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	07/15/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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
	245187	A. Building B. Wing	07/15/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop a care and furnish services according to the providers orders for 1 of 3 residents (R4) reviewed. R4 was ordered to wear compression stocking and an abdominal binder. These services were not being completed. Findings include: R4's physician orders dated 4/17/25 at 9:00 a.m. indicated R4 was to have lymphedema therapy (aims to reduce swelling, alleviate symptoms, and manage symptoms of swelling in the arms and the leg). Wash and apply personal lotion daily. Apply compression compressions in the morning to wear 23/24 hours maximum of 48 years. Compression Xspan (brand name of sock) size 5 toes to just below the knee, 4 extra-long ace wrap from toes to just below the knee in a herring bone (figure 8) pattern. Tubi-grip (elasticated tubular bandage that provides support and compression) from toes to just below the knee-double extra over foot. Remove if painful or irritating. R4's quarterly MDS dated [DATE] indicated R4's BIMS score was a 15 indicating he was cognitively intact. R4 was dependent upon staff for toileting hygiene and bathing, chair to chair and toileting transfers. She required maximum assistance with lower body dressing and set-up with upper body dressing. R4's pertinent diagnoses were fracture left tibia, Diabetes Mellitus, hypothyroidism, morbid obesity. R4's care plan did not indicate the use of compression stockings/ACE wraps or the abdominal binder. R4's physician orders dated 7/12/25 indicated R4 was to have compression stockings to bilateral lower extremities daily, can use ACE wraps if stockings are too tight.R4's physician orders dated 7/12/25 indicated R4 was to wear an abdominal binder to her abdomen. Upon observation and interview on 7/14/25 at 2:03 p.m. R4, a morbidly obese resident was in bed wearing a hospital gown. She had a 4x4 dressing on her right lower extremity. R4's legs were swollen and red. Below the dressing she had clear mild drainage from 10-12 weeping blisters. She was not wearing an abdominal binder and did not have any wrapping on her legs. She stated she had not worn the abdominal binder in weeks because the facility could not find it. The reason her legs were not wrapped was because the facility did not have a staff member who could do the lymphedema wraps. She stated her order had recently changed from the lymphedema wraps to just compression stockings or ACE wraps, which have not been completed. R4 had compression stockings and ACE wraps in her closet. Upon interview on 7/14/25 at 2:30 p.m. nursing assistant (NA)-C stated she had searched for R4's abdominal binder a few weeks ago and could not find it. She reported the missing binder to the nurse manager. She was not certain why R4's lymphedema wraps had stopped, and she was not aware that R4 had been ordered to wear compression stockings or ACE wraps. Upon interview on 7/15/25 at 2:44 p.m. licensed practical nurse (LPN)-A the nurse manager stated she was not aware of the missing abdominal binder and was not certain as to why R4 did not have compression stockings or ACE wraps on. Upon interview on 7/15/25 at 3:23 p.m. the Director of Nursing stated if they residents are ordered treatments, they should be wearing them, if they are refusing, they should be educated and if they are completed, they should discontinue. A facility policy titled Care Planning, revised 11/2024 indicated a comprehensive care plan shall be used in developing the resident's daily care routines and will be utilized by staff personnel for the purposes of providing care or services to the resident, modified and updated as the condition and care needs of the resident changes.

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	07/15/2025

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. (continued on next page)

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	07/15/2025

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to provide the necessary services recommended by physical therapy to maintain or improve a residents ability to carry out her own activities of daily living for 1 of 3 residents (R4) reviewed. R4 was ordered a functional maintenance program when her physical therapy treatment period ended, and the facility did not initiate the program delaying R4's discharge goals. Based on interview, and record review the facility failed to provide the necessary services recommended by physical therapy to maintain or improve a residents ability to carry out her own activities of daily living for 1 of 3 residents (R4) reviewed. R4 was ordered a functional maintenance program when her physical therapy treatment period ended, and the facility did not initiate the program delaying R4's discharge goals. Findings included: R4's Annual Minimum Data Set (MDS) dated [DATE] indicated R4 had a Brief Inventory of Mental Status (BIMS) score of 15 indicating R4 was cognitively intact. R4 did not exhibit any behaviors. R4 was dependent upon staff for showering and lower body dressing, required maximum assistance with upper body dressing and rolling side-to-side in bed. R4 was incontinent of bowel and bladder. Her pertinent diagnoses were unspecified dementia, renal insufficiency (kidney failure, cardiovascular accident (stroke) and seizure disorder. A facility Functional Maintenance Program undated created by physical therapy (PT) indicated five exercises for R4. One of the exercises required the use of a ball to be squeezed between her leg and another required the use of a belt. The document did not indicate whether R4 was to do the exercises on her own or with staff assistance. R4's care plan dated 7/7/25 did not indicate any exercises for R4 to complete from PT. Upon interview on 7/14/25 at 2:30 R4 stated she fears she will be stuck at the facility forever. Her discharge goal was to be able to stand and not use a bariatric mechanical lift. There is a facility close to her home that will admit her when she is off the bariatric mechanical lift. She received physical therapy, but stated therapy stopped due to her payor source. She was told by PT that she would receive a program to do so she does not decline. R4 was doing well but ended up in the hospital due to a rash that covered a large portion of her body. She returned to the facility having gained weight and required the use of the mechanical lift. R4 felt without a restorative program she would continue to decline. Upon interview on 7/15/25 at 1:30 p. m. physical therapy assistant (PTA)-A the director of PT stated R4's therapy did end, and he provided the nursing staff with a functional maintenance program for them to work with her. He stated when therapy ends, he provides the nursing staff with a maintenance program of exercises for the residents to complete. Staff is educated on the plan. There is a place on the form where staff signs off that they have completed training. He stated R4 could discharge to a facility closer to home if she was able to stand and pivot transfer. PTA-A was unable to locate the form he had provided the nursing staff with. Upon interview on 7/15/25 at 2:44 the nurse manager, licensed practical nurse (LPN)-A stated she was not aware of any PT recommendations for R4. She stated the health unit coordinator (HUC) had been away from work for a few weeks and it could be in pile to scan into the system. She did locate the form from the HUC's scanning pile. LPN-A stated the recommendations should have been started and added to R4's care plan. Upon interview on 7/15/25 at 3:23 p.m. the director of nursing (DON) stated the facility did not have one staff member who acts as a restorative nurse for a restorative program, however the nursing assistants work with residents who have therapy recommendations. A facility policy titled Activities of Daily Living (ADL's)/Maintain Abilities Policy dated 3/31/25 indicated It is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided are person-centered, and honor and support each resident's preferences, choices, values and beliefs. Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility will provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. The facility will ensure a resident is given the appropriate treatment and services to maintain or improve their ability to carry out the activities of daily living.

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	07/15/2025

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. (continued on next page)

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	07/15/2025

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to attempt alternative devices before using bedrails on residents beds. The failed to accurately assess the residents for risk of entrapment by assessing residents medical diagnosis, size and weight, cognition, communication and mobility for 5 of 7 residents (R1, R2, R3, R6 and R7) reviewed for bed rails. In addition, R6 had side rails used in conjunction with an air mattress. Based on observation, interview, and record review the facility failed to attempt alternative devices before using bedrails on residents beds. The failed to accurately assess the residents for risk of entrapment by assessing residents medical diagnosis, size and weight, cognition, communication and mobility for 5 of 7 residents (R1, R2, R3, R6 and R7) reviewed for bed rails. In addition, the facility failed to use caution as R6 had side rails used in conjunction with an air mattress. This deficient practice had the potential to affect all 72 residents who used bed/side rails. Findings include:A website https://www.cms.gov/files/document/finalmds-30-rai-manual-v11811october2023.pdf. reviewed 7/15/25 indicated a physical restraint or method physical or mechanical device, material or equipment attached or adjacent to the residents body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. Residents who are cognitively impaired are at a higher risk of entrapment and injury or death caused by physical restraints. It is vital that physical restraints used on this population be carefully considered and monitored. Any manual method or physical or mechanical device, material or equipment should be classified as a restraint definition. This can only be deterred on a case-by-case basis by individually assessing each and every manual method or physical or mechanical device, material, or equipment. https://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/HomeHealthandConsumer/ConsumerProducts/BedRailSafety/ucm362848.htm reviewed 7/15/25 Food and Drug Administration (FDA) guidelines (Recommendations for Health Care Providers about Bed Rails) 2018 indicated health care providers should base the use of bed rails on individual resident assessments to ensure the individual is an appropriate candidate to reduce the risk of entrapment. Recommendations made for health care providers to evaluate the individual's need, to use the guidance documented Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment to have knowledge that not all bedrails, mattresses, and bed frames are interchangeable; check the manufacture instructions, health care providers are to avoid the routine use of adult bed rails without first conducting an individual patient or resident assessment, and restrict the use of physical restraints including restrictive use of bed rails, or chest, abdominal, wrist, or ankle restraints of any kind on individuals in bed. When installing and using bedrails select the appropriate bed rail, follow the health care providers procedures or manufacture recommendations, inspect, evaluate, and regularly check bedrails are appropriately matched to equipment and patient needs considering all relevant risk factors, to identify and remove potential fall and entrapment hazards. Be aware that gaps can be created by movement or compression of the mattress, which may be caused by patient weight, movement, bed position, or by using a specialty mattress. Retrieved from on 5/2/25https://www.fda.gov/medical-devices/adult-portable-bed-rail-safety/recommendations-health-care-providers-using-adult-portable-bed-rails reviewed 7/15/25 indicated: Be aware that not all bed rails, mattresses, and bed frames are interchangeable and not all bed rails fit all beds. Check with the manufacturers to make sure the bed rails, mattress, and bed frame are compatible. Use caution when using bed rails with a soft mattress as this may increase risk of entrapment between the mattress and bed rail. Be aware that gaps can be created by movement or compression of the mattress which may be caused by patient weight, patient movement or bed position, or by using a specialty mattress, such as an air mattress, mattress pad or waterbed.R1's annual Minimum Data Set (MDS) dated [DATE] indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 15 indicating R1 was cognitively intact. R1 did not exhibit any behaviors. R1 was dependent upon staff for showering and lower body dressing, required maximum assistance with upper body dressing and rolling side-to-side in bed. R1 was incontinent of bowel and bladder. Her pertinent diagnoses were unspecified dementia, renal insufficiency (kidney failure, cardiovascular accident (stroke) and seizure disorder. R2's MDS did not indicate the use of bed rails on her bed.R1's care plan dated 7/1/25 did not indicate the use of bed rails.R1's Bed mobility device evaluation dated 7/1/25 indicated R1and her representative had a preference for grab bars as a bed mobility device. R1 had not attempted to get out by climbing over a bed mobility device or became entangled in a device in the last quarter. R1 did not use the rails with transferring, however used them to

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	07/15/2025

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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	07/15/2025

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure sufficient nursing staff available at all times to provide nursing services to meet the residents needs for 3 of 3 residents (R1, R2 and R4) reviewed when staff were unavailable to provide necessary care and services according to assessed needs leading to long wait times for incontinence cares.Findings include: The Facility Assessment Tool dated 1/7/25 indicated under staff acuity:-Dressing assistance the facility had 8 independents residents, 67 residents with assistance of 1-2 staff and 1 dependent resident. -Bathing - 4 independent residents, 21 with assistance of 1-2 and 23 dependent residents.Transferring 14 independent residents, 49 residents with assistance of 1-2 staff, 10 dependent residents-Eating - 62 independent residents, 12 residents with assistance of 1-2 and 2 dependent residents.-Toileting - 11 independent residents, 64 residents with assistance of 1-2, and 1 dependent resident.-Mobility - 7 independent residents, 23 residents with assistive devices and 57 residents in chair most of the time. -The assessment did include how residents required assistance with behaviors. R1's Annual Minimum Data Set (MDS) dated [DATE] indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 15 indicating R1 was cognitively intact. R1 did not exhibit any behaviors. R1 was dependent upon staff for showering and lower body dressing, required maximum assistance with upper body dressing and rolling side-to-side in bed. R1 was incontinent of bowel and bladder. Her pertinent diagnoses were unspecified dementia, renal insufficiency (kidney failure, cardiovascular accident (stroke) and seizure disorder. A facility report and investigation dated 7/9/25 indicated R1 complained that a staff member was rough during care and made inappropriate comments. A facility interview undated from R4. R4 stated at times she turns on her all light waiting for up to an hour for assistance. R4 was aware she was to have cares in pairs (two staff with all cares). The day of the allegations nursing assistant, NA-C completed cares alone. NA-C was suspended during the facilities investigation. A facility statement dated 7/9/25 by NA-C indicated she sometimes went into R1's room with two staff and other times alone. Sometimes she completed her change cares by herself. R1's care plan dated 7/1/25 indicated R1 was a total assistance of two staff for all bed mobility. For toileting R1 was extensive assistance of two staff to check and change her brief. R1 was to have care in pairs due to behaviors and accusations against staff. Upon interview on 7/14/25 at 11:28 a.m. R1 stated the week of July 4th she put on her call light because she was incontinent of bowel and needed her incontinent pad changed. NA-C answered her call light and told R1 that she needed to wait because NA-C did not have time. R1 stated she waited half-an-hour and turned on her light again and this time NA-C proceeded to change her without assistance, was rough with her and used inappropriate language. Upon interview on 7/15/25 at 8:40 a.m. NA-D stated she was accused of rough cares with R1. She was aware that R1 was to be cares in pair and stated, damned if I do, damned if I don't. She explained if she waited for another staff member all the time R1 would complain and call family complaining of the wait time, therefor she performed cares alone with R1. NA-D stated the nurses do not assist when asked as they are busy with their jobs. She stated the unit had at least three bariatric residents who require two nursing assistants, two residents on cares in pairs and approximately 10 mechanical lift residents who require two nursing assistants. R2's quarterly MDS dated [DATE] indicate R2's BIMS score was a 9 indicating she was cognitively impaired. R2 required moderate assistance with toileting hygiene, upper body dressing, personal hygiene, toilet transfer and sit to stand transfer. She required maximum assistance with lower body dressing and touching/supervision to sit and stand. R2's pertinent diagnoses were Parkinson's disease (neurological disorder primarily affecting movement, restless leg syndrome, mild cognitive impairment, anorexia, and obsessive-compulsive disorder (mental health disorder characterized by unwanted thoughts and repetitive behaviors). R2's care plan dated 7/3/25 did not indicate R2 required cares in pairs, nor did it indicate how R2 transferred. R2's social work progress notes dated 7/10/25 at 8:54 a.m. indicated social services completed a BIMS, PHQ9 (depression screening) and trauma questionnaire due to R2's abuse allegation. R2 scored 15/15 on BIMS indicating she was cognitively intact she scored 0/27 indicating minimal depression. R2's nursing progress note dated 7/10/25 at 10:02 a.m. indicated writer arrived in the morning and was immediately told about an accusation R2 had with the night nursing assistant (NA). Writer made sure R2 was safe and then notified the director of nursing (DON) and the Administrator at 7:30 a.m. R2 reported that just after midnight she put on her call light to use the toilet, and the nursing assistant did not get there in time, so the resident ended up wetting the bed. When the NA arrived, she got upset with R2 for wetting then bed and

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	07/15/2025

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. (continued on next page)

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	07/15/2025

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to conduct regular inspections of all bed frames, mattresses, and bed rails as a part of the regular maintenance program to identify areas of possible entrapment for 6 of 7 residents (R1, R2, R3, R4, R6 and R7) reviewed. The bed manufacturer guidelines indicated to visually inspect the bed and accessories monthly and indicated to follow the FDA guidance. Findings include: Recommendations for Health Care Providers Using Adult Portable Bed rails dated 2/27/2023 retrieved on 7/15/25 from https://www.fda. gov/medical-devices/general-hospital-devices-and-supplies/hospital-beds indicated, When evaluating the safe use of a hospital bed, component or accessory, manufacturers and caregivers should recognize that the risk for entrapment may increase if a hospital bed system is used for purposes, or used in a care setting, not intended by the manufacturer. Evaluating the dimensional limits of gaps in hospital beds may be one component of a bed safety program which includes a comprehensive plan for patient and bed assessment. Bed safety programs may also include plans for the reassessment of hospital bed systems. Reassessment may be appropriate when (1) there is reason to believe that some components are worn (e.g., rails wobble, rails have been damaged, mattresses are softer) and could cause increased spaces within the bed system, (2) when accessories such as mattress overlays or positioning poles are added or removed, or (3) when components of the bed system are changed or replaced (e.g., new bed rails or mattresses). This guidance describes seven zones in the hospital bed system where there is a potential for patient entrapment. Entrapment may occur in flat or articulated bed positions, with the rails fully raised or in intermediate positions. Descriptions of the seven entrapment zones appear on pages 15-21 in this guidance. Summary drawings of entrapment for all the zones appear in Appendix E. The seven areas in the bed system where there is a potential for entrapment are identified in the drawing below. Zone 1: Within the Rail Zone 2: Under the Rail, Between the Rail Supports or Next to a Single Rail Support Zone 3: Between the Rail and the Mattress Zone 4: Under the Rail, at the Ends of the Rail Zone 5: Between Split Bed Rails Zone 6: Between the End of the Rail and the Side Edge of the Head or Foot Board Zone 7: Between the Head or Foot Board and the Mattress End. Health Care providers should base the use of bed rails on individual resident assessments to ensure the individual is an appropriate candidate to reduce the risk of entrapment. Recommendations made for health care providers to evaluate the individual's need, to use the guidance documented Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment to have knowledge that not all bedrails, mattresses, and bed frames are interchangeable; check the manufacture instructions, health care providers are to avoid the routine use of adult bed rails without first conducting an individual patient or resident assessment, and restrict the use of physical restraints including restrictive use of bed rails, or chest, abdominal, wrist, or ankle restraints of any kind on individuals in bed. When installing and using bedrails select the appropriate bed rail, follow the health care providers procedures or manufacture recommendations, inspect, evaluate, and regularly check bedrails are appropriately matched to equipment and patient needs considering all relevant risk factors, to identify and remove potential fall and entrapment hazards. Be aware that gaps can be created by movement or compression of the mattress, which may be caused by patient weight, movement, bed position, or by using a specialty mattress. The manufacture user-service manual for Joerns Assist Device and Side Rails [NAME]-Care Models, undated, indicated Maintenance/Inspection Information: Visuallyinspect the assist handle and mounting bracket, and check for loose hardware on a monthly basis. Tighten loose hardware as stated in the installation instructions. Warning: Risk of Serious Injury or Death. Properly locate the mounting brackets. The gap between the head/foot panel and the assist device or side rail must be small enough to prevent a resident from getting their head or neck caught in this location (see the installation instructions for more information, if applicable). If multiple assist devices are needed, position them such that the gap between them is large enough that the trunk and hips can easily pass through. Make sure that raising or lowering the bed, or adjusting the sleep surface, does not create hazardous gaps. The assist devices or side rails should not be used if ANY openings within the bed system allow a resident to get their head or neck lodged within these openings. Failure to do so could result in serious injury or death.Warning: An optimal bed system assessment should be conducted for each resident by a qualified clinician or medical provider to ensure maximum safety of the resident. The assessment should be conducted within the context of, and in compliance with, the state and

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	07/15/2025

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 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. (continued on next page)

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	07/15/2025

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure call lights, or another means to request assistance were accessible for 3 of 3 (R2, R5, and R7) residents who were dependent on staff for activities of daily living.Findings include: Upon observation and interview on 7/14/25 at 1:21 p.m. R2 was found in her room seated in her wheelchair with her pants off wearing an incontinent brief. R2 was attempting to get a pair of sweatpants on by herself. R2's bed was in the lowest position, there was a matt on the floor so R2 could not scoot herself in her wheelchair to reach her call light which was placed on her bed wrapped around her 1/4 side rail against the wall. R2 became agitated stating why can't you help me, why can't you help put my pants on? R2 attempted to stand up. The surveyor went to get assistance from registered nurse RN-A at 1:46 p.m. to assist R2. RN-A assisted R2 with getting her pants back on. RN-A left the room and got nursing assistant (NA)-A to assist with getting the call light within R2's reach. Upon observation and interview on 7/15/25 at 1:57 p.m. NA-A untangled R2's call button and untangled the bed cord from R2's side rail. R2 stated they would have to speak with maintenance as the call light would not reach R2 when she was in her chair with the floor mat in place. NA-A was not certain how the staff usually made sure R2 had her call light, but all residents must have access to their call light. R2's care plan dated 2/21/25 indicated R2 had a soft call button and to have the call light kept within reach. R2 had falls on 2/21/25, 3/9/25, 3/27/25 and 6/10/25 and the interventions were a call don't fall sign in her room and a soft call button. R2's quarterly MDS dated [DATE] indicate R2's BIMS score was a 9 indicating she was cognitively impaired. R2 required moderate assistance with toileting hygiene, upper body dressing, personal hygiene, toilet transfer and sit to stand transfer. She required maximum assistance with lower body dressing and touching/supervision to sit and stand. R2's pertinent diagnoses were Parkinson's disease (neurological disorder primarily affecting movement), restless leg syndrome, mild cognitive impairment, anorexia, and obsessive-compulsive disorder (mental health disorder characterized by unwanted thoughts and repetitive behaviors) Upon observation on 7/14/25 at 2:09 p.m. R5 was seated in a Geri-chair (specialized wheelchair) in her room with the door closed. R5 was seated with her back against the door and looking out her window. Her bed and call light were approximately 10 feet away from on her bed. R5 could not move herself in her chair to get to light. R5 was nonverbal, only able to make sounds when questioned. R5's quarterly MDS dated [DATE] indicated R5 BIMS score was a 00 indicating severe cognitive impairment. R5 required maximum assistance with eating and oral hygiene. She was dependent upon staff for showering, dressing upper and lower body, chair to bed transfers and personal hygiene She required maximum assistance to roll from left to right in bed. Sitting to lying, sitting to standing were documented as nonapplicable. R5's pertinent diagnoses were unspecified dementia without behaviors, weakness, dysphagia (difficulty swallowing), and encephalopathy (neurological brain dysfunction). R5's care plan dated 6/2/25 indicated R5's call light was to always be within reach, answer promptly. Upon interview on 7/14/25 at 2:15 p.m. RN-A stated R5 cannot use a call light and normally she would be in the community room to be visualized by staff. RN-A stated she checked onR5 every ten minutes to make sure she was safe. Ten-minute safety checks were not on the care plan that was RN-A's personal practice. Upon observation and interview on 7/14/25 at 2:18 p.m. R7's was seated in her wheelchair her call light was on her bed, she stated she was able to move herself to reach the call light if she needed assistance. She stated her room call light was not the problem, her bathroom call light had not been working for a few days, she told staff, and maintenance had not been by to fix it. She stated she gets herself off the toilet without any help. When pulling the call light with the string, the drop-down plastic portion moved; however, the light did not light up outside her door to alert staff R7 needed assistance. Upon observation and interview 7/14/25 at 2:24 p.m. NA-B was passing R7's room and looked at the bathroom call light. He tried it couple of times and noticed there was a knot in the string that was used to trigger the light. He untied the knot, and the light worked. He stated R7 had not mentioned to him the light was not working. Upon interview on 7/15/25 at 2:44 p.m. licensed practical nurse, (LPN)-A stated residents should always have access to their call lights when they are in their rooms. She was not aware that R2's light did not reach her with the mat on the floor. She was not certain why R5 had been placed in room without being in bed because after lunch she laid down in her bed. R7's admission MDS dated [DATE] indicated R7 had a BIMS score of 15 indicating she was cognitively intact. R7 was independent with eating, oral hygiene, toileting hygiene, upper and lower body dressing, rolling left to right in bed, lying to sitting and sitting to standing and transferring to her chair