DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 5, 2025

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

RE: CCN: 276542000
Cycle Start Date: July 15, 2025

Dear Administrator:

On July 2, 2025, we informed you that we may impose enforcement remedies.

On July 15, 2025, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

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

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 26, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 26, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective on September 26, 2025.

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

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

NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by September 26, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, THE VILLAS AT THE CEDARS will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 26, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of

Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 26, 2025 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

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

https://forms.web.health.state.mn.us/form/NHDisputeResolution

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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

| 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 07/15/2025 |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0000 | INITIAL COMMENTS<br><br>On 7/14/25 – 7/15/25, 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.<br><br>The following complaint was reviewed. H51879407C / MN114554<br><br>The following complaints were reviewed. H51879170C / MN114528/MN114521 with a deficiencies issued at F558, F684 and F725.<br><br>Deficient practice was identified related to incidental finding at F677, F700 and F909.<br><br>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.<br><br>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 | | 08/26/2025 |
| F0656<br>SS = D | Develop/Implement Comprehensive Care Plan<br><br>CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br><br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br><br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, | F0656 | R4 has been discharged from the facility.<br><br>All residents with ACE wraps/ compression stockings or abdominal binders have the potential to be affected by the deficient practice.<br><br>Education will be provided to nurse managers in regards to care planning abdominal binders and/or ACE wraps/ Compression Stockings.<br><br>Audits will be completed by the DON and/or designee for all affected residents: Reviewing TAR to ensure that abdominal binders and/or ACE wraps/ compression stockings are care planned of 1 resident per day, 7 residents per week for 4 weeks and then twice a month | 08/26/2025 |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245187 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 07/15/2025 |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0656 SS = D | Continued from page 1<br>mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br><br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br><br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br><br>(iv)In consultation with the resident and the resident's representative(s)-<br><br>(A) The resident's goals for admission and desired outcomes.<br><br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br><br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br><br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(iii) Be culturally-competent and trauma-informed.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, and record review the facility failed to develop a care and furnish services according to the providers orders for 1 of 3 residents (R4) reviewed. R4 was ordered to wear compression stocking and an abdominal binder. These services were not being completed.<br><br>Findings include:<br><br>R4's physician orders dated 4/17/25 at 9:00 a.m. indicated R4 was to have lymphedema therapy (aims to reduce swelling, alleviate symptoms, and manage symptoms of swelling in the arms and the leg). Wash and | F0656 | Continued from page 1<br>for 1 month and then 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule is needed. | |

| 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 07/15/2025 |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0656 SS = D | Continued from page 2<br>apply personal lotion daily. Apply compression compressions in the morning to wear 23/24 hours maximum of 48 years. Compression Xspan (brand name of sock) size 5 toes to just below the knee, 4” extra-long ace wrap from toes to just below the knee in a herring bone (figure 8) pattern. Tubi-grip (elasticated tubular bandage that provides support and compression) from toes to just below the knee-double extra over foot. Remove if painful or irritating.<br><br>R4’s quarterly MDS dated 5/1/25 indicated R4’s BIMS score was a 15 indicating he was cognitively intact. R4 was dependent upon staff for toileting hygiene and bathing, chair to chair and toileting transfers. She required maximum assistance with lower body dressing and set-up with upper body dressing. R4’s pertinent diagnoses were fracture left tibia, Diabetes Mellitus, hypothyroidism, morbid obesity.<br><br>R4’s care plan did not indicate the use of compression stockings/ACE wraps or the abdominal binder.<br><br>R4’s physician orders dated 7/12/25 indicated R4 was to have compression stockings to bilateral lower extremities daily, can use ACE wraps if stockings are too tight.<br><br>R4’s physician orders dated 7/12/25 indicated R4 was to wear an abdominal binder to her abdomen.<br><br>Upon observation and interview on 7/14/25 at 2:03 p.m. R4, a morbidly obese resident was in bed wearing a hospital gown. She had a 4x4 dressing on her right lower extremity. R4’s legs were swollen and red. Below the dressing she had clear mild drainage from 10-12 weeping blisters. She was not wearing an abdominal binder and did not have any wrapping on her legs. She stated she had not worn the abdominal binder in weeks because the facility could not find it. The reason her legs were not wrapped was because the facility did not have a staff member who could do the lymphedema wraps. She stated her order had recently changed from the lymphedema wraps to just compression stockings or ACE wraps, which have not been completed. R4 had compression stockings and ACE wraps in her closet.<br><br>Upon interview on 7/14/25 at 2:30 p.m. nursing assistant (NA)-C stated she had searched for R4’s abdominal binder a few weeks ago and could not find it. | F0656 | | |

| 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 07/15/2025 |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0656 SS = D | Continued from page 3<br>She reported the missing binder to the nurse manager. She was not certain why R4's lymphedema wraps had stopped, and she was not aware that R4 had been ordered to wear compression stockings or ACE wraps.<br><br>Upon interview on 7/15/25 at 2:44 p.m. licensed practical nurse (LPN)-A the nurse manager stated she was not aware of the missing abdominal binder and was not certain as to why R4 did not have compression stockings or ACE wraps on.<br><br>Upon interview on 7/15/25 at 3:23 p.m. the Director of Nursing stated if they residents are ordered treatments, they should be wearing them, if they are refusing, they should be educated and if they are completed, they should discontinue.<br><br>A facility policy titled Care Planning, revised 11/2024 indicated a comprehensive care plan shall be used in developing the resident's daily care routines and will be utilized by staff personnel for the purposes of providing care or services to the resident, modified and updated as the condition and care needs of the resident changes. | F0656 | | |
| F0676 SS = D | Activities Daily Living (ADLs)/Mntn Abilities<br><br>CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii)<br><br>§483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:<br><br>§483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...<br><br>§483.24(b) Activities of daily living.<br><br>The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: | F0676 | R4 has been discharged from the facility.<br><br>All residents that have been discharged from therapy have the potential to be affected by the deficient practice.<br><br>Nursing staff will be re-educated on the functional maintenance program and signing off in the TAR when exercises are completed. DOR and/or designee will bring all functional maintenance programs to daily meeting for IDT education and care planning purposes.<br><br>Audits will be completed by the DON and/or designee for all affected residents: Reviewing 3 residents with restorative programs to ensure exercises are in care plans, staff are trained, and documentation supports completion for 4 weeks and then twice a month for 1 month and then 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule is needed | 08/26/2025 |

| 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 07/15/2025 |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0676 SS = D | Continued from page 4<br><br>§483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,<br><br>§483.24(b)(2) Mobility-transfer and ambulation, including walking,<br><br>§483.24(b)(3) Elimination-toileting,<br><br>§483.24(b)(4) Dining-eating, including meals and snacks,<br><br>§483.24(b)(5) Communication, including<br><br>(i) Speech,<br><br>(ii) Language,<br><br>(iii) Other functional communication systems.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview, and record review the facility failed to provide the necessary services recommended by physical therapy to maintain or improve a residents ability to carry out her own activities of daily living for 1 of 3 residents (R4) reviewed. R4 was ordered a functional maintenance program when her physical therapy treatment period ended, and the facility did not initiate the program delaying R4's discharge goals.<br><br>Based on interview, and record review the facility failed to provide the necessary services recommended by physical therapy to maintain or improve a residents ability to carry out her own activities of daily living for 1 of 3 residents (R4) reviewed. R4 was ordered a functional maintenance program when her physical therapy treatment period ended, and the facility did not initiate the program delaying R4's discharge goals.<br><br>Findings included:<br><br>R4's Annual Minimum Data Set (MDS) dated 3/31/25 indicated R4 had a Brief Inventory of Mental Status (BIMS) score of 15 indicating R4 was cognitively intact. R4 did not exhibit any behaviors. R4 was dependent upon staff for showering and lower body | F0676 | | |

| 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 07/15/2025 |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0676 SS = D | Continued from page 5<br>dressing, required maximum assistance with upper body dressing and rolling side-to-side in bed. R4 was incontinent of bowel and bladder. Her pertinent diagnoses were unspecified dementia, renal insufficiency (kidney failure, cardiovascular accident (stroke) and seizure disorder.<br><br>A facility Functional Maintenance Program undated created by physical therapy (PT) indicated five exercises for R4. One of the exercises required the use of a ball to be squeezed between her leg and another required the use of a belt. The document did not indicate whether R4 was to do the exercises on her own or with staff assistance.<br><br>R4's care plan dated 7/7/25 did not indicate any exercises for R4 to complete from PT.<br><br>Upon interview on 7/14/25 at 2:30 R4 stated she fears she will be "stuck" at the facility forever. Her discharge goal was to be able to stand and not use a bariatric mechanical lift. There is a facility close to her home that will admit her when she is off the bariatric mechanical lift. She received physical therapy, but stated therapy stopped due to her payor source. She was told by PT that she would receive a program to do so she does not decline. R4 was doing well but ended up in the hospital due to a rash that covered a large portion of her body. She returned to the facility having gained weight and required the use of the mechanical lift. R4 felt without a restorative program she would continue to decline.<br><br>Upon interview on 7/15/25 at 1:30 p.m. physical therapy assistant (PTA)-A the director of PT stated R4's therapy did end, and he provided the nursing staff with a functional maintenance program for them to work with her. He stated when therapy ends, he provides the nursing staff with a maintenance program of exercises for the residents to complete. Staff is educated on the plan. There is a place on the form where staff signs off that they have completed training. He stated R4 could discharge to a facility closer to home if she was able to stand and pivot transfer. PTA-A was unable to locate the form he had provided the nursing staff with.<br><br>Upon interview on 7/15/25 at 2:44 the nurse manager, licensed practical nurse (LPN)-A stated she was not aware of any PT recommendations for R4. She stated the | F0676 | | |

| 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 07/15/2025 |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0676<br>SS = D | Continued from page 6<br>health unit coordinator (HUC) had been away from work for a few weeks and it could be in pile to scan into the system. She did locate the form from the HUC's scanning pile. LPN-A stated the recommendations should have been started and added to R4's care plan.<br><br>Upon interview on 7/15/25 at 3:23 p.m. the director of nursing (DON) stated the facility did not have one staff member who acts as a restorative nurse for a restorative program, however the nursing assistants work with residents who have therapy recommendations.<br><br>A facility policy titled Activities of Daily Living (ADL's)/Maintain Abilities Policy dated 3/31/25 indicated It is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided are person-centered, and honor and support each resident's preferences, choices, values and beliefs. Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility will provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. The facility will ensure a resident is given the appropriate treatment and services to maintain or improve their ability to carry out the activities of daily living. | F0676 | | |
| F0700<br>SS = E | Bedrails<br><br>CFR(s): 483.25(n)(1)-(4)<br><br>§483.25(n) Bed Rails.<br><br>The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.<br><br>§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. | F0700 | All residents identified during the survey (R1, R2, R3, R6, R7) had their bed mobility device/bedrail assessments reviewed and updated to include a complete assessment of medical diagnosis, size and weight, cognition, communication, mobility, risk of falls, sleep habits, medications, acute medical conditions, and any specialty mattress use, documentation of alternatives attempted prior to bedrail placement, and care planned.<br><br>All residents have the potential to be affected by the deficient practice.<br><br>Nursing staff, therapy staff, and maintenance staff will be educated on bedrail policy, the requirement for | 08/26/2025 |

| 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 07/15/2025 |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0700 SS = E | Continued from page 7<br><br>§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.<br><br>§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, and record review the facility failed to attempt alternative devices before using bedrails on residents beds. The failed to accurately assess the residents for risk of entrapment by assessing residents medical diagnosis, size and weight, cognition, communication and mobility for 5 of 7 residents (R1, R2, R3, R6 and R7) reviewed for bed rails. In addition, R6 had side rails used in conjunction with an air mattress.<br><br>Based on observation, interview, and record review the facility failed to attempt alternative devices before using bedrails on residents beds. The failed to accurately assess the residents for risk of entrapment by assessing residents medical diagnosis, size and weight, cognition, communication and mobility for 5 of 7 residents (R1, R2, R3, R6 and R7) reviewed for bed rails. In addition, the facility failed to use caution as R6 had side rails used in conjunction with an air mattress. This deficient practice had the potential to affect all 72 residents who used bed/side rails.<br><br>Findings include:<br><br>A website https://www.cms.gov/files/document/finalmds-30-rai-manual-v11811october2023.pdf. reviewed 7/15/25 indicated a physical restraint or method physical or mechanical device, material or equipment attached or adjacent to the residents body that the individual cannot remove easily, which restricts freedom of movement or normal access to one’s body. Residents who are cognitively impaired are at a higher risk of entrapment and injury or death caused by physical restraints. It is vital that physical restraints used on this population be carefully considered and monitored.<br><br>Any manual method or physical or mechanical device, | F0700 | Continued from page 7<br>complete assessments, and safe installation/ use per manufacture's instructions.<br><br>Audits will be completed by the DON and/or designee for all affected residents: Reviewing 5 residents with bedrails 4 weeks and then twice a month for 1 month and then 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule is needed | |

| 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 07/15/2025 |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0700 SS = E | Continued from page 8<br>material or equipment should be classified as a restraint definition. This can only be deterred on a case-by-case basis by individually assessing each and every manual method or physical or mechanical device, material, or equipment.<br><br>https://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/HomeHealthandConsumer/ConsumerProducts/BedRailSafety/ucm362848.htm reviewed 7/15/25 Food and Drug Administration (FDA) guidelines ("Recommendations for Health Care Providers about Bed Rails") 2018 indicated health care providers should base the use of bed rails on individual resident assessments to ensure the individual is an appropriate candidate to reduce the risk of entrapment. Recommendations made for health care providers to evaluate the individual's need, to use the guidance documented "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment" to have knowledge that not all bedrails, mattresses, and bed frames are interchangeable; check the manufacture instructions, health care providers are to avoid the routine use of adult bed rails without first conducting an individual patient or resident assessment, and restrict the use of physical restraints including restrictive use of bed rails, or chest, abdominal, wrist, or ankle restraints of any kind on individuals in bed. When installing and using bedrails select the appropriate bed rail, follow the health care providers procedures or manufacture recommendations, inspect, evaluate, and regularly check bedrails are appropriately matched to equipment and patient needs considering all relevant risk factors, to identify and remove potential fall and entrapment hazards. Be aware that gaps can be created by movement or compression of the mattress, which may be caused by patient weight, movement, bed position, or by using a specialty mattress. Retrieved from on 5/2/25<br><br>https://www.fda.gov/medical-devices/adult-portable-bed-rail-safety/recommendations-health-care-providers-using-adult-portable-bed-rails reviewed 7/15/25 indicated:<br>Be aware that not all bed rails, mattresses, and bed frames are interchangeable and not all bed rails fit all beds. Check with the manufacturers to make sure the bed rails, mattress, and bed frame are compatible. Use caution when using bed rails with a soft mattress as this may increase risk of entrapment between the mattress and bed rail. Be aware that gaps can be created by movement or compression of the mattress which may be caused by patient weight, patient movement or bed position, or by using a specialty mattress, such as an air mattress, mattress pad or waterbed.<br><br>R1's annual Minimum Data Set (MDS) dated 3/31/25 | F0700 | | |

| 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 07/15/2025 |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0700 SS = E | Continued from page 9<br>indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 15 indicating R1 was cognitively intact. R1 did not exhibit any behaviors. R1 was dependent upon staff for showering and lower body dressing, required maximum assistance with upper body dressing and rolling side-to-side in bed. R1 was incontinent of bowel and bladder. Her pertinent diagnoses were unspecified dementia, renal insufficiency (kidney failure, cardiovascular accident (stroke) and seizure disorder. R2's MDS did not indicate the use of bed rails on her bed.<br><br>R1's care plan dated 7/1/25 did not indicate the use of bed rails.<br><br>R1's Bed mobility device evaluation dated 7/1/25 indicated R1and her representative had a preference for grab bars as a bed mobility device. R1 had not attempted to get out by climbing over a bed mobility device or became entangled in a device in the last quarter. R1 did not use the rails with transferring, however used them to reposition in bed. She demonstrated appropriate use of the grab bars. The assessment indicated the device was not a restraint as it did not restrict R1's movement. The form documented not applicable to alternatives attempted prior to placement. R1 had ¼ or ½ side rails listed as in use. No risk or benefits or any other education was documented as provided to R1 or representative. In addition, R1's medical diagnosis, size and weight, cognition, communication and mobility were not assessed for the medical device evaluation or if R1 could remove the device on her own indicating the device was not a restraint.<br><br>Upon observation and interview on 7/14/25 at 11:28 a.m. R1 was laying in her bed on her back wearing a hospital gown. R1 had ¼ side rails at the head of her bed on both sides. At 12:01 p.m. she pressed her call light for a skin inspection and to have her brief changed. She used the side rails to hold herself with turning for the brief change. R1 did not recall any education on the side rails. She stated the facility may have educated her months ago but was not certain. She stated she would not be able to remove them herself due to weakness.<br><br>R2's clinical assessment list dated 5/1/25 – 7/15/25 did not indicate a bed mobility assessment had been completed.<br><br>R2's quarterly MDS dated 6/16/25 indicate R2's BIMS score was a 9 indicating she was cognitively impaired. R2 required moderate assistance with toileting hygiene, | F0700 | | |

| 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 07/15/2025 |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0700 SS = E | Continued from page 10<br>upper body dressing, personal hygiene, toilet transfer and sit to stand transfer. She required maximum assistance with lower body dressing and touching/supervision to sit and stand. R2's pertinent diagnoses were Parkinson's disease (neurological disorder primarily affecting movement, restless leg syndrome, mild cognitive impairment, anorexia and obsessive-compulsive disorder (mental health disorder characterized by unwanted thoughts and repetitive behaviors. R2's MDS did not indicate the use of side rails on her bed.<br><br>R2's care plan dated 7/3/25 did not indicate the use of bed rails on her bed.<br><br>Upon observation and interview on 7/14/25 at 1:21 p.m. R2 was seated in her wheelchair. R2's bed was in the lowest position with a mat on the floor. R2 had ¼ side rails at the head of her bed on both sides.<br><br>R3's admission MDS dated 7/1/25 indicated R3's BIMS score was a 14 indicating he was cognitively intact. R3 was dependent upon staff for eating and oral hygiene. He required supervision or moderate assistance with toileting hygiene and partial/moderate assistance with upper and lower body dressing and personal hygiene. R1 was independent with rolling from left to right in bed. Sitting to lying or chair to bed and toilet transfers were documented as unapplicable. R3's pertinent diagnoses were chronic obstructive pulmonary disease (emphysema), unspecified kidney disorder and dependence on renal dialysis. R3's MDS did not indicate the use of side rails on his bed.<br><br>R3's care plan dated 7/1/25 did not indicate side rails were used on R3's bed.<br><br>R3's bed mobility device evaluation dated 7/1/24 indicated R1 and his representative requested grab bars as a bed mobility device. The evaluation indicated R3 was not informed regarding risks and benefits regarding bruising, skin tears, entrapment and entanglement. R3 used the device to assist with transfers and repositioning in bed and had the ability to demonstrate appropriate use. Nonapplicable was documented in response to alternatives attempted prior to placement. In addition, R3's medical diagnosis, size and weight, cognition, communication and mobility were not assessed for the medical device evaluation or if R3 could remove the device on her own indicating that it was not a restraint.<br><br>Upon observation and interview on 7/15/25 at 10:39 a.m. R3 was lying in bed on his back with his right arm | F0700 | | |

| 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 07/15/2025 |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0700 SS = E | Continued from page 11<br>through the ¼ side rail at the head of his bed on his right side. He had ¼ side rails on both sides of the head of his bed. Family member (FM)-A was visiting R3. She removed his arm from the rail. She stated she had never been taught anything about risks and benefits of side rails. She stated R3 would not have the strength or the cognition to remove a rail on his own. She stated staff does most of the work when transferring and repositioning R3, she had seen him hold the bars at times when he was rolled on his side.<br><br>R6's admission MDS dated 5/26/25 indicated R6 had a BIMS score of 14 indicating she was cognitively intact. R6 was dependent on staff for oral hygiene, toileting hygiene, bathing, upper and lower dressing, personal hygiene, rolling from left to right in bed, sitting to lying positioning and bed to chair transferring. R6's pertinent diagnoses were orthopedic aftercare, trigeminal neuralgia (chronic pain disorder characterized by sudden and severe electric shock like pain in the face), and neuropathy (damage of the nerves outside of the brain and spinal cord). R6's MDS did not indicate the use of side rails on her bed.<br><br>R6's bed mobility device evaluation dated 5/20/25 indicated R6 stated a preference about a bed mobility device. Her representative did not, however the document indicated the representative gave consent for the use of the device. The evaluation did not indicate what type of device was used grab bars, or ¼ or ½ size rails. The residents representative was informed regarding the risk and benefits of the device including bruising, skin tears, entrapment or entanglement. R6 had not attempted to climb over the device or become entangled in the last quarter. The device did not restrict the freedom of movement, indicating it was not a restraint. R6 was able to demonstrate proper use of the device. The evaluation document did not indicate any alternatives had been attempted prior to the placement of the device. In addition, R6's medical diagnosis, size and weight, cognition, communication and mobility were not assessed for the medical device evaluation or if R6 could remove the device on her own indicating it was not a restraint.<br><br>R6's care plan dated 7/15/25 did not indicate the use of side rails on R6's bed.<br><br>Upon observation and interview on 7/16/25 at 9:42 a.m. R6 was working on her laptop. Her bed was elevated at to 30 degrees. R6 had an air mattress and ¼ side rails at the head of her bed on both sides. R6 stated she used the rails to hold onto when staff were provider cares for her. She stated she would not be able to | F0700 | | |

| 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 07/15/2025 |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0700 SS = E | Continued from page 12<br>remove them by herself due to weakness. She stated she liked the rails because they made her feel safe when staff was turning her and felt safe with the rails as she would not fall out of bed while sleeping.<br><br>R7's admission MDS dated 6/4/25 indicated R7 had a BIMS score of 15 indicating she was cognitively intact. R7 was independent with eating, oral hygiene, toileting hygiene, upper and lower body dressing, rolling left to right in bed, lying to sitting and sitting to standing and transferring to her chair. She required moderate assistance with putting on/taking off footwear and showering. R7's pertinent diagnoses were chronic ulcer of the left foot, chronic ulcer of the skin of sites with necrosis (death of bone tissue) of the bone, opioid dependence, polyneuropathy (nervous system disorder that impacts nervous function in multiple areas of the body). R7's MDS did not indicate the use of side rails on her bed.<br><br>R7's care plan dated 7/1/25 did not indicate any use of side rails on her bed.<br><br>R7's bed mobility device evaluation dated 4/29/25 indicated R7 stated a preference about grab bars as bed mobility device. The evaluation did not indicate that R7 was informed regarding the risk and benefits of the device including bruising, skin tears, entrapment or entanglement. R7 had not attempted to climb over the device or become entangled in the last quarter. The device did not restrict the freedom of movement, indicating it was not a restraint. R7 was able to demonstrate proper use of the device. The evaluation form indicated no alternatives had been attempted prior to the placement of the device. In addition, R7's medical diagnosis, size and weight, cognition, communication and mobility were not assessed for the medical device evaluation or if R7 could remove the device on her own indicating was not a restraint.<br><br>Upon observation and interview on 7/14/25 at 2:16 p.m. R7 had ¼ side rails at the head of her head on both sides. R7 stated she uses her rails in bed and to get out of bed. She did not recall any special education regarding risk and benefits. R7 stated she could probably remove the rails by herself if she were taught how.<br><br>Upon interview on 7/15/25 at 1:30 p.m. the physical therapy assistant, therapy director (PTA)-A stated therapy assessed residents to see how they were able to roll in bed and how they completed sitting to standing. Therapy would then let the nursing staff know they were recommending the grab bars for the residents. He stated | F0700 | | |

| 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 07/15/2025 |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0700 SS = E | Continued from page 13<br>he will try have the head of bed raised on some residents before recommending grab bars but could not provide any documentation of that. He denied any other alternatives attempted prior to the use of the grab bars. He stated if any measuring of the grab bars were completed it would be by the nursing staff. He stated he had not ever asked or taught residents to attempt to remove the rails on their own, but stated “most” of them would not be able to.<br><br>Upon interview on 7/15/25 at 1:45 p.m. registered nurse (RN)-A nursing manager stated when a resident wanted grab bars the facility made sure they got them. She asked the residents if they wanted them for transferring, bed mobility or both. She stated nursing performed the device evaluation and maintenance installed the devices and she was not certain of any measuring or assessments maintenance did.<br><br>Upon interview on 7/15/25 at 2:44 p.m. licensed practical nurse, LPN-A stated all residents who had devices on their beds should have had quarterly assessments. She stated once therapy recommended, or the resident or family requested grab bars them the staff let maintenance know to place one on the bed. She stated she checked on her quarterly assessment is the resident still requires them. She stated nursing does not completely any measurements because the rails are all standard for the beds at the facility. She stated residents are taught risks and benefits.<br><br>Upon interview on 7/15/25 at 3:33 p.m. the director of nursing (DON) stated the facility does not educate the residents or representative about the risk and benefits of the grab bars unless the use was inappropriate. An example of inappropriate use would be for a resident who is unable to move at all in wanting rails and then they would be educated on entrapment. Her expectation was that all residents be assessed quarterly by the nursing staff for the use of rails. She stated it did not make sense that a resident should be able to remove a grab bar on their own because that defeated the purpose of having them. She stated the grab bars are all sized to fit the beds at the facility.<br><br>Upon interview on 7/15/25 at 3:32 p.m. the Administrator stated the facility used grab bars and they were not restraints and the nurses completed quarterly assessments on the residents if they had any devices on their beds.<br><br>Email correspondence dated 7/16/25 at 4:47 p.m. following the survey exit from the administrator indicated the facility completed a house wide audit to | F0700 | | |

| 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 07/15/2025 |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0700 SS = E | Continued from page 14<br>assess for entrapment. Evaluations were sent for 72 residents. The evaluations included the definition “A bed mobility device is any device or equipment that is permanently affixed to the bed or the resident is unable to remove independently. The purpose of such devices is to allow residents to achieve their highest level of physical and psychosocial well being.” Each evaluation indicated the patient and or responsible party was educated on the benefits of grab bar use including increased safety, stability and independence as well as potential risk such as bruising, skin tears, entrapment and enlargement.<br><br>The follow-up evaluations failed to assess:<br><br>Medical diagnosis, conditions, symptoms, and/or behavioral symptoms;<br><br>• Size and weight;<br><br>• Sleep habits;<br><br>• Medication(s);<br><br>• Acute medical or surgical interventions;<br><br>• Underlying medical conditions;<br><br>• Existence of delirium;<br><br>• Ability to toilet self safely;<br><br>• Cognition;<br><br>• Communication;<br><br>• Mobility (in and out of bed); and<br><br>• Risk of falling<br><br>In addition, the updated evaluations did not include any alternatives attempted or if the rails could be a restraint to the resident and any specialty mattresses or residents with wander guards.<br><br>A facility policy on side rails/grab bars was requested and an email correspondence dated 7/15/25 at 4:51 indicated the facility did not have a policy they followed manufacture guidelines.<br><br>The manufacturer user service manual undated indicated: An optimal bed system assessment should be conducted for each resident by a qualified clinician or medical provider to ensure maximum safety of the resident. The | F0700 | | |

| 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 07/15/2025 |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0700 SS = E | Continued from page 15<br>assessment should be conducted within the context of, and in compliance with, the state and federal guidelines related to the use of restraints and bed system entrapment guidance, including the Clinical Guidance for the Assessment and Implementation of Side Rails published by the Hospital Bed Safety Workgroup of the U.S. Food and Drug Administration. Further information can be obtained at the following web address: http://www.fda. gov/MedicalDevices/ProductsandMedicalProcedures/GeneralHospitalDevicesandSupplies/HospitalBeds/ default.htm<br><br>When assessing the risk for entrapment, you need to consider your bed, mattress, head/foot panels, assist devices and other accessories, as a system. It is also extremely important to review the resident's physical and mental condition and initiate an appropriate individual care plan to address entrapment risk.<br><br>While the guidelines apply to all healthcare settings, (hospitals, nursing homes and at home), long-term care facilities have exposure since serious entrapment events typically involve frail, elderly or dementia patients. | F0700 | | |
| F0725 SS = D | Sufficient Nursing Staff<br><br>CFR(s): 483.35(a)(1)(2)<br><br>§483.35 Nursing Services.<br><br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71.<br><br>§483.35(a) Sufficient Staff.<br><br>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br><br>(i) Except when waived under paragraph (f) of this section, licensed nurses; and | F0725 | All residents identified during the survey (R1, R2, and R4) care plans were reviewed, to ensure accuracy of transfer and toileting requirements, including cares in pairs where indicated. The DON verified that adequate staff were assigned to provide two-person assistance for all required residents during shifts.<br><br>All residents that require cares in pairs have the potential to be affected by the deficient practice.<br><br>Staff will be educated of all residents identified as requiring cares in pairs and expectation for following the care plan to meet the resident needs. Staff will be educated that when a partner is unavailable to assist with the cares in pairs, staff will ask for another staff member on unit to assist as second person.<br><br>Audits will be completed by the DON and/or designee for all affected residents: Reviewing 5 residents with cares in pairs for 4 weeks and then twice a month for 1 month and then 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule is needed. | 08/26/2025 |

| 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 07/15/2025 |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0725 SS = D | Continued from page 16<br>(ii) Other nursing personnel, including but not limited to nurse aides.<br><br>§483.35(a)(2) Except when waived under paragraph (f) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, and record review the facility failed to ensure sufficient nursing staff available at all times to provide nursing services to meet the residents needs for 3 of 3 residents (R1, R2 and R4) reviewed when staff were unavailable to provide necessary care and services according to assessed needs leading to long wait times for incontinence cares.<br><br>Findings include:<br><br>The Facility Assessment Tool dated 1/7/25 indicated under staff acuity:<br><br>-Dressing assistance the facility had 8 independents residents, 67 residents with assistance of 1-2 staff and 1 dependent resident.<br><br>-Bathing – 4 independent residents, 21 with assistance of 1-2 and 23 dependent residents.<br><br>Transferring 14 independent residents, 49 residents with assistance of 1-2 staff, 10 dependent residents<br><br>-Eating – 62 independent residents, 12 residents with assistance of 1-2 and 2 dependent residents.<br><br>-Toileting – 11 independent residents, 64 residents with assistance of 1-2, and 1 dependent resident.<br><br>-Mobility – 7 independent residents, 23 residents with assistive devices and 57 residents in chair most of the time.<br><br>-The assessment did include how residents required assistance with behaviors.<br><br>R1’s Annual Minimum Data Set (MDS) dated 3/31/25 indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 15 indicating R1 was cognitively intact. R1 did not exhibit any behaviors. R1 was dependent upon staff for showering and lower body dressing, required maximum assistance with upper body | F0725 | | |

| 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 07/15/2025 |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0725 SS = D | Continued from page 17<br>dressing and rolling side-to-side in bed. R1 was incontinent of bowel and bladder. Her pertinent diagnoses were unspecified dementia, renal insufficiency (kidney failure, cardiovascular accident (stroke) and seizure disorder.<br><br>A facility report and investigation dated 7/9/25 indicated R1 complained that a staff member was rough during care and made inappropriate comments. A facility interview undated from R4. R4 stated at times she turns on her all light waiting for up to an hour for assistance. R4 was aware she was to have cares in pairs (two staff with all cares). The day of the allegations nursing assistant, NA-C completed cares alone. NA-C was suspended during the facilities investigation. A facility statement dated 7/9/25 by NA-C indicated she sometimes went into R1's room with two staff and other times alone. Sometimes she completed her change cares by herself.<br><br>R1's care plan dated 7/1/25 indicated R1 was a total assistance of two staff for all bed mobility. For toileting R1 was extensive assistance of two staff to check and change her brief. R1 was to have "care in pairs" due to behaviors and accusations against staff.<br><br>Upon interview on 7/14/25 at 11:28 a.m. R1 stated the week of July 4th she put on her call light because she was incontinent of bowel and needed her incontinent pad changed. NA-C answered her call light and told R1 that she needed to wait because NA-C did not have time. R1 stated she waited half-an-hour and turned on her light again and this time NA-C proceeded to change her without assistance, was rough with her and used inappropriate language.<br><br>Upon interview on 7/15/25 at 8:40 a.m. NA-D stated she was accused of rough cares with R1. She was aware that R1 was to be cares in pair and stated, "damned if I do, damned if I don't." She explained if she waited for another staff member all the time R1 would complain and call family complaining of the wait time, therefor she performed cares alone with R1. NA-D stated the nurses do not assist when asked as they are busy with their jobs. She stated the unit had at least three bariatric residents who require two nursing assistants, two residents on "cares in pairs" and approximately 10 mechanical lift residents who require two nursing assistants. | F0725 | | |

| 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 07/15/2025 |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0725 SS = D | Continued from page 18<br><br>R2's quarterly MDS dated 6/16/25 indicate R2's BIMS score was a 9 indicating she was cognitively impaired. R2 required moderate assistance with toileting hygiene, upper body dressing, personal hygiene, toilet transfer and sit to stand transfer. She required maximum assistance with lower body dressing and touching/supervision to sit and stand. R2's pertinent diagnoses were Parkinson's disease (neurological disorder primarily affecting movement, restless leg syndrome, mild cognitive impairment, anorexia, and obsessive-compulsive disorder (mental health disorder characterized by unwanted thoughts and repetitive behaviors).<br><br>R2's care plan dated 7/3/25 did not indicate R2 required cares in pairs, nor did it indicate how R2 transferred.<br><br>R2's social work progress notes dated 7/10/25 at 8:54 a.m. indicated social services completed a BIMS, PHQ9 (depression screening) and trauma questionnaire due to R2's abuse allegation. R2 scored 15/15 on BIMS indicating she was cognitively intact she scored 0/27 indicating minimal depression.<br><br>R2's nursing progress note dated 7/10/25 at 10:02 a.m. indicated writer arrived in the morning and was immediately told about an accusation R2 had with the night nursing assistant (NA). Writer made sure R2 was safe and then notified the director of nursing (DON) and the Administrator at 7:30 a.m. R2 reported that just after midnight she put on her call light to use the toilet, and the nursing assistant did not get there in time, so the resident ended up wetting the bed. When the NA arrived, she got upset with R2 for wetting then bed and started "beating her up."<br><br>Upon interview on 7/14/25 at 1:21 p.m. R2 stated she did not recall exactly what happened in reference to her allegations. R2 was not certain if she was supposed to be taken care by two staff members or one. She stated most of the time there was only one staff caring for her.<br><br>Upon interview on 7/14/25 at 1:46 p.m. RN-A stated R2 was to have cares in pairs due to her behaviors. She was not certain how long she had been on cares in pairs. | F0725 | | |

| 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 07/15/2025 |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0725 SS = D | Continued from page 19<br><br>Upon interview on 7/14/25 at 1:57 p.m. NA-A stated R2 had always been cares in pairs due to her behaviors. He stated he only uses another staff member when R2 is visually agitated.<br><br>Upon interview on 7/15/25 at 10:45 a.m. NA-E stated she had been informed there were allegations again her on R2. She stated she was not aware R2 was “cares in pairs”. When NA-E was told about told about the allegations she did not follow the care plan when she changed R2 on the night of the allegations because she was “cares in pairs” and NA-E did the cares alone. NA-E was not aware when and if R2’s care plan and changed and she told the nurse manager the staff cannot leave residents to wait for care to get another staff member especially on the night shift. The staffing is not “feasible”.<br><br>Upon interview on 7/15/25 at 1:00 p.m. the facility social worker (SW)-A stated R2 had been cares in pairs as long as she had known.<br><br>Upon observation and interview on 7/14/25 at 2:03 p.m. R4 was in a hospital gown in her bed. She stated she had not been out of bed in eight days. She stated staff was always “too busy” or would “come back later, and later never happened.” R4 pressed her call light at 2:05 p.m. NA-A answered the call light at 2:07 p.m. R4 told NA-A that she wanted to get out of bed and sit in her wheelchair. NA-A told R4 that the other NA was assisting with a shower so it would be about 30-45 minutes before he could assist her, and his shift was ending so he would pass it on to the next shift. At 2:25 p.m. licensed practical nurse (LPN)-A the nurse manager, NA-A and NA-C into the room and asked the surveyor what was needed. The staff left the room to get the mechanical lift. R4 stated there had been times when she presses her call light and had to wait when she was incontinent sitting her bowel movement. At 2:30 p.m. LPN-A and NA-A, NA-B and NA-C came back and used the mechanical lift and got R4 seated in her chair. R4 stated she felt with having 4 staff assist her because 8 days ago two staff assisted to get her out of bed, and she did not feel safe in the lift due to her weight of 516 lbs.<br><br>R4’s quarterly MDS dated 5/1/25 indicated R4’s BIMS score was a 15 indicating he was cognitively intact. R4 | F0725 | | |

| 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 07/15/2025 |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0725<br>SS = D | Continued from page 20<br>was dependent upon staff for toileting hygiene and bathing, chair to chair and toileting transfers. She required maximum assistance with lower body dressing and set-up with upper body dressing. R4's pertinent diagnoses were fracture left tibia, Diabetes Mellitus, hypothyroidism, morbid obesity.<br><br>Upon interview on 7/15/25 at 3:23 p.m. the DON stated the facility staffs correctly per the patient acuity. She stated the nurses assist the NA's, so residents do not have to wait to receive care.<br><br>Upon interview on 7/15/25 at 3:32 p.m. the Administrator stated the facility staffing is adequate, and the nurses assist when the NA's ask. She was not certain how the residents were assessed with one to two staff on the facility assessment and was not certain how residents required assistance of two staff members.<br><br>A policy regarding nursing services was requested, how none was received. | F0725 | | |
| F0909<br>SS = E | Resident Bed<br><br>CFR(s): 483.90(d)(3)<br><br>§483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, and record review the facility failed to conduct regular inspections of all bed frames, mattresses, and bed rails as a part of the regular maintenance program to identify areas of possible entrapment for 6 of 7 residents (R1, R2, R3, R4, R6 and R7) reviewed. The bed manufacturer guidelines indicated to visually inspect the bed and accessories monthly and indicated to follow the FDA guidance.<br><br>Findings include:<br><br>Recommendations for Health Care Providers Using Adult Portable Bed rails dated 2/27/2023 retrieved on 7/15/25 | F0909 | All residents identified during the survey (R1, R2, R3, R4, R6, and R7) were addressed by maintenance by inspecting the beds and either repairing them to manufacture specifications or removing them.<br><br>All residents that have grab bars have the potential to be affected by the deficient practice. Residents with grab bars were assessed and those found to be defective, damaged, or incompatible with its mattress was removed.<br><br>Maintenance staff will be educated in bed/rail safety standards and proper documentation requirements. Maintenance staff will routinely evaluate/inspect the beds/rails in accordance with the FDA guidance and manufacturing manual.<br><br>Audits will be completed by the Administrator and/or designee for all affected residents: Reviewing 10 residents with grab bars for 4 weeks and then twice a month for 1 month and then 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule is needed. | 08/26/2025 |

| 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 07/15/2025 |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0909 SS = E | Continued from page 21<br>from https://www.fda.gov/medical-devices/general-hospital-devices-and-supplies/hospital-beds indicated, When evaluating the safe use of a hospital bed, component or accessory, manufacturers and caregivers should recognize that the risk for entrapment may increase if a hospital bed system is used for purposes, or used in a care setting, not intended by the manufacturer. Evaluating the dimensional limits of gaps in hospital beds may be one component of a bed safety program which includes a comprehensive plan for patient and bed assessment. Bed safety programs may also include plans for the reassessment of hospital bed systems. Reassessment may be appropriate when (1) there is reason to believe that some components are worn (e.g., rails wobble, rails have been damaged, mattresses are softer) and could cause increased spaces within the bed system, (2) when accessories such as mattress overlays or positioning poles are added or removed, or (3) when components of the bed system are changed or replaced (e.g., new bed rails or mattresses). This guidance describes seven zones in the hospital bed system where there is a potential for patient entrapment. Entrapment may occur in flat or articulated bed positions, with the rails fully raised or in intermediate positions. Descriptions of the seven entrapment zones appear on pages 15-21 in this guidance. Summary drawings of entrapment for all the zones appear in Appendix E. The seven areas in the bed system where there is a potential for entrapment are identified in the drawing below. Zone 1: Within the Rail Zone 2: Under the Rail, Between the Rail Supports or Next to a Single Rail Support Zone 3: Between the Rail and the Mattress Zone 4: Under the Rail, at the Ends of the Rail Zone 5: Between Split Bed Rails Zone 6: Between the End of the Rail and the Side Edge of the Head or Foot Board Zone 7: Between the Head or Foot Board and the Mattress End. Health Care providers should base the use of bed rails on individual resident assessments to ensure the individual is an appropriate candidate to reduce the risk of entrapment. Recommendations made for health care providers to evaluate the individual's need, to use the guidance documented "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment" to have knowledge that not all bedrails, mattresses, and bed frames are interchangeable; check the manufacture instructions, health care providers are to avoid the routine use of adult bed rails without first conducting an individual patient or resident assessment, and restrict the use of physical restraints including restrictive use of bed rails, or chest, abdominal, wrist, or ankle restraints of any kind on individuals in bed. When installing and using bedrails select the appropriate bed rail, follow the health care providers procedures or manufacture recommendations, | F0909 | | |

| 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 07/15/2025 |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0909 SS = E | Continued from page 22<br>inspect, evaluate, and regularly check bedrails are appropriately matched to equipment and patient needs considering all relevant risk factors, to identify and remove potential fall and entrapment hazards. Be aware that gaps can be created by movement or compression of the mattress, which may be caused by patient weight, movement, bed position, or by using a specialty mattress.<br><br>The manufacture user-service manual for Joerns Assist Device and Side Rails Vari-Care Models, undated, indicated Maintenance/Inspection Information: Visually<br><br>inspect the assist handle and mounting bracket, and check for loose hardware on a monthly basis. Tighten loose hardware as stated in the installation instructions.<br><br>Warning: Risk of Serious Injury or Death. Properly locate the mounting brackets. The gap between the head/foot panel and the assist device or side rail must be small enough to prevent a resident from getting their head or neck caught in this location (see the installation instructions for more information, if applicable). If multiple assist devices are needed, position them such that the gap between them is large enough that the trunk and hips can easily pass through. Make sure that raising or lowering the bed, or adjusting the sleep surface, does not create hazardous gaps. The assist devices or side rails should not be used if ANY openings within the bed system allow a resident to get their head or neck lodged within these openings. Failure to do so could result in serious injury or death.<br><br>Warning: An optimal bed system assessment should be conducted for each resident by a qualified clinician or medical provider to ensure maximum safety of the resident. The assessment should be conducted within the context of, and in compliance with, the state and federal guidelines related to the use of restraints and bed system entrapment guidance, including the Clinical Guidance for the Assessment and Implementation of Side Rails published by the Hospital Bed Safety Workgroup of the U.S. Food and Drug Administration. Further information can be obtained at the following web address: http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/GeneralHospitalDevicesandSupplies/HospitalBeds/default.htm<br><br>Upon observation 7/14/25 at 11:28 a.m. R1 was laying in | F0909 | | |

| 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 07/15/2025 |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0909 SS = E | Continued from page 23<br>her bed on her back wearing a hospital gown. R1 had ¼ side rails on the head of her bed.<br><br>R1's annual Minimum Data Set (MDS) dated 3/31/25 indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 15 indicating R1 was cognitively intact. R1 did not exhibit any behaviors. R1 was dependent upon staff for showering and lower body dressing, required maximum assistance with upper body dressing and rolling side-to-side in bed. R1 was incontinent of bowel and bladder. Her pertinent diagnoses were unspecified dementia, renal insufficiency (kidney failure, cardiovascular accident (stroke) and seizure disorder. R2's MDS did not indicate the use of bed rails on her bed.<br><br>Upon observation and interview on 7/14/25 at 1:21 p.m. R2's bed was in lowest position with ¼ side rails on each side at the head the bed.<br><br>R2's quarterly MDS dated 6/16/25 indicate R2's BIMS score was a 9 indicating she was cognitively impaired. R2 required moderate assistance with toileting hygiene, upper body dressing, personal hygiene, toilet transfer and sit to stand transfer. She required maximum assistance with lower body dressing and touching/supervision to sit and stand. R2's pertinent diagnoses were Parkinson's disease (neurological disorder primarily affecting movement, restless leg syndrome, mild cognitive impairment, anorexia, and obsessive-compulsive disorder (mental health disorder characterized by unwanted thoughts and repetitive behaviors. R2's MDS did not indicate the use of side rails on her bed.<br><br>Upon observation 7/14/25 at 10:39 a.m. R3 was lying in bed on his back with his right arm through the ¼ side rail at the head of his bed on his right side. He had ¼ side rails on both sides of the head of his bed.<br><br>R3's admission MDS dated 7/1/25 indicated R3's BIMS score was a 14 indicating he was cognitively intact. R3 was dependent upon staff for eating and oral hygiene. He required supervision or moderate assistance with toileting hygiene and partial/moderate assistance with upper and lower body dressing and personal hygiene. R1 was independent with rolling from left to right in bed. Sitting to lying or chair to bed and toilet transfers were documented as unapplicable. R3's pertinent | F0909 | | |

| 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 07/15/2025 |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0909 SS = E | Continued from page 24 | F0909 | | |

diagnoses were chronic obstructive pulmonary disease (emphysema), unspecified kidney disorder and dependence on renal dialysis. R3's MDS did not indicate the use of side rails on his bed.

Upon observation on 7/14/25 at 3:54 p.m. R4 was in her bed on her back wearing a hospital gown. R4 had a bariatric bed (large bed) with ¼ side rails at the bed of the head of the bed on both sides.

R4's quarterly MDS dated 5/1/25 indicated R4's BIMS score was a 15 indicating he was cognitively intact. R4 was dependent upon staff for toileting hygiene and bathing, chair to chair and toileting transfers. She required maximum assistance with lower body dressing and set-up with upper body dressing. R4's pertinent diagnoses were fracture left tibia, Diabetes Mellitus, hypothyroidism, morbid obesity. R4's MDS did not indicate the use of side rails on her bed.

Upon observation on 7/16/25 at 9:42 a.m. R6 had an air mattress and ¼ side rails at the head of her bed on both sides.

R6's admission MDS dated 5/26/25 indicated R6 had a BIMS score of 14 indicating she was cognitively intact. R6 was dependent on staff for oral hygiene, toileting hygiene, bathing, upper and lower dressing, personal hygiene, rolling from left to right in bed, sitting to lying positioning and bed to chair transferring. R6's pertinent diagnoses were orthopedic aftercare, trigeminal neuralgia (chronic pain disorder characterized by sudden and severe electric shock like pain in the face), and neuropathy (damage of the nerves outside of the

brain and spinal cord). R6's MDS did not indicate the use of side rails on her bed.

Upon observation and interview on 7/14/25 at 2:16 p.m. R7 had ¼ side rails at the head of her head on both sides.

R7's admission MDS dated 6/4/25 indicated R7 had a BIMS score of 15 indicating she was cognitively intact. R7 was independent with eating, oral hygiene, toileting hygiene, upper and lower body dressing, rolling left to right in bed, lying to sitting and sitting to standing

| 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 07/15/2025 |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0909 SS = E | Continued from page 25<br>and transferring to her chair. She required moderate assistance with putting on/taking off footwear and showering. R7's pertinent diagnoses were chronic ulcer of the left foot, chronic ulcer of the skin of sites with necrosis (death of bone tissue) of the bone, opioid dependence, polyneuropathy (nervous system disorder that impacts nervous function in multiple areas of the body). R7's MDS did not indicate the use of side rails on her bed.<br><br>Upon interview on 7/15/25 at 10:10 a.m. the facility maintenance director stated he placed the rails on the beds, and he checked them monthly, but does not have a system in place of documentation of the checks he completed. He denied measuring any beds. He stated the checks consisted of making sure the rails were not loose or visibility damaged. No entrapment assessments were assessed during his inspection.<br><br>Upon interview on 7/15/25 at 1:30 p.m. the physical therapy assistant, therapy director (PTA)-A stated his role was ordering the rails for residents. Nursing completed all safety and compliance assessments, and he was not certain the role maintenance had expected for placement of the rails on the bed and fixing if there was a problem.<br><br>Upon interview on 7/15/25 at 1:45 p.m. registered nurse (RN)-A stated she was not certain who or how the beds were assessed ongoing for safety. She stated all the residents have staff in their rooms daily so those staff would easily find a concern.<br><br>Upon interview on 7/15/25 at 2:44 p.m. licensed practical nurse, LPN-A stated all residents who have devices on their beds should have quarterly assessments. She stated once therapy recommended or the resident or family requests grab bars them the staff lets maintenance know to place them on the bed. She stated she checked on her quarterly assessment if the resident still requires them. She stated nursing did not complete any measurements because the rails are all standard for the beds at the facility. She stated residents are taught risks and benefits.<br><br>Upon interview on 7/15/25 at 3:33 p.m. the director of nursing (DON) stated the grab bars are all sized to fit the beds at the facility. She was not certain of how often or what exactly the maintenance department | F0909 | | |

| 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 07/15/2025 |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0909 SS = E | Continued from page 26<br>completed on their safety checks.<br><br>Upon interview on 7/15/25 at 3:32 p.m. the Administrator stated the facility used grab bars and they were not restraints and the nurses completely quarterly assessments on the residents if they have any devices on their beds.<br><br>Email correspondence dated 7/16/25 attached with maintenance inspection reports from 4/18/25 -6/16/25 indicated monthly maintenance checks these included:<br><br>-Inspect connectors on rails and tighten, as necessary.<br><br>-Remove any burs or rough edges to prevent injury.<br><br>-Verify the function of the spring latch-knob assembly, if applicable. Ensure the latch is free of dirt and/or foreign material that could impair its function.<br><br>-Ensure that the rails engage, and lock as specified.<br><br>-Tighten, adjust, or replace any parts such as end caps, knobs, bolts, screws, etc., that are loose, show signs of wear or are missing.<br><br>The checklist did not include any entrapment assessments or any resident specific criteria.<br><br>A facility policy on side rails/grab bars was requested and an email correspondence dated 7/15/25 at 4:51 indicated the facility did not have a policy they followed manufacture guidelines. | F0909 | | |
| F0919 SS = D | Resident Call System<br><br>CFR(s): 483.90(g)(1)(2)<br><br>§483.90(g) Resident Call System<br><br>The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from-<br><br>§483.90(g)(1) Each resident's bedside; and<br><br>§483.90(g)(2) Toilet and bathing facilities. | F0919 | All residents rooms and bathrooms identified during the survey as having non-functioning or missing call lights were immediately repaired or replaced.<br><br>All residents have the potential to be affected by the deficient practice.<br><br>A facility wide audit audit of the call light system will be completed to ensure all call lights in resident rooms and bathrooms are functioning properly.<br><br>Maintenance staff will be educated on testing the call light system monthly. Any call light malfunction will have a temporary safety measure put in place until | 08/26/2025 |

| 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 07/15/2025 |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0919 SS = D | Continued from page 27<br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, and record review, the facility failed to ensure call lights, or another means to request assistance were accessible for 3 of 3 (R2, R5, and R7) residents who were dependent on staff for activities of daily living.<br><br>Findings include:<br><br>Upon observation and interview on 7/14/25 at 1:21 p.m. R2 was found in her room seated in her wheelchair with her pants off wearing an incontinent brief. R2 was attempting to get a pair of sweatpants on by herself. R2's bed was in the lowest position, there was a matt on the floor so R2 could not scoot herself in her wheelchair to reach her call light which was placed on her bed wrapped around her ¼ side rail against the wall. R2 became agitated stating "why can't you help me, why can't you help put my pants on?" R2 attempted to stand up. The surveyor went to get assistance from registered nurse RN-A at 1:46 p.m. to assist R2. RN-A assisted R2 with getting her pants back on. RN-A left the room and got nursing assistant (NA)-A to assist with getting the call light within R2's reach.<br><br>Upon observation and interview on 7/15/25 at 1:57 p.m. NA-A untangled R2's call button and untangled the bed cord from R2's side rail. R2 stated they would have to speak with maintenance as the call light would not reach R2 when she was in her chair with the floor mat in place. NA-A was not certain how the staff usually made sure R2 had her call light, but all residents must have access to their call light.<br><br>R2's care plan dated 2/21/25 indicated R2 had a soft call button and to have the call light kept within reach. R2 had falls on 2/21/25, 3/9/25, 3/27/25 and 6/10/25 and the interventions were a "call don't fall" sign in her room and a soft call button.<br><br>R2's quarterly MDS dated 6/16/25 indicate R2's BIMS score was a 9 indicating she was cognitively impaired. R2 required moderate assistance with toileting hygiene, upper body dressing, personal hygiene, toilet transfer and sit to stand transfer. She required maximum assistance with lower body dressing and touching/supervision to sit and stand. R2's pertinent diagnoses were Parkinson's disease (neurological disorder primarily affecting movement), restless leg | F0919 | Continued from page 27<br>repair is completed.<br><br>Audits will be completed by the Administrator and/or designee for all affected residents: Reviewing 10 call lights for 4 weeks and then twice a month for 1 month and then 1x for 1 month. Audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified, and recommendations for adjustments to the audit schedule is needed. | |

| 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 07/15/2025 |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0919 SS = D | Continued from page 28<br>syndrome, mild cognitive impairment, anorexia, and obsessive-compulsive disorder (mental health disorder characterized by unwanted thoughts and repetitive behaviors)<br><br>Upon observation on 7/14/25 at 2:09 p.m. R5 was seated in a Geri-chair (specialized wheelchair) in her room with the door closed. R5 was seated with her back against the door and looking out her window. Her bed and call light were approximately 10 feet away from on her bed. R5 could not move herself in her chair to get to light. R5 was nonverbal, only able to make sounds when questioned.<br><br>R5's quarterly MDS dated 5/12/25 indicated R5 BIMS score was a 00 indicating severe cognitive impairment. R5 required maximum assistance with eating and oral hygiene. She was dependent upon staff for showering, dressing upper and lower body, chair to bed transfers and personal hygiene She required maximum assistance to roll from left to right in bed. Sitting to lying, sitting to standing were documented as nonapplicable. R5's pertinent diagnoses were unspecified dementia without behaviors, weakness, dysphagia (difficulty swallowing), and encephalopathy (neurological brain dysfunction).<br><br>R5's care plan dated 6/2/25 indicated R5's call light was to always be within reach, answer promptly.<br><br>Upon interview on 7/14/25 at 2:15 p.m. RN-A stated R5 cannot use a call light and normally she would be in the community room to be visualized by staff. RN-A stated she checked on<br><br>R5 every ten minutes to make sure she was safe. Ten-minute safety checks were not on the care plan that was RN-A's personal practice.<br><br>Upon observation and interview on 7/14/25 at 2:18 p.m. R7's was seated in her wheelchair her call light was on her bed, she stated she was able to move herself to reach the call light if she needed assistance. She stated her room call light was not the problem, her bathroom call light had not been working for a few days, she told staff, and maintenance had not been by to fix it. She stated she gets herself off the toilet without any help. When pulling the call light with the string, the drop-down plastic portion moved; however, | F0919 | | |

| 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 07/15/2025 |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0919 SS = D | Continued from page 29<br>the light did not light up outside her door to alert staff R7 needed assistance.<br><br>Upon observation and interview 7/14/25 at 2:24 p.m. NA-B was passing R7's room and looked at the bathroom call light. He tried it couple of times and noticed there was a knot in the string that was used to trigger the light. He untied the knot, and the light worked. He stated R7 had not mentioned to him the light was not working.<br><br>Upon interview on 7/15/25 at 2:44 p.m. licensed practical nurse, (LPN)-A stated residents should always have access to their call lights when they are in their rooms. She was not aware that R2's light did not reach her with the mat on the floor. She was not certain why R5 had been placed in room without being in bed because after lunch she laid down in her bed.<br><br>R7's admission MDS dated 6/4/25 indicated R7 had a BIMS score of 15 indicating she was cognitively intact. R7 was independent with eating, oral hygiene, toileting hygiene, upper and lower body dressing, rolling left to right in bed, lying to sitting and sitting to standing and transferring to her chair. She required moderate assistance with putting on/taking off footwear and showering. R7's pertinent diagnoses were chronic ulcer of the left foot, chronic ulcer of the skin of sites with necrosis (death of bone tissue) of the bone, opioid dependence, polyneuropathy (nervous system disorder that impacts nervous function in multiple areas of the body).<br><br>R7's care plan dated 7/1/25 indicated R7 was to accept assistance with self-cares and would be dressed, groomed, and bathed per her preference. Staff was to monitor R7's bowel movements. The care plan did not indicate R7's transfer status or any call light interventions.<br><br>Upon interview on 7/15/25 at 3:23 p.m. the DON stated residents should always have access to their call lights and she was not aware that R7's was not working in her bathroom.<br><br>Email correspondence dated 7/16/25 at 4:51 p.m. from the administrator stated there have been no call light concerns from any residents or family brought to her attention. | F0919 | | |

| 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 07/15/2025 |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0919 SS = D | Continued from page 30<br><br>A facility policy titled Call Light Policy with a revision date of 5/23/23 indicated: A nurse call must be provided for each resident's bed or other sleeping accommodations. Call cords, buttons, or other communication devices must be placed where they are within reach of each resident. Each facility will have a process in place to monitor the call light system to identify if the system is functioning properly. A scheduled task will be placed in the TELS system to check the system monthly at a minimum. If a call light system is identified as not operational at any time, the facility will take the following steps:<br><br>a) The facility will provide residents with a means to call for help at the<br><br>bedside and in toileting and bathing facilities through an audible or<br><br>visual signal (i.e., bell, walkie talkie, whistle, etc.)<br><br>b) The Director of Nursing and Administrator will be notified of<br><br>the system not functioning.<br><br>c)The facility will keep a log of time the system was not functional and<br><br>repair efforts made. | F0919 | | |

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 5, 2025

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

Re: Event ID: HGNG11

Dear Administrator:

The above facility survey was completed on July 15, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement

Health Regulation Division

**Minnesota Department of Health**

Kamala.Fiske-Downing@state.mn.us

Office: 651-201-4112

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED<br>**07/15/2025** |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| 20000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>On 7/14/25 – 7/15/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure<br><br>The following complaints were reviewed during the survey.<br><br>H51879170C / MN114528/MN114521 | 20000 | | 08/26/2025 |



| 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<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED<br>**07/15/2025** |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| 20000 | Continued from page 1<br><br>H51879407C / MN114554<br><br>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.<br><br>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. | 20000 | | |