



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 7, 2023

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

RE: CCN: 245187
Cycle Start Date: May 16, 2023

Dear Administrator:

On May 16, 2023, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically delivered CMS-2567, whereby corrections are not required.

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On May 1, 2023, the situation of immediate jeopardy to potential health and safety cited at F689 was removed.

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 listed below to the CMS Region V Office for imposition: You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty, (42 CFR 488.430 through 488.444).

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 \$11,995; 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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 16, 2023. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, The Villas At The Cedars is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective May 16, 2023. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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:

Steven.Delich@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) 565-9462

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

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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 Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Feel free to contact me if you have questions.

Sincerely,



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245187		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/16/2023	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT THE CEDARS				STREET ADDRESS, CITY, STATE, ZIP CODE 7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 5/9/2023 to 5/10/2023 and 5/15/23 to 5/16/23 a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. H51872051C (MN00093195, MN00093243),with a deficiency issued at F689 at PAST NON-COMPLIANCE. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.			F 000			
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide adequate supervision to prevent an elopement for 1 of 3 residents (R1) reviewed for missing person/elopement. This resulted in immediate jeopardy when R1 exited the facility and was			F 689	Past noncompliance: no plan of correction required.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	Continued From page 1 found on the ground on near a street intersection on the sidewalk by law enforcement (LE)-A, late at night. The facility was unaware of R1's absence from 11:20 p.m. until 11:47 p.m. which placed him at risk for serious harm, impairment, or death. The immediate jeopardy began on 4/29/23 at 11:20 p.m., when R1 left the facility unsupervised and was found at 11:47 p.m., outside the facility on the on the ground by law enforcement (LE)-A. The administrator and director of nursing (DON) were notified of the immediate jeopardy on 5/16/23, at 4:41 p.m. The facility immediately implemented corrective action on 5/1/23 prior to the survey and was issued at Past Noncompliance. Findings include: R1's progress note dated 5/23/22, indicated staff met with R1 about a recent self harm incident over the weekend. R1 reported that he self-harmed because he "spaced out" after trying to remove the wander guard. The note included, "the need for a wanderguard as resident has a history of going outside in the evening without (appropriate) clothing." R1's quarterly Minimum Data Set (MDS) dated 3/4/2023, identified R1 had diagnoses of nontraumatic intracerebral hemorrhage of the brain stem, seizure disorder, difficulty walking, agnosia (loss of the ability to identify objects using one or more senses), generalized muscle weakness, cerebral infarction (stroke), and psychiatric disorder. R1 is not cognitively impaired, independent with activities of daily living (ADLs), used a walker for mobility, was	F 689			

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F 689	Continued From page 2 occasionally incontinent of urine, and had two falls without injury since the previous assessment. Further identified R1 was administered antipsychotic medication. R1's ADL care plan dated 11/20/20, identified R1 was ambulatory with four wheeled walker. R1's fall care plan dated 11/20/20, identified R1 was at risk for falls related to seizures and stroke. Further identified R1 had three falls since 2/21/23. R1's care plan dated 12/14/20, informed staff R1 had impaired thought process related to unspecified mental disorder to known physiological condition R1's communication care plan dated 1/21/21, identified R1 had hearing impairment. He required communication through writing and directed staff to use ADL cards, approach resident face to face, and provide white board or note pad. R1's activity care plan dated 5/13/21, informed staff R1 had weakened muscles with some paralysis and also had neurological neglect of one side of his body. R1's behavior care plan dated 12/16/21, indicated R1 needed frequent checks to determine resident needs and offer assistance if needed (12/30/21). Monitor/assess for delusional thinking, paranoia, and inform nurse manager/social services of changes to mood behavior (2/6/23). R1's care plan dated 3/14/23, indicated R1 refused assistance for cares, yelled at staff, and setting self down on the floor. R1's wandering care plan dated 4/18/23 identified R1 had a history of wandering due to episodic confusion/impaired cognitive function related to history of organic mood disorder and paranoia. Corresponding interventions included complete			F 689			

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F 689	Continued From page 3 wander/elopement risk assessment quarterly/as needed to assess risk and assist resident to exercise regimen per physical/occupational therapy. R1's psychotropic medication care plan dated 12/14/23, identified R1's target behaviors as confusion, irritability, and agitation. R1's physician order dated 2/14/23, included R1's Wanderguard to be removed and document any behaviors in a nurse progress note every shift for 7 days; end date of 2/21/23. R1's Elopement Risk Evaluation dated 2/15/23, identified R1 had a habit/history of wandering or attempts to leave the building, was ambulatory, had diagnoses of a cognitive disorder. R1's antipsychotic medications, history of calling the police, somatic complaints, and history of self-harm was not identified as a risk factor on the assessment. The evaluation indicated R1 had a risk score of '3'. The evaluation tool directed if the score was 4 or greater include elopement plan. R1's progress note dated 2/15/23, indicated interdisciplinary team (IDT) met to review current status and elopement risk. Elopement risk assessment indicated R1 was low risk for elopement. R1 had not exhibited behaviors indicating risk since last quarter. IDT concluded trial removal of wanderguard at this time. Monitoring would be completed for seven days. There was no indication an assessment for on-going interventions was developed or implemented after the seven day monitoring had ended. R1's Elopement Risk Evaluation dated 3/4/23, was inconsistent with the evaluation dated	F 689			

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F 689	Continued From page 4 2/15/23. Indicated R1 did not have a habit/history of wandering or attempts to leave the building and identified R1 currently taking medications that caused confusion. The evaluation did not identify a history of somatic complaints or self-harm. The section labeled "additional considerations" was blank. R1's elopement risk was scored as a level '3'. R1's elopement care plan dated 4/18/22, indicated R1 was at risk for elopement related to impaired cognition, episodic confusion, and independently mobile with interventions to reduce the risk of elopement with a "wander alert" attached to right side of walker was discontinued on 3/14/23. R1's Wander/Elopement Risk Evaluation dated 4/10/23, indicated R1 was physically able to leave the building and was ambulatory with a walker. R1 was a risk for wandering/elopement however the section labeled "Summary" was blank. R1's evaluation lacked evidence staff included interventions or had revised the care plan to address R1's risk for wandering/elopement. R1's psychology visit note dated 4/24/23, indicated the physician had made the decision to increase R1's Zyprexa (antipsychotic medication) to 20 milligrams (mg) due to his delusional thinking that is somatic in nature. R1 reported his mood was stable and was strong on his feet. R1 was "getting out of bed and walking again. This is a very positive change." A police report, dated 4/30/2023 at 12:53 a.m., included law enforcement (LE)-A was completing a routine patrol of the area surrounding the facility. On 4/29/23 at 11:47 p.m. LE-A observed a	F 689			

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F 689	Continued From page 5 male (R1) on the ground with his walker and was at the corner of a street intersection. The male appeared in distress and was waving LE-A over. A nurse saw LE-A's squad emergency lights and came out (of the facility). She (nurse) stated "[R1] is a resident there and he must have snuck out." The report indicated R1 had requested to go to the hospital for unknown an medical reason and complained his bed linens were always soiled. R1 was walked back into the facility to wait for emergency medical services (EMS). Once inside the facility LE-A asked the facility supervisor "how it was possible [R1] who could barely walk was able to make it out of his room in Unit [unit number specified] on the second floor and walk out to the location that he was found. The supervisor stated he must have not locked the front door." LE-A took pictures of R1's room which "appeared filthy". There were ants on the floor along with feces stains, his bed was soiled, and the room smelled of feces. On 4/29/2023, the temperature in St. Louis Park, MN was 45 degrees Fahrenheit (F) at 11:53 p.m. per the national weather service. On 5/15/2023, the surveyor observed the distance between the point R1 was found by Law Enforcement (LE)-A and the facility main entrance which was approximately 80 yards. R1's progress note dated 4/30/2023 at 2:45 a.m., Licensed Practical Nurse (LPN)-A indicated R1 had become agitated at an unspecified time and requested facility staff contact 911. R1's vital signs were stable. R1 started yelling at LPN-A to leave his room after she informed R1 he seemed to be okay and would need a reason to call an ambulance. LPN-A stated she intercepted R1 in			F 689			

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F 689	Continued From page 6 the facility parking lot, where he fell onto his bottom and police happened to be driving by. The progress note indicated LE-A contacted paramedics and R1 was subsequently transported to the hospital for further evaluation. R1's representative was contacted who requested he resumed wearing his wanderguard. R1's Elopement Risk Evaluation dated 4/30/23, identified a risk score of 7 which directed staff to include an elopement care plan. Documentation indicated R1 was at risk for elopement, goals included, R1 will not leave the building, and family will be kept informed. The section "Wander guard in place" was not documented, however in the Additional Comments sections documentation included, "Resident to resume use of wander guard". R1's Readmit Data Collection dated 5/1/23, indicated R1 was readmitted from the hospital with a closed non-displaced fracture of anterior process of right calcaneus (prominence on the heel bone). R1's progress note dated 5/2/23, included IDT met to review resident fall outside facility. Resident was sent to acute care hospital after being found. Team met to review R1's behavior of exiting the facility. After communication with power of attorney, it was determined that R1 would be more appropriate on a secure unit. R1's progress note dated 5/9/23, included R1 continues to have sporadic episodes of requesting to go to the hospital. Elopement risk completed with a score of 4.0. physician was notified of the same with orders received and a wander guard applied to resident's walker. Staff	F 689			

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F 689	Continued From page 7 will continue to monitor and initiate frequent check with rounds at nigh and as needed. R1's revised care plan for wandering on 5/9/23, indicated the following interventions: Monitor R1's whereabouts every 2 hours. Document any noticed wandering behavior and attempted diversional interventions. R1's trigger for wandering/eloping were needing to go to the hospital. R1 behaviors can be de-escalated by offering coffee/snacks of choice, and getting family involved. During an interview on 5/12/2023 at 10:52 a.m., LE-A stated he had been patrolling the area on the night of 4/29/2023 at approximately 11:45 p.m. and was waved over by R1 who was sitting on the ground. LE-A stated R1 was located on the sidewalk of the northeast corner of Texas Ave S and 28th St W, before the entrance of the facility parking lot. LE-A stated there were several bystanders from the neighborhood, but no facility staff present. LE-A indicated he exited his squad car, helped R1 to stand, then returned to his squad car to turn on his emergency lights. LE-A stated he was with R1 for approximately 30-60 seconds before he noted LPN-A exiting the facility front doors. LE-A indicated when he spoke to LPN-A, she had stated they knew R1 had left his unit but were unaware R1 had left the facility. LE-A stated he does not know how long R1 had been outside the facility without supervision. R1's psychiatric visit note dated 5/8/23, indicated staff reported R1 left the building at night, wanting to go to the hospital, and fell while outside. He is currently on a secured unit pending cognitive screenings. R1 displayed some challenges with recall regarding hospitalization.			F 689			

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F 689	Continued From page 8 During an interview on 5/15/2023, at 11:07 a.m., NA-C stated R1 had been agitated since approximately 10:00 p.m. on 4/29/2023, and had been using his call light to request assistance and contacting the police with unspecified concerns. NA-C notified LPN-A about R1's concerns. NA-C stated NA-E had told LPN-A R1 was not allowed outside the facility without supervision. NA-C stated neither she nor NA-E were made aware of any issues with R1 until LE-A arrived on the unit. During an interview on 5/9/23 at 3:07 p.m., and 5/15/23 at 1:18 p.m., LPN-A indicated on 4/29/23, R1's agitation and behavioral disturbances began around 10:00 p.m. LPN-A stated R1 was insistent on contacting the police but would not provide a medical concern for her to assess. LPN-A indicated R1 walked past the nurses station and got on an elevator shortly after midnight. R1 was wearing a long-sleeved collared shirt and shorts. LPN-A stated she was unaware R1 could not be in the community by himself. During an interview on 5/10/2023 at 9:46 a.m., the Director of Nursing (DON) stated R1 needed to be accompanied to all appointments by a family member or staff. The DON stated R1 was not safe to leave the facility independently. A facility policy titled Elopement Guideline, dated 2/27/2023, stated documentation of an elopement event must include all attempts to locate the resident and time specific entries detailing the initiation and results of these efforts. The policy states there should be a unit-wide search for the resident and the Administrator should be notified of the elopement. The policy indicates a facility-wide search should be completed,	F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/07/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245187	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/16/2023
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT THE CEDARS			STREET ADDRESS, CITY, STATE, ZIP CODE 7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page 9 followed by a thorough search of the facility grounds involving all available facility staff. The immediate jeopardy that began on 4/29/23, was removed on 5/1/23 before the survey and was issued at Past Non-Compliance when the facility implemented the following: Completed an assessment of R1 for wandering, confusion, anxiety, paranoia, and behaviors that increased R1's risk for elopement. The facility updated R1 care plan to include a wanderguard on R1's walker, frequent checks, and identified triggers and intervention to decrease R1's behaviors associated with leaving the facility, and placed in a secure unit. All staff were educated on elopement policy, and code white missing person procedures. Licensed nursing staff were educated on how to complete a comprehensive assessment and care plan interventions for resident at risk for elopement.	F 689			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 7, 2023

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

Re: Event ID: VN8111

Dear Administrator:

The above facility survey was completed on May 16, 2023 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,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00144	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/16/2023
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT THE CEDARS			STREET ADDRESS, CITY, STATE, ZIP CODE 7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/9/2023 to 5/10/2023 and 5/15/23 to 5/16/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN in compliance with the MN State Licensure The following complaints were reviewed.	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00144	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/16/2023
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT THE CEDARS		STREET ADDRESS, CITY, STATE, ZIP CODE 7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 000	Continued From page 1 H51872051C (MN00093195, MN00093243) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000			