol succinate ER Sprinkle 25 mg, 3 tablets were administered at 8:00 a.m. from 2/1/26 to 2/4/26 and 4:00 p.m. from 2/1/26 to 2/3/26. Metoprolol tartrate was administered at 8:00 a.m. from 2/5/25 to 2/20/26. R1's provider progress note dated 2/10/26 at 2:09 p.m., indicated R1 received double the prescribed dose of metoprolol, with repeated symptoms of dizziness.	F0760		

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F0760 SS = D	Continued from page 14 During an interview on 1/26/26 at 8:36 a.m., R1 stated she didn't question her medications when they were administered but felt like she was getting sicker instead of better. R1 stated her cardiology provider told her she was getting the wrong dose of metoprolol, and the nurse practitioner (NP)-A, told her, she had been getting the wrong dose. R1 stated she was supposed to get metoprolol 50 mg once a day, and the dose was increased to 75 mg daily for a while but was getting 75 mg twice daily instead. R1 could not state what dates the changes occurred. During an interview on 2/27/26 at 10:38 a.m., the NP-A stated she remembered talking to R1 about her dizziness and there were duplicate orders for metoprolol which was an error. The NP-A stated she called R1's cardiologist to clarify the orders because R1 was taking metoprolol succinate 75 mg (a long-acting medication to manage blood pressure and heart rate typically given once daily) twice daily and should not have been. The order was changed to metoprolol tartrate (short-acting) 50 mg once daily because that was in error. The NP-A stated R1 did not appear to have severe adverse effects from the medication errors, had no blood pressure variations from the extra doses and no change in her heart rate, only some dizziness and lightheadedness which she had prior to the errors. During an interview on 2/27/26 at 11:47 a.m., licensed practical nurse (LPN)-B stated she noticed in February two doses of metoprolol were in R1's orders, one for 50 mg daily, and one for 75 mg twice daily, and stated R1 expressed concern about the medication dosing. The LPN-B stated she looked at the provider orders for changes and informed registered nurse (RN)-C of her concern. During an interview on 2/27/26 at 3:55 p.m. RN-C stated R1 was on the correct metoprolol dose from 12/12/25 until 12/30/25, but then a nurse received a telephone order from the cardiologist to decrease the medication from 75 mg twice a day to 50 mg once a day but didn't discontinue the 75 mg twice daily order. The process after for when a telephone order was received was to have another nurse and a nurse manager verify the orders, but that had not occurred. The nurses involved in the error were educated about the error and the process. RN-C acknowledged not seeing two different doses ordered by the cardiologist, both metoprolol succinate 75 mg daily and metoprolol succinate 75 mg daily. During an interview on 2/27/26 at 4:36 p.m., RN-A	F0760		

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F0760 SS = D	Continued from page 15 stated the error was when the medication order was entered into the medical record, with the wrong type of metoprolol; tartrate was ordered instead of succinate. RN-A acknowledged not knowing the difference between the two, but educated about the error on 2/26/26, a month after the error occurred. RN-A further acknowledged after the medication order was entered, he should have completed a progress note about the dose change to alert the other nurses but had not. RN-A stated R1 told him she had gotten both doses and had dizziness, which could have occurred as a result of taking more metoprolol than prescribed. Further RN-A stated the 2nd and 3rd verification checks for the telephone order had not occurred, and should have before the medication was administered to the resident but had not. During an interview on 2/27/26 at 1:35 p.m. pharmacist (PH)-A stated metoprolol succinate is an extended-release medication and is typically prescribed once daily. The PH-A stated R1 should not have gotten both metoprolol tartrate 50 mg daily and metoprolol succinate 75 mg twice daily. once dose should have been discontinued when the other started. Getting both doses could cause blood pressure to be too low and could cause dizziness and falls. During an interview on 3/3/26 at 11:53 a.m. the director of nursing stated the education started for R1's medication error on 2/26/26, to teach the difference between metoprolol succinate and metoprolol tartrate. The wrong dose and type would have unintended effects in the blood pressure, with potential for low blood pressure and falls. It was a transcription error that went unnoticed. R2's admission Minimum Data Set (MDS) dated 2/2/26 indicated R2 had intact cognition, had diagnoses that included spinal stenosis (narrowing of the spaces within the spine which puts pressure on the nerves and spinal cord) of the cervical (neck) region and required active care at the facility for aftercare for surgery that involved fusion of the spinal bones. R2 received opioid pain medications as needed (PRN), and pain occasionally interfered with activities. R2's hospital discharge orders included:Oxycodone 5 mg every 4 hours as needed for pain. Tylenol 325 mg 2 tablets by mouth every 4 hours as needed for mild pain R2's initial admission nursing assessment dated 1/28/26 at 1:30 p.m., indicated R2 had occasional mild pain in the previous five days.	F0760		

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F0760 SS = D	Continued from page 16 R2's pain evaluation dated 1/28/26, indicated R2 had pain that occasionally affected sleep, therapy activities, and day-to-day activities, and administer Oxycodone 5 mg 1 tablet every 4 hours as needed (PRN) for pain. R2's baseline care plan dated 1/28/26 indicated intact cognition, pain/comfort issues, with a goal for adequate pain relief, and interventions that included non-medicinal forms of pain relief such as position, rest, and massage, and included pain medications as ordered by the physician. R2's provider orders dated indicated the following:1/28/26 at 11:30 a.m., acetaminophen 325 milligrams (mg), 2 tablets by mouth every 4 hours as needed for mild pain1/28/26 at 11:30 a.m., oxycodone HCl (narcotic pain medication administered for moderate to severe pain), 5 mg, 1 tablet by mouth every 4 hours as needed for pain R2's January 2026 MAR indicated the following:acetaminophen was not administered in January, although the progress notes on 1/29/26 at 9:47 p.m. indicated it was administered. Oxycodone was administered for the first time on 1/29/26 at 8:59 p.m. for pain rated as 7/10 and twice on 1/30/26 and 1/31/26 for pain rated between 7-10/10. [The January 2026 MAR indicated R2's pain was rated as 0/10 on 1/30/26 at 9:10 a.m., but during an interview on 2/27/26 at 4:36 p.m., registered nurse (RN)-A stated the pain rating was entered incorrectly and should have been entered as 10/10.]The MAR lacked indication oxycodone was administered again on 1/29/26 at 9:47 p.m., but the progress notes at that time indicated it was administered with acetaminophen and Flexeril (muscle relaxer). R2's progress note dated 1/29/26 at 7:53 p.m., indicated R2's family member requested pain medications for R2, for pain R2 rated as 7/10. The progress note indicated the nurse had to call a provider to request an order for oxycodone 5 mg. The progress notes lack indication the medication was available or administered prior to that date and time. Further the progress notes indicated oxycodone 5 mg was administered on 1/29/26 at 8:59 p.m., and again on 1/29/26 at 9:47 p.m., with acetaminophen and Flexeril for pain management, which was too early according to the "every 4 hours as needed" time frame in the order.	F0760		

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F0760 SS = D	Continued from page 17 During an interview on 2/26/26 at 11:29 a.m., with R2 and family member (FM)-A, R2 stated when he arrived at the facility his pain was constant, and would get “harder” at times, rated as an 8/10 or 9/10. “It would get pretty damn hard.” The FM-A stated R2 did not get pain medications until 1/30/26 but should have on 1/29/26. During an interview on 2/26/26 at 11:29 a.m., FM-A stated R2 came to the facility after surgery for fused spinal discs in his neck, and when R2 arrived the facility did not have R2’s pain medication, oxycodone 5 mg, that was ordered. FM-A stated during a visit with R2 on 1/29/26 around 6:00 p.m., R2 was in pain. The FM-A stated, “He shouldn’t have had to wait for them [pain medications - oxycodone]. He was hurting so much.” Further, FM-A stated R2 reported to her he had a terrible ride to the facility, and the facility did not have pain medication to help with the pain when he arrived. During an interview on 2/26/26 at 1:31 p.m., licensed practical nurse (LPN)-A stated when a resident was newly admitted, the process was the admitting nurse completed a form for the pharmacy to request medications, faxed the form with any required prescriptions to the pharmacy, and then the nurse called the pharmacy to ensure the pharmacy received the fax. The LPN-A stated the pharmacy delivers medications to the facility twice a day. Additionally, the LPN-A stated residents should not have to wait for pain medications because nurses can get narcotic pain medication from the facility medication bank with an access code provided by a pharmacist and a witness and did not know why R2 waited so long to get pain medication but it was an error to not have them. During an interview on 2/27/26 at 10:38 a.m., the NP-A stated if R2 had pain rated as 7/10 or higher, he would have had pain medications and would not be comfortable. NP-A stated the nurse could have called the pain team for a one-time dose and waiting over 24 hours for pain relief was too long, and NP-A thought the medication was available in the facility medication bank. During an interview on 3/3/26 at 11:53 a.m., the DON stated the process for obtaining pain medications upon admission was to get the hospital orders, review the orders, and if the orders didn’t include required pain medication orders, to get an order from the hospital or the facility provider. The DON acknowledged a disruption in the process for obtaining pain medications upon admission for R2, and there were gaps	F0760		

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 03/03/2026

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F0760 SS = D	Continued from page 18 in the process the nurses had not followed. “It sounded like [R2] had pretty severe pain.” A Medication Error Policy was requested and not provided.	F0760		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/03/2026**

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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 1/26/26, 1/27/26, and 3/3/26 a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		04/07/2026

Office of Primary Care and Health Systems Management

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

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/03/2026**

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20000	Continued from page 1 The following complaints were reviewed: H51876981C (2788115), H51876981C (2785632), and H51875985 (2704838) with a licensing order issued at 1545. As a result of the investigation a licensing order was issued at 0265. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	20000		
20265	Notification of Chg in Resident Health Status CFR(s): MN Rule 4658.0085 A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician	20265	Corrected.	04/07/2026

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20265	Continued from page 2 assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to report a change in condition to the provider and family for 1 of 3 residents (R2) when R2 had an acute episode of hypoxemia (low levels of oxygen in the blood characterized by symptoms that may include shortness of breath and bluish lips) during a combined physical and occupational therapy assessment. Findings include: R2's admission Minimum Data Set (MDS) dated 2/2/26 indicated intact cognition, R2 did not require oxygen or respiratory assistive devices, and had diagnoses that included chronic lung disease.	20265		

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20265	Continued from page 3 R2's Admission Data Collection (nursing assessment) dated 1/28/26 at 3:45 p.m., indicated R2's oxygen saturation rate on 1/28/26 at 2:26 p.m., was 96% on room air with a respiration rate of 18 breaths per minute, normal respirations, and R2 used a continuous positive airway pressure (CPAP) machine (used to treat sleep apnea - a condition where breathing repeatedly stops and starts during sleep). R2's provider orders dated 1/28/26, indicated CPAP machine on at night and for oxygen at 2 liters per nasal cannula to maintain oxygen saturation above 90%. R2's baseline care plan dated 1/28/26, indicated intact cognition and alteration in oxygen/gas exchange with interventions to monitor oxygen saturations as ordered and as needed (PRN), monitor for cyanosis (bluish or discoloration of lips caused by lack of oxygen), monitor and document on respiratory status, administer oxygen as ordered, and keep doctor informed of changes. R2's physical therapy (PT) assessment dated 1/29/26, and signed at 6:05 p.m., indicated R2 demonstrated signs of respiratory distress, the registered nurse (RN) was immediately informed, and R2 was placed on CPAP. R2's occupational therapy (OT) assessment 1/29/26, signed at 8:13 p.m., indicated R2's oxygen saturations fluctuated significantly with his lips turning blue during the evaluation, nursing was notified, and R2 was placed on CPAP. R2's progress notes from 1/29/26 at 11:52 a.m., to 1/30/26 at 9:17 a.m., lacked indication R2's provider or family were notified of the hypoxic incident. During an interview on 2/26/26 at 11:29 a.m., R2 stated on his second day at the facility (1/29/26), during therapy, he had a hard time breathing, a nurse assessed his oxygen saturation rate, and it was 66%, and the nurse put the CPAP on him as there was no oxygen in the room. During an interview on 2/26/26 at 2:46 p.m., family member (FM)-B stated when she visited R2 the evening of 1/29/26, R2 stated a nurse was in his room earlier	20265		

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20265	Continued from page 4 because his lips were turning blue. The FM-B asked if nursing checked his oxygen again later, and R2 stated staff had not checked it again. A nurse went to assess R2's vital signs (VS) and stated the oxygen was low, at 89%, but not as low as earlier in the day. FM-B further stated the facility staff had not informed her of the hypoxic event, R2 did. During an interview on 2/27/26 at 11:47 a.m., licensed practical nurse (LPN)-B stated if R2's oxygen rate was at 66%, or 89%, the oxygen rate was low. The nurse should have documented the rate and notified the provider. LPN-B acknowledged the medical record lacked indication the provider was notified. During an interview on 2/27/26 at 2:13 p.m., registered nurse (RN)-B stated if a nurse intervened for a resident's low oxygen rate, the nurse should have notified the provider and the family. During an interview on 3/3/26 at 10:09 a.m., RM-D stated if a resident had a sudden low oxygen saturation, that was considered a change in condition, and a provider and family should have been notified. During an interview on 2/27/26 at 10:38 a.m., the nurse practitioner (NP)-A stated if R2 had an episode of O2 saturations of 66% she would have liked to be notified, and the family should have been notified. During an interview on 3/3/26 at 11:53 a.m., the director of nursing (DON) stated she would have expected the nurse to notify R2's provider and family of the change. The Notification of Changes policy dated 3/2024 indicated it is the policy of this facility that changes in a resident's condition or treatment be shared with the resident and/or the resident representative, according to their authority, and reported to the attending physician or delegate (hereafter designated as the physician). Suggested Method of Correction: The director of nursing (DON) or designee could work with the medical director to update policies and procedures for when to notify the family of changes in condition. The DON or designee could educate staff about the policies and procedures.	20265		

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20265	Continued from page 5 The DON or designee could perform audits to determine if the family had been notified as appropriate and bring the results of the audits to the QA committee. Time Period for Correction: Twenty-one (21) days.	20265		
21545	Medication Errors CFR(s): MN Rule 4658.1320 A.B.C A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an	21545	Corrected	04/07/2026

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21545	Continued from page 6 explanation must be made in the resident's clinical record. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to verify and accurately transcribe orders for 1 of 3 residents (R1) when a blood pressure medication with conflicting dose and types were prescribed for R1 and then then transcribed incorrectly. Additionally, the facility failed to timely administer prescribed pain medication for 1 of 3 residents (R2) who was admitted post-surgically after a cervical (neck) spinal fusion. Findings include: R1's admission Minimum Data Set (MDS) dated 12/5/25, indicated intact cognition, with diagnoses that included heart failure, orthostatic hypotension (blood pressure that drops significantly when first sitting up or standing up), and stroke. R1’s hospital discharge summary dated 12/12/25 indicated R2 was prescribed metoprolol succinate (long-acting type) 50 milligrams (mg) twice daily, in the morning and bedtime. R1’s facility orders indicated the following:Metoprolol succinate ER (extended release) 50 mg, give 1 tablet daily by mouth 12/13/25 to 1/16/25 at 8:00 a.m. Metoprolol succinate ER (extended release or long-acting), give 50 mg 1 tablet daily by mouth from 12/12/25 to 1/15/26 at 8:00 p.m. R1’s December 2025 Medication Administration Records (MAR) indicated the following:Metoprolol succinate ER 50 mg was administered daily at 8:00 a.m., and at bedtime from 12/12/25 to 12/31/25, with one dose omitted 12/14/25 at bedtime with no reason for the omission documented. R1’s cardiology provider note dated 1/15/26, indicated R1 entered the appointment prescribed metoprolol succinate 50 mg once daily and recommendations after the appointment included increasing the metoprolol succinate to 75 mg daily. R1’s cardiology provider order from the cardiology clinic dated 1/15/26 indicated increase metoprolol succinate to 75 mg twice daily (BID), contrary to the	21545		

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21545	Continued from page 7 dose recommended in the cardiology Provider Note. R1’s facility orders indicated the following:Metoprolol succinate ER 24 hour sprinkles 25 mg, give 3 tablets by mouth two times a day 1/16/26 to 2/4/26.The progress notes lacked indication facility staff clarified the conflicting cardiology order and cariology provider note from the same visit, or clarified with the cardiologist the discrepancy in dosing with the admitting order from the hospital. R1’s provider orders sent from the facility pharmacy to the facility dated 1/30/26 indicated metoprolol succinate ER 50 mg, take 1 tablet once daily. R1’s facility orders indicated:Metoprolol succinate ER 24 hour sprinkles 25 mg, give 3 tablets by mouth two times a day 1/16/26 to 2/4/26Metoprolol tartrate 50 mg, give 1 tablet by mouth daily 1/30/26 to 2/2/26 instead of metoprolol succinateMetoprolol tartrate 50 mg, give 1 tablet by mouth daily 2/3/26 to 2/5/26 The facility orders were clarified and corrected on 2/6/26 to:Metoprolol tartrate 50 mg, give 1 tablet by mouth daily 2/6/26 , instead of metoprolol succinate that was prescribed The progress notes lacked indication nursing staff clarified the conflicting and duplicate orders. R1’s January and February MARs indicated both metoprolol succinate 75 mg BID and metoprolol tartrate 50 mg daily were given from 1/30/26 to 2/4/26, and doses of metoprolol succinate were given twice daily from 1/15/26 to 2/4/26 without clarifying the conflicting order of once daily versus twice daily. R1’s January 2026 MAR indicated the following:Metoprolol succinate ER 50 mg was administered daily at 8:00 a.m., from 1/1/26 to 1/15/26.Metoprolol succinate ER 50 mg was administered daily at 8:00 p.m., from 1/1/26 to 1/14/26.Metoprolol succinate ER Sprinkle 25 mg, 3 tablets were administered daily at 8:00 a.m., and 4:00 p.m., except one dose was omitted on 1/30/26 at 4:00 p.m.Metoprolol tartrate [wrong form or metoprolol] 50 mg was administered one time at 6 p.m., on 1/30/26.R1’s February 2026 MAR indicated the following:Metoprolol tartrate 50 mg was administered at 12:00 p.m. on 2/3/26 and refused on 2/4/26.Metoprolol tartrate 50 mg was	21545		

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21545	Continued from page 8 administered at 6:00 p.m. on 2/1/26 and 2/2/26.Metoprolol succinate ER Sprinkle 25 mg, 3 tablets were administered at 8:00 a.m. from 2/1/26 to 2/4/26 and 4:00 p.m. from 2/1/26 to 2/3/26.Metoprolol tartrate was administered at 8:00 a.m. from 2/5/25 to 2/20/26. R1's provider progress note dated 2/10/26 at 2:09 p.m., indicated R1 received double the prescribed dose of metoprolol, with repeated symptoms of dizziness. During an interview on 1/26/26 at 8:36 a.m., R1 stated she didn't question her medications when they were administered but felt like she was getting sicker instead of better. R1 stated her cardiology provider told her she was getting the wrong dose of metoprolol, and the nurse practitioner (NP)-A, told her, she had been getting the wrong dose. R1 stated she was supposed to get metoprolol 50 mg once a day, and the dose was increased to 75 mg daily for a while but was getting 75 mg twice daily instead. R1 could not state what dates the changes occurred. During an interview on 2/27/26 at 10:38 a.m., the NP-A stated she remembered talking to R1 about her dizziness and there were duplicate orders for metoprolol which was an error. The NP-A stated she called R1's cardiologist to clarify the orders because R1 was taking metoprolol succinate 75 mg (a long-acting medication to manage blood pressure and heart rate typically given once daily) twice daily and should not have been. The order was changed to metoprolol tartrate (short-acting) 50 mg once daily because that was in error. The NP-A stated R1 did not appear to have severe adverse effects from the medication errors, had no blood pressure variations from the extra doses and no change in her heart rate, only some dizziness and lightheadedness which she had prior to the errors. During an interview on 2/27/26 at 11:47 a.m., licensed practical nurse (LPN)-B stated she noticed in February two doses of metoprolol were in R1's orders, one for 50 mg daily, and one for 75 mg twice daily, and stated R1 expressed concern about the medication dosing. The LPN-B stated she looked at the provider orders for changes and informed registered nurse (RN)-C of her concern. During an interview on 2/27/26 at 3:55 p.m. RN-C stated R1 was on the correct metoprolol dose from 12/12/25 until 12/30/25, but then a nurse received a telephone order from the cardiologist to decrease the medication from 75 mg twice a day to 50 mg once a day but didn't discontinue the 75 mg twice daily order. The process	21545		

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

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21545	Continued from page 9 after for when a telephone order was received was to have another nurse and a nurse manager verify the orders, but that had not occurred. The nurses involved in the error were educated about the error and the process. RN-C acknowledged not seeing two different doses ordered by the cardiologist, both metoprolol succinate 75 mg daily and metoprolol succinate 75 mg daily. During an interview on 2/27/26 at 4:36 p.m., RN-A stated the error was when the medication order was entered into the medical record, with the wrong type of metoprolol; tartrate was ordered instead of succinate. RN-A acknowledged not knowing the difference between the two, but educated about the error on 2/26/26, a month after the error occurred. RN-A further acknowledged after the medication order was entered, he should have completed a progress note about the dose change to alert the other nurses but had not. RN-A stated R1 told him she had gotten both doses and had dizziness, which could have occurred as a result of taking more metoprolol than prescribed. Further RN-A stated the 2nd and 3rd verification checks for the telephone order had not occurred, and should have before the medication was administered to the resident but had not. During an interview on 2/27/26 at 1:35 p.m. pharmacist (PH)-A stated metoprolol succinate is an extended-release medication and is typically prescribed once daily. The PH-A stated R1 should not have gotten both metoprolol tartrate 50 mg daily and metoprolol succinate 75 mg twice daily. once dose should have been discontinued when the other started. Getting both doses could cause blood pressure to be too low and could cause dizziness and falls. During an interview on 3/3/26 at 11:53 a.m. the director of nursing stated the education started for R1's medication error on 2/26/26, to teach the difference between metoprolol succinate and metoprolol tartrate. The wrong dose and type would have unintended effects in the blood pressure, with potential for low blood pressure and falls. It was a transcription error that went unnoticed. R2's admission Minimum Data Set (MDS) dated 2/2/26 indicated R2 had intact cognition, had diagnoses that included spinal stenosis (narrowing of the spaces within the spine which puts pressure on the nerves and spinal cord) of the cervical (neck) region and required active care at the facility for aftercare for surgery that involved fusion of the spinal bones. R2 received	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/03/2026**

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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21545	Continued from page 10 opioid pain medications as needed (PRN), and pain occasionally interfered with activities. R2's hospital discharge orders included:Oxycodone 5 mg every 4 hours as needed for pain.Tylenol 325 mg 2 tablets by mouth every 4 hours as needed for mild pain R2's initial admission nursing assessment dated 1/28/26 at 1:30 p.m., indicated R2 had occasional mild pain in the previous five days. R2's pain evaluation dated 1/28/26, indicated R2 had pain that occasionally affected sleep, therapy activities, and day-to-day activities, and administer Oxycodone 5 mg 1 tablet every 4 hours as needed (PRN) for pain. R2's baseline care plan dated 1/28/26 indicated intact cognition, pain/comfort issues, with a goal for adequate pain relief, and interventions that included non-medicinal forms of pain relief such as position, rest, and massage, and included pain medications as ordered by the physician. R2's provider orders dated indicated the following:1/28/26 at 11:30 a.m., acetaminophen 325 milligrams (mg), 2 tablets by mouth every 4 hours as needed for mild pain1/28/26 at 11:30 a.m., oxycodone HCl (narcotic pain medication administered for moderate to severe pain), 5 mg, 1 tablet by mouth every 4 hours as needed for pain R2's January 2026 MAR indicated the following:acetaminophen was not administered in January, although the progress notes on 1/29/26 at 9:47 p.m. indicated it was administered.Oxycodone was administered for the first time on 1/29/26 at 8:59 p.m. for pain rated as 7/10 and twice on 1/30/26 and 1/31/26 for pain rated between 7-10/10. [The January 2026 MAR indicated R2's pain was rated as 0/10 on 1/30/26 at 9:10 a.m., but during an interview on 2/27/26 at 4:36 p.m., registered nurse (RN)-A stated the pain rating was entered incorrectly and should have been entered as 10/10.]The MAR lacked indication oxycodone was administered again on 1/29/26 at 9:47 p.m., but the progress notes at that time indicated it was administered with acetaminophen and Flexeril (muscle relaxer). R2's progress note dated 1/29/26 at 7:53 p.m., indicated R2's family member requested pain medications	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/03/2026**

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21545	Continued from page 11 for R2, for pain R2 rated as 7/10. The progress note indicated the nurse had to call a provider to request an order for oxycodone 5 mg. The progress notes lack indication the medication was available or administered prior to that date and time. Further the progress notes indicated oxycodone 5 mg was administered on 1/29/26 at 8:59 p.m., and again on 1/29/26 at 9:47 p.m., with acetaminophen and Flexeril for pain management, which was too early according to the “every 4 hours as needed” time frame in the order. During an interview on 2/26/26 at 11:29 a.m., with R2 and family member (FM)-A, R2 stated when he arrived at the facility his pain was constant, and would get “harder” at times, rated as an 8/10 or 9/10. “It would get pretty damn hard.” The FM-A stated R2 did not get pain medications until 1/30/26 but should have on 1/29/26. During an interview on 2/26/26 at 11:29 a.m., FM-A stated R2 came to the facility after surgery for fused spinal discs in his neck, and when R2 arrived the facility did not have R2’s pain medication, oxycodone 5 mg, that was ordered. FM-A stated during a visit with R2 on 1/29/26 around 6:00 p.m., R2 was in pain. The FM-A stated, “He shouldn’t have had to wait for them [pain medications - oxycodone]. He was hurting so much.” Further, FM-A stated R2 reported to her he had a terrible ride to the facility, and the facility did not have pain medication to help with the pain when he arrived. During an interview on 2/26/26 at 1:31 p.m., licensed practical nurse (LPN)-A stated when a resident was newly admitted, the process was the admitting nurse completed a form for the pharmacy to request medications, faxed the form with any required prescriptions to the pharmacy, and then the nurse called the pharmacy to ensure the pharmacy received the fax. The LPN-A stated the pharmacy delivers medications to the facility twice a day. Additionally, the LPN-A stated residents should not have to wait for pain medications because nurses can get narcotic pain medication from the facility medication bank with an access code provided by a pharmacist and a witness and did not know why R2 waited so long to get pain medication but it was an error to not have them. During an interview on 2/27/26 at 10:38 a.m., the NP-A stated if R2 had pain rated as 7/10 or higher, he would have had pain medications and would not be comfortable. NP-A stated the nurse could have called the pain team for a one-time dose and waiting over 24 hours for pain relief was too long, and NP-A thought the medication	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/03/2026**

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21545	Continued from page 12 was available in the facility medication bank. During an interview on 3/3/26 at 11:53 a.m., the DON stated the process for obtaining pain medications upon admission was to get the hospital orders, review the orders, and if the orders didn't include required pain medication orders, to get an order from the hospital or the facility provider. The DON acknowledged a disruption in the process for obtaining pain medications upon admission for R2, and there were gaps in the process the nurses had not followed. "It sounded like [R2] had pretty severe pain." A Medication Error Policy was requested and not provided. SUGGESTED METHOD OF CORRECTION: (DON) or designee could review facility policies and procedures, educate staff, and implement an ongoing monitoring system to ensure all resident orders are correctly transcribed and implemented as directed by physician orders. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 18, 2026

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

RE: CCN:245187
Cycle Start Date: March 3, 2026

Dear Administrator:

On March 3, 2026, 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:

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 June 3, 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 September 3, 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.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 18, 2026

Administrator
The Villas at the Cedars
7900 West 28th Street
St. Louis Park, MN 55426

Re: State Nursing Home Licensing Orders
Event ID: 1F1AFE-H1

Dear Administrator:

The above facility survey was completed on March 3, 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:

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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