DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 2, 2025

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

RE: CCN: 245187
Cycle Start Date: June 26, 2025

Dear Administrator:

On June 26, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 September 26, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 26, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

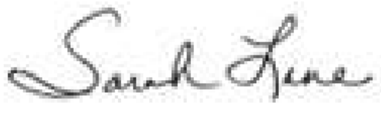
In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments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

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

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

Feel free to contact me if you have questions.

Sincerely,



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

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July 2, 2025

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

Re: Event ID: ZSBF11

Dear Administrator:

The above facility survey was completed on June 26, 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,

Sarah Lane

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245187	A. BUILDING _____ B. WING _____	C 06/26/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 6/25/25 and 6/26/25, 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: H51877869C (MN00114054), H51877871C (MN00114020). No deficiencies were cited. However, based on the investigation, deficiencies were cited at F609 and F610. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events	F 609		7/16/25

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

Electronically Signed | 07/08/2025

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

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F 609	Continued From page 1 that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an allegation of potential abuse was reported timely to the administrator and to the State agency (SA) in accordance with established policies and procedures for 1 of 1 residents (R1) who was reviewed for an allegation of abuse. Findings include: A Facility Reported Incident (FRI), dated 6/21/25, at 4:55 p.m., was submitted to the SA which reported an alleged act of abuse towards R1. The report identified nursing assistant (NA)-D reported to the director of nursing (DON), that NA-A handled R1 "roughly and [was] being verbally aggressive with [R1]." R1 was agitated by NA-A and attempted to bite NA-A. In response, NA-A "held [R1's] arm to [R1's] mouth and said bite	F 609	Resident R1 was assessed and determined to be safe and free from harm. R1 has voiced feeling safe in the facility. The alleged incident was subsequently reported to the state agency and the administrator as required. All residents have the potential to be affected by the deficient practice. All reports of verbal or physical abuse will be reported to the administrator or DON and reported to the state agency in a timely manner. Education will be provided to employees on abuse prevention and reporting policy.¿¿ Audits will be completed by Administrator	

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F 609	Continued From page 2 yourself." The report indicated this incident occurred 6/20/25, at 5:00 p.m.; however, additionally identified the administrator was updated 6/21/25, at 3:20 p.m. The report identified staff became aware of the incident on 6/20/25, at 3:15 p.m.; however, this date was in error as interviews identified the DON was initially updated on 6/21/25, and the incident occurred on 6/20/25, at approximately 5:00 p.m. When interviewed on 6/25/25, at 2:00 p.m., registered nurse (RN)-A identified herself as the unit manager. She stated she was present in the facility on 6/20/25, until approximately 9:00 p.m. and neither NA-D nor licensed practical nurse (LPN)-B informed her of the abuse allegation. RN-A explained she expected staff to act immediately when abuse was witnessed and/or alleged which required staff to ensure resident(s) safety and to update the immediate supervisor. This would then follow the chain of command to ensure the allegation was reported to the SA within two hours and an internal investigation was started. During an interview on 6/25/25, at 2:24 p.m., NA-D was able to articulate examples of abuse which included rough handling of a person, pulling aggressively on their limbs, verbally talking bad to a resident, etc. If witnessed, she was to report this "as soon as possible" to the nurse. NA-D explained when she walked into R1's room, she witnessed NA-A "roughing [R1] up." NA-A grabbed R1's upper arms "aggressively" as R1 attempted to swing out at NA-A, along with attempts to bite him. In response, NA-A pushed R1's arm to R1's mouth hard while NA-A stated to R1 he was not going to bite him, but to bite himself. NA-D stated she asked NA-A why he did	F 609	and/or designee related to investigations of allegations and interviews are completed thoroughly.¿ 3 residents will be audited weekly for 4 weeks, 3 residents twice a month for 1 month, and then 3 residents 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule is needed.¿	

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F 609	Continued From page 3 this - NA-A responded he "did not give a ....." Just after this, RN-A entered the room and NA-A stopped the abuse. Despite RN-A's presence, she did not update RN-A at that time; however, she updated LPN-B about the situation, but LPN-B did not appear to have listened to her and appeared to have "bypassed" the information. She tried to update RN-A that evening; however, due to her being behind with her cares and the need for her break, she was unable. She explained she did write the information down but forgot to turn it in. Additionally, she explained she did not know who to turn it in to at that point. NA-A indicated she was able to update the DON the next morning around 7:00 a.m. or 8:00 a.m. When interviewed on 6/25/25, at 2:39 p.m., LPN-B stated she was expected to report abuse allegations immediately to her supervisor, the DON, or the administrator. She explained that on 6/20/25, she was R1's nurse that evening and that NA-D updated her on the abuse allegation after it happened; however, she understood from NA-D that NA-D was going to update RN-A as RN-A was in the facility. LPN-B indicated she did not follow up with NA-D or RN-A about the allegation that evening to ensure it was reported to RN-A, nor did she update administration on the allegation, as she felt it had been taken care of. During an interview on 6/25/25, at 2:58 p.m., the DON stated abuse was expected to be reported right away to staff's immediate supervisor and then the chain of command was to be followed, which included her and the administrator. When verbal and/or physical abuse were alleged, and/or were witnessed, the facility had two hours to file a report with the SA. The DON identified she was updated about the allegation during the	F 609		

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F 609	Continued From page 4 "afternoon" of 6/21/25, not after the incident on 6/20/25, as she would have expected. When interviewed on 6/26/25, at 12:18 p.m., the administrator stated she expected staff to report abuse, once the resident's safety was ensured, to their direct supervisor, herself, and/or the DON [chain of command] to ensure the two-hour abuse reporting requirement was met and for an internal investigation to begin which included the suspension of any alleged perpetrator. The administrator considered the allegation verbal and physical abuse which was expected to be reported to the SA within the two-hour timeframe. An Abuse Prohibition/Vulnerable Adult Policy, dated 4/2025, identified its purpose was to protect residents against abuse and to promptly report all incidents of alleged or suspected abuse. The policy indicated all staff were responsible to report situations that were considered abuse, and a completed incident report was routed per facility procedure. Additionally, a supervisor, and the administrator, were to be notified immediately for situation assessment to determine if any emergency treatment or action was required. If the administrator was absent or unavailable, staff were to follow the chain of command for notification. Immediately, upon learning of the situation, staff were further directed to take necessary steps to protect residents from possible subsequent incidents of misconduct or injury while the matter was investigated. The policy indicated suspected abuse was to be reported to the SA no later than two hours after the suspicion of abuse was formed.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610		7/16/25

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F 610	Continued From page 5 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an allegation of potential verbal/ physical abuse was thoroughly investigated and protection was provided when the alleged perpetrator was allowed to continue to work with residents after the allegation was identified for 1 of 1 resident (R1) reviewed for an allegation of abuse. Findings include: A Facility Reported Incident (FRI), dated 6/21/25, at 4:55 p.m., was submitted to the State agency (SA) which reported an alleged act of abuse towards R1. The report identified nursing assistant (NA)-D reported to the director of nursing (DON), that NA-A handled R1 "roughly and [was] being verbally aggressive with [R1]."	F 610	Resident R1 was immediately assessed for physical and emotional well-being. No new injuries were noted. Pain assessment was completed, the provider and family were notified, and R1 verbalized feeling safe. The involved staff member was suspended pending completion of the investigation. All residents have the potential to be affected by deficient practice. All allegations of verbal/physical abuse will be thoroughly investigated and interventions put into place. Education will be provided to NHA and DON related to investigating an allegation of resident abuse.	

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F 610	Continued From page 6 R1 was agitated by NA-A and attempted to bite NA-A. In response, NA-A "held [R1's] arm to [R1's] mouth and said bite yourself." The report indicated the incident occurred 6/20/25, at 5:00 p.m.; however, additionally identified the administrator was updated 6/21/25, at 3:20 p.m. The report identified staff became aware of the incident on 6/20/25, at 3:15 p.m.; however, this date was in error as interviews identified the DON was initially updated on 6/21/25, and the incident occurred on 6/20/25, at approximately 5:00 p.m. Immediate actions taken were identified as NA-A's suspension, R1 emotional well-being checks, and initiation of a facility investigation. R1's admission Minimum Data Set (MDS), dated 4/7/25, indicated R1 was severely cognitively impaired with lack of speech. R1 was rarely/never understood, but sometimes understood others. R1 was free of behaviors. Range of motion limitations noted to his bilateral upper and lower extremities, and he was overall dependent on staff for his activities of daily living. His diagnoses included, but were not limited to, a stoke with left dominant side hemiplegia (weakness), aphasia (impaired ability to speak), and non-Alzheimer's dementia. A comprehensive care plan Focus, initiated 4/1/25, identified R1 was a vulnerable adult with decreased cognitive and physical abilities in setting of the stroke, hemiparesis (weakness) on one side of his body, vascular dementia, expressive aphasia ... R1's goal was to remain free of abuse and/or neglect and directed staff to follow the facility's vulnerable adult and abuse reporting policy, along with notifying local Ombudsman, Adult Protection, Police, and/or state/financial agencies as needed if abuse or	F 610	Audits will be completed by Administrator and/or designee related to investigations of allegations and interviews are completed thoroughly.¿ 3 residents will be audited weekly for 4 weeks, 3 residents twice a month for 1 month, and then 3 residents 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule is needed.¿	

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F 610	Continued From page 7 financial exploitation was suspected. R1's progress notes were reviewed and lacked any documented evidence of the 6/20/25, alleged abuse, and/or any facility investigation updates and/or process updates (family and provider updates, provider follow-up, R1's status, monitoring, etc.) R1's Weekly Skin Inspection V-5, dated 6/21/25 5:06 p.m., the DON evaluated R1's skin due to "reports of rough handling." No swelling or bruising were noted to R1's arms and no pain was noted with "touch PROM (passive range of motion). R1 denied pain. R1's June 2025 Treatment Administration Record (TAR), indicated on 6/21/25, starting at 11:00 p.m., staff were directed to "Monitor for change in resident's mood, depressed, angry, crying, ETC every shift." No end date was indicated and no rationalization as to the monitoring needs. A facility incident/event report listing, since 5/21/25, was requested. This was provided; however, the listing lacked any incidents/events related to R1. Facility vulnerable adult SA reports, and all facility investigation information, since 5/21/25, was requested. Information was provided related to R1's 6/20/25, abuse allegation on 6/25/25, at 10:37 a.m. via email, and included the following information: · The SA FRI report. · R1's face sheet. · R1's 6/21/25 Weekly Skin Inspection V-5. · A typed telephone interview between NA-A and the DON, dated 6/20/25; however, based on	F 610		

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F 610	Continued From page 8 interviews this was conducted on 6/21/25. NA-A indicated NA-A had not worked with R1 previously but was asked to get R1 up for supper. During this task, R1 tried to punch NA-A. NA-A did not expect that and "was holding his elbow." He explained to R1 they needed to get him up but R1 did not speak. The statement: 'Don't touch him" was made (by unknown speaker) and a "Lady (unidentified) was laughing. Trying to make him feel comfortable." Again, explained to R1 they were going to get him up but again R1 did not speak. RN-A showed up and talked to him step by step in which R1 was aggressive at that time also. NA-A stated 'he didn't want me to touch [him]. Don't touch me." R1 was not happy with him wiping him, only wanted a female. R1 was about to bite the other aide on the hand and the female said, 'don't bite me, I am your friend. remember me.' R1 was 'fine when I put his brief on. And we got him up for supper." The interview lacked any additional clarifying and/or allegation details. ·NA-D's handwritten statement, dated 6/21/25, indicated, NA-D went to assist with R1's bed to wheelchair transfer. As she and NA-A helped R1, R1 became "very agitated with [NA-A] and asked for him to stop touching me and let me do it." NA-A ignored the request. R1 "started to get uncomfortable and attempted to 'hit' [NA-A]. [NA-A] grabbed [R1] by his arm and roughed handled him aggressively." R1 "managed to grab his hand and put it towards his mouth and try to bite him. [NA-A] then grabbed [R1's] arm and forced it over his mouth and stated, 'you want to bite here bite yourself' and continued to press down firmly and verbal abuse [R1]. I asked [NA-A] why is he doing these things, he stated 'I don't give a s...' This occurred before dinner around 5:15 p.m. and 5:35 p.m.	F 610		

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	245187	A. BUILDING _____ B. WING _____	C 06/26/2025

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F 610	Continued From page 9 · NA-D hand wrote an additional statement on 6/21/25, which indicated NA-A "had a very nasty attitude towards [R8]" on 6/20/25. NA-A "kept telling [R8] that he was 'fat and nasty' and that he did not want to help him because R8 'is a nasty f...' Additionally, NA-A "made fun of [R8's] choice to eat 6 (six) sandwiches and called him ugly names the whole time he was in the room with me." NA-A told NA-D, she "shouldn't be nice to [R8] because he doesn't like 'our skin.' This occurred during bedtime between 8:50 p.m. and 9:20 p.m. · A typed interview statement, dated 6/21/25, between R8 and the DON, identified R8 stated, 'you have that male cocky son of a b....' "walking around everywhere but doesn't like helping any of the residents. I had words and straightened him out [and] by the end of [the] shift he was helping like he should. He was going to let [the] young girl to do everything by herself, he wasn't going to help. She can't do cares of [sic] me by herself.' After he talked to him, he finally started to get me to bed and was fine once he started working. The interview lacked clarification if NA-D's statements of verbal abuse or additional clarifying information related to the interaction that evening, if R8 felt safe, and/or if he felt abused by NA-A. · An undated typed statement from RN-A identified she entered R1's room to interact with R1's roommate on 6/20/25, approximately around 5:00 p.m. As she was about to exit the room, the unidentified NAs reported R1 was 'fighting.' She approached R1 and noticed R1 struggled with the male caregiver at times. She stopped to observe the cares and provided education to both NAs on what do to before proceeding with cares and appropriate bedside care when interacting with an agitated resident. RN-A assisted the female NA to place R1 in the wheelchair.	F 610		

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F 610	Continued From page 10 · NA-A's education on Identifying and Reporting Elder Abuse and Identifying and Reporting Neglect and Abuse in Adults - A Refresher. · The facility investigation information lacked an incident/event report (based on facility policy), documentation R1's representative and provider were updated, additional staff interviews who worked the evening of 6/20/25, for additional details, additional resident interviews whom NA-A may have worked with, an interview with R1's roommate, a written statement of R1's interview, a written statement from LPN-B, and evidence of documented education related to abuse procedures. NA-A's time sheet identified on 6/20/25, he clocked in at 2:31 p.m. and clocked out at 10:28 p.m. He then clocked back in at 11:00 p.m. that same evening, and clocked out on 6/21/25, at 6:38 a.m. During interviews on 6/25/25, at 1:23 p.m., 1:35 p.m., and 1:43 p.m., NA-B, NA-C, and LPN-A respectively were unaware of the recent abuse allegation related to R1, despite R1's unit being their primary working units, and all three stated they had not received any recent abuse education related to such an allegation. When interviewed on 6/25/25, at 2:00 p.m., registered nurse (RN)-A identified herself as the unit manager. She stated she was present in the facility on 6/20/25, until approximately 9:00 p.m. She indicated she was first made aware of the allegation on 6/21/25. RN-A explained she expected staff to act immediately when abuse was witnessed and/or alleged which required staff to ensure resident(s) safety. This would then	F 610		

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F 610	Continued From page 11 follow the chain of command to ensure the allegation investigation was started immediately. RN-C explained she entered R1's room while NA-A and NA-D were providing cares to R1. When she went to leave, the NAs indicated R1 was "fighting" them as they tried to get the mechanical sling lift sheet under him. She explained she moved NA-A out of the way, and she assisted NA-D with the rest of R1's transfer task. Additionally, she updated both NAs on how to decrease resident anxiety and how to properly reposition residents. She denied education/coaching documentation related to this. RN-A denied any witnessed or heard abuse while in R1's room; however, she indicated she was not in R1's room during the entire R1/NA interaction. RN-A denied involvement in the investigation as the DON and administrator managed these processes. She was unaware if staff were provided abuse education since the allegation. RN-A stated she did not update the provider and/or R1's representative related to the allegation despite family being there typically every day as the DON and/or the administrator managed the investigation procedures. During an interview on 6/25/25, at 2:24 p.m., NA-D stated when she walked into R1's room, she witnessed NA-A "roughing [R1] up." NA-D explained she witnessed NA-A grab R1's upper arms "aggressively" as R1 attempted to swing out and bite at NA-A. In response, NA-A pushed R1's arm to R1's mouth hard while NA-D identified that NA-A stated to R1 that R1 was not going to bite him, but to bite himself. She asked NA-A why he did this - NA-A responded to her that he "did not give a s..." Just after this, RN-A entered the room and NA-A stopped the rough handling. Despite RN-A's presence, she did not update RN-A at that	F 610		

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F 610	Continued From page 12 time; however, she updated LPN-B about the situation, but LPN-B did not appear to have listened to her and appeared to have "bypassed" the information. NA-D identified she tried to update RN-A that evening; however, due to her being behind with her cares and the need for her break, she was unable. She explained she did write the information down but forgot to turn it in. Additionally, she explained she did not know who to turn it in to at that point. NA-D indicated she was able to update the DON the next morning around 7:00 a.m. or 8:00 a.m. NA-D explained the DON verbally reminded her about timely reporting; however, she was not provided any formal education related to abuse since the allegation. NA-D indicated she worked an evening shift on 6/21/25. NA-D denied any additional potential resident abuse concerns. When interviewed on 6/25/25, at 2:39 p.m., LPN-B stated that on 6/20/25, she was R1's nurse that evening, and NA-D updated her that R1 tried to bite NA-A and NA-A put R1's arm up to R1's face, which occurred prior to RN-A's entrance into R1's room. She identified there was a misunderstanding about who (she versus NA-D) was going to report the allegation to RN-A, as RN-A was in the building at the time. LPN-B initially stated that evening, she obtained R1's vitals and did a skin assessment; however, did not document such. Later in the interview, LPN-B indicated she did not perform any abuse allegation investigation processes after NA-D updated her. Further, she confirmed NA-A continued to work the "rest of the night." LPN-B identified she was not provided any formal education related to abuse since the allegation. During an interview on 6/25/25, at 2:58 p.m., the	F 610		

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F 610	Continued From page 13 DON stated she was updated about the allegation during the "afternoon" of 6/21/25, not after the incident on 6/20/25, as she would have expected so that an investigation could have started right away. She considered the allegation as abuse; however, their investigation, so far, was not able to substantiate it as their understanding was RN-A walked in and did not witness or hear evidence of abuse, but the investigation was still ongoing with initial interviews conducted with NA-A, NA-B, RN-A, R8, and R1. Initially she indicated LPN-B and additional NAs were interviewed but then indicated she was unsure. She conducted a skin assessment on R1 with no findings and setup monitoring for him. During this, R1 felt he was safe in the facility, denied pain, and did not feel he was handled roughly. He was unable to verbalize what agitated him that evening. R8 updated her on the confrontation with NA-A but he felt safe and did not feel he was abused - only that NA-A was cocky and did not think he needed to work. The DON was unsure if additional resident interviews were conducted as this was a social services responsibility. She identified staff were not yet formally provided abuse education; however, this was an expected step in their investigation. She stated they have until 6/27/25, to complete this and their investigation processes. The DON verbalized LPN-B worked since 6/20/25; however, she was unsure if NA-D had. On 6/25/25, at approximately 3:15 p.m., the administrator was asked if there was any additional information to be provided to support their ongoing R1 investigation. The administrator denied they had any additional information to provide.	F 610		

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F 610	Continued From page 14 When interviewed on 6/26/25, at 11:56 a.m., social services designee (SSD)-A stated her only involvement with abuse allegations was to complete resident interviews when instructed by administration, upon their investigation, if they deemed them necessary. Often, this request came days after the allegation and typically she was not made aware of the allegation details. She was made aware on 6/23/25, there was a potential abuse allegation related to R1 where one staff accused another staff; however, had only heard some of the details through the "rumor mill." Despite this, she was directed on 6/25/25, after the surveyor entered the facility, to complete resident interviews which she indicated involved "pretty broad questions." She completed these and provided them to the administrator between 3:30 p.m. and 4:00 p.m. No concerns were identified. SSD-A indicated concerns with her limited involvement in abuse allegation investigations and felt additional information related to the allegations would assist her to ensure resident safety, along with mental health and psychosocial well-being. During an interview on 6/26/25, at 12:18 p.m., the administrator stated abuse allegations were discussed in daily "morning meetings" and thus involved staff, which included social services, who were updated on all allegations. She considered the allegation surrounding R1 both verbal and physical abuse and she expected an investigation to have started on 6/20/25, which included interventions such as removal of NA-A from resident care, conducted initial resident and staff interviews to figure out immediate interventions to keep everyone safe, a skin check and pain assessment on R1, and following the chain of command for reporting. She identified there were	F 610		

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F 610	Continued From page 15 concerns with her expectations as she stated none of these interventions occurred on 6/20/25. Administrator confirmed NA-A had not been immediately removed from the schedule after the allegation of abuse occurred and stated he should have been. Due to being updated of these concerns by the DON on 6/25/25, she stated LPN-B underwent corrective action on 6/25/25, and was provided education on abuse reporting. The administrator stated NA-A was currently on suspension as the facility had yet to conclude their investigation. So far, their investigation consisted of staff and resident interviews with no concerns for abuse identified. Resident interviews were expected to be completed within five days of the allegation, but they attempted to not wait until the last minute. She identified staff interviews consisted of both NAs and RN-A; however, she was unsure who else was interviewed without looking at her file. The administrator indicated RN-A, and the DON have connected with R1's family and provider as expected; however, was unsure as when completed. The administrator explained the facility worked on three additional complaints this week which increased their workload. During a follow-up interview on 6/26/25, at 1:00 p.m., the DON was questioned on the status of the process for updating R1's representative and provider related to the allegations. In response, she identified the provider was updated but she was unsure when. Initially, she stated she was unsure if the representative was updated; however, followed up with a statement that she should have updated them before she left however, she had forgotten. When interviewed on 6/26/25, at 1:09 p.m., NA-A	F 610		

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F 610	Continued From page 16 stated he had only worked with R1 once, when instructed to get him up for supper on 6/20/25. NA-A explained when he started to prep things to get R1 out of bed, R1 required an incontinence pad change but was not positioned in the center of the bed but more on the left side. This required him to move R1 to safely manage the cares. He started to turn R1 towards him after he provided R1 with assistance instructions: R1 did not respond to him. Shortly after, NA-D entered the room. When he went to put R1's hand on his hand and started to hold onto R1's shoulder, R1 punched him in the arm. He thought R1 did not want to turn. R1 stated, 'Don't touch me.' NA-A asked R1 to turn toward him and explained they needed to get him cleaned up. NA-D called R1's name and told R1 he should not have hit NA-A. NA-D told R1 not to touch NA-A as NA-A was her friend and just tried to help him. After, RN-A entered the room to work with R1's roommate. When she finished, she was updated R1 hit NA-A which prompted RN-A to provide cues to both about how to manage such situations, and her assistance to finish the cares. During the incontinence product care, NA-A stated R1 attempted to bite NA-D. NA-A denied R1 attempted to bite him. Additionally, he denied he placed R1's arm against R1's mouth with a statement to bite himself; however, R1 may have placed his arm closer to his mouth when he was moving it around himself. He indicated he only grabbed R1's arm when R1 went to initially hit him to protect himself but this was not a forced grab despite R1's aggression. R1 was still able to move his arm around. NA-A identified there were no concerns that evening between him and R8. NA-A identified he was concerned NA-D was retaliating against him after he refused to give her money that she had requested that shift, in	F 610		

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F 610	Continued From page 17 addition to comments she directed towards him about herself. An Abuse Prohibition/Vulnerable Adult Policy, dated 4/2025, identified its purpose was to protect residents against abuse and to promptly document and investigate all incidents of alleged or suspected abuse while also promptly identifying and remedying any potential abusive situations. The policy directed an immediate investigation was to begin which assessed for any emergency treatment or required actions which included necessary steps to protect residents from possible subsequent incidents of misconduct or injury while the investigation was conducted. If staff were identified as the alleged perpetrator, they were to be immediately suspended pending the investigation. Additionally, the provider and appropriate family (representatives) were to be notified regarding the facts of the situation, that an investigation was in progress, and any applicable additional follow-up information. The investigation team was to review all Incident Reports no later than the next working day following the incident and would determine next steps which may include staff and resident interviews, or other witnesses to the incident. Corrective action was based on the investigation and all documentation was to be kept in a facility file. Additionally, social services, and other staff as appropriate, were to provide ongoing support and counseling to the residents and family as needed. The facility was also to provide proper follow up communication related to the incident across all shifts.	F 610		

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	00144	A. BUILDING: _____ B. WING _____	C 06/26/2025

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/25/25 and 6/26/25, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was found in compliance with the MN State Licensure. The following complaints were reviewed: H51877869C (MN00114054),	2 000		

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2 000	Continued From page 1 H51877871C (MN00114020). No licensing orders were issued. 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.	2 000		