STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245182	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at St Louis Park	7500 West 22nd Street Saint Louis Park, MN 55426

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to ensure medications were properly labeled to prevent medication errors for 4 residents (R48, R56, R109, and R102) observed during review of medication carts. Additionally, the facility failed to permanently affix two lock boxes used for controlled medications in the medication room refrigerator reviewed for medication storage. Findings include: During observation and interview on 2/12/26 at 10:58 a.m., review of transitional care unit (TCU) medication cart was completed. R48 had two Lantus insulin pens which were not clearly marked with open date and expiration dates. Additionally, R56's bottle of prednisolone 1% solution (eye drop) had no open date or expiration date. Care Coordinator (CC) stated all injectable medications as well as eye drops, ear drops, nasal sprays and creams must be labeled with open and expiration dates otherwise staff would not know if the medication were safe to use. CC confirmed the items were not clearly labeled for use. During observation and interview on 2/12/26 at 11:23 a.m., review of long-term (LTC) medication cart station 3 was performed. A blue water cup contained the following: 2 Humalog, 2 Lantus, and 1 Victoza injectable pens; no pharmacy labels were affixed on the pens. Licensed practical nurse (LPN)-D stated she was unsure how to perform the 3 checks. LPN-D confirmed there was no pharmacy label located on the pens to indicate name/dose/route/time. During observation and interview on 2/12/26 at 12:33 p.m., two square locked metal boxes were noted inside the medication refrigerator in med room [ROOM NUMBER] on the first floor. Director of Nursing (DON) was unable to locate keys for the boxes and requested maintenance to pry open the locked boxes which revealed two bottles of liquid lorazepam intensol in one box and one bottle of liquid lorazepam intensol in the second lock box. During observation and interview on 2/12/26 at 12:43 p.m., review of LTC medication cart station 4 was completed. A Lantus insulin pen for R109 was found to have no pharmacy label. A Lantus insulin pen for R102 was found to have no pharmacy label. LPN-E confirmed there was no pharmacy label located on the pens to indicate dose/route/time. During interview 2/13/26 at 11:28 a.m., DON stated all medications were required to have a pharmacy label affixed with clear dosing instructions for every medication. She went on to say, all insulin pens, eye drops, nasal sprays and creams required an opened date and an expiration date attached to the container. DON stated it was her expectation staff ensured these items were present prior to administering any medications and expected all metal lock boxes use for controlled medication storage to be permanently affixed to a cabinet or refrigerator. DON stated these things were important to ensure residents were not receiving expired medications, to ensure residents were receiving the medications per physician orders, and to reduce the potential of drug diversion. Facility policy titled Medications Storage in the Facility dated May 2022 indicated the following: Certain medications or package types such as multiple dose injectables, and Ophthalmic, once opened require an expiration date shorter than the manufacturer 's expiration date to insure medication purity and potency. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated; the nurse shall place a date opened sticker on the medication and enter the date opened and the new date (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

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	245182	A. Building B. Wing	02/13/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of expiration. The nurse will check the expiration date of each medication before administering it. The policy lacked instructions specific to controlled medication storage.

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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 facial hair was trimmed for 1 of 1 residents (R84) reviewed for dignity.R84's quarterly Minimum Data Set (MDS) dated [DATE], included R84 was cognitively intact. R84's diagnoses included arthritis, stroke, and dementia. R84 had impairment to both upper extremities. R84 required substantial to maximum assistance with personal hygiene, which included shaving. During observation on 2/9/26 at 1:30 p.m., R84 was observed with 1/4 to 1/2 inch long white hairs on her chin. R84 had contractures on both of her hands and commented on how she was unable to open her hands because it was too painful. R84's electronic medical record included a note entered by social worker (SW)-A on 2/9/26 at 3:04 p.m., including SW-A offered to have her face shaved, which resident agreed too. During interview on 2/11/26 at 8:14 a.m., SW-A stated she does not do hands on care with residents. SW-A confirmed she noticed R84 had long chin hair and offered to find someone shave it for her. SW-A declined to estimate on the length of the chin hair prior to it being shaved. SW-A stated facial hair preference should have been included in a resident's care plan. During interview on 2/11/26 at 11:42 a.m., nursing assistant (NA)-A stated staff offeres to shave facial hair daily when they are assisting residents with morning grooming. NA-A stated she did not know any female residents who refused to have their face shaved when offered. During interview on 2/11/26 at 11:48 a.m., NA-B confirmed staff assisted with shaving facial hair. NA-B stated she was unaware of R84 refusing to have her facial hair shaved when offered. During interview on 2/11/26 at 12:32 p.m., family member (FM)-A stated R84 would have preferred to have her facial hair removed. During interview on 2/12/26 at 12:01 p.m., R84 confirmed she would have preferred her facial hair to be shaved. During interview on 2/11/26 at 1:03 p.m., director of nursing (DON) stated she expected staff to brush hair, teeth and other basic grooming daily. DON stated she expected nail care to be completed weekly and shaving to be offered weekly. DON expected staff to reapproach if the resident refused and to add a progress note if a resident continued to refuse. Facility policy for activities of daily living dated 3/31/23, included care and services would be person-centered and honor and support each resident's preferences.

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure a self-administration of medications assessment was completed to allow residents to safely administer their own medications for 2 of 2 residents (R37, R75) observed with medications at bedside. Findings include:R37's admission record dated 12/4/25, indicated R37 admitted to the facility 12/4/25, and had the following diagnoses: heart failure, chronic kidney disease stage 4, anemia and hypertensive urgency. R37's order summary report dated 2/17/26, included orders for the following medications: Carvedilol 25mg, Ergocalciferol 1.25mg, Furosemide 20mg, Omeprazole 20mg, Sodium bicarbonate 650mg, Lyrica 25mg, Methocarbamol 500mg. The provider signed order summary report lacked an order for self-administration of medications or an order to leave dispensed medications at the bedside. R37's medical record lacked evidence of a self-administration of medication evaluation being completed. During initial resident screening/observation on 2/10/26 at 8:58 a.m., R37 was in room seated on bed with bedside table pushed next to bed. A tray of food was noted on bedside table. A medication cup with approximately 6 unidentified pills/capsules was noted on the food tray. Registered nurse (RN-E) entered room and asked R37 if she was done with her meds. R37 stated she was not but that she would take them. RN-E then picked up the medication cup of unidentified medications and left the room. R37 stated staff 'always leaves my meds here'. During interview on 2/13/26 at 11:28 a.m., Director of Nursing (DON) stated residents who wish to take medications independently needed to have a physician's order and must be assessed as being competent to safely self-administer medications. DON stated staff should never leave medications at the beside for a resident to self-administer without an order or a complete self-administer assessment. DON confirmed R37 did not have an order to self-administer medications and no self-administering assessment had been completed for R37. DON stated she expected staff to confirm a resident had a physician's order and self-administering assessment completed prior to allowing a resident to self-administer medications. DON stated this was important to ensure a resident was taking medications as prescribed and not missing doses or stockpiling medications. R75's quarterly Minimum Data Set (MDS) dated [DATE], included R75 was cognitively intact. R75's diagnoses included stroke and Barrett's esophagus with dysplasia (a condition where the lining of the esophagus changes). R75's order summary report dated 2/13/26, included an order for biotine lozenges per package directions per patient request. Order summary report failed to include an order for self-administration of medications. R75's self-administration of medication evaluation dated 11/5/25, included a summary that R75 lacked the capacity for self-administration of medications. During observation on 2/9/26 at 4:49 p.m., R75 had throat lozenges in her room on her bedside table. R75 stated her provider was aware she used them and recommended them for her dry mouth. She said her brother currently purchased them and brought them to her. (continued on next page)

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	245182	A. Building B. Wing	02/13/2026

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 2/10/26 at 1:04 p.m., R75 had a biotine lozenge in a white cup on her tray table and two Halls cough drops. R75 stated she had more lozenges in a box in her room. During interview on 2/10/26 at 4:09 p.m., registered nurse (RN)-A confirmed R75 had biotine lozenges in her room and that she was able to take them independently. RN-A stated a resident would need an assessment completed by the nurse manager and an order from a provider prior to keeping medications in their room. During interview on 2/10/26 at 4:16 p.m., nurse manager (RN)-B stated an order was needed from a provider prior to self-administration of medication and a self-administration assessment completed to ensure the resident was safe to manage medications. RN-B confirmed R75 did not have a provider order for self-administration of medication or a current self-administration assessment that stated she was able to manage the medications. During interview on 2/11/26 at 1:20 p.m., director of nursing (DON) stated an assessment needed to be completed prior to a resident self-administering medication. The DON stated an order was also needed from a provider. The DON confirmed the facility was aware R75 was utilizing the biotin lozenges, but a self-administration assessment was not completed. Facility self-administration policy dated February 2024, included a resident who wished to self-administer medications would have a comprehensive assessment to evaluate the cognitive and physical abilities of the resident. The resident would need to be able to store the medication in a safe area that was not accessible to other residents.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a Notice of Medicare Non-Coverage (CMS-10123 - NOMNC) was provided at least two days before the end of a Medicare-covered Part A stay for for 1 of 3 residents (R23) whose Medicare covered Part A stay ended.Findings include: R27's Comprehensive Minimum Data Set (MDS) dated [DATE], indicated R27 was cognitively intact. R27's Notice of Medicare Non-Coverage (NOMNC) indicated services would end on 1/30/26. However, R27 signed and dated the form on 1/29/26, which was less than two days before the end of Medicare-covered Part A services. R27's electronic health record (EHR) lacked evidence that a NOMNC had been provided to R27 at least two days before the end of the Medicare-covered Part A stay. On 2/12/26 at 11:34 a.m., the business office manager (BOM) verified R27's NOMNC indicated the last covered day was 1/30/26, and R27 signed the NOMNC on 1/29/26. BOM stated the NOMNC should have been provided to the resident three days before the last covered day. On 2/13/26 at 3:09 p.m., the associate administrator stated staff were expected to provide and explain the NOMNC at lease 48 hours before the end of a Medicare-covered Part A stay so residents had adequate time to make decisions regarding their care. The facility's ABN/NOMNC Policy and Procedure, effective 2/20/23, indicated the NOMNC was used for communicating appeal rights and appeal information, and would be completed within 48 hours of being notified of the last covered day for a Medicare/Manage Care primary resident.

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	245182	A. Building B. Wing	02/13/2026

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure resident rooms were kept in good working condition for 1 of 2 (R82) reviewed for environment.Findings include:R82's undated face sheet, indicated R82 was admitted on [DATE], and had the following diagnoses: borderline personality disorder, pain, anxiety, insomnia, neuropathy (nerve pain), and depression.Durning the screening process on 2/10/26 at approximately 9:20 a.m., R82 stated their drawers, and closet had been broken for a long time, and they had nowhere to keep their belongings. R82 stated they had reported their concern to the facility social worker, filed maintenance reports and they were still broken. R82 stated the maintenance department had come and tried to fix the issue but were not able to, and it needed to be replaced. Writer observed the drawers and closet in the room, the drawers lacked any pull tracks and when pulled would come out of the cabinet with very little effort, if they were not being held strongly, they would have fallen to the floor. All the drawers shared the same characteristics. Additionally, the closet doors did not close. R82 voiced their frustration of not being able to store anything other than very light weight items in the drawers and having no shelving in the closets to be able to store items, because of this they had to keep their belongings in bags and boxes throughout the room.The Facility work order #12986 dated 9/3/25, indicated maintenance had been requested for R82's room, which stated, the front of the drawers are coming off, and hooks for hanging. The order was marked as complete on 9/22/25.The facility work order #13074 dated 10/15/25, indicated a maintenance request for R82's room, which stated, Drawers and cabinets need to be addressed and resolved. The order was marked as complete on 10/17/25.The facility work order #13135 dated 11/19/2025, indicated a maintenance request for R82's room, which stated, Drawers are unusable-off the track and broken. The order was marked as complete on 11/26/25.On 12/16/2025 at 1:44 p.m., an email chain between the administrator and the director of plant operations of Monarch indicated they were aware of the need for room renovations.On 2/13/26 at 10:02 a.m., the maintenance director (MD) stated they had been aware of the maintenance concerns and request related to the R82's broken drawers and closet. MD confirmed they had attempted to fix the problem however the items were due to be replaced in a remodel of the building; however, they were unable to move forward with the upgrades until it had been approved by upper management. MD confirmed the broken drawers and closet were broken and needed to be replaced, and it was their expectation it would have already been completed.On 2/13/26 at 1:04 p.m., the administrator stated they were aware of the concerns related to the drawers and closet doors in R82's room. The administrator stated their expectation was if drawers or cabinets were broken, they should be addressed right away and was important to protect the safety of the resident. The administrator confirmed they were aware of the plan to update the long-term care unit, however, was unsure of the timeline of the project, and confirmed R82's cabinets should have been fixed as they had been aware of the concern since September of 2025.A facility maintenance policy was requested; however, none were provided.

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	245182	A. Building B. Wing	02/13/2026

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to complete regular care conferences for 1 of 1 residents (R9) reviewed for care conferences.Findings include:R9's quarterly Minimum Data Set (MDS) dated [DATE], included R9 was cognitively intact. R9's diagnoses included anxiety, depression, bipolar disorder, and schizophrenia. R9's last four care conferences listed in her electronic medical record (EMR) were dated 8/22/24, 2/5/25, 6/15/25 and 11/13/25. During interview on 2/9/26 at 4:58 p.m., R9 stated she does not get invited to quarterly care conferences. During interview on 2/11/26 at 8:14 a.m., social worker (SW)-A stated care conferences were completed quarterly. SW-A stated she contacted families to invite them to the care conference and informed the resident. SW-A stated the care conference would still be completed if the resident and family did not want to attend. SW-A stated all care conferences were documented on the care conference assessment form, and a progress note was added with any refusals from the resident and family. SW-A confirmed she was unable to locate any additional notes regarding care conferences for R9 in addition to the ones held 8/22/24, 2/5/25, 6/15/25 and 11/13/25. During interview on 2/11/26 at 1:03 p.m., director of nursing (DON) stated she did not typically attend care conferences. DON stated social work set them up and the nurse managers attended them to review the nursing aspect of care. The DON stated it was important to have these conferences to discuss the care and give the resident and family a regular update. No facility policy for care conferences provided.

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	245182	A. Building B. Wing	02/13/2026

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to maintain fingernails at a reasonable length for 1 of 4 residents (R84) reviewed for activities of daily living (ADLs).R84's quarterly Minimum Data Set (MDS) dated [DATE], included R84 was cognitively intact. R84's diagnoses included arthritis, stroke, and dementia. R84 had impairment to both upper extremities. R84 required substantial to maximum assistance with personal hygiene. During observation on 2/9/26 at 1:30 p.m., R84 was observed having contractures on both of her hands and commented on how she was unable to open her hands because it was too painful. R84's fingernails were long, had uneven, chipping red paint. During interview on 2/11/26 at 11:42 a.m., nursing assistant (NA)-A stated assistance with nail care happened on shower days. During interview on 2/11/26 at 11:44 a.m., registered nurse (RN)-C stated residents were offered nail care every shower day. The nurse manager was updated with continued refusals. During interview on 2/11/26 at 12:32 p.m., family member (FM)-A stated she brought up the length of R84's fingernails at the most recent care conference because she was concerned about the length with R84's contractures. R84's last care conference in electronic medical record was dated 1/23/26. During interview on 2/11/26 at 1:03 p.m., director of nursing (DON) stated she expected nail care to be completed weekly. DON expected staff to reapproach if the resident refused and to add a progress note if a resident continued to refuse. DON confirmed R84's nails tend to be long and she has contracted hands which she is unable to open. DON stated all concerns brought forward from a resident or family member should have been addressed in a timely manner. Facility policy for activities of daily living dated 3/31/23, included residents who were unable to carry out ADLs would received necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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	245182	A. Building B. Wing	02/13/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to update the provider with insulin readings outside of parameters for 1 of 1 residents (R101) reviewed for physician parameters.Findings include:R101's quarterly Minimum Data Set (MDS) dated [DATE], included R101 was cognitively intact. R101 had diagnoses of heart failure, diabetes, and traumatic brain injury. R101 received insulin injections 7 out of 7 days. R101's order review report dated 2/11/26, included to check blood sugars three times a day and Lantus SoloStar 100 unit/ml (a long acting insulin used to control blood sugar levels) inject 10 units subcutaneously in the morning. R101's medication administration record (MAR) for 2/1/26 - 2/28/26 included blood sugar readings as follows:2/9/26 at 1100: 469 2/9/26 at 1700: 415 2/10/26 at 700: 513 2/10/26 at 1100: 466 2/10/26 at 1700: 510 2/11/26 at 700: 539 2/11/26 at 1100: 542 2/11/26 at 1700: 481 R101's standing orders signed 1/8/26, include to notify the provider with two blood glucose readings less than 70 or greater than 400 in a 24 hour time frame and/or change in condition. R101's electronic medical record (EMR) included a progress note dated 2/10/26 at 4:37 p.m., which included the nurse practitioner was updated on the blood sugar reading of 510. No additional updates were noted in R101's EMR. During interview on 2/12/26 at 11:08 a.m., licensed practical nurse (LPN)-B stated blood sugar orders typically have parameters with the order that indicate when the provider should be updated. LPN-B confirmed R101's blood sugar reading orders did not include parameters on when to update the provider. LPN-B stated she would use her own judgement based on the resident when no parameters were provided. During interview on 2/12/26 at 11:13 a.m., registered nurse manager (RN)-B stated the nurse should follow the parameters included in the order for when to update the provider. The nurse should use the standing orders when no parameters were provided in the order to obtain a blood sugar. RN-B confirmed R101's order for blood sugars did not include parameters on when to update the provider. RN-B confirmed R101's blood sugar readings were elevated, and the provider should have been updated prior to the 2/10/26 update. During interview on 2/12/26 at 2:30 a.m., director of nursing (DON) stated orders should contain parameters on when to update the provider. DON stated it was important to update the provider when readings were outside of parameters so they could address concerns about high or low values. Facility policy for blood sugar parameters not provided.

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	245182	A. Building B. Wing	02/13/2026

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to ensure gastrostomy tube water flushes with medication administration were provided per physician orders for 1 of 1 residents (R48) reviewed for tube feedings. Findings include: R48's admission Minimum Data Set (MDS) dated [DATE] indicated R48 was severely cognitively impaired, dependent on staff for nutrition/hydration needs, medication administration, oral and personal hygiene, and mobility. In addition, R48 had diagnoses of stroke (poor blood flow to a part of the brain causing cell death resulting in parts of the brain to not function properly), hypertension (high blood pressure), diabetes, and a gastrostomy (feeding tube inserted into the stomach). R48's signed order review history report with a provider reviewed date of 2/1/26, indicated an order for facility Standing Orders: May use facility standing orders as signed by provider. The orders also indicated the following medication orders to be administered via gastrostomy tube: Folic Acid 1mg one time a day, Aspirin 81mg one time a day, Metoprolol Tartrate 50mg one time a day, multivitamin 400mcg one time a day, Amlodipine 10mg one time a day, Acetaminophen 500mg three times per day, Miralax 17 grams one time a day. Facility standing orders indicated the following: If a patient has a feeding tube-Medication administration: flush tube with 30mL water before and after administering each medication. Flush with 50mL water after all medications have been administered and upon completion of enteral feeding. R48's care plan indicated a focus of the resident has actual alteration in nutrition and interventions listed as administer medications as ordered. Monitor/document for side effects and effectiveness. The care plan focus/intervention was dated 1/20/26. The care plan lacked a specific focus related to medication administration. During observation and interview on 2/11/26 at 8:14 a.m., Registered Nurse (RN)-D entered R48's room to administer medication via gastrostomy tube (GT). R48 was lying in bed with the head of the bed elevated to 30 degrees. R48's GT was connected to her enteral feeding using a feeding pump. RN-D performed hand hygiene and donned personal protective equipment (PPE). RN-D set 8 medication cups containing crushed medications on a counter. RN-D mixed 20mL of water to each medication cup and stirred with spoon. RN-D paused and then disconnected R48's tube feeding from the pump and capped the tube. RN-D used a large piston syringe and drew the crushed medication/water solution from a cup, removed the GT cap and slowly pushed the solution into the GT. RN-D did not administer a 30mL water flush after administering the medication. RN-D then repeated this process until all 8 medications had been administered. RN-D did not administer a 50mL water flush after administering all medications. RN-D reattached R48's enteral feeding and restarted the pump. RN-D confirmed she had not performed a 30mL flush between medications, or a 50mL flush after administering all medications. During interview on 2/13/26 at 10:35 a.m., licensed practical nurse (LPN)-B stated when administering multiple medications via GT you need to flush between each medication and after you have completed all medications. LPN-B was unsure of the amount needed to flush between or after medications and stated a doctor would specify the amount in an order. LPN-B stated this was important to avoid potential interactions of medications or meds getting stuck in the tube. During interview on 2/13/26 at 10:44 a.m., RN-F stated to flush with 15-20mL of water between medications when administering multiple medications via GT. RN-F stated to use the same amount to flush the GT after completing all medications. RN-F stated this was important to avoid clogging the GT and ensure the resident received the medications and they were not sitting in the GT. During interview on 2/13/26 at 11:28 a.m., Director of Nursing (DON) stated a water flush of 15-20mL was required between medications for residents receiving medications via GT. DON stated a final flush was needed after all medication had been administered but she was unsure of the amount needed for the final flush. DON stated her expectation was staff would complete this step with all residents who received medications via GT. DON stated it was important to follow the correct steps of medication (continued on next page)

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	245182	A. Building B. Wing	02/13/2026

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administration via GT to ensure the GT did not become clogged and the resident received all meds as prescribed by the provider. Facility policy titled Medication Administration - General Guidelines dated May 2022 lacked specific instructions related to flushes with medication administration via GT. A policy on medication administration via GT was requested but not provided.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure oxygen was administered as ordered for 1 of 1 resident (R38) reviewed for oxygen therapy.R38's quarterly Minimum Data Set (MDS) dated [DATE], included R38 was cognitively intact, could understand others and could express ideals and wants. R38's diagnoses include heart failure, multiple sclerosis (a chronic condition that can lead to vision loss, numbness, fatigue and mobility issues), and respiratory failure. R38's summary report dated 2/13/26, included an order for oxygen at 2-3 liters per minute (LPM) via nasal cannula continuously to maintain oxygen saturation at 90% or above. During observation on 2/10/26 at 9:28 a.m., R38 was in her wheelchair at the side of her bed with her feet in footrests. R38's oxygen nasal cannula was hanging off of her right ear and not properly placed in her nostrils. R38 stated she just got back to her room but was unsure where she came from. R38 stated she was looking forward to laying down in bed because she was tired but was unable to reach her call light for assistance. On 2/10/26 at 9:35 a.m., business office manager (BOM) entered R38's room. BOM confirmed R38's oxygen nasal cannula was not properly placed in R38's nose and she was unable to reach her call light. BOM stated she would alert a nurse with any medial concerns when answering a call light. On 210/26 at 9:52 a.m., licensed practical nurse (LPN)-A entered R38's room and adjusted R38's nasal cannula to place it over both ears and fitted into her nostrils. LPN-A confirmed R38's oxygen was not properly on when she came into her room and LPN-A was unsure how long R38 was without her oxygen. LPN-A checked R38's oxygen saturation with a reading of 86%. LPN-A confirmed R38 was not showing signs of respiratory distress including gasping, shortness of breath, confusion or cyanosis (blue tint on her lips due to low oxygen).During interview on 2/11/26 at 1:15 p.m., director of nursing (DON) stated the nurse should ensure oxygen was placed correctly and then check oxygen saturations if a resident was found without their oxygen as ordered. The DON stated the nurse should encourage deep breathing and utilize an incentive spirometer if the oxygen was below the ordered level. The nurse should update the provider if the oxygen was unable to be maintained at the ordered level. No policy for call lights provided.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to implement a system to monitor stored narcotics and complete controlled substance reconciliation for discontinued medications/discharged residents to prevent potential diversion. Additionally, the facility failed to complete medication reconciliation and medication destruction of non controlled medications that were stored in trash bags and boxes throughout the facility. Findings include:During observation and interview on 2/11/26 at 1:52 p.m., approximately 25 cards containing discontinued/expired medications were noted on a shelf in the Care Coordinators (CC) office located in the transitional care unit. CC stated the medication cards were from residents who had discharged or had their orders changed and the medications needed to be destroyed but she didn't have any time to destroy them. During medication storage observation and interview on 2/12/26 at 10:58 a.m., CC stated the facility had previously had two care coordinators who were responsible for medication destruction but that recently one had quit leaving all medication destruction to one staff. CC stated she was doing the work of two people and destroying medications just isn't a priority and she relied on the pharmacy staff to assist in auditing the medication rooms and carts. The following medications for discharged /deceased residents were observed on the transitional care unit (TCU) medication cart #1:104 capsules of Lyrica 50mg45 tablets of Oxycodone 5mg61 tablets of Oxycodone 2.5mg27 tablets of Percocet 10mg/325mg2 tablets of Norco 30mg/300mg8 tablets of Zolpidem 5mg11 tablets of Tramadol 50mg10 tabs of Fioricet 50mg/325mg/40mg During medication storage observation on 2/12/26 at 12:05 p.m., the following was observed in the TCU medication room [ROOM NUMBER]:1 30-gallon clear plastic bag full of non-controlled medication cards for discharge/deceased residents During medication storage observation on 2/12/26 at 12:07 p.m., the following medications for discharged /deceased residents were observed in the TCU medication cart #2:57 tablets of Oxycodone 5mg25 tablets of Oxycodone 10mg37 tablets of Lorazepam 0.5mg61 tablets of Hydromorphone 2mg6 tablets of Norco 7.5mg/325mg8 tablets of Norco 5mg/325mg11 tablets of Lyrica 100mg9 patches of Belcuca 900mcg15mL of Hydromorphone 10mcg/mL During medication storage observation on 2/12/26 at 12:17 p.m., the following was observed in the TCU medication room [ROOM NUMBER]:2 40-45-gallon clear plastic trash bags full of non-controlled medication cards for discharge/deceased residents2 boxes approximately 12-14 inches high by 20-24 inches long overflowing with non-controlled medication cards for discharge/deceased residents2 metal boxes approximately 6 inches by 6 inches; box 1 contained 2 bottles of liquid lorazepam, box 2 contained 1 bottle of liquid lorazepam. The metal boxes were inside the unlocked medication refrigeratorDocuments titled PolarisRX Medication Unit Review dated 9/11/25 indicated the following: Station 1(first floor)- Med room door was not locked, Cart was unlocked; Station 2- (Second floor) Medication room cabinets not secured, discontinued/expired med were not removed from the medication room. Did not indicate who reviewed findings.Documents titled PolarisRX Medication Unit Review dated 10/22/25 indicated the following: Station 1(first floor) - Door to medication room unlocked, lock box in fridge locked but not attached; Station 2 (Second floor)- Lock box in fridge locked but not attached. Did not indicate who reviewed findings.Documents titled PolarisRX Medication Unit Review dated 12/08/25 indicated the following: Station 1(first floor) - Reviewed expired medications with nurse on cart; Nurse informed to remove any discontinued or expired meds, refrigerator lock box locked but not secured. Indicated findings reviewed with AdministratorDocuments titled PolarisRX Medication Unit Review dated 1/06/26 indicated the following: Station 1(first floor)-medication room door unlocked and propped open, unauthorized drugs or supplies noted; Station 2 (First floor)- medication room unlocked; Station 4 (Second floor)-medication room unlocked; medication cart unlocked. Indicated findings reviewed with (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	AdministratorDuring interview on 2/13/26 at 11:28 a.m., Director of Nursing stated the metal boxes located in the TCU medication room [ROOM NUMBER] refrigerator contained controlled medications that were required to be double locked and counted. DON stated she was unaware the medication boxes were in the refrigerator and could not locate any documentation indicating the medications had been counted in the required narcotic counts. DON stated the medication carts were routinely monitored by facility staff and audited monthly by a pharmacy consultant. DON stated the most recent pharmacy cart audit was in January 2026 and she had not seen a report for that visit. DON stated she was aware there were medications to be destroyed from discharged /deceased residents and that she had been trying to slowly complete the process since she was hired in the fall of 2025. DON stated she had previously gone through the bagged and boxed medications located in the TCU medication rooms to be sure there were no narcotics but didn't have time to destroy the medications. DON stated when a resident discharged or passed away, she expected staff to package all medications together and put in a locked medication room for destruction as soon as possible. DON stated the overnight nurses assisted with medication destruction, but narcotics were to be destroyed by the unit managers/care coordinators. DON stated this was important to avoid a resident gaining access to excess medications and to reduce the risk of drug diversion.During interview on 2/13/26 at 2:00 p.m., Polaris Pharmacy consultant (PC) stated she completed monthly audits of facility medication carts and medication rooms. PC stated she looked for expired/outdated medications, medication carts/rooms locked, opened date stickers and loose pills in carts. PC stated after each visit a copy of the audit report was reviewed with facility staff, preferably the DON or Administrator (Admin), but would review with floor staff if DON and Admin were unavailable. PC stated a copy of the audit would be electronically shared with the DON, the medical director, Admin, the pharmacy nurse consultant, consulting pharmacist and the director of the Monarch facilities. PC stated if she repeatedly identified a concern, it would be indicated on the audit report as well as addressed in an email to the facility leadership.Facility Policy titled Disposal of Medications and Medication-Related Supplies with a last review date of May 2022 lacked a specific timeline for destruction of discontinued/discharged resident medications.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed follow up on pharmacist recommendations for 1 of 5 residents (R9) reviewed for monthly pharmacist reviews.Findings include:R9's quarterly Minimum Data Set (MDS) dated [DATE], included R9 was cognitively intact. R9's diagnoses included anxiety, depression, bipolar disorder and schizophrenia. MDS included R9 was taking antipsychotic medication and antianxiety medication. Review of R9's electronic medical record (EMR) included progress notes from the consultant pharmacist indicating recommendations for the facility on 9/8/25, 10/13/25, 11/9/25, 12/7/25, 1/12/26, and 2/8/26. R9's pharmacy recommendation dated 1/12/26 included a recommendation to complete an AIMS assessment (a tool used to monitor and evaluate side effects of certain medications) with a notation that the recommendation was reissued from November 2025. R9's pharmacy recommendation dated 2/8/26, again included a recommendation to complete an AIMS assessment with a notation it was reissued from November 2025. R9's EMR included an AIMS assessment completed 2/10/26.-after start of survey? - yes During interview on 2/12/26 at 12:04 p.m., consultant pharmacist (CP) stated he reviews resident's monthly to ensure all necessary monitoring was in place, that there were no interactions with medications and that gradual dose reductions were completed. CP confirmed he had requested AIMS assessments be completed on residents and has had to reissue the request because they were not getting completed. During interview on 2/12/26 at 11:22 a.m., registered nurse manager (RN)-B stated she received pharmacist reviews monthly. RN-B confirmed she had received some requests to complete AIMS assessments and had not kept up with the requests. RN-B stated the facility did not have a process for completing the AIMS assessment and only completed the assessment when recommended by the CP. During interview on 2/11/26 at 9:15 a.m., director of nursing (DON) stated the monthly pharmacist review came to her and she passed them on to either the nurse managers or the provider for follow up. DON stated there had been a problem tracking the pharmacist reviews to ensure they were all addressed timely. Facility policy for psychotropic medication dated 5/2025, included an AIMS would be completed semi-annually.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to provide physician ordered physical and occupational therapy (PT and OT) services in a timely manner for 1 of 1 residents (R95) reviewed for rehab services. Findings include: R95's admission minimum data set (MDS) dated [DATE], indicated R95 admitted to the facility on [DATE] and had the following diagnosis: hypertension (high blood pressure), hyperlipidemia (high levels of fat in blood) and displaced fracture of left tibial spine (broken ankle bones). The MDS also indicated R95 required substantial/maximal assistance with rolling in bed from side to side, sit to stand, chair/bed-to-chair transfers, toilet transfers, and mobility with wheelchair 50 ft. R95's hospital discharge paperwork dated 12/22/25, indicated an order for referral to physical and occupational therapy services. It further indicated R95 would likely need a Transitional Care Unit (TCU) stay, PT/OT post op. R95's historical care plan with a closed date of 2/3/26, indicated R95 had an alteration in mobility and listed interventions to include PT per medical doctor (MD) orders and follow PT instructions. The care plan also indicated R95 was a fall risk and listed interventions to follow PT and OT instructions for mobility function. The care plan indicated an initiated date of 12/29/25. During interview on 2/10/26 at 4:46 p.m., R95's family member (FM-B) stated R95 admitted on [DATE] but was not evaluated by PT/OT services until 12/29/25. FM-B stated they asked several staff when therapy would start but were not given a clear answer. FM-B stated on approximately 12/28/25, R95 and FM-B were reportedly advised by TCU care coordinator (CC) that the facility was switching therapy companies. FM-B went on to state later that same day a male who identified himself as therapy staff advised R95 that therapy staff was unaware R95 had been admitted on [DATE] and was waiting for therapy services. OT evaluation and plan of treatment note dated 12/29/25 indicated the following: patient presents with impairments in balance, mobility and strength resulting in limitations and/or participation restrictions in the areas of self-care, social life , mobility, general tasks and demands, and domestic life which requires skilled OT services to provision modalities and strengthening, increase safety awareness, increase independence with activities of daily living (ADL's), increase functional activity tolerance and facilitate dynamic standing balance in order to be able to return to prior level of living and return to prior level of skill performance. PT Evaluation and Plan of Treatment assessment record dated 12/29/25, indicated R95 required PT 3 times per week for a duration of 32 days. During interview on 2/11/26 at 10:44 a.m., Certified Occupational Therapy Assistant/Therapy Director (COTA/TD) stated when a resident was admitted with orders for PT or OT, they were seen by therapy staff within 2-3 days. COTA/TD stated it was a goal as a company to see all new residents within 3 days. COTA/TD confirmed R95 was admitted to the facility on [DATE] but was not seen by therapy staff until 12/29/25. COTA/TD stated she was unsure why there was a 7-day delay from admission to start of therapy services. There were no notes in R95's medical record that indicated a reason for delay. She went on to state she was unsure if facility staff communicated with R95 on any delays. During interview on 2/13/25 at 10:51 a.m., facility Associate Administrator (AA) stated when a new resident admitted to the facility, the AA was responsible for communication of the new resident's referral information to the care team, which included therapy staff. AA stated it was her expectation that residents who have a referral for therapy services were seen within 48 hours. AA stated it was important to start therapy as soon as possible for better outcomes and to reduce the risk of a negative outcomes like delayed recovery. An untitled facility policy with a published date of 11/18/25 and subtitle of Service Delivery Policies indicated the purpose to standardize the initial of therapy following referral, ensuring timeliness and proper authorization. It went on to indicate new referrals should be evaluated within 24-48 hours and to communicate plans with nursing staff and residents/family.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and document review, the facility failed to ensure the Quality Assurance Assessment and Performance Improvement Plan (QAPI) committee effectively sustained ongoing compliance related to repeat citations from past surveys regarding quality of care, infection control, respiratory care, and resident call system which were also identified during this survey. This had the potential to affect all 92 residents residing in the facility.Findings include: Review of the facility CASPER Report updated 1/14/26, identified the facility was cited at F684 for quality of care on the surveys exited 11/2/23 and 1/9/25. See F684: Based on interview and document review, the facility failed to update the provider with insulin readings outside of parameters for 1 of 1 resident (R101) reviewed for physician parameters. Review of the facility CASPER Report updated 1/14/26, identified the facility was cited at F695 on the survey exited 1/9/25. See F695: Based on observation and interview, the facility failed to ensure oxygen orders were administered as ordered for 1 of 1 resident (R38) reviewed for oxygen therapy. Review of the facility CASPER Report updated 1/14/26, identified the facility was cited at F880 Infection Prevention and Control on the surveys exited 11/2/23 and 1/9/25. See F880: Based on observation, interview and document review the facility failed to ensure infection control measures were maintained when performing wound care for 1 of 1 resident (R61) reviewed for wound care. Review of the facility CASPER Report updated 1/14/26, identified the facility was cited at F919 on the surveys exited 11/2/23 and 1/9/25. See F919: Based on observation and interview, the facility failed to ensure a call light was within reach for 1 of 1 resident (R38) reviewed for call lights. On 2/13/26 at 3:09 p.m., the associate administrator stated previous citations were addressed with facility plan of correction which included audits, and once QAPI determined continued compliance based on audit results, the audits were decreased or suspended, but QAPI still discussed the concerns. The associate administrator stated staff were expected to notify providers per parameters to maintain residents' health, and staff were expected to maintain proper placement of oxygen was important to sustain resident oxygen saturations. Staff were expected to complete hand hygiene between glove changes for infection control, and staff were expected to ensure call lights were within resident reach to prevent potential negative outcomes if not available. The facility's QAPI Plan reviewed 9/25/25, indicated the performance improvement plan (PIP) project, once it has met its goals, will be reviewed in the following quarterly QAPI meeting to ensure the project is being sustained. If the QAPI committee identifies that the PIP project has failed to sustain itself, it will decide what the next steps are to improve and ensure sustainability of the goals. To ensure the PIP project is implemented and effective for sustaining projects, the committees will choose data and measurement tools that directly impact and is effective to meet the goals of the project. The measurements will be reviewed by the committees to ensure it is effective.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to ensure infection control measures were maintained when performing wound care for 1 of 1 resident (R61) reviewed for wound care. Findings include: R61's admission Minimum Data Set (MDS) dated [DATE], indicated R61's cognition was intact and included diagnoses of pressure ulcer of left buttock-stage 3 (a severe, full-thickness wound extending through the skin to the subcutaneous fat layer, appearing as a deep crater), local infection of the skin and subcutaneous tissue, and morbid obesity. R61's historical care plan with a last review date of 12/5/25, included the following: Focus-resident is currently on Enhanced Barrier Precautions (EBP) relate to wound; Interventions- staff to follow enhanced barrier precautions, staff to don/doff personal protective equipment (PPE) per enhanced barrier precautions when providing high contact care. R61's order review history report signed/dated 2/1/26, indicated the following orders: Buttocks-1) Cleanse with generic wound cleanser 2) Apply skin prep thoroughly 3) Apply collagen to wound bed 4) Apply hydrocolloid dressing over areas 5) Change every 3 days and PRN every day shift related to pressure ulcer of buttock stage 3; and Follow EBP (Enhanced barrier precautions) while providing wound cares and other high contact care activities. During observation on 2/11/26 at 10:04 a.m., registered nurse (RN-D) was observed providing wound care. RN-D donned PPE (gown, gloves and surgical mask) gathered supplies and positioned R61 to lay on his left side exposing his buttocks. RN-D cleansed the wound with wound cleanser and clean 4x4 gauze; removed soiled gloves and applied clean gloves. RN-D did not perform hand hygiene before applying clean gloves. RN-D patted area dry with 4x4 gauze and removed soiled gloves, then applied clean gloves. RN-D did not perform hand hygiene before applying clean gloves. RN-D applied collagen powder into wound bed and calcium alginate, covered wound with hydrocolloid dressing, dated and initialed dressing and removed soiled gloves. RN-D applied clean gloves but did not perform hand hygiene. RN-D applied Vanicream to surrounding tissue, assisted R61 to his back and removed PPE and placed it in trash and then washed hands and exited room. During interview on 2/11/26 at 10:37 a.m., RN-D stated she should perform hand hygiene when entering the room, before applying gloves and when changing gloves. RN-D stated she should wash hands when they were visibly soiled and apply hand sanitizer after removing soiled gloves before applying clean gloves. RN-D stated she believed wearing two pairs of gloves was an acceptable alternative to performing hand hygiene between glove changes. RN-D stated she would remove the outermost glove and believed it was not necessary to perform hand hygiene as she believed the inner gloves would still be clean. During interview on 2/11/26 at 11:02 a.m., licensed practical nurse (LPN-C) stated hand hygiene was performed when you enter a resident room, when changing gloves from dirty to clean and upon exiting room. LPN-C went on to say hand washing should be done if hands were visibly soiled. During interview on 2/11/26 at 1:52 p.m., transitional care unit care coordinator (CC) stated staff should perform hand hygiene going into a resident room, between glove changes and when exiting a resident room. CC stated wearing two sets of gloves was not an acceptable alternative to hand hygiene when removing soiled gloves. The first set of gloves was basically like your skin. During interview on 2/13/26 at 11:28 a.m., Director of Nursing (DON) stated hand hygiene was completed after using bathroom, when entering or exiting a resident's room and after removing soiled gloves but before applying clean gloves. DON stated wearing two pairs of gloves was not a safe alternative to hand hygiene. DON stated it was her expectation that staff completed hand hygiene by washing hands or using hand sanitizer. DON stated it was important to accurately complete hand hygiene, so you were not introducing new bacteria or germs into an open wound, contaminating dressing supplies and reducing the risk of new or worsening infections with residents. Facility policy titled Infection Prevention and Control Program indicated the facility has established policies and procedures regarding infection control among employees and those with potential direct exposure to blood or body fluids are trained in and required to use appropriate precautions and personal protective equipment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245182	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at St Louis Park	7500 West 22nd Street Saint Louis Park, MN 55426

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure 1 of 5 residents (R11) was offered, educated and/or provided the pneumococcal vaccination series as recommended by the Centers for Disease Control (CDC), who were reviewed for immunizations.Findings include: A CDC Adult Immunization Schedule by age topic dated 08/07/2025, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over [AGE] years old had not received the complete series of pneumococcal vaccination (i.e., PPSV23, PCV20 and PCV13) or their history was unknown, then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20), 1 dose of PCV-15, or PCV-21. R11's undated face sheet, indicated R11 was [AGE] years of age, admitted to the facility on [DATE], and had the following diagnoses: bipolar disorder, post-traumatic stress disorder, weakness, hypertension (high blood pressure) and chronic kidney disease. R11's Minnesota Immunization Information Connection (MIIC) undated report, indicated R1 had received a pneumococcal vaccination on 4/3/2015, it did not indicate which variation. This made R11 eligible for a pneumococcal vaccination. R11's resident vaccine administration consent form signed 10/6/2025, indicated R11 gave consent to receive a Pneumococcal vaccination. R11's medical record lacked any evidence a vaccine was administered. On 2/13/26 at 1:47 p.m., the director of nursing (DON) stated they had offered R11 a vaccination approximately one month ago, but it had not been provided. The DON's expectation was vaccination eligibility was evaluated upon admission to the facility and provided after the resident's status was verified. The DON confirmed R11's vaccination had not been administered. The DON stated the importance of keeping the vaccination status of resident up to date to prevent the risk of respiratory complications. The facility Pneumococcal Policy last revised 2/2024, indicated prior to or upon admission to the facility (within 5 days), all residents will be assessed for current immunization status and eligibility to receive the pneumococcal vaccine. Within 30 days of admission, resident will be offered the vaccine, when indicated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245182	A. Building B. Wing	02/13/2026

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure a call light was within reach for 1 of 1 resident (R38) reviewed for call lights.Findings include:R38's quarterly Minimum Data Set (MDS) dated [DATE], included R38 was cognitively intact, could understand others and could express ideals and wants. R38's diagnoses include heart failure, multiple sclerosis (a chronic condition that can lead to vision loss, numbness, fatigue and mobility issues), and respiratory failure. During observation on 2/10/26 at 9:28 a.m., R38 was in her wheelchair at the side of her bed. Feet were in footrests. R38 was leaning to the right, oxygen nasal cannula was out of nostrils. R38 stated she just got back from somewhere but could not remember where. R38 stated she was tired and looking forward to laying down. R38 stated her call light was somewhere over there while pointing to the opposite side of her bed. Call light cord was wrapped around bed rail on opposite side of bed and out of reach. On 2/10/26 at 9:35 a.m., business office manager (BOM) was seen entering R38's room. BOM stated she would get a nurse if there were any medical concerns when she answered a call light. BOM confirmed R38's oxygen nasal cannula was not in her nose, and her call light was on the opposite side of her bed, out of reach. BOM left R38's room without moving her call light within her reach. On 2/10/26 at 9:52 a.m., licensed practical nurse (LPN)-A entered R38's room and adjusted nasal cannula into nose. LPN-A stated she was unsure how long the oxygen was not properly in place. LPN-A check R38's oxygen saturation with a reading of 86%. LPN-A confirmed R38 was not showing any signs of respiratory distress, no gasping, confusion or bluing lips. During interview on 2/11/26 at 8:28 a.m., BOM confirmed R38 was unable to reach her call light the previous day when she was in R38's room. BOM confirmed she left R38's room without ensuring the call light was within reach. BOM stated she informed a nurse at the nurses' station that R38's oxygen nasal cannula needed to be adjusted after she left her room. During interview on 2/11/26 at 1:15 p.m., director of nursing (DON) stated a call light should always be within reach. DON stated every employee should be watching to ensure a call light was within reach. The DON stated if a resident was unable to reach a call light, they were unable to call for help when needed. No policy for call lights provided.