



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 11, 2025

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

RE: CCN: 245187

Cycle Start Date: July 15, 2025

Dear Administrator:

On August 5, 2025, we notified you a remedy was imposed. On August 26, 2025 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 26, 2025.

As authorized by CMS the remedy of:

• **Mandatory denial of payment for new Medicare and Medicaid admissions effective September 26, 2025 did not go into effect. (42 CFR 488.417 (b))**

In our letter of August 5, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 26, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on August 26, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement

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



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September 11, 2025

Administrator

THE VILLAS AT THE CEDARS

7900 WEST 28TH STREET

SAINT LOUIS PARK, MN 55426

Re: Reinspection Results

Event ID: 1D2D8D-H2

Dear Administrator:

On August 25, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 5, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

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



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August 19, 2025

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

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

Dear Administrator:

On August 5, 2025, we informed you of imposed enforcement remedies.

On August 5, 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), 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 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 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:

Stefanie Salberg, Regional Operations Supervisor
Metro B District Office
Health Regulation Division

Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

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,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive, flowing style.

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



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August 19, 2025

Administrator

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

Re: State Nursing Home Licensing Orders

Event ID: 1D2D8D-H1

Dear Administrator:

The above facility survey was completed on August 5, 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 one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Stefanie Salberg, Regional Operations Supervisor
Metro B District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/05/2025	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT THE CEDARS				STREET ADDRESS, CITY, STATE, ZIP CODE 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 *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/4/25 to 8/5/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.		20000			08/26/2025	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/05/2025	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT THE CEDARS				STREET ADDRESS, CITY, STATE, ZIP CODE 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 The following complaints were reviewed: H51879916C (MN2566071, MN2566527, MN2566150). No licensing orders were issued regarding these complaints. The following complaint was reviewed H51879831C (MN2564434) with a licensing order issued at 20965. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.		20000				
20965	Dietary Service -Nutritional Status CFR(s): MN Rule 4658.0600 Subp. 2 Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served.		20965	Corrected.		08/26/2025	

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/05/2025	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT THE CEDARS				STREET ADDRESS, CITY, STATE, ZIP CODE 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	
20965	Continued from page 2 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to comprehensively and accurately re-assess, develop and implement interventions to reduce/prevent significant and continued weight loss for 1 of 3 resident (R2) reviewed for weight loss. This resulted in actual harm when R2 was hospitalized for malnutrition. Findings include: Center for Medicare & Medicaid Services (CMS) considers weight loss ‘significant’ if it exceeds 5 percent (%) within one month, 7.5% within three months, or 10% within six months. R2’s admission Minimum Data Set (MDS) assessment dated 3/19/25, identified an admission date of 3/13/25, indicated R2 was severely cognitively impaired and had diagnoses of cerebral palsy, depression, and enlarged prostate know as benign prostatic hyperplasia (BPH), obstructive uropathy (blockage hindering urine flow), and Rhabdomyolysis (muscle breakdown). R2 weighed 147 pounds, received a mechanically altered diet, was not on a weight prescribed regimen, and a box was marked “yes” for weight loss of 5% or more in the last month or loss of 10% or more in the last six months. The MDS documented R2 had no issues with swallowing, was dependent on staff for all cares including eating, hygiene, and mobility. Care Areas triggered were cognitive loss, visual function, communication, urinary catheter, psychosocial well-being, mood, behavior, falls, nutritional status, pressure ulcer, and psychotropic drug use. R2 received antipsychotics, antidepressants, and antianxiety medications. R2’s Nutrition Care Area Assessment dated 3/16/25, was triggered due to significant weight loss and altered diet. It lacked identification of care plan considerations and included a note to refer to nutrition evaluation for additional information. R2’s Clinical Nutritional Evaluation dated 3/15/25, identified R2’s weight as 147.8 pounds with a usual weight of 160 pounds, no weight loss or gain of 5 percent (%) or more in the last month, body mass index (BMI) as greater than 30 indicating obese, had a regular diet, difficulty chewing, intake at 26-50%, took supplements twice a day, and required staff assistance with feeding. A report titled IDT Care Conference dated 3/26/25 identified nutrition concerns as low/sporadic meal consumption. R2 was on a regular diet with modified thick liquids and weighed 143 pounds. The note identified R2 was totally dependent on staff for all needs. R2’s record lacked documentation for additional quarterly care conferences. R2’s quarterly Minimum Data Set (MDS) assessment dated		20965				

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/05/2025	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT THE CEDARS				STREET ADDRESS, CITY, STATE, ZIP CODE 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
20965	Continued from page 3 6/11/25, identified R2 used a wheelchair, was dependent on staff for all mobility, cares and eating, weighed 138 pounds, and required a mechanical and therapeutic diet. R2’s provider orders included a house supplement (magic cup) twice a day from 3/15/25-7/6/25 and were documented as given 17 times out of 226 opportunities. R2’s provider orders also identified weekly weights were ordered 3/17/25-3/24/25. R2 was weighed one time out of two opportunities during this period. R2’s provider orders identified weekly weighs were ordered 3/26/25-4/16/25. R2 was weighed one time out of four opportunities during this period. R2’s provider orders identified weekly weights were ordered 4/23/25-7/19/25. R2 was weighed five times out of fifteen opportunities. R2’s medical record identified the following weights (in pounds): 3/15/2025 14:21 147.8 3/16/2025 13:10 147.8 3/20/2025 15:45 143.0 3/31/2025 09:21 141.0 4/17/2025 13:15 139.0 4/23/2025 10:54 136.4 5/1/2025 12:55 135.2 5/28/2025 14:37 138.0 6/12/2025 14:38 132.2 6/25/2025 15:41 128.2 7/23/2025 14:44 127.6 7/24/2025 14:44 126.0 R2’s was seen by the medical director on 4/6/25, 5/14/25, and 6/18/25, and the provider visit notes described R2 as pleasantly confused with no distress a satisfactory appetite. The record lacked documentation related to weight loss. An Associated Clinic of Psychology (ACP) note dated 6/18/25, identified R2 as calm and relaxed throughout the session. R2 reported frequent hunger and consumed a snack during the session. R2 denied any stressors outside of feeling hungry. R2’s nutrition care plan focus dated of 6/19/25, identified a nutritional risk due to dysphagia and hot liquids. /Goals included weight gain, intake greater than 50%, and no adverse incident related to hot liquids. The interventions included total assist of one with eating and drinking, obtain weights weekly and as needed, offer adequate fluids at and between meals, supplements per MD order, provide assist with meal intake, and speech therapy to consult as needed. A report titled Clinical Nutritional Evaluation dated 7/6/25, identified R2’s weight as 128.2 pounds and height as 65 inches tall, with a usual weight of 160 pounds, no weight loss or gain of 5% or more in the last month, BMI greater than 30 indicating obese, regular diet, difficulty chewing, intake at 26-50%, took supplements, and required staff assistance with feeding. R2’s progress note dated 7/6/25, indicated a weight warning was triggered and weight was 128.2 pounds, and the registered dietician increased supplements from twice per day to three times per day. R2’s orders to give supplements three times a day from 7/6/25-7/12/25, were documented as given three times out of 21 opportunities. Documentation indicated R2 refused three times during this period. R2’s Census			20965			

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/05/2025	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT THE CEDARS				STREET ADDRESS, CITY, STATE, ZIP CODE 7900 WEST 28TH STREET , SAINT LOUIS PARK, Minnesota, 55426			
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20965	Continued from page 4 information identified he was in the hospital from 7/12/25 to 7/19/25. R2's Transfer Information document dated 7/19/25, indicated R2 was admitted to Methodist Hospital on 7/12/25 for malnutrition and failure to thrive and treated for a urinary tract infection (UTI) and weakness. During the hospital stay R2 was given antibiotics and referred to a dietician. The hospital note identified R2 as a "patient with moderate malnutrition in context of acute illness/injury". The results of abdominal imaging dated 7/13/25, revealed no medical reason for weight loss, "no evidence for occult malignancy or CT findings to explain the patient's symptoms or weight loss". The document indicated R2 required additional resources due to the degree of malnutrition during the hospital stay. /The hospital dietitian recommended in discharge orders for strawberry boost in the morning and at night with daily snacks, updated food preferences, and high calorie-high protein eating. R2's hospital weight on 7/13/25 was recorded as 115 pounds and 11.9 ounces, which was a 21.7% weight loss from R2's admission to the long-term care facility and indicated severe weight loss. R2's Census information indicated he returned to the facility on 7/19/25 and discharged on 7/30/25 to another care setting. During an interview on 8/4/25 at 12:03 p.m., dietary aid (DA)-A stated nutrition supplements were brought up from the kitchen and passed to the residents by the nursing assistants with meals if the dining ticket had a supplement ordered. Extra supplements were brought up from the kitchen and given to the nurses to store at the nurse's station for snacks in between meals. During an interview on 8/4/25 at 12:08 p.m., nursing assistant (NA)-B stated if a resident needed a nutritional supplement it was printed on the dining ticket, and nursing assistants passed the supplements along with the meal tray. If a resident was allergic or refused the supplement the nurse would be notified. During an interview on 8/4/25 at 12:20 p.m., registered nurse (RN)-B stated 'mighty shakes' were liquid and 'magic cups' were frozen, and both came up from the kitchen and were served with meals. If the supplement was ordered to be given between meals, the kitchen sent up the supplements, but no labels identified who the supplements were for, and the nurses knew who was supposed to receive them. RN-B stated a provider would be notified of weight loss only if there was a three-to-five-pound loss. The nursing assistants were responsible for weighing residents and recording the weights in a binder located at the nurse station. RN-B stated the nurses reviewed the logs daily for weight loss; however, no parameters were printed on the logs to instruct staff regarding when to notify the manager or provider. RN-B confirmed if a resident was losing weight month after month the nurse would be			20965			

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20965	Continued from page 5 aware but couldn't confirm if the dieticians reviewed the weight logs or used the recorded weights in the medical records to discuss at care conferences. During an interview on 8/4/25 at 12:27 p.m., RN-C confirmed when a resident returned from a hospitalization and their discharge orders recommended nutritional supplements or other interventions the dietician would get involved. All supplements were documented on the treatment assessment record (TAR) and the nurse manager would be informed if a resident consistently refused. RN-C stated If a resident refused meals or consumed less than 50% of their meal the chart was flagged, and the entire team would monitor for weight loss. The provider was notified if there was a significant decrease in weight by the dietician or nurse manager. RN-C stated the resident should be weighed at the same time and in the same manner each time, and the entire team monitored for weight discrepancies. During an interview on 8/4/25 at 1:00 p.m., registered dietician (RD)-C stated if nutrition supplements were ordered with meals they were served with the meal tray, but supplements were also stocked on the floor and served as a snack. The supplement would be labeled with the resident's name. /RD-C stated preferences were discussed at care conferences and if a resident didn't like the supplement or if they refused the supplement many alternatives were offered including snacks. RD-C indicated if a resident was losing weight, a weight warning would be triggered in the electronic health record when they lost 5% or greater. The team would discuss the weight loss, and the nurse manager would notify the provider. A nutritional assessment was completed for R2 on 3/15/25 & 7/6/25. RN-C confirmed the weight warning triggered on 7/6/25 and indicated a 5% decrease over 30 days. R2's record lacked additional interventions implemented until 7/23/25, when another weight warning was identified. RD-C confirmed a high calorie supplement was ordered for R2 after the hospital stay dated 7/12/25-7/19/25, but confirmed the record did not reflect R2 received the additional supplements. During an interview on 8/5/25 at 9:04 a.m., registered nurse (RN)-A stated it was the NA's responsibility to pass the supplements. RN-A stated weights were documented, and if weight was triggered for significant weight loss the provider was notified. The nurse manager was responsible for notifying the provider who would consult with the dietician and order labs to rule out illness and would then identify likes and dislikes with food or the root cause for the appetite being down. The family was notified only if there was a definite decline in weight. RN-A stated when residents returned from the hospital the discharge summary was reviewed, and any provider orders were implemented. RN-A stated R2 had weight loss, the family		20965				

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20965	Continued from page 6 was consulted, and the family offered ideas to stimulate appetite such as finger foods but confirmed R2’s record lacked documentation of these interventions. RN-A confirmed R2’s weight loss was documented, and the care plan was not updated to implement personalized interventions but would expect nutrition interventions should have been implemented with continued weight loss. RN-A confirmed the provider was never notified of R2’s weight loss. During an interview on 8/5/25 at 9:54 a.m., family member (FM)-A, FM-B, and FM-C, FM-A stated R2 was 165 pounds while living at home in March of 2025. During a care conference on 3/26/25, R2 was 145 pounds. FM-B stated the primary discussion during the care conference was about R2’s weight loss and approximately 90-120 minutes was spent discussing interventions. FM-B stated the social worker confirmed to them R2 received a nutritional supplement, “Ensure”, and when the family requested additional Ensures, they were told, “well he gets one”. FM-B denied the nurse manager discussed any type of personalized interventions such as finger foods. FM-C stated they visited approximately five weeks later in 6/4/25, and R2 weighed approximately 135 pounds, was “alarmingly thin,” and cognitively altered. FM-C stated the facility notified R2’s wife on 7/11/25, R2 hadn’t eaten for the past two days and wasn’t taking any medications. They stated when they visited at 4:00 p.m. on 7/12/25, R2 was lying in bed and appeared to have lost 30 pounds, was “massively” dehydrated, and cognitively altered. /They stated staff were unable to tell the family R2’s current weight, and indicated staff were directed to “push fluids,” but were unable identify or locate any protocol, and unable to determine if they had pushed any fluids. FM-C stated given R2’s altered behavior, how staff couldn’t determine a current weight, or if orders were followed, family called 911. /They stated R2 was admitted to Methodist Hospital from 7/12/25 to 7/19/24, for malnutrition, failure to thrive, and dehydration, and was treated for a urinary tract infection (UTI). FM-C stated after 24 hours of antibiotics the infection started to clear, R2 was hungry and began eating and drinking. FM-A stated the family was aware R2 had lost weight but didn’t know the extent until the day they called emergency services on 7/12/25. During an interview on 8/5/25 at 10:58 a.m., nurse practitioner (NP)-B stated the facility would notify them of resident concerns by phone or leave a post it notes if they were onsite, and stated notifications were not always documented in a progress note. NP-B could not recall meeting with R2 regarding weight loss or whether staff notified them specifically about weight loss but was aware sometimes R2 would indicate he was hungry, but when food was offered continued refusing. After			20965			

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20965	Continued from page 7 reviewing R2’s medical record, NP-B confirmed there should have been a notification if there was a ten-pound weight loss and NP-B would have implemented interventions such as labs to rule out illness or decreased renal function, prescribed appetite stimulants, or referred R2 to ACP. NP-B confirmed staff first notified the on-call nurse practitioner on 7/11/25, when R2 wasn’t eating or taking medication. NP-B stated other interventions for weight loss could have been implemented sooner, including neuro-psych testing and medications, hospice, or feeding tubes, though not ideal, but in hindsight additional interventions should have been applied due to the weight loss. During an interview on 8/5/25 at 11:12 a.m., LPN-A stated the provider, or family would be notified if weight triggered a warning for significant weight loss of 5% or more. LPN-A stated weekly weights were the standard and should be done on bath day. LPN-A confirmed R2 had an order, but R2’s record lacked documentation of weekly weights. LPN-A stated R2 transferred to the unit in April 2025, and no interventions for weight loss would be implemented until a weight warning was triggered. LPN-A indicated R2 first triggered for weight loss on 7/24/25. LPN-A stated there was not a concern for the other weights in R2’s medical chart because they were not triggered in the electronic record for significant weight loss, but LPN-A had noticed a downward trend. LPN-A would not notify the provider unless it met the weight loss parameter of three pounds per day or five pounds per week but could not identify what document was used for that guidance. LPN-A recalled feeding R2 breakfast three to five times per week and recognized there were times R2 wouldn’t eat breakfast but did finish all lunches. LPN-A had no other concerns after the hospitalization in July because R2 was eating on and off. LPN-A stated R2 only had one care conference during the thirteen-week stay at the facility and confirmed the care plan lacked personalized interventions due to the system not triggering weight loss until July. During an interview on 8/5/25 at 12:00 p.m., the DON stated staff should review all weekly weights, identify any decrease in weight, and any resident with weight loss should be discussed at the daily meeting. /The provider should be notified, interventions for nutrition such as supplements or offering extra snacks should be implemented, and staff would document this in a progress note. DON indicated some residents refused everything offered but were encouraged with more snacks depending on their diet, however staff should monitor consumed meals and notice if a resident wasn’t eating and if their weight had decreased. DON stated they had witnessed R2 tell staff he was hungry and then refuse to eat when staff			20965			

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20965	Continued from page 8 attempted feeding, but could not identify what, if any, interventions were attempted relating to this behavior. The DON stated R2’s weight was discussed during their initial care conference, however the record lacked documentation of that discussion. The DON confirmed R2 had an order for weekly weights and stated staff should have recognized R2’s gradual 20-pound weight decrease even without the triggered warnings in the electronic health record. DON stated staff should have added new individualized interventions to the care plan to increase R2’s weight upon identification of the weight loss and/or during quarterly care conferences, but no quarterly care conference took place. Staff also should have updated the provider, and DON verified there were no provider notifications regarding weight loss, nutrition, or refusing to eat or take medications until 7/11/25, prior to the hospitalization at Methodist Hospital. /The DON stated R2’s weight loss was a combination of deconditioning and a UTI that led to the hospitalization on 7/12/25. The facility Weight Policy dated 5/1/24, identified the registered dietitian (RD) and or responsible party shall be notified of weight changes at the discretion of the IDT. The RD shall review residents who trigger for significant weight gain or loss. Significant is defined as a person with 5% weight change over 30 days, 7.5% weight change over 90 days, or 10% weight change over 180 days. The IDT and or facility designee shall review weights for significant weight changes and will be discussed to determine individualized care plan interventions and documented in the electronic medical record. Facility policy, Notification of Change dated 3/24, identified nurses and other care staff are educated to identify changes in a resident's status and define changes that require notification of the residents and or their representative and the resident's physician to ensure best outcomes of care for residents. /Significant change in status-deterioration in health, mental or psychosocial status in life threatening conditions or clinical complications. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee should ensure weights are monitored and dietary interventions are implemented in a timely manner. The facility should review and/or update or create policies and procedures and educate staff on specific requirements or interventions related to weight and nutrition. The administrator, registered dietician, or designee should perform audits for a measurable amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure food items given, offered, or consumed by residents are implemented as identified or ordered. The facility should report those findings to QAPI for further recommendations and determine the need for further			20965			

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20965	Continued from page 9 monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20965			

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F0000	INITIAL COMMENTS On 8/4/25 to 8/5/25, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H51879916C (MN2566071, MN2566527, MN2566150). NO related deficiencies were cited. The following complaint was reviewed H51879831C (MN2564434) with deficiencies cited at F692. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.			F0000			08/26/2025
F0692 SS = G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;			F0692	R2 is no longer at the facility. All residents have the potential to be affected by this practice. All residents will be reviewed to identify those who trigger for significant weight loss and facility will review residents for adequate intake and interventions. Facility will ensure the provider is updated, appropriate interventions are in place, and the care plan is updated to prevent any further weight loss. Education will be completed with RD and nurse managers to ensure any significant weight loss or gain is reviewed, interventions documented in PCC, provider, and care plan are updated.		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
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F0692 SS = G	Continued from page 1 §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to comprehensively and accurately re-assess, develop and implement interventions to reduce/prevent significant and continued weight loss for 1 of 3 resident (R2) reviewed for weight loss. This resulted in actual harm when R2 was hospitalized for malnutrition. Findings Include: Center for Medicare & Medicaid Services (CMS) considers weight loss ‘significant’ if it exceeds 5 percent (%) within one month, 7.5% within three months, or 10% within six months. R2’s admission Minimum Data Set (MDS) assessment dated 3/19/25, identified an admission date of 3/13/25, indicated R2 was severely cognitively impaired and had diagnoses of cerebral palsy, depression, and enlarged prostate know as benign prostatic hyperplasia (BPH), obstructive uropathy (blockage hindering urine flow), and Rhabdomyolysis (muscle breakdown). R2 weighed 147 pounds, received a mechanically altered diet, was not on a weight prescribed regimen, and a box was marked “yes” for weight loss of 5% or more in the last month or loss of 10% or more in the last six months. The MDS documented R2 had no issues with swallowing, was dependent on staff for all cares including eating, hygiene, and mobility. Care Areas triggered were cognitive loss, visual function, communication, urinary catheter, psychosocial well-being, mood, behavior, falls, nutritional status, pressure ulcer, and psychotropic drug use. R2 received antipsychotics, antidepressants, and antianxiety medications. R2’s Nutrition Care Area Assessment dated 3/16/25, was triggered due to significant weight loss and altered diet. It lacked identification of care plan considerations and included a note to refer to nutrition evaluation for additional information. R2’s Clinical Nutritional Evaluation dated 3/15/25, identified R2’s weight as 147.8 pounds with a usual weight of 160 pounds, no weight loss or gain of 5 percent (%) or more in the last month, body mass index (BMI) as greater than 30 indicating obese, had a regular diet, difficulty chewing, intake at 26-50%, took supplements twice a day, and required staff assistance with feeding. A report titled IDT Care			F0692	Continued from page 1 Education will be provided to all nursing staff on notification to provider for any significant weight gain or loss, as well as how to document any refusals of meals, supplements, or weights, and the change of condition policy. DON or designee will complete 5 audits weekly x4 weeks to identify any residents with significant weight loss or gain and that interventions have been put into place, documentation in PCC, provider notification, and care plan is updated. Then monthly x 2 months. All audits will be reviewed in QAPI for trends.		

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F0692 SS = G	Continued from page 2 Conference dated 3/26/25 identified nutrition concerns as low/sporadic meal consumption. R2 was on a regular diet with modified thick liquids and weighed 143 pounds. The note identified R2 was totally dependent on staff for all needs. R2’s record lacked documentation for additional quarterly care conferences. R2’s quarterly Minimum Data Set (MDS) assessment dated 6/11/25, identified R2 used a wheelchair, was dependent on staff for all mobility, cares and eating, weighed 138 pounds, and required a mechanical and therapeutic diet. R2’s provider orders included a house supplement (magic cup) twice a day from 3/15/25-7/6/25 and were documented as given 17 times out of 226 opportunities. R2’s provider orders also identified weekly weights were ordered 3/17/25-3/24/25. R2 was weighed one time out of two opportunities during this period. R2’s provider orders identified weekly weighs were ordered 3/26/25-4/16/25. R2 was weighed one time out of four opportunities during this period. R2’s provider orders identified weekly weights were ordered 4/23/25-7/19/25. R2 was weighed five times out of fifteen opportunities. R2’s medical record identified the following weights (in pounds): 3/15/2025 14:21 147.8 3/16/2025 13:10 147.8 3/20/2025 15:45 143.0 3/31/2025 09:21 141.0 4/17/2025 13:15 139.0 4/23/2025 10:54 136.4 5/1/2025 12:55 135.2 5/28/2025 14:37 138.0 6/12/2025 14:38 132.2 6/25/2025 15:41 128.2 7/23/2025 14:44 127.6 7/24/2025 14:44 126.0 R2’s was seen by the medical director on 4/6/25, 5/14/25, and 6/18/25, and the provider visit notes described R2 as pleasantly confused with no distress a satisfactory appetite. The record lacked documentation related to weight loss. An Associated Clinic of Psychology (ACP) note dated 6/18/25, identified R2 as calm and relaxed throughout the session. R2 reported frequent hunger and consumed a snack during the session. R2 denied any stressors outside of feeling hungry. R2’s nutrition care plan focus dated of 6/19/25, identified a nutritional risk due to dysphagia and hot liquids. /Goals included weight gain, intake greater than 50%, and no adverse incident related to hot liquids. The interventions included total assist of one with eating and drinking, obtain weights weekly and as needed, offer adequate fluids at and between meals, supplements per MD order, provide assist with meal intake, and speech therapy to consult as needed. A report titled Clinical Nutritional Evaluation dated 7/6/25, identified R2’s weight as 128.2 pounds and height as 65 inches tall, with a usual weight of 160 pounds, no weight loss or gain of 5% or more in the last month, BMI greater than 30 indicating obese, regular diet, difficulty chewing, intake at 26-50%, took supplements, and required staff assistance with			F0692			

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F0692 SS = G	Continued from page 3 feeding. R2’s progress note dated 7/6/25, indicated a weight warning was triggered and weight was 128.2 pounds, and the registered dietician increased supplements from twice per day to three times per day. R2’s orders to give supplements three times a day from 7/6/25-7/12/25, were documented as given three times out of 21 opportunities. Documentation indicated R2 refused three times during this period. R2’s Census information identified he was in the hospital from 7/12/25 to 7/19/25. R2’s Transfer Information document dated 7/19/25, indicated R2 was admitted to Methodist Hospital on 7/12/25 for malnutrition and failure to thrive and treated for a urinary tract infection (UTI) and weakness. During the hospital stay R2 was given antibiotics and referred to a dietician. The hospital note identified R2 as a “patient with moderate malnutrition in context of acute illness/injury”. The results of abdominal imaging dated 7/13/25, revealed no medical reason for weight loss, “no evidence for occult malignancy or CT findings to explain the patient’s symptoms or weight loss”. The document indicated R2 required additional resources due to the degree of malnutrition during the hospital stay. /The hospital dietitian recommended in discharge orders for strawberry boost in the morning and at night with daily snacks, updated food preferences, and high calorie-high protein eating. R2’s hospital weight on 7/13/25 was recorded as 115 pounds and 11.9 ounces, which was a 21.7% weight loss from R2’s admission to the long-term care facility and indicated severe weight loss. R2’s Census information indicated he returned to the facility on 7/19/25 and discharged on 7/30/25 to another care setting. During an interview on 8/4/25 at 12:03 p.m., dietary aid (DA)-A stated nutrition supplements were brought up from the kitchen and passed to the residents by the nursing assistants with meals if the dining ticket had a supplement ordered. Extra supplements were brought up from the kitchen and given to the nurses to store at the nurse’s station for snacks in between meals. During an interview on 8/4/25 at 12:08 p.m., nursing assistant (NA)-B stated if a resident needed a nutritional supplement it was printed on the dining ticket, and nursing assistants passed the supplements along with the meal tray. If a resident was allergic or refused the supplement the nurse would be notified. During an interview on 8/4/25 at 12:20 p.m., registered nurse (RN)-B stated ‘mighty shakes’ were liquid and ‘magic cups’ were frozen, and both came up from the kitchen and were served with meals. If the supplement was ordered to be given between meals, the kitchen sent up the supplements, but no labels identified who the supplements were for, and the nurses knew who was supposed to receive them. RN-B stated a provider would be notified of weight loss only if there			F0692			

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F0692 SS = G	Continued from page 4 was a three-to-five-pound loss. The nursing assistants were responsible for weighing residents and recording the weights in a binder located at the nurse station. RN-B stated the nurses reviewed the logs daily for weight loss; however, no parameters were printed on the logs to instruct staff regarding when to notify the manager or provider. RN-B confirmed if a resident was losing weight month after month the nurse would be aware but couldn't confirm if the dieticians reviewed the weight logs or used the recorded weights in the medical records to discuss at care conferences. During an interview on 8/4/25 at 12:27 p.m., RN-C confirmed when a resident returned from a hospitalization and their discharge orders recommended nutritional supplements or other interventions the dietician would get involved. All supplements were documented on the treatment assessment record (TAR) and the nurse manager would be informed if a resident consistently refused. RN-C stated If a resident refused meals or consumed less than 50% of their meal the chart was flagged, and the entire team would monitor for weight loss. The provider was notified if there was a significant decrease in weight by the dietician or nurse manager. RN-C stated the resident should be weighed at the same time and in the same manner each time, and the entire team monitored for weight discrepancies. During an interview on 8/4/25 at 1:00 p.m., registered dietician (RD)-C stated if nutrition supplements were ordered with meals they were served with the meal tray, but supplements were also stocked on the floor and served as a snack. The supplement would be labeled with the resident's name. /RD-C stated preferences were discussed at care conferences and if a resident didn't like the supplement or if they refused the supplement many alternatives were offered including snacks. RD-C indicated if a resident was losing weight, a weight warning would be triggered in the electronic health record when they lost 5% or greater. The team would discuss the weight loss, and the nurse manager would notify the provider. A nutritional assessment was completed for R2 on 3/15/25 & 7/6/25. RN-C confirmed the weight warning triggered on 7/6/25 and indicated a 5% decrease over 30 days. R2's record lacked additional interventions implemented until 7/23/25, when another weight warning was identified. RD-C confirmed a high calorie supplement was ordered for R2 after the hospital stay dated 7/12/25-7/19/25, but confirmed the record did not reflect R2 received the additional supplements. During an interview on 8/5/25 at 9:04 a.m., registered nurse (RN)-A stated it was the NA's responsibility to pass the supplements. RN-A stated weights were documented, and if weight was triggered for significant weight loss the provider was notified. The nurse manager was responsible for notifying the			F0692			

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F0692 SS = G	Continued from page 5 provider who would consult with the dietician and order labs to rule out illness and would then identify likes and dislikes with food or the root cause for the appetite being down. The family was notified only if there was a definite decline in weight. RN-A stated when residents returned from the hospital the discharge summary was reviewed, and any provider orders were implemented. RN-A stated R2 had weight loss, the family was consulted, and the family offered ideas to stimulate appetite such as finger foods but confirmed R2's record lacked documentation of these interventions. RN-A confirmed R2's weight loss was documented, and the care plan was not updated to implement personalized interventions but would expect nutrition interventions should have been implemented with continued weight loss. RN-A confirmed the provider was never notified of R2's weight loss. During an interview on 8/5/25 at 9:54 a.m., family member (FM)-A, FM-B, and FM-C, FM-A stated R2 was 165 pounds while living at home in March of 2025. During a care conference on 3/26/25, R2 was 145 pounds. FM-B stated the primary discussion during the care conference was about R2's weight loss and approximately 90-120 minutes was spent discussing interventions. FM-B stated the social worker confirmed to them R2 received a nutritional supplement, "Ensure", and when the family requested additional Ensures, they were told, "well he gets one". FM-B denied the nurse manager discussed any type of personalized interventions such as finger foods. FM-C stated they visited approximately five weeks later in 6/4/25, and R2 weighed approximately 135 pounds, was "alarmingly thin," and cognitively altered. FM-C stated the facility notified R2's wife on 7/11/25, R2 hadn't eaten for the past two days and wasn't taking any medications. They stated when they visited at 4:00 p.m. on 7/12/25, R2 was lying in bed and appeared to have lost 30 pounds, was "massively" dehydrated, and cognitively altered. /They stated staff were unable to tell the family R2's current weight, and indicated staff were directed to "push fluids," but were unable identify or locate any protocol, and unable to determine if they had pushed any fluids. FM-C stated given R2's altered behavior, how staff couldn't determine a current weight, or if orders were followed, family called 911. /They stated R2 was admitted to Methodist Hospital from 7/12/25 to 7/19/24, for malnutrition, failure to thrive, and dehydration, and was treated for a urinary tract infection (UTI). FM-C stated after 24 hours of antibiotics the infection started to clear, R2 was hungry and began eating and drinking. FM-A stated the family was aware R2 had lost weight but didn't know the extent until the day they called emergency services on 7/12/25. During an interview on 8/5/25 at 10:58 a.m., nurse practitioner			F0692			

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F0692 SS = G	Continued from page 6 (NP)-B stated the facility would notify them of resident concerns by phone or leave a post it notes if they were onsite, and stated notifications were not always documented in a progress note. NP-B could not recall meeting with R2 regarding weight loss or whether staff notified them specifically about weight loss but was aware sometimes R2 would indicate he was hungry, but when food was offered continued refusing. After reviewing R2's medical record, NP-B confirmed there should have been a notification if there was a ten-pound weight loss and NP-B would have implemented interventions such as labs to rule out illness or decreased renal function, prescribed appetite stimulants, or referred R2 to ACP. NP-B confirmed staff first notified the on-call nurse practitioner on 7/11/25, when R2 wasn't eating or taking medication. NP-B stated other interventions for weight loss could have been implemented sooner, including neuro-psych testing and medications, hospice, or feeding tubes, though not ideal, but in hindsight additional interventions should have been applied due to the weight loss. During an interview on 8/5/25 at 11:12 a.m., LPN-A stated the provider, or family would be notified if weight triggered a warning for significant weight loss of 5% or more. LPN-A stated weekly weights were the standard and should be done on bath day. LPN-A confirmed R2 had an order, but R2's record lacked documentation of weekly weights. LPN-A stated R2 transferred to the unit in April 2025, and no interventions for weight loss would be implemented until a weight warning was triggered. LPN-A indicated R2 first triggered for weight loss on 7/24/25. LPN-A stated there was not a concern for the other weights in R2's medical chart because they were not triggered in the electronic record for significant weight loss, but LPN-A had noticed a downward trend. LPN-A would not notify the provider unless it met the weight loss parameter of three pounds per day or five pounds per week but could not identify what document was used for that guidance. LPN-A recalled feeding R2 breakfast three to five times per week and recognized there were times R2 wouldn't eat breakfast but did finish all lunches. LPN-A had no other concerns after the hospitalization in July because R2 was eating on and off. LPN-A stated R2 only had one care conference during the thirteen-week stay at the facility and confirmed the care plan lacked personalized interventions due to the system not triggering weight loss until July. During an interview on 8/5/25 at 12:00 p.m., the DON stated staff should review all weekly weights, identify any decrease in weight, and any resident with weight loss should be discussed at the daily meeting. /The provider should be notified, interventions for nutrition such as supplements or			F0692			

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F0692 SS = G	Continued from page 7 offering extra snacks should be implemented, and staff would document this in a progress note. DON indicated some residents refused everything offered but were encouraged with more snacks depending on their diet, however staff should monitor consumed meals and notice if a resident wasn't eating and if their weight had decreased. DON stated they had witnessed R2 tell staff he was hungry and then refuse to eat when staff attempted feeding, but could not identify what, if any, interventions were attempted relating to this behavior. The DON stated R2's weight was discussed during their initial care conference, however the record lacked documentation of that discussion. The DON confirmed R2 had an order for weekly weights and stated staff should have recognized R2's gradual 20-pound weight decrease even without the triggered warnings in the electronic health record. DON stated staff should have added new individualized interventions to the care plan to increase R2's weight upon identification of the weight loss and/or during quarterly care conferences, but no quarterly care conference took place. Staff also should have updated the provider, and DON verified there were no provider notifications regarding weight loss, nutrition, or refusing to eat or take medications until 7/11/25, prior to the hospitalization at Methodist Hospital. /The DON stated R2's weight loss was a combination of deconditioning and a UTI that led to the hospitalization on 7/12/25. The facility Weight Policy dated 5/1/24, identified the registered dietitian (RD) and or responsible party shall be notified of weight changes at the discretion of the IDT. The RD shall review residents who trigger for significant weight gain or loss. Significant is defined as a person with 5% weight change over 30 days, 7.5% weight change over 90 days, or 10% weight change over 180 days. The IDT and or facility designee shall review weights for significant weight changes and will be discussed to determine individualized care plan interventions and documented in the electronic medical record. Facility policy, Notification of Change dated 3/24, identified nurses and other care staff are educated to identify changes in a resident's status and define changes that require notification of the residents and or their representative and the resident's physician to ensure best outcomes of care for residents. /Significant change in status-deterioration in health, mental or psychosocial status in life threatening conditions or clinical complications.			F0692			