

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245187	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024
NAME OF PROVIDER OR SUPPLIER The Villas at the Cedars		STREET ADDRESS, CITY, STATE, ZIP CODE 7900 West 28th Street Saint Louis Park, MN 55426	

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)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49337</p> <p>Based on interview and document review, the facility failed to ensure accurate documentation of medications and treatments when residents were hospitalized for 2 of 3 (R1, R3) residents reviewed for documentation.</p> <p>Findings include:</p> <p>R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 was cognitively intact, and required a two person assist for transferring and toileting.</p> <p>R1's Face Sheet undated, indicated R1 had diagnoses of peripheral vascular disease, type II diabetes, personal history of venous thrombosis and embolism.</p> <p>R1's June medication administration record (MAR) had the following omissions:</p> <p>-Hydromorphone Hydrochloride (narcotic pain medication) tablet 4 milligrams (mg). Give 4 milligrams by mouth every 4 hours for pain, start date 6/19/25. On 6/23 at 8:00 p.m., the box was left blank. LPN-D was assigned to R1 for that shift.</p> <p>-Acticoat (silver dressing) dry to incision line Xeroform (occlusive dressing) and the rest, cover with gauze and tape to secure. One time a day for wound. Start date 6/26/24. On 6/28/24, the box was left blank.</p> <p>-Daily weight one time a day, start date 6/18/24. 6/21/24 and 6/25/24 were left blank.</p> <p>R3's 6/16/24 quarterly MDS indicated R3 was severely cognitively impaired, and required a one person assist for all activities of daily living.</p> <p>R3's Face Sheet undated, indicated R3 had diagnoses of dementia, and rheumatoid arthritis.</p> <p>On 8/12/24 an email from the director of nursing (DON) stated R3 left the facility to go to the hospital on 7/19/24 at 6:05 a.m.</p> <p>R3's July MAR had the following medications and treatments marked as administered:</p> <p>(continued on next page)</p>

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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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Melatonin Oral Tablet 10 milligrams, give 1 tablet by mouth at bedtime for sleep. On 7/19/24 at 8 p.m. it was administered by LPN-A. On 7/20/24 at 8:00 p.m. it documented as administered by licensed practical nurse (LPN)-B.</p> <p>-Seroquel oral tablet, give 50 milligrams by mouth at bedtime. On 7/19/24 at 8 p.m. it was documented as administered by LPN-A. On 7/20/24 at 8:00 p.m. it was documented as administered by LPN-B.</p> <p>-Barrier cream to coccyx area twice daily with cares and incontinent episodes every day and evening shift for prevention. On the 7/19/24 evening shift it was documented as administered by LPN-A. On the 7/20/24 evening shift it was documented as administered by LPN-B.</p> <p>-Depakote (seizure medication) Oral tablet delayed release 250 mg by mouth two times a day for seizures. On 7/19/24 at 8 p.m. it was documented as administered by LPN-A. On 7/20/2024 at 8:00 p.m. it was documented as administered by LPN-B.</p> <p>-2 Calorie Supplement after meals 120 milliliters HiKcal or Med Pass for weight loss. On 7/19/24 at 7 p.m. it was documented as administered by LPN-A. On 7/20/24 at 7:00 p.m. it was documented as administered by LPN-B.</p> <p>-House supplement with meals three times a day with meals for weight loss. On 7/19/24 at 5 p.m., LPN-A documented 40 ounces were given. On 7/20/24 at 5 p.m., LPN-B documented 4 ounces were given.</p> <p>-Resident specific targeted interventions for behaviors, monitor resident for signs and symptoms of medication side effects every shift. On the 7/19/24 evening shift, LPN-A documented it as completed. On the 7/20/24 evening shift, LPN-B documented it as completed.</p> <p>-Artificial tears Ophthalmic Solution 0.1-0.3%, instill 2 drop in both eyes four times a day for excessive cornea and conjunctive dryness. On 7/19/24 at 4:00 p.m. and 8:00 p.m., LPN-A documented it as administered. On 7/20/24 at 4:00 p.m. and 8:00 p.m., LPN-B documented it as administered.</p> <p>-Sleep monitoring document hours of sleep during shift every evening and night shift for sleep behavior. On the 7/19/24 evening shift, LPN-A documented it as completed.</p> <p>-Follow enhanced barrier precautions while providing urinary catheter maintenance, contact with the catheter, tubing and collection bag, and other high contact care activities. On the 7/19/24 evening shift, LPN-A documented it as completed.</p> <p>-Monitor catheter output every shift for catheter related to obstructive and reflux uropathy. On the 7/19/24 evening shift, LPN-A documented that R3 had 500 milliliters of urine output.</p> <p>-Monitor effectiveness of fall interventions, hourly checks on resident until interdisciplinary meet Monday post fall times 72 hours, every shift for bruises to heal. On the 7/19/24 evening shift, LPN-A documented it as completed.</p> <p>-Monitor for pain daily. On the 7/19/24 evening shift, LPN-A documented it as completed.</p> <p>-Monitor for seizure activity. On the 7/19/24 evening shift, LPN-A documented it as completed.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/13/24 at 9:45 a.m., LPN-E stated she was not working the day R3 went to the hospital, and was unaware nurses were documenting medications and treatments as administered while R3 was hospitalized . She would check with the nurses why they were signing off medications and treatments for a resident who wasn't there. She would make sure the orders were discontinued while R3 was in the hospital. She was unaware of medication administration boxes being left blank for R1, and unaware of any processes already in place to manage blank boxes in the electronic health record (EHR) MAR.</p> <p>On 8/13/24 at 10:25 a.m., registered nurse (RN)-A stated no box in the MAR should be left blank, and the 24-hour report should pull any omissions in the MAR. She was not aware of any issues with staff documenting medications and treatments were administered while the resident was not in the facility.</p> <p>On 8/13/24 at 12:25 p.m., LPN-B confirmed she worked on the evening of 7/20/24. Her coworkers informed her R3 went to the hospital the prior day. When asked why she documented medications as administered for R3 when R3 was not at the facility. she stated it must have been a mistake, and everyone knew R3 was gone.</p> <p>On 8/13/24 at 11:03 a.m., and 12:58 p.m., the director of nursing (DON) stated when a medication was not administered, the number 9 should be documented in that space for Other and a nurse's note should be entered to explain the medication was not given. She was unaware R1's wound care and daily weights were not completed as ordered. She was also unaware nurses were charting medications and treatments as administered while residents were not in the facility. She had a lot of concerns about that, and nurses should pull the resident out of the system while they are in the hospital to avoid that mistake.</p> <p>On 8/13/24, LPN-A, LPN-C and LPN-D were called for interview requests and did not return the call.</p> <p>The facility policy Medication Error Procedure last reviewed in 2023, directed the interdisciplinary team evaluates medication usage in order to prevent and detect adverse consequences and medication related problem. Medication errors should be assessed, documented, and reported according to federal or state guidelines.</p>		