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	06/26/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and document review, the facility failed to ensure an allegation of potential abuse was reported timely to the administrator and to the State agency (SA) in accordance with established policies and procedures for 1 of 1 residents (R1) who was reviewed for an allegation of abuse. Findings include: A Facility Reported Incident (FRI), dated 6/21/25, at 4:55 p.m., was submitted to the SA which reported an alleged act of abuse towards R1. The report identified nursing assistant (NA)-D reported to the director of nursing (DON), that NA-A handled R1 roughly and [was] being verbally aggressive with [R1]. R1 was agitated by NA-A and attempted to bite NA-A. In response, NA-A held [R1's] arm to [R1's] mouth and said bite yourself. The report indicated this incident occurred 6/20/25, at 5:00 p.m.; however, additionally identified the administrator was updated 6/21/25, at 3:20 p.m. The report identified staff became aware of the incident on 6/20/25, at 3:15 p.m.; however, this date was in error as interviews identified the DON was initially updated on 6/21/25, and the incident occurred on 6/20/25, at approximately 5:00 p.m. When interviewed on 6/25/25, at 2:00 p.m., registered nurse (RN)-A identified herself as the unit manager. She stated she was present in the facility on 6/20/25, until approximately 9:00 p.m. and neither NA-D nor licensed practical nurse (LPN)-B informed her of the abuse allegation. RN-A explained she expected staff to act immediately when abuse was witnessed and/or alleged which required staff to ensure resident(s) safety and to update the immediate supervisor. This would then follow the chain of command to ensure the allegation was reported to the SA within two hours and an internal investigation was started. (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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/25/25, at 2:24 p.m., NA-D was able to articulate examples of abuse which included rough handling of a person, pulling aggressively on their limbs, verbally talking bad to a resident, etc. If witnessed, she was to report this as soon as possible to the nurse. NA-D explained when she walked into R1's room, she witnessed NA-A roughing [R1] up. NA-A grabbed R1's upper arms aggressively as R1 attempted to swing out at NA-A, along with attempts to bite him. In response, NA-A pushed R1's arm to R1's mouth hard while NA-A stated to R1 he was not going to bite him, but to bite himself. NA-D stated she asked NA-A why he did this - NA-A responded he did not give a . Just after this, RN-A entered the room and NA-A stopped the abuse. Despite RN-A's presence, she did not update RN-A at that time; however, she updated LPN-B about the situation, but LPN-B did not appear to have listened to her and appeared to have bypassed the information. She tried to update RN-A that evening; however, due to her being behind with her cares and the need for her break, she was unable. She explained she did write the information down but forgot to turn it in. Additionally, she explained she did not know who to turn it in to at that point. NA-A indicated she was able to update the DON the next morning around 7:00 a.m. or 8:00 a.m. When interviewed on 6/25/25, at 2:39 p.m., LPN-B stated she was expected to report abuse allegations immediately to her supervisor, the DON, or the administrator. She explained that on 6/20/25, she was R1's nurse that evening and that NA-D updated her on the abuse allegation after it happened; however, she understood from NA-D that NA-D was going to update RN-A as RN-A was in the facility. LPN-B indicated she did not follow up with NA-D or RN-A about the allegation that evening to ensure it was reported to RN-A, nor did she update administration on the allegation, as she felt it had been taken care of. During an interview on 6/25/25, at 2:58 p.m., the DON stated abuse was expected to be reported right away to staff's immediate supervisor and then the chain of command was to be followed, which included her and the administrator. When verbal and/or physical abuse were alleged, and/or were witnessed, the facility had two hours to file a report with the SA. The DON identified she was updated about the allegation during the afternoon of 6/21/25, not after the incident on 6/20/25, as she would have expected. When interviewed on 6/26/25, at 12:18 p.m., the administrator stated she expected staff to report abuse, once the resident's safety was ensured, to their direct supervisor, herself, and/or the DON [chain of command] to ensure the two-hour abuse reporting requirement was met and for an internal investigation to begin which included the suspension of any alleged perpetrator. The administrator considered the allegation verbal and physical abuse which was expected to be reported to the SA within the two-hour timeframe. An Abuse Prohibition/Vulnerable Adult Policy, dated 4/2025, identified its purpose was to protect residents against abuse and to promptly report all incidents of alleged or suspected abuse. The policy indicated all staff were responsible to report situations that were considered abuse, and a completed incident report was routed per facility procedure. Additionally, a supervisor, and the administrator, were to be notified immediately for situation assessment to determine if any emergency treatment or action was required. If the administrator was absent or unavailable, staff were to follow the chain of command for notification. Immediately, upon learning of the situation, staff were further directed to take necessary steps to protect residents from possible subsequent incidents of misconduct or injury while the matter was investigated. The policy indicated suspected abuse was to be reported to the SA no later than two hours after the suspicion of abuse was formed.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure an allegation of potential verbal/ physical abuse was thoroughly investigated and protection was provided when the alleged perpetrator was allowed to continue to work with residents after the allegation was identified for 1 of 1 resident (R1) reviewed for an allegation of abuse. Findings include: A Facility Reported Incident (FRI), dated 6/21/25, at 4:55 p.m., was submitted to the State agency (SA) which reported an alleged act of abuse towards R1. The report identified nursing assistant (NA)-D reported to the director of nursing (DON), that NA-A handled R1 roughly and [was] being verbally aggressive with [R1]. R1 was agitated by NA-A and attempted to bite NA-A. In response, NA-A held [R1's] arm to [R1's] mouth and said bite yourself. The report indicated the incident occurred 6/20/25, at 5:00 p.m.; however, additionally identified the administrator was updated 6/21/25, at 3:20 p.m. The report identified staff became aware of the incident on 6/20/25, at 3:15 p.m.; however, this date was in error as interviews identified the DON was initially updated on 6/21/25, and the incident occurred on 6/20/25, at approximately 5:00 p.m. Immediate actions taken were identified as NA-A's suspension, R1 emotional well-being checks, and initiation of a facility investigation. R1's admission Minimum Data Set (MDS), dated [DATE], indicated R1 was severely cognitively impaired with lack of speech. R1 was rarely/never understood, but sometimes understood others. R1 was free of behaviors. Range of motion limitations noted to his bilateral upper and lower extremities, and he was overall dependent on staff for his activities of daily living. His diagnoses included, but were not limited to, a stoke with left dominant side hemiplegia (weakness), aphasia (impaired ability to speak), and non-Alzheimer's dementia. A comprehensive care plan Focus, initiated 4/1/25, identified R1 was a vulnerable adult with decreased cognitive and physical abilities in setting of the stroke, hemiparesis (weakness) on one side of his body, vascular dementia, expressive aphasia . R1's goal was to remain free of abuse and/or neglect and directed staff to follow the facility's vulnerable adult and abuse reporting policy, along with notifying local Ombudsman, Adult Protection, Police, and/or state/financial agencies as needed if abuse or financial exploitation was suspected. R1's progress notes were reviewed and lacked any documented evidence of the 6/20/25, alleged abuse, and/or any facility investigation updates and/or process updates (family and provider updates, provider follow-up, R1's status, monitoring, etc.) R1's Weekly Skin Inspection V-5, dated 6/21/25 5:06 p.m., the DON evaluated R1's skin due to reports of rough handling. No swelling or bruising were noted to R1's arms and no pain was noted with touch PROM (passive range of motion). R1 denied pain. R1's June 2025 Treatment Administration Record (TAR), indicated on 6/21/25, starting at 11:00 p.m., staff were directed to Monitor for change in resident's mood, depressed, angry, crying, ETC every shift. No end date was indicated and no rationalization as to the monitoring needs. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility incident/event report listing, since 5/21/25, was requested. This was provided; however, the listing lacked any incidents/events related to R1. Facility vulnerable adult SA reports, and all facility investigation information, since 5/21/25, was requested. Information was provided related to R1's 6/20/25, abuse allegation on 6/25/25, at 10:37 a.m. via email, and included the following information: · The SA FRI report. · R1's face sheet. · R1's 6/21/25 Weekly Skin Inspection V-5. · A typed telephone interview between NA-A and the DON, dated 6/20/25; however, based on interviews this was conducted on 6/21/25. NA-A indicated NA-A had not worked with R1 previously but was asked to get R1 up for supper. During this task, R1 tried to punch NA-A. NA-A did not expect that and was holding his elbow. He explained to R1 they needed to get him up but R1 did not speak. The statement: 'Don't touch him was made (by unknown speaker) and a Lady (unidentified) was laughing. Trying to make him feel comfortable. Again, explained to R1 they were going to get him up but again R1 did not speak. RN-A showed up and talked to him step by step in which R1 was aggressive at that time also. NA-A stated 'he didn't want me to touch [him]. Don't touch me. R1 was not happy with him wiping him, only wanted a female. R1 was about to bite the other aide on the hand and the female said, 'don't bite me, I am your friend. remember me.' R1 was 'fine when I put his brief on. And we got him up for supper. The interview lacked any additional clarifying and/or allegation details. ·NA-D's handwritten statement, dated 6/21/25, indicated, NA-D went to assist with R1's bed to wheelchair transfer. As she and NA-A helped R1, R1 became very agitated with [NA-A] and asked for him to stop touching me and let me do it. NA-A ignored the request. R1 started to get uncomfortable and attempted to 'hit' [NA-A]. [NA-A] grabbed [R1] by his arm and roughed handled him aggressively. R1 managed to grab his hand and put it towards his mouth and try to bite him. [NA-A] then grabbed [R1's] arm and forced it over his mouth and stated, 'you want to bite here bite yourself' and continued to press down firmly and verbal abuse [R1]. I asked [NA-A] why is he doing these things, he stated 'I don't give a s .' This occurred before dinner around 5:15 p.m. and 5:35 p.m. · NA-D hand wrote an additional statement on 6/21/25, which indicated NA-A had a very nasty attitude towards [R8] on 6/20/25. NA-A kept telling [R8] that he was 'fat and nasty' and that he did not want to help him because R8 'is a nasty f .' Additionally, NA-A made fun of [R8's] choice to eat 6 (six) sandwiches and called him ugly names the whole time he was in the room with me. NA-A told NA-D, she shouldn't be nice to [R8] because he doesn't like 'our skin.' This occurred during bedtime between 8:50 p.m. and 9:20 p. m. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	· A typed interview statement, dated 6/21/25, between R8 and the DON, identified R8 stated, 'you have that male cocky son of a b ' walking around everywhere but doesn't like helping any of the residents. I had words and straightened him out [and] by the end of [the] shift he was helping like he should. He was going to let [the] young girl to do everything by herself, he wasn't going to help. She can't do cares of [sic] me by herself.' After he talked to him, he finally started to get me to bed and was fine once he started working. The interview lacked clarification if NA-D's statements of verbal abuse or additional clarifying information related to the interaction that evening, if R8 felt safe, and/or if he felt abused by NA-A. · An undated typed statement from RN-A identified she entered R1's room to interact with R1's roommate on 6/20/25, approximately around 5:00 p.m. As she was about to exit the room, the unidentified NAs reported R1 was 'fighting.' She approached R1 and noticed R1 struggled with the male caregiver at times. She stopped to observe the cares and provided education to both NAs on what do to before proceeding with cares and appropriate bedside care when interacting with an agitated resident. RN-A assisted the female NA to place R1 in the wheelchair. · NA-A's education on Identifying and Reporting Elder Abuse and Identifying and Reporting Neglect and Abuse in Adults - A Refresher. · The facility investigation information lacked an incident/event report (based on facility policy), documentation R1's representative and provider were updated, additional staff interviews who worked the evening of 6/20/25, for additional details, additional resident interviews whom NA-A may have worked with, an interview with R1's roommate, a written statement of R1's interview, a written statement from LPN-B, and evidence of documented education related to abuse procedures. NA-A's time sheet identified on 6/20/25, he clocked in at 2:31 p.m. and clocked out at 10:28 p.m. He then clocked back in at 11:00 p.m. that same evening, and clocked out on 6/21/25, at 6:38 a.m. During interviews on 6/25/25, at 1:23 p.m., 1:35 p.m., and 1:43 p.m., NA-B, NA-C, and LPN-A respectively were unaware of the recent abuse allegation related to R1, despite R1's unit being their primary working units, and all three stated they had not received any recent abuse education related to such an allegation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 6/25/25, at 2:00 p.m., registered nurse (RN)-A identified herself as the unit manager. She stated she was present in the facility on 6/20/25, until approximately 9:00 p.m. She indicated she was first made aware of the allegation on 6/21/25. RN-A explained she expected staff to act immediately when abuse was witnessed and/or alleged which required staff to ensure resident(s) safety. This would then follow the chain of command to ensure the allegation investigation was started immediately. RN-C explained she entered R1's room while NA-A and NA-D were providing cares to R1. When she went to leave, the NAs indicated R1 was fighting them as they tried to get the mechanical sling lift sheet under him. She explained she moved NA-A out of the way, and she assisted NA-D with the rest of R1's transfer task. Additionally, she updated both NAs on how to decrease resident anxiety and how to properly reposition residents. She denied education/coaching documentation related to this. RN-A denied any witnessed or heard abuse while in R1's room; however, she indicated she was not in R1's room during the entire R1/NA interaction. RN-A denied involvement in the investigation as the DON and administrator managed these processes. She was unaware if staff were provided abuse education since the allegation. RN-A stated she did not update the provider and/or R1's representative related to the allegation despite family being there typically every day as the DON and/or the administrator managed the investigation procedures. During an interview on 6/25/25, at 2:24 p.m., NA-D stated when she walked into R1's room, she witnessed NA-A roughing [R1] up. NA-D explained she witnessed NA-A grab R1's upper arms aggressively as R1 attempted to swing out and bite at NA-A. In response, NA-A pushed R1's arm to R1's mouth hard while NA-D identified that NA-A stated to R1 that R1 was not going to bite him, but to bite himself. She asked NA-A why he did this - NA-A responded to her that he did not give a s . Just after this, RN-A entered the room and NA-A stopped the rough handling. Despite RN-A's presence, she did not update RN-A at that time; however, she updated LPN-B about the situation, but LPN-B did not appear to have listened to her and appeared to have bypassed the information. NA-D identified she tried to update RN-A that evening; however, due to her being behind with her cares and the need for her break, she was unable. She explained she did write the information down but forgot to turn it in. Additionally, she explained she did not know who to turn it in to at that point. NA-D indicated she was able to update the DON the next morning around 7:00 a.m. or 8:00 a.m. NA-D explained the DON verbally reminded her about timely reporting; however, she was not provided any formal education related to abuse since the allegation. NA-D indicated she worked an evening shift on 6/21/25. NA-D denied any additional potential resident abuse concerns. When interviewed on 6/25/25, at 2:39 p.m., LPN-B stated that on 6/20/25, she was R1's nurse that evening, and NA-D updated her that R1 tried to bite NA-A and NA-A put R1's arm up to R1's face, which occurred prior to RN-A's entrance into R1's room. She identified there was a misunderstanding about who (she versus NA-D) was going to report the allegation to RN-A, as RN-A was in the building at the time. LPN-B initially stated that evening, she obtained R1's vitals and did a skin assessment; however, did not document such. Later in the interview, LPN-B indicated she did not perform any abuse allegation investigation processes after NA-D updated her. Further, she confirmed NA-A continued to work the rest of the night. LPN-B identified she was not provided any formal education related to abuse since the allegation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/25/25, at 2:58 p.m., the DON stated she was updated about the allegation during the afternoon of 6/21/25, not after the incident on 6/20/25, as she would have expected so that an investigation could have started right away. She considered the allegation as abuse; however, their investigation, so far, was not able to substantiate it as their understanding was RN-A walked in and did not witness or hear evidence of abuse, but the investigation was still ongoing with initial interviews conducted with NA-A, NA-B, RN-A, R8, and R1. Initially she indicated LPN-B and additional NAs were interviewed but then indicated she was unsure. She conducted a skin assessment on R1 with no findings and setup monitoring for him. During this, R1 felt he was safe in the facility, denied pain, and did not feel he was handled roughly. He was unable to verbalize what agitated him that evening. R8 updated her on the confrontation with NA-A but he felt safe and did not feel he was abused - only that NA-A was cocky and did not think he needed to work. The DON was unsure if additional resident interviews were conducted as this was a social services responsibility. She identified staff were not yet formally provided abuse education; however, this was an expected step in their investigation. She stated they have until 6/27/25, to complete this and their investigation processes. The DON verbalized LPN-B worked since 6/20/25; however, she was unsure if NA-D had. On 6/25/25, at approximately 3:15 p.m., the administrator was asked if there was any additional information to be provided to support their ongoing R1 investigation. The administrator denied they had any additional information to provide. When interviewed on 6/26/25, at 11:56 a.m., social services designee (SSD)-A stated her only involvement with abuse allegations was to complete resident interviews when instructed by administration, upon their investigation, if they deemed them necessary. Often, this request came days after the allegation and typically she was not made aware of the allegation details. She was made aware on 6/23/25, there was a potential abuse allegation related to R1 where one staff accused another staff; however, had only heard some of the details through the rumor mill. Despite this, she was directed on 6/25/25, after the surveyor entered the facility, to complete resident interviews which she indicated involved pretty broad questions. She completed these and provided them to the administrator between 3:30 p.m. and 4:00 p.m. No concerns were identified. SSD-A indicated concerns with her limited involvement in abuse allegation investigations and felt additional information related to the allegations would assist her to ensure resident safety, along with mental health and psychosocial well-being. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/26/25, at 12:18 p.m., the administrator stated abuse allegations were discussed in daily morning meetings and thus involved staff, which included social services, who were updated on all allegations. She considered the allegation surrounding R1 both verbal and physical abuse and she expected an investigation to have started on 6/20/25, which included interventions such as removal of NA-A from resident care, conducted initial resident and staff interviews to figure out immediate interventions to keep everyone safe, a skin check and pain assessment on R1, and following the chain of command for reporting. She identified there were concerns with her expectations as she stated none of these interventions occurred on 6/20/25. Administrator confirmed NA-A had not been immediately removed from the schedule after the allegation of abuse occurred and stated he should have been. Due to being updated of these concerns by the DON on 6/25/25, she stated LPN-B underwent corrective action on 6/25/25, and was provided education on abuse reporting. The administrator stated NA-A was currently on suspension as the facility had yet to conclude their investigation. So far, their investigation consisted of staff and resident interviews with no concerns for abuse identified. Resident interviews were expected to be completed within five days of the allegation, but they attempted to not wait until the last minute. She identified staff interviews consisted of both NAs and RN-A; however, she was unsure who else was interviewed without looking at her file. The administrator indicated RN-A, and the DON have connected with R1's family and provider as expected; however, was unsure as when completed. The administrator explained the facility worked on three additional complaints this week which increased their workload. During a follow-up interview on 6/26/25, at 1:00 p.m., the DON was questioned on the status of the process for updating R1's representative and provider related to the allegations. In response, she identified the provider was updated but she was unsure when. Initially, she stated she was unsure if the representative was updated; however, followed up with a statement that she should have updated them before she left however, she had forgotten. When interviewed on 6/26/25, at 1:09 p.m., NA-A stated he had only worked with R1 once, when instructed to get him up for supper on 6/20/25. NA-A explained when he started to prep things to get R1 out of bed, R1 required an incontinence pad change but was not positioned in the center of the bed but more on the left side. This required him to move R1 to safely manage the cares. He started to turn R1 towards him after he provided R1 with assistance instructions: R1 did not respond to him. Shortly after, NA-D entered the room. When he went to put R1's hand on his hand and started to hold onto R1's shoulder, R1 punched him in the arm. He thought R1 did not want to turn. R1 stated, 'Don't touch me.' NA-A asked R1 to turn toward him and explained they needed to get him cleaned up. NA-D called R1's name and told R1 he should not have hit NA-A. NA-D told R1 not to touch NA-A as NA-A was her friend and just tried to help him. After, RN-A entered the room to work with R1's roommate. When she finished, she was updated R1 hit NA-A which prompted RN-A to provide cues to both about how to manage such situations, and her assistance to finish the cares. During the incontinence product care, NA-A stated R1 attempted to bite NA-D. NA-A denied R1 attempted to bite him. Additionally, he denied he placed R1's arm against R1's mouth with a statement to bite himself; however, R1 may have placed his arm closer to his mouth when he was moving it around himself. He indicated he only grabbed R1's arm when R1 went to initially hit him to protect himself but this was not a forced grab despite R1's aggression. R1 was still able to move his arm around. NA-A identified there were no concerns that evening between him and R8. NA-A identified he was concerned NA-D was retaliating against him after he refused to give her money that she had requested that shift, in addition to comments she directed towards him about herself. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Abuse Prohibition/Vulnerable Adult Policy, dated 4/2025, identified its purpose was to protect residents against abuse and to promptly document and investigate all incidents of alleged or suspected abuse while also promptly identifying and remedying any potential abusive situations. The policy directed an immediate investigation was to begin which assessed for any emergency treatment or required actions which included necessary steps to protect residents from possible subsequent incidents of misconduct or injury while the investigation was conducted. If staff were identified as the alleged perpetrator, they were to be immediately suspended pending the investigation. Additionally, the provider and appropriate family (representatives) were to be notified regarding the facts of the situation, that an investigation was in progress, and any applicable additional follow-up information. The investigation team was to review all Incident Reports no later than the next working day following the incident and would determine next steps which may include staff and resident interviews, or other witnesses to the incident. Corrective action was based on the investigation and all documentation was to be kept in a facility file. Additionally, social services, and other staff as appropriate, were to provide ongoing support and counseling to the residents and family as needed. The facility was also to provide proper follow up communication related to the incident across all shifts.