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	12/02/2025

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. (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	12/02/2025

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 0679 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 support the facility-sponsored and individual activities for residents' preference to support their physical, mental, and psychosocial well-being for 2 of 3 residents (R1 & R2) who were dependent on staff for activities.Findings include: R1's care plan dated 6/10/25 indicated R1 had little or no activity involvement and wished not to participate. R1's goal was that he would express satisfaction with the type of activities and the level of activity involvement when asked. R1's interventions was staff was to respect his right to decline involvement in group activities. The care plan did not indicate any self-guided activities offered to R1 or how the facility encouraged the support and development of his interests, hobbies, and skills. R1's Evaluation and Social History assessment dated [DATE] indicated R1 was oriented to self, person, place, and time. He had visual deficits, but no hearing deficits to impact activity participation. R1 liked arts and crafts such as metal working, sports and exercising, going for walks, music, reading, writing, and watching television. He enjoyed one-to-one activity, large group and or small group, for leisure he was given a handheld radio for music. R1's admission Minimum Data Set, dated [DATE] indicated R1 had a Brief Inventory of Mental of Status (BIMS) score of 12 indicating R1 had moderate cognitive impairment. R1 used a wheelchair for mobility. R1 required moderate/partial assistance with showering, upper and lower body dressing, personal hygiene, sitting to standing, chair/bed-to-chair transfer, toilet transfer, tub, or shower transfer. R1 was not assessed for walking due to a medical condition or safety concerns. R1's diagnoses were Type 2 Diabates Mellitus with foot ulcer, non-pressure chronic ulcer, adult failure to thrive, tobacco use and dependence on renal dialysis, heart failure. R1 was not at risk for pressure ulcers/injuries and did not have an unhealed pressure ulcer. R1 had a diabetic foot ulcer. R1's activity report indicated:6/9/25 the activity was smoking.6/23/25 the activity was a community event where R1 spent 2.5 hours.7/13/25 the activity was a music event where R1 spent 1.25 hours.7/27/25 the activity was Bingo and Bible study where R1 spent 2 hours.7/28/25 the activity was smoking.8/3/25 the activity was Bingo where R1 spent 1 hour.8/10/25 the activity was Music where R1 spent 1.25 hours, and the other activity was smoking.8/11/25 the activity was Bingo, and the note indicated was R1 was not available, yet time spent was 1 hour.8/13/25 the activity was Bingo where R1 spent 1 hour.8/14/25 the activity was movie and television the time spent was non-applicable and the other activity was smoking.8/15/24 the activity was Bingo where R1 spent 1 hour, and the other activity was smoking.8/24/25 the activity was Bingo where R1 spent 1.25 hours.8/27/25 the activity was Bingo where R1 spent 1 hour at, and the other activity was smoking.8/28/25 the activity was Trivia R1 refused yet the time spent was 45 minutes the other activity was smoking.9/2/25 the activity was other the note indicated R1 was not available, yet time spent was 1 hour. 9/3/25 the activity was other the note indicated R1 was not available, yet time spent was 1 hour.9/4/25 the activity was Bingo where R1 spent 1 hour. Bible study he refused yet the time spent was 45 minutes and smoking were the other activity.9/5/25 the activity was a pop-in visit the note indicated R1 was not available. 9/6/25 the activity was a pop-in visit the note indicated R1 was not available. 9/7/25 the activity was bingo, and the note indicated R1 was not available, yet time spent was 1 hour and R1 was not available for smoking. 9/8/25 the activity was smoking and other the note indicated R1 was not available.9/14/25 the activity was reminiscing and the note indicated R1 was not available, yet the time spent was 30 minutes.9/16/25 the activity was a virtual event, and the note indicated R1 was not available, yet time spent was 1 hour. The other event was smoking.9/19/25 the activity was physical therapy and reminiscing R1 refused.9/21/25 the activities were Bingo and reminiscing, the note indicated R1 was not available, and the time spent was 1.5 hours.9/22/25 the activities were trivia, games and Reminiscing R1 refused. Upon observation and interview on 9/29/25 at 12:01 p.m. during R1's wound cares the licensed practical nurse (LPN)-B mentioned R1's smoking to him. After the LPN-B left the room R1 stated if he had something other to do maybe he would not go out and smoke so much. He stated he had attempted Bingo a few times and would continue, but he had been asking staff over and over to get a remote control for his television so he could watch news, sit coms, and sports. He denied having a hand-held radio to use as identified on his assessment. He complained that the activities were all the same, reminiscing, games, and Bingo he would like some more self-guided activities for his room and some group activities that would take place outside. R2's admission MDS dated [DATE] indicated R2 had a BIMS score of 15 indicating she was cognitively intact. R2 was dependent on staff for toileting, showering, lower body dressing, and transferring from chair to bed. R2 required moderate

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	12/02/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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	12/02/2025

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 0684 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 a resident received treatment and care professional standards of practice for 1 of 3 residents (R1) reviewed for quality of care. R1 received treatments that were not ordered and R1 was simultaneously seeing an outpatient wound clinic and the facilities inhouse wound care team who both prescribed different wound care orders leading to inconsistent treatment for R1's wound including missed treatments and inaccurate assessments. Based on observation, interview, and record review the facility failed to ensure a resident received treatment and care professional standards of practice for 1 of 3 residents (R1) reviewed for quality of care. R1 received treatments that were not ordered and R1 was simultaneously seeing an outpatient wound clinic and the facilities inhouse wound care team who both prescribed different wound care orders leading to inconsistent treatment for R1's wound including missed treatments and inaccurate assessments. Findings include: Upon observation and interview on 9/29/25 at 12:01 p.m. R1 was observed wheeling himself back from Dialysis in his wheelchair. He was using his feet to scoot along the floor. His left foot was wrapped in an ace wrap, the wrap was soiled with dirt and a yellowish/red discharge. R1 stated he had been at the facility for four months. He had a surgery on his ankle and was aware he had a small diabetic foot ulcer upon admission. He stated received services from both outpatient and inhouse wound care providers. He was not certain why he saw both. He stated the and the facility did not follow the orders given from outpatient therapy. The facility did not perform his dressing changes daily, sometimes it was left for a few days. R1 had returned from the hospital about two weeks ago. He stated he had a blood infection throughout his body from his foot wound and had part of his heel cut off. Upon observation on 9/29/25 at 12:01 Licensed Practical Nurse (LPN)-B was asked to complete R1's dressing change as his ace bandage was saturated with reddish/yellowish drainage. R1's ace wrap was removed, the drainage had bled through a tubular stretch stocking (a seamless elastic tube-shaped bandage used to secure dressings in place), kerlix wrap (cotton wrap to assist with a fast-wicking absorbent) and the ace wrap. R1 was actively bleeding from the open surgical wound on his heel. The wound measured approximately 8-centimeters (cm) in Length (L), 6 cm in Width (W). The wound depth could not be identified due to the bleeding. What appeared to be a blood clot or skin tag measuring approximately 3-centimeter (cm) (L), 2 cm (W) was dangling from the wound. LPN-B applied pressure with the soiled Kerlix to the active bleeding from the wound for 4 minutes. LPN-B did not have new dressing supplies in R1's room. She came back into the room with the new supplies, placed them on R1's bed. LPN-B cleansed the wound with betadine solution (a brownish-yellow antiseptic). LPN-B saturated the same gauze she used to cleanse the wound, formed it into a ball and placed it inside the wound. She covered the wound with an ABD pad (absorbent pad), cut the soiled portion of R1's tubular stocking off and placed the cut tubular stocking over R1's foot and wrapped his foot in the same ace bandage she had removed from R1 and secured it with the same tape she had taken off the ace wraps. R1's orders dated 6/8/25 - 10/1/25 did not include any orders for betadine to be used for R1's wound care. R1's facility admission Skin and Wound Evaluation dated 6/2/25 indicated R1 had a diabetic wound on his left middle heel that was present on admission.-How long the wound was present - No documentation was completed-The wound was not staged-Wound measurements - an area was of 4x4 centimeters squared (cm2), 3.4 centimeters (cm) in length (L), 2.0 cm in width (W), and 5. 6 cm in depth (D).-Wound bed was 100% granulated-Evidence of infection - no documentation was completed- Heavy serosanguinous/bloody-No odor-Peri-wound - attached: edge appears flush with wound bed or as a sloping edge-Surrounding tissue - was macerated (softening or breakdown of the skin resulting from prolonged exposure to moisture): wet, white, waterlogged tissue-Induration - no documentation was completed.-Edema - no documentation was completed,-Pain - no documentation was completed.-Orders - goals of care- wound slow to heel, wound healing is slow or stalled but stable, little or no deterioration, -Dressing appearance - saturated.-Cleansing solution - normal saline.-Debridement - no documentation completed.-Primary dressing - Iodoform packed and compression wrap.-Additional care - no documentation completed i.e., air flow pad, compression, cushion, customized show ear, foam mattress, foot cradle, heel suspension/protective device, incontinence management, mattress with pump, mobility aid, moisture barrier, moisture control, dietary, padded rails/chair, repositioning devices, turning or repositioning.-Progress - stalled R1's Treatment Administration Record (TAR) dated 6/1/25 - 6/30/25 indicated on 6/3/25 R1 was ordered wound care to his left heel ulcer to cleanse the wound with normal saline, apply Santyl lotion (antimicrobial)

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	12/02/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (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	12/02/2025

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 0880 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 follow enhanced barrier precautions (an infection control intervention designed to reduce transmission of multidrug-resident organisms that employs targeted gown and glove use during high contact resident activities) for 1 of 3 residents reviewed (R1). In addition, during a wound care dressing change staff failed to follow proper infection control protocol.Findings include: Upon observation on 9/29/25 at 11:50 a.m. R1 had an enhanced barrier precaution (EBP) sign posted outside his room. The sign indicated everyone must: clean their hands, including before entering and leaving the room. Providers must also wear gloves and a gown for the following high contact resident care activities:-Dressing-Bathing/Showering-Transferring-Changing linens-Providing hygiene-Changing brief or assisting with toileting-Device care use, central line, urinary catheter, feeding tube and tracheostomy-Wound care - any skin opening requiring a dressing. R1's admission Minimum Data Set, dated [DATE] indicated R1 had a Brief Inventory of Mental of Status (BIMS) score of 12 indicating R1 had moderate cognitive impairment. R1 used a wheelchair for mobility. R1 required moderate/partial assistance with showering, upper and lower body dressing, personal hygiene, sitting to standing, chair/bed-to-chair transfer, toilet transfer, tub, or shower transfer. R1 was not assessed for walking due to a medical condition or safety concerns. R1's diagnoses were Type 2 Diabates Mellitus with foot ulcer, non-pressure chronic ulcer, adult failure to thrive, tobacco use and dependence on renal dialysis, heart failure. R1 was not at risk for pressure ulcers/injuries and did not have an unhealed pressure ulcer. R1 had a diabetic foot ulcer. R1's providers order dated 9/15/25 indicated R1 was to have every other day dressing change for his surgical incision. The wound was to be cleansed with saline and pat dry with sterile gauze, apply zero form (a petroleum-based foam dressing) to the surgical incision then dry gauze, ABD pad (absorbent pad), gauze roll and secure with a 4-inch ace wrap. Upon observation on 9/29/25 at 12:01 p.m. R1 was wheeling himself in his wheelchair down the hall using his feet to propel. His left foot was wrapped in an ace wrap with visible dirt and reddish yellow drainage. Licensed Practical Nurse (LPN)-B was asked to complete his dressing change. She entered the room and washed her hands in the bathroom sink. She did not set-up a sterile field for the dressing supplies. R1's ace wrap was removed, the drainage had bled through a tubular stretch stocking (a seamless elastic tube-shaped bandage used to secure dressings in place), kerlix wrap (cotton wrap to assist with a fast-wicking absorbent) and the ace wrap. R1 was actively bleeding from the open surgical wound on his heel. The wound measured approximately 8-centimeters (cm) in Length (L), 6 cm in Width (W). The wound depth could not be identified due to the bleeding. What appeared to be a blood clot or skin tag measuring approximately 3-centimeter (cm) (L), 2 cm (W) was dangling from the wound. LPN-B applied to pressure with the soiled Kerlix to the active bleeding of the wound for 4 minutes. LPN-B did not have new dressing supplies in R1's room. She wrapped the soiled kerlix around the wound and left the room to gather supplies. She doffed her soiled gloves, did not sanitize her hands. She came back into the room with the new supplies, placed them on R1's bed, went in the bathroom washed her hands and donned clean gloves. LPN-B cleansed the wound with betadine solution (a brownish-yellow antiseptic). LPN-B saturated the gauze she used to cleanse the wound, formed it into a ball and placed it inside the wound. She covered the wound with an ABD pad (absorbent pad), took R1's soiled tubular stocking, cut it in half with the same scissors, without sanitizing, she had used to remove R1's dressing. LPN-B placed the cut tubular stocking over R1's foot and wrapped his foot in the same soiled ace bandage she had removed from R1 and used the same tape she removed from his dressing to secure the ace wrap. LPN-B placed the soiled dressing supplies in R1's garbage can and left in the room. Upon observation and interview on 9/29/25 at 1:35 p.m. the director of nurse, DON was asked to change R1's dressing along with an interview. The DON had donned a gown, gloves, and a face mask per the EBP guidelines. She gathered supplies, sanitized the bedside table to place the new supplies. She undressed the dressing using proper technique and completed the dressing change per the provider's current order. As she was undressing the wound she stated betadine was not part of R1's order as she removed the ball of betadine gauze from the wound. The DON cleansed the wound with saline, pat dry. She used pressure from the saline syringe and the questionable skin tag vs. a blood clot separated from the wound and the DON identified it as a blood clot and discarded. She donned clean gloves and sanitized her hands prior to placing the zero-form dressing in the wound. R1's wound was covered with an ABD pad, wrapped in kerlix. A tubular stocking was placed over the kerlix and then wrapped with an ace