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	08/28/2025

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 Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to report an elopement/missing resident immediately to the State Agency within 2 hours for 1 of 1 resident (R98) who had eloped from a medical appointment.Findings include:R98's admission Minimum Data Set (MDS), dated [DATE], identified R98 had moderate cognitive impairment and required assistance with ADL's. R98's diagnoses included non-traumatic brain dysfunction (condition where the brain sustains damage or injury without any external physical trauma to the head), atrial fibrillation (common heart rhythm disorder where the upper chambers of the heart (atria) beat irregularly and rapidly), hypertension (high blood pressure), renal failure (occurs when the kidneys lose their ability to effectively filter waste products and excess fluid from the blood), diabetes mellitus (chronic metabolic disease characterized by persistently high blood sugar (glucose) levels) and chronic obstructive pulmonary disease (group of lung diseases that cause airflow obstruction and breathing problems).R98's care plan dated 9/27/24, identified R98 was categorized as a vulnerable adult while residing in a Skilled Nursing Facility and was at risk for decreased cognitive and physical abilities related to diagnoses. Interventions included: Safety monitoring as needed to ensure resident's safety and for the local Ombudsman, Adult Protection, Police and state agencies to be notified of any suspected abuse as needed.R98's progress note dated 10/14/24 at 6:22 p.m., identified facility was contacted by the transportation company inquiring on R98's whereabouts as R98 was not at the clinic when transportation arrived to return R98 to the facility. Progress note identified R98's daughter and significant other were not aware of where R98 was. A missing person report was filed at that time with the St. Louis Park Police department.R98's progress note dated 10/14/24 at 7:30 p.m., identified police called facility and stated that they were in contact with R98's daughter and girlfriend who were not sure where R98 was and that they were going to go to a few places R98 frequently visited to attempt to locate R98.R98's progress note dated 10/15/24 at 8:19 a.m., identified facility reached out to Hennepin County Medical Center (HCMC) regarding R98's medical appointment on 10/14/24. Security cameras were reviewed, and it was noted R98 was seen on camera leaving the clinic after his appointment and got on the Metro Transit bus system. Progress note identified facility administrator reached out to a homeless shelter where R98 was previously living with no success and social services was driving around the North Loop area searching for R98.Progress note dated 10/15/24 at 8:45 a.m., identified director of nursing (DON) reached out to R98's daughter who reported that she had not seen resident nor had R98's girlfriend.Progress note dated 10/15/24 at 12:23 p.m., identified administration reached out to R98's girlfriend regarding R98's whereabouts with girlfriend stating she had not heard from R98.Progress noted dated 10/15/24 at 4:49 p.m., identified R98's girlfriend contacted the facility with an update on R98's whereabouts. R98's girlfriend stated R98 went to HCMC to get some medications and then showed up at her house. Facility spoke with R98 who stated he was not returning to the facility. Progress note identified a Minnesota Adult Abuse Reporting Center (MAARC) report was filed regarding R98 leaving against medical advice (AMA).R98's electronic health record (EHR) lacked evidence a MAARC report was submitted to the state agency, in a timely manner, regarding R98 missing for more than 24 hours.Review of a report made to the state agency (SA) on 10/15/24 at 4:41., indicated R98 left the facility against medical advice following a medical appointment. Report indicated a MAARC report was submitted for that reason and due to the concerns related to safety of the resident (needing supervision due to cognitive impairments). During an interview on 8/28/25 at 1:24 p.m., social service designee (SSD) stated R98 was sent to the clinic for an appointment when he left the appointment and did not return back to the facility. SSD stated they went out to his usual haunts looking for him as he lived on the streets, and could not locate him. SSD confirmed MAARC report had been completed and submitted on 10/15/24 at 4:41 p.m., when R98 had finally been located and stated he was not coming back to facility and discharged AMA. SSD stated a MAARC report should have been submitted to the state agency right away when facility was aware R98 was missing.During interview on 8/28/25 at 5:17 p.m., director of nursing (DON) stated when a resident was missing, the facility would contact resident's emergency contacts to see if they knew of the resident's location. DON stated the police would then be notified the facility had a missing resident. DON stated she believed it should have also been reported to the state agency at that time. DON stated she was told by the administrator a MAARC report was to be made after 24 hours regarding the resident leaving AMA. DON confirmed the MAARC report had been submitted on 10/15/24 at 4:41 p.m., and was submitted to report the resident left AMA and not as a missing person