STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245187	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at the Cedars	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43367 Based on interview and document review, the facility failed to ensure the physician was notified timely of elevated blood sugars and a change condition for 1 of 2 residents (R2) reviewed for change of condition. Findings include: R2's admission Minimum Data Set (MDS) dated [DATE], identified he was admitted to facility on 3/1/25, from an acute care hospital with moderately impaired cognition. He required partial/moderate assistance with personal hygiene and dependent for chair/bed to chair transfers and toileting hygiene. His medical diagnoses included diabetes mellitus (DM) and hyperkalemia (high potassium). R2's provider orders identified: -3/1/25, insulin Aspart (rapid-acting insulin) flex-pen injector 100 unit/ml. Inject 10 units subcutaneously (SQ) with meals for diabetes. -3/1/25, blood sugars before meals and at bedtime for DM. -3/1/25, blood sugar ranges below 75 or greater than 400 update provider. -3/1/25, observe for dehydration, decreased skin turgor, dry mucus membranes, lethargy, fatigue, weakness, low urine output, hypotension, tachycardia (rapid heart rate), orthostatic hypotension (blood pressure drops when sitting or standing up), and increase in falls or gait. 3/1/25, monitor for signs/symptoms (s/s) of hyper/hypoglycemia (high and low blood sugars) including but not limited to lethargy, sweating, weakness, confusion, pale, vomiting, and excessive thirst. -3/2/25, Insulin Glargine (long-acting insulin) 100 units/ml solution pen-injector. Inject 30 units SQ at bedtime for DM2. -3/2/25, Novolog (fast acting insulin) flex-pen 100 unit/ml solution pen-injector. Inject as per sliding scale: if blood sugar is 70 to 149 =0 units. 150-199=1 unit, 200-249 = 2 units, 250-299 =3 units, 300-349 = 4 units, 350-399 = 5 units, 400-999 = 6 units Call medical doctor (MD), SQ three times a day for DM. (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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's care plan dated 4/16/25, directed staff to administer diabetic medication as ordered monitor/document for side effects and effectiveness, monitor for edema, abnormalities in urinary output, and report significant changes to MD. R2's vital signs on 5/8/25, identified: Blood pressure at 7:59 a.m. 123/62, 2:56 p.m. 119/57, and 6:42 p.m. 144/81. Oxygen saturation (SaO2) (normal range 95 to 100% anything below 90% is considered low) at 2:56 p.m. 92% and 6:42 p.m. 89%. Heart rate at 7:59 a.m. 99 beats per minute (bpm), 2:56 p.m. 88 bpm, and 6:42 100 bpm. Respirations at 2:56 p.m. 16 breaths per minute and 6:42 p.m. 16 breaths per minute. Temperature at 2:56 p.m. 98.7 degrees Fahrenheit (F) and 6:42 p.m. 99.3 degree F. Blood sugar at 8:09 a.m. 324 milligrams/deciliter (mg/dl), 11:50 a.m. 400 mg/dl, and 5:43 p.m. 451 mg/dl. R2's progress notes from 5/8/25 through 5/14/25, identified: -on 5/8/25 at 3:22 p.m. R2 was noted unable to cough out when he coughed. He was unable to feed himself per his baseline. Vital signs stable (VSS), O2 at 92%. Administration of as needed (PRN) nebulizer. Updated nurse practitioner (NP) line pending orders. -on 5/8/25 at 7:12 p.m. R2 was more lethargic. Blood glucose at 451 and hypoxic oxygen 89%. Called ambulance to be transferred to local hospital. Updated on call provider, sister and DON. -on 5/14/25 at 7:43 a.m. R2 was sent to emergency room (ER) (on 5/8/25) with altered mental status. At emergency department (ED) he was febrile, hypertensive (171/111), and on 6 liters (L) oxygen SaO2 92%. His diagnoses were acute respiratory failure, urinary tract infection (UTI) sepsis community acquired pneumonia of the left lung, metabolic encephalopathy versus cerebral vascular accident (CVA) (stroke). Antibiotics intravenously (IV) Zithromax and Rocephin. New orders dated 5/8/25 at 4:10 p.m. emailed to director of nursing (DON) and signed by nurse practitioner (NA): 1. Complete blood count (CBC) with differential, Basic Metabolic Panel (BMP) on 5/9/25. 2. COVID, Respiratory Syncytial Virus (RSV), influenza A and B Swab. 3. Chest x-ray two views 4. Monitor vitals every four hours times 24 hours. The fax sent to the facility on [DATE], with provider orders was unable to be located during the survey per DON. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's hospital history and physical notes dated 5/8/25 at 10:31 p.m. identified admitted to hospital for altered mental status, sepsis due to acute cystitis (bladder infection) versus pneumonia and atrial fibrillation (AFIB) with rapid ventricular response (RVR) (irregular heartbeat). History obtained from chart review and discussion with ER MD. R2 was unable to contribute due to aphasia (unable to communicate). By report, he lived in the nursing facility. He was last seen normal sometime around 8:00 a.m. and then found this evening to be aphasic, confused appearing with right facial droop and left arm weakness. He tracks with his eyes but did not speak or follow commands. He was spontaneously moving his right upper and lower extremity but not the left side. During an interview on 5/12/25 at 9:15 p.m. police officer (PO) was dispatched to the facility after a call came in regarding a resident had low oxygen level as a code three level and sirens. When he arrived at the facility R2 sat in a wheelchair in the day room. His face was droopy on the right side, he was unable to verbally respond, staff stated he had been like that since morning. PO requested R2 be moved to his room. While in his room he asked R2 if he could hear and shock his head yes. PO was concerned in the delayed response of the facility staff when R2 had stroke symptoms since morning and an ambulance had not been called until after 7:00 p.m. The emergency medical services (EMS) arrived, loaded R2 onto the gurney, and transported him to the hospital. During an interview on 5/13/25 at 3:40 p.m., trained medication assistant (TMA) stated R2's had impaired cognition, forgetful and was able to make his needs known. He had worked on 5/8/24 and at 7:30 a.m. R2 was see in TV lounge not his normal self, sleepier and more lethargic. He checked blood sugar, was elevated, and updated registered nurse (RN)-A. RN-A checked vitals, administered insulin and he was unsure if a provider was contacted but was instructed to continue to monitor R2. During breakfast R2 was unable to feed himself which was unusual for him. He also requested assistance with lunch. The nurse should have contacted the provider with a marked change in condition and elevated blood sugars. During an interview on 5/13/25 at 3:50 p.m. nursing assistant (NA)-A stated she had worked the evening shift on 5/8/25 at 2:30 p.m. At 2:40 p.m. she saw R2 in his room and seemed different. R2 sat quietly in his room, in wheel chair, usually sat upright, was noted leaning backwards. She informed RN-A and vitals were taken. Around supper time she pushed him from his room to the dining room and he was unable to feed himself, had a tremor in the right hand, and RN-A assisted him with his meal. After supper NA-A had taken him to the TV lounge and his face appeared pale, looked sick and he was not talking. She had not seen him like that before, informed the nurse, and vitals were taken. RN-A informed her she had to send him in. R2 sat in his wheelchair in the TV room until paramedics arrived and removed him from the facility. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/14/25 at 11:24 a.m. medical doctor (MD) stated the staff would have been expected to have reported concerns of R2 unable to sit up straight in wheelchair, fatigue, weakness and hard time feeding himself. The NP should have been notified, examined him, and possibly sent to the hospital. A change in condition could have affected his health and wellbeing, and if a provider was contacted right away could have prevented his condition from worsening, most likely needed to be assessed. Additionally, the staff nurse would have been expected to notify the provider for the high blood sugars. it was clearly in the orders, when R2's blood sugar was 400 at 11:50 a.m. on 5/8/25, for further orders. R2's blood sugar should have been rechecked within mostly likely 30 minutes to one hour after sliding scale 6 units were given. At that point if the blood sugar had not come down a provider should have been contacted again for further orders. R2 most likely developed sepsis from something and his hyperglycemia was a result of that. Probably could have changed R2's outcome if something was done earlier, the provider could have sent him in earlier, been more aggressive with insulin treatment, check labs for ketoacidosis and possibly a continuous infusion of insulin was needed. During an interview on 5/14/25 at 12:16 p.m. NP stated she had been contacted one time on 5/8/25 at 3:03 p. m. by facility nurse regarding concerns with R2, pain management related to infection or pneumonia. She had not recalled any mention about elevated blood sugars. Orders were sent at 4:00 p.m. and expected to be completed as ordered: complete blood count (CBC) with differential, basic metabolic panel (BMP) on 5/9/25, COVID, RSV, influenza A and B Swab, chest x-ray two views, and monitor vitals every four hours times 24 hours. If R2's assessment was not base line, far from it, unstable vitals, high blood pressure, or altered mental status she would have expected staff nurse to have contacted her for further orders and/or direction. Most likely sufficient to have waited until 3:00 p.m. but hard to say one way or another, would be considered extrapolation (the act of estimating or concluding something by assuming that existing trends will continue or a current method remained applicable). Prior to supper if R2's blood sugar was elevated over 400 the on-call provider should have been contacted at that time for further direction per orders. During an interview on 5/14/25 at 1:26 p.m. DON stated she would have expected RN-A to have contacted a provider at 11:50 a.m. when R2 had a BS of 400, hard time feeding self and provided more information. The provider would have most likely given orders. RN-A should have rechecked BS in 30 to 60 minutes. She would have expected RN-A to follow the provider orders, if over 400 BS or change in condition contact provider. The provider should have been contacted again after 5:30 p.m. when R2's BS was 451. The BS was high prior to both meals (lunch and supper), most likely would have gone up higher with his infection and continued to go up. She had received the orders on 5/8/25 at 4:11 p.m. via email. The labs were ordered for 5/9/25, and unable to be completed at the facility. The COVID (antigen test) could have been completed at the facility, RSV could have been done but not until lab would have been ready to pick up the test, and the chest x-ray could have been completed on 5/8/25, if the order had been placed right away, and was not done. The orders had not been placed yet and unsure what happened to the fax. R2 had a serious change in cognition when he was unable to feed himself. RN-A should have completed a full assessment, listened to lungs, stroke assessment, and documented all findings. R2 should have been sent to the ED sooner. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/14/25 at 2:35 p.m. registered nurse (RN)-A stated she had worked the day shift on 5/8/25 and did not remember if she received report from the previous shift. She administered R2's morning medications, he seemed weak, answered yes and no questions, checked vital signs and blood sugar were baseline stable. His BS at 11:50 a.m. was 400, administered 6 units of sliding scale Novolog insulin, and no signs/symptoms of hyperglycemia noted. She had consulted with TMA and provider was to be notified only if the BS was over 400 three consecutive times in a row. A BS was not checked again until prior to supper per orders. His BS before supper was 451, she administered 6 units of sliding scale Novolog insulin. She planned on notifying the provider right away, did not, and assisted another resident. He held a glass and drank from it and she fed him both meals (lunch and supper) due to weakness. He usually fed himself, was not at base line, just thought he was depressed. She was unaware of his everyday baseline. He requested to go to bed at 3:00 p.m., coughing, administered a nebulizer treatment, and denied shortness of breath. She completed a lung assessment, lungs sounded clear and was not documented. She called the provider at 3:22 p.m. and left message he was coughing, elevated BS, may have had an infection (pneumonia). She waited for the orders to be received via fax, they may have been dislocated, unsure. Around 6:30 p.m. she had found the faxed orders, there was not enough time to get orders completed. In the afternoon around supper time R2 was sliding from his chair, vitals were normal, SaO2 was 89%, he looked weak and was not responding well. She called 911. Facility policy Notifications of Changes dated 3/2024, identified changes in resident condition or treatment be reported to the attending physician or delegate (hereafter designated as the physician). Nurses and other care staff are educated to identify changes in a resident's status and define changes that require notification of the resident's physician, to ensure best outcomes of care for the resident. The objective of the notification policy is to ensure that the facility staff made appropriate notification to the physician and delegated non-physician practitioner when there was a change in resident's condition or an accident that may require physician intervention. The intent of the policy is to provide appropriate and timely information about changes relevant to the resident's condition to those parties who will make decision about care, treatment, and preferences to address the changes.