STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245083	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at the Park	4415 West 36 1/2 Street Saint Louis Park, MN 55416

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure a resident received appropriate interventions to prevent contractures for a resident who was admitted to the care facility without contractures (permanent shortening of tissue, such as muscle, tendon or skin leading to the inability to straighten joints fully and to permanent deformity and disability) for one of two residents (R20) reviewed for range of motion. This resulted in actual harm when R20 developed severe contractures of bilateral upper and lower extremities. Findings include:R20s significant change Minimum Data Set (MDS), dated [DATE], indicated R20 was admitted to the care facility on 3/20/19. The MDS indicated R20 was not on any range of motion or restorative nursing programs. R20's previous MDS dated [DATE] further indicated R20 had range of motion impairment on only one side of his body and also lacked any mention of a range of motion or nursing restorative program. The MDS dated [DATE] further indicated R20 was independent with bed mobility rolling side to side. R20's diagnoses list indicated R20 had several medical diagnoses including aphasia (impaired ability to understand or produce speech as a result of brain disease or damage) and hemiplegia (a form of paralysis that affects one side of the body, usually due to a brain or spinal cord injury) and hemiparesis (weakness or the inability to move on one side of the body) following cerebral infarction (stroke) affecting right dominant side, dated 4/19/20.R20's care plan, dated 7/9/2019, indicated R20 had an activity of daily living self-care performance deficit r/t [related to] acute ischemic CVA [cerebral vascular accident] and dementia, refusal of cares and varying level of cares needed indicating resident has preference to lie on sides in ?fetal position' as this is most comfortable for him. The care plan indicated R20 required a Hoyer lift for transfers, dated 4/20/20, however fall interventions were in place on 8/27/23, indicating R20 was utilizing a walker and to keep walker in reach and also had a wandering guard, dated 2/2/23 for exit seeking behavior. The care plan further indicated R20 was independent with transfers upon admission and lacked any interventions regarding, or to prevent, R20's contractures (i.e. range of motion). R20's Balance/ROM (range of motion) Assessment, dated 5/14/24, indicated R20 had no impairment of his upper and lower extremities including shoulder, elbow, wrist, hand and hip, knee, ankle, foot joints.R20's Census report indicated R20 was admitted to hospice services on 7/24/24, and his guardian revoked hospice services on 10/10/25.R20's electronic medical record (EMR) indicated R20 was hospitalized on [DATE] after hospice services were revoked due to refusing oral intake. It was noted R20 had visible signs of pain with right lower and upper extremity movement but was able to tolerate passive range of motion and was dependent on staff for bed mobility. The note further indicates R20's lack of range of motion affect R20's ability to safely and independently engage in all activities of daily living. R20's physical therapy note from his hospitalization, dated 10/16/25, indicated R20 had contractures of all extremities; right lower extremity: contracted in 45-degree knee flexion, left lower extremity: contracted in about 15-20-degree flexion, left upper extremity: contracted at 50-60-degree flexion.R20's facility occupational therapy evaluation, dated 11/11/25, indicated R20 was unable to sit up unassisted and due to contractures of all extremities, it was not attempted to have R20 bear (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Actual harm Residents Affected - Few	weight or attempt ambulation.During observation on 11/17/25 at 2:41 p.m., R20 was lying in bed on his right side in a fetal position in bed.During observation on 11/18/25 at 12:33 p.m., R20 was lying in bed on his right side in a fetal position in bed.During observation and interview on 11/19/25 at 8:20 a.m., nursing assistant (NA)-B stated R20 use to be able to sit up in bed and get up in his broda chair (specialized wheelchair designed for comfort, posture support, and safety) but was no longer getting out of bed due to contractures in his knees, stating when R20 came off hospice he declined and now doesn't move. NA-B and NA-C provided morning cares and a brief change for R20. R20's legs were extremely contracted, with the knees bent and unable to straighten as NA-B and NA-C rolled him side to side to provide peri care and a clean brief. R20 was noted to grimace and call out in distress when rolling side to side. NA-B confirmed R20 was unable to straighten his legs and was not receiving any passive stretching from the NAs, nurses or therapy staff.During an interview on 11/18/25 at 1:32 p.m., physical therapist (PT)-A stated R20 had been able to move all extremities spontaneously and was getting up onto his broda chair while on hospice. PT-A stated R20 had declined and she would be surprised if he could tolerate getting up in a chair anymore. PT-A stated R20 was last on physical therapy caseload in July of 2024 but had received an occupational therapy consult on 11/11/25.During an interview on 11/18/25 at 2:19 p.m., occupational therapist (OT)-A stated she completed an evaluation with R20 on 11/11/25 due to his brother requesting a consult for fall prevention and to help R20 walk again. OT-A stated R20 used to get up walking but had been bed-bound for quite a bit. OT-A stated during her evaluation, R20 was unable to maintain a sitting position, was contracted in all of his joints, and due to the severe contractures in his knees preventing him from straightening his legs she could not even attempt to get him to bear weight.During an interview on 11/19/25 at 11:44 a.m., nurse manager and licensed practical nurse (LPN)-A stated R20's contractures progressed while he was on hospice and therapy and/or range of motion was not initiated due to R20 being on hospice.During an interview on 11/19/25 at 1:35 p.m., R20's provider and physician assistant (PA)-A stated R20's care would have been managed by hospice until about mid-October when he was revoked from hospice services. PA-A stated it was never brought to her attention while R20 was on hospice that he was becoming more contracted and over the summer hospice chose not to do anything about his contractures. PA-A stated R20 should be evaluated by occupational therapy for his contractures and that range of motion or stretching had not been initiated sooner because R20 was on hospice, stating she assumed hospice would have been addressing those needs.During an interview on 11/19/25 at 1:16 p.m., R20's hospice registered nurse case manager (RNCM)-A stated she became R20's RNCM in June or July of this year. RNCM-A stated at that time R20 was able to stand and pivot transfer and did not have any contractures. RNCM-A stated R20 would always lay in bed with his legs crossed and straight. RNCM-A stated after she took over as case manager, R20's legs started becoming more and more contracted until they could not be straightened anymore. RNCM-A stated since R20 was on hospice services, therapy and/or range of motion services were not provided.During an interview on 11/20/25 at 7:50 a.m., the director of nursing (DON) stated she believed R20 was not as severely contracted until the end of R20's hospice service in October, worsening after his revocation from hospice in mid-October. The DON stated neither hospice nor the hospital post hospice revocation recommended any therapy or range of motion programs so range of motion exercises were never initiated for R20. The DON stated when OT evaluated R20 on 11/11/25, she would have expected them to initiate a range of motion program if needed despite the goal of the evaluation being to determine if R20 would benefit from services to gain strength in hopes to walk again. The DON confirmed R20 was no longer getting up in his Broda chair, confirming it may be too uncomfortable for him.During an interview on 11/20/25 at 8:25 a.m., OT-A stated range of motion exercises are used to slow down or prevent the development of contractures and are a comfort thing as even dressing can become painful when someone is as contracted as R20 has become. OT-A stated she checked her evaluation with R20 from 11-11-25 and had recommended staff to do range of motion exercises with dressing. During an interview on (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	11/20/25 at 9:54 a.m., R20's provider physician-A stated there were multiple ways to prevent contractures and/or prevent them from getting worse, including in R20's situation. Physician A stated hospice residents' care would be decided by the hospice care team as some residents may want or benefit from therapies to focus on comfort even when they are on hospice services, confirming hospice resident can and should receive therapy services focused on comfort while they are on hospice. Physician-A stated he was not aware of how severe R20s contractures had become and would have expected R20's contractures to be assessed for treatment to prevent them from getting so severe, stating he would have also expected to be notified if hospice was not adequately addressing R20's contractures so he could be involved with treatment. Physician-A stated therapy and range of motion is helpful, but nursing care is also important (i.e. elevating legs in bed to help straighten them) and at times medication such as muscle relaxers are used.A facility policy on range of motion service and/or services to prevent contractures was requested and not received.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. During observation and interview, the facility failed to implement interventions to ensure resident's personal care information was kept secured and out of public view when stored on 1 of 3 mobile medication carts. This had the potential to affect 14 residents (R3, R4, R9, R14, R27, R28, R30, R32, R35, R40, R43, R47, R48, and a discharged resident) on the long-term care unit whose personal information was left unattended on a medication cart in the hallway corridor. Findings include:During observation and interview on 11/19/25 at 9:05 a.m., an unattended medication cart had a form titled East nursing care sheet with 13 resident names, room numbers, and notations including other personal information such as nutritional needs such as tube feeding, blood sugars, blood pressures, heart rates, recent falls with confusion and wearing adaptive equipment. Electronic medical record (EMR) access username, password, and wifi information was also included. In addition, the cart had an opened narcotic logbook with two residents' information including name, room number, and narcotic dosage information. Two residents and one staff member walked past the unattended medication cart. At 9:07 a.m., registered nurse (RN-A) walked out of a resident room down the hall and towards the unattended medication cart. RN-A stated she was responsible for the unattended medication cart with the exposed resident care sheet and the opened narcotic logbook. RN-A stated, it should not be left open like that because of HIPAA. RN-A stated the narcotic logbook should be closed so the information is not visible to anyone walking past it.During interview with director of nursing (DON) on 11/1925 at 9:08 a.m., DON stated expectation of patient information to be covered and secured.Electronic mail received from DON 11/19/25 at 9:37 a.m., identified the two residents who names and information exposed from the narcotic logbook were R3, and R30.During an interview on 11/19/25 at 12:59 p.m., nursing assistant (NA)-A stated care sheets should not be kept in an open area to ensure patient privacy. NA-A stated it was important that this information was kept out of the open to ensure staff members or visitors who were not permitted didn't see resident's private medical information.During an interview on 11/19/25 at 1:10 p.m., registered nurse (RN)-A stated all documents with resident personal information should be kept private such as in the nursing station with the door locked or turned over if it is a document that is actively being used. RN-A stated this was important ensure patient privacy.Undated facility policy titled HIPAA and Confidentiality of Client Matters identify, The Resident [NAME] of Rights and the HIPAA Privacy and Security Standards require protection of and restrict the disclosure and use of clients' individual health information.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure a resident (R20) was assessed and care planned for a dignified toileting experience for a continent resident who was told to wet himself for toileting.Findings include:R12's admission minimal data set (MDS), dated [DATE], indicated R12 was admitted to the care facility on 10/29/25, had moderate cognitive impairment and required extensive assistance with most activities of daily living (ADLs).R12's diagnoses list, dated 10/29/25 indicated R12 as admitted to the care facility with a primary diagnosis of sequelae of cerebral infarction (long term conditions post stroke).R12's bladder evaluation, dated 11/4/25, indicated R12 had functional incontinence which could be related to the following impaired mobility, manual dexterity impairment, lack of toilet or toilet substitute, use of restraints, medications. R12's care plan, dated 11/6/25, indicated R12 transferred with the assistance of an easy stand (a machine that lifts an individual directly from a seated surface, like a wheelchair or bed, into a standing position.)During an interview on 11/17/25 at 1:51 p.m., R12 stated he was able to sense when he needed to urinate, and facility staff would tell him to wet himself when he asked to use the toilet. R12 stated it felt awful to have to urinate in his brief and would prefer to use a urinal or the toilet.During an interview on 11/18/25 at 2:19 p.m., occupational therapist (OT)-A stated she worked with R12 last week to get him to use the urinal, stating he was more fatigued last week than he has been this week so they will work on getting him to the commode today. OT-A stated R12 was able to sit on the side of the bed and shimmy his pants down and just needed assistance to place the handheld urinal. OT-A stated she could understand why R12 was frustrated because staff were telling him to go [urinate] in his pants when he could control his bladder. OT-A stated the floor staff could be assisting him with the handheld urinal placement. During an interview on 11/19/25 at 8:20 a.m., nursing assistant (NA)-B and registered nurse (RN)-B both stated R12 was able to let them know when he needed to urinate but he needed to use his brief because his hands shake, and he could not place the handheld urinal on his own.During an interview on 11/19/25 at 11:44 a.m., nurse manager and licensed practical nurse (LPN)-A stated it was expected of staff to use a bed pan or a urinal with resident who was asking to use one, or asking to use the toilet, indicating the resident could sense the need to urinate. LPN-A confirmed the floor staff should assist R12 with placement of the handheld urinal if he was asking or aware he needed to urinate. LPN-A stated it was never okay for staff to tell a resident to wet yourself.A facility policy titled Activities of Daily Living (ADLs)/Maintain Abilities Policy, dated 3/31/23, indicated It is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided are person-centered, and honor and support each resident's preferences, choices, values and beliefs.

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The Villas at the Park	4415 West 36 1/2 Street Saint Louis Park, MN 55416

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to obtain and document an informed consent, including with explanation of risk and benefits, for 2 of 5 residents (R7, R12) reviewed for use of psychotropic medications. Findings include:R7 R7's admissions Minimum Data Set (MDS) dated [DATE] identified R7 with severely impaired cognition, dependent for all cares, and diagnoses of anoxic brain damage (loss of oxygen to the brain for a period of time resulting in damage), seizures, schizophrenia, and dysphagia (impaired swallowing). In addition, R7 had a feeding tube for nutrition. R7 physician orders dated 8/18/25 identified: Haloperidol [psychotropic] Oral Tablet 5MG, Give 5mg via G-Tube two times a day for . related to SCHIZOPHRENIA,UNSPECIFIED (F20.0);CATATONIC SCHIZOPHRENIA (F20.2). R7's medication administration records (MARs) identified R7 was administered Haloperidol August 2025: 51 doses, September 2025: 60 doses, October 2025: 61 doses, missing dose on October 29 8:00 a.m. timeslot, November 2025: 31 doses as of 11/18/2025. However, R7's EMR was reviewed and lacked evidence a signed consent for use of the medication was obtained prior to it being provided. Further, R7's EMR lacked evidence the risks of expected benefits of the medication regimen had been reviewed or discussed with R7's resident representative (FM-B) prior to administering it. During interview with nurse manager (NM) on 11/19/25 at 8:59 a.m., NM stated facility expectation to receive or obtain written informed consents for psychotropic medications upon admission from resident or residents' family. NM stated, it was done with [R7's] daughter (FM-B). NM looked in R7's electronic medical record (EMR) and verified consent was missing. During interview with FM-B on 11/19/2025, at 11:09 a.m., FM-B stated she did not recall signing a form or being told by the facility specifically about any of R7's Haloperidol. FM-B stated she did not receive explanation of the risk or benefits, other treatment alternatives or other options to prescribing Haloperidol to R7. Findings include: R12's admission minimal data set (MDS), dated [DATE], indicated R12 was admitted to the care facility on 10/29/25, had moderate cognitive impairment and had received antipsychotic medication during the 7-day lookback period. R12's physician orders, dated 10/29/25, indicated R12 had an order for Seroquel (an antipsychotic (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication) 12.5 milligrams (mg) at bedtime. R12's November medication administration record (MAR) indicated R12 had received a dose of Seroquel every evening that month for a total of 19 doses. R12's electronic medical record (EMR) lacked evidence R12 and/or their representative was informed in advance of the risks and benefits of the medication and any treatment alternatives or other options available. During an interview on 11/17/25 at 1:58 p.m., R12 stated he could not recall signing a consent for any medication upon admittance to the care facility. During an interview on 11/19/25 at 11:44 a.m., nurse manager and licensed practical nurse (LPN)-A confirmed she was not able to find a consent for R12's Seroquel and that it would be expected that a consent would be received during admission to the care facility. Electronic messaging (email) from director of nursing (DON) on 11/19/2025 at 1:01 p.m., DON stated, We did not complete informed consents for [R7] and [R12] on admission as medications were started in the hospital. There was a misunderstanding if informed consents only needed to be done if facility started a psychotropic or increased the dosage. Facility policy titled Psychotropic Medication Use Policy, revised 5/2025 identified, 6. Consent: Provide the resident/resident representative with information on the medication, indication, dose, side effects, adverse consequences and goal of treatment. a. Obtain informed consent from the resident and/or resident representative and document education, information regarding the medication indication and directions for use, side effects and potential adverse consequences, risks and benefits of the medication and resident choice.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based in interview and document review, the facility failed to ensure a resident had an appropriate diagnosis and indication for use for a prescribed antipsychotic medication for one of five residents (R12) reviewed for unnecessary medications. Findings include:R12's admission minimal data set (MDS), dated [DATE], indicated R12 was admitted to the care facility on 10/29/25, had moderate cognitive impairment and had received antipsychotic medication during the 7-day lookback period.R12's diagnoses list, dated 10/29/25, indicated R12 was at the care facility with a primary diagnosis of sequelae of cerebral infarction (long term conditions post stroke).R12's physician orders, dated 10/29/25, indicated R12 had an order for Seroquel (an antipsychotic medication) 12.5 milligrams (mg) at bedtime.R12's November medication administration record (MAR) indicated R12 had received a dose of Seroquel every evening that month for a total of 19 doses.R12's electronic medical record (EMR) lacked evidence R12 had an appropriate diagnosis and indication for use for Seroquel.During an interview on 11/19/25 at 11:44 a.m., nurse manager and licensed practical nurse (LPN)-A confirmed R12 did not have an appropriate diagnosis of indication for use in the EMR for Seroquel use and stated it would be expected that medications, including indication for use, would be reviewed during admission to the care facility.A facility policy titled Psychotropic Medication Use, dated 5/2025, indicated the indication for any psychotropic medication will be thoroughly documented in the clinical record to include an appropriate supporting diagnosis and identification of behavioral symptom(s) being treated. The medical record must show documentation of adequate indication and diagnosed condition.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure a bed bound resident was care planned for, and received, adequate activities for social and mental stimulation for one of two residents (R20) reviewed for activities. Findings include:R20s significant change minimal data set (MDS), dated [DATE], indicated R20 was admitted to the care facility on 3/20/19 and was dependent on staff for all activities of daily living. The MDS further indicated R20 was not assessed for activity preferences nor did staff complete an activity assessment. R20's diagnoses list indicated R20 had several medical diagnoses including aphasia and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, dated 4/19/20.R20's Census report indicated R20 was admitted to hospice services on 7/24/24 and revoked hospice on 10/10/25.R20's Activity Participation Review, dated 9/18/25, indicated R20 preferred to listen to his favorite music in his room and watch[es] TV. He likes to have visitors from hospice staff and with his brother.R20's care plan, dated 9/18/25, indicated R20 lived at this facility for some time. The resident is formerly from [another country] and was a lawyer for many years. [R20] occasionally will attend activities but not participate as he likes to watch and be in the company of others. In his free time, the resident enjoys people-watching, snacking, resting, reading, and relaxing. He enjoyed painting in the past. English is his second language. Most current interventions were also dated 9/18/25 and lacked updated interventions when R20 discharged from hospice services. During observation on 11/17/25 at 2:41 p.m., R20 was lying in bed, his eyes were open, and he was unable to verbally communicate. No music was on his room, and his roommates TV was on, but he did not have a TV that could be seen from his bed. During observation on 11/18/25 at 12:33 p.m., R20 was again lying in bed, in the fetal position with music, TV or any other type of activity or stimulation. R20 appeared to be awake. During observation and interview on 11/19/25 at 8:20 a.m., R20 was again lying in in bed, in the fetal position with music, TV or any other type of activity or stimulation. R20 appeared to be awake. Nursing assistant (NA)-B and NA-C entered R30's room to provide morning cares. NA-B stated R20 used to get out of bed with hospice but since he revoked hospice services R20 doesn't move and does not get out of bed or attend activities. During an interview on 11/19/25 at approximately 11:58 a.m., the therapeutic recreation director (TRD) stated it was expected that residents were reassessed for activity preference quarterly and with a significant change in condition, such as admitting or discharging from hospice services. The TRD stated the care plan would then be updated after the correlating assessment, stating she would have to look at whether R20's care planned activities had been updated after discharging from hospice services. The TRD stated R20 was in a private room while on hospice services and staff would play special music for R20 on his TV. The TRD confirmed R20 had been in bed for quite some time now. The TRD did not follow up with any additional information regarding R20 being reassessed for activity preference or care plan updates since 9/18/25.During an interview on 11/19/25 at 11:44 a.m., nurse manager and licensed practical nurse (LPN)-A stated R20 was isolated per his choice, saying he will either ignore you or bat you away if he didn't want to engage, or give thumbs-up if he was happy. During an interview on 11/20/25 at 7:55 a.m., the director of nursing (DON) stated she believed R20 had a radio with CDs from hospice, indicating she would care plan for R20 to have music playing in his room and ensure a CD and/or CDs were in his room for use. A facility policy on activities was requested but not received.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245083	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at the Park	4415 West 36 1/2 Street Saint Louis Park, MN 55416

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are assessed for appropriateness for a feeding assistant program, receive services as per their plan of care, and feeding assistants are trained and supervised. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure that residents requiring assistance with eating were provided services by qualified staff for 1 of 1 residents (R47) reviewed requiring a mechanically altered diet.Findings include: R47's quarterly Minimum Data Set (MDS), dated [DATE], indicated R47 had severe cognitive impairment and was dependent on staff for assistance with eating. The MDS indicated R47 was on a mechanically altered diet and utilized a feeding tube.R47's care plan dated 7/2/25, indicated R47 required assistance from staff with eating. R47's speech therapy discharge note dated 10/7/25, indicated R47 had a diagnosis of dysphagia, respiratory failure, and a traumatic brain injury. The note from the speech therapist recommended R47 be on a minced & moist (food consists of small, soft lumps) diet with thin liquids. The note indicated R47 required staff supervision/assistance at mealtime to swallow safely. The note indicated R47 should be sitting at 90 degrees while intaking food/liquids. R47's order summary dated 11/12/25, indicated R47 required a minced and moist textured diet with thin liquids. The summary indicated R47 received nutrition through a feeding tube twice a day. During the entrance conference on 11/17/25 at 12:29 p.m. with the administrator and director of nursing (DON), the administrator confirmed that the facility did not employ any paid feeding assistants. During an observation and interview on 11/18/25 at 8:20 a.m., R47 was observed lying in bed in his room with the head of the bed (HOB) at a 30-to-45-degree angle, with solely the social services director (SSD) accompanying him. The SSD was observed sitting next to R47 and assisting the resident with eating, repeatedly bringing utensils full of food to R47's mouth. R47 was observed with no signs of choking or coughing, and his HOB remained at a 30-to-45-degree angle. At 8:30 a.m., the SSD confirmed he had assisted R47 with eating his morning meal. The SSD stated he helped with feeding residents whenever it was needed and had assisted residents with eating in the past at the facility. The SSD confirmed he was not a certified nursing assistant (CNA), and although he had attended a seminar in college on assisting residents with eating, he was not formally certified to do so. The SSD stated he thought he had completed some training on assisting residents with eating while at the facility but wasn't exactly sure when. The SSD's training records regarding feeding residents from before the survey start were requested from the facility and not received. During an interview on 11/18/25 at 9:28 a.m., the administrator stated that after hearing about the incident with the SSD assisting a resident with eating earlier in the day, she had completed immediate education with the SSD on feeding residents. The administrator stated the SSD did not have any previous training at the facility regarding feeding and was not certified to do so. The administrator stated she would expect nursing staff to assist R47 with eating, and this was not something the SSD should assist with. During an interview on 11/19/25 at 9:43 a.m., the DON stated the nurses and nursing assistants were the only ones at the facility who had met the requirements to feed residents. The DON stated that the SSD had not met the requirements as he did not have a certification to feed residents. The SSD stated that if he wanted to help with feeding residents, he would need to take a class to become certified in this. The SSD stated that after she had found out that the SSD had assisted R47 with eating, she had completed an assessment on R47 and determined that no harm had occurred. A policy regarding assisting residents with eating was requested but not received.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245083	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at the Park	4415 West 36 1/2 Street Saint Louis Park, MN 55416

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure binding arbitration agreements of 1 of 3 residents (R23) were clearly communicated in a form and manner that they understood prior to signing the forms. Findings include:R23's quarterly Minimum Data Set, dated [DATE] identified R23 with intact cognition and no impairment in memory or mood.Record review of R23's MN admission Packet in her electronic medical record (EMR) identified admission to facility on 1/20/23, however it was electronically signed 11/17/25, by both R23 and the social services director (SS-D).During interview with R23 on 11/18/25 at 10:56 a.m., R23 verified she had been a resident of the facility since January of 2023 and had no memory issues. R23 stated she was aware of what arbitration is and defined it as, arbitration is when you have a dispute of some kind and both sides agree to have somebody to listen to both sides. Let them decide instead of going to a jury. R23 stated no one from the facility spoke to her on 11/17/25 about signing and agreeing to arbitration in cases of disputes. R23 stated she did not sign paperwork or computer on 11/17/25. In addition, R23 stated, I am not sure I would agree to it anyways.During interview with R23's emergency contact family member (FM-A) on 11/18/25 at 12:08 p.m., FM-A stated she was familiar with the forms that were signed when R23 was admitted to facility in 2023. RM-A stated, [R23] can let you know whether she agreed to it [arbitration] or not. She would remember.During interview with SS-D on 11/18/25 at 11:08 a.m., SS-D stated process for reviewing the arbitration process with new admissions was to present a video and explain to the resident or their representative how arbitration works. SS-D reviewed R23's MN admission Packet in her EMR dated 11/17/25. SS-D stated the signature throughout the packet was his and it was all dated 11/17/25 and not the date of R23's admission to facility in 2023. SS-D stated, I don't recall talking to [R23] yesterday. I did not sign that form yesterday.During interview with administrator on 11/18/25 at 11:18 a.m., the administrator reviewed R23's MN admission Packet in her EMR and stated, we audited [the resident charts] yesterday [when SA entered the facility]. I don't know if [R23] admission packet was scanned in or not in 2023, so SS-D went in and reviewed it with R23. The admission packet was signed yesterday and downloaded yesterday into the EMR. Administrator stated, this is definitely confusing that [SS-D] signed the scanned forms here and he doesn't remember discussing this form with [R23]. R23 would definitely remember if she signed the paperwork yesterday or not. If she said she did not sign anything then she did not.Facility policy on arbitration was requested and not received.