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	01/27/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to review and revise the comprehensive care plan in a timely manner following a verbal altercation for 1 of 3 residents (R2) reviewed for abuse. This failure placed R2 at risk for psychosocial distress and potential recurrence of resident-to-resident conflict.Findings include:R2's hospital Discharge summary dated [DATE], identified R2 diagnoses included severe recurrent major depression (MDD) and neurocognitive deficits.R2's associated clinic of psychology note dated 12/22/25, identified R2 diagnoses included posttraumatic stress disorder and major depressive disorder, recurrent episode, moderate.R2's activity of daily living (ADLs) care plan dated 3/7/25 indicated R2 was at risk for decreased cognitive related to PTSD (post traumatic syndrome disorder) and MDD. ADLs care plan dated 3/10/25 directed staff to monitor for signs of emotional distress or mood and behavior changes and safety monitoring will be implemented as needed to ensure residents safety. ADls care plan dated 3/10/25 directed staff to utilize trauma informed care when working with the resident. The care plan dated 3/10/25 identified triggers as unannounced visitors and no male attendees, nightmares, and flashbacks.IncidentReview of an alleged incident report dated 1/16/26 outlined R2 was involved in a verbal altercation with another resident (R3). The report indicated R3 became visibly upset, raised his voice, and R2 asked him to leave the room. R3 continued yelling in the hallway toward the nursing station, requiring staff intervention. Review of R2's care plan showed no evidence the facility reviewed R1's comprehensive care plan following the altercation, no documentation of updated interventions addressing triggers, supervision needs, conflict-prevention strategies, or psychosocial follow up. No documentation of a care plan meeting or interdisciplinary review since the incident on 1/16/26.During an interview on 1/21/26 at 4:30 p.m., R2 stated she did not feel safe in the facility because people continued entering her room without knocking. R2 reported on 1/16/26, R3 entered her room and displayed aggressive behavior by putting his fingers in her face, which triggered her PTDS and caused fear for her safety. During an interview on 1/22/26 at 2:38 p.m., R3 stated on 1/16/26, he knocked before entering R2's room to visit her roommate. R3 reported R2 became rude and threatened to call the police. R3 stated he became upset and left the room. R3 denied being aggressive toward R2 and reported he continued to knock and open the door slightly so his friend could come out for smoke break after the incident.During an interview on 1/21/26 at 3:50 p.m., a nursing assistant (NA)-A stated she did not recall receiving an education recently on trauma-informed care. NA-A explained she was not aware of an incident between R2 and R3 but realized R2 stayed in her room for the most part. Staff typically separate residents and initiate 15-minute safety checks after altercations. NA-A asserted she was not aware of any recent review of R2's care plan.During an interview on 1/22/26 at 1:26 p.m., a registered nurse (RN)-B, the unit manager stated when staff made her aware of the altercation between R2 and R3 on 1/16/26, she went in the unit while R3 was still yelling in the hallway. RN-B explained R2 reported (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	01/27/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3 put his fingers in her face, invading her personal space. RN-B stated R3 reported R2 was the aggressor, being rude and wanted to call the police on him which R2's roommate confirmed. RN-B explained she instructed R3 not to return to the room and to call his friend instead for smoke break. RN-B stated she did not update R2's care plan with new interventions addressing triggers, supervision needs, conflict -prevention strategies, or psychosocial follow-up following the altercation.During an interview on 1/27/26 at 1:17 p.m., the director of nursing (DON) explained the care plan should have been reviewed and revised after an altercation incident to address triggers, supervision needs, and other safety measures. The DON stated he did not recall any care plan meeting or interdisciplinary (IDT) review following the altercation.The facility Trauma Informed care policy dated 2/24/23 showed staff were required to add goals and interventions to the care plan for the residents with a history of trauma to address potential triggers and approaches to minimize or eliminate their effects. The policy directed the interdisciplinary team (IDT) to monitor the effectiveness of interventions and update the care plan as needed.

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	01/27/2026

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a medication was available for administration for 1 of 3 residents (R1) reviewed for medication errors. This resulted in immediate jeopardy (IJ) when R1 was not administered physician prescribed anti-seizure medication which resulted in hospital intensive care unit (ICU) admission for medical management and treatment. The IJ began on 1/17/26 when the facility failed to ensure R1 received scheduled dose Lacosamide (anti-seizure medication) on 1/17/26, 1/18/26, and 1/19/2026 (six doses) and an additional dose not administered on morning of 1/20/26 this caused R1 to have 3 seizures over the span of 7 minutes resulting in hospital ICU admission where R1 remains. The administrator, the director of nursing, and the regional director of operations were notified of the IJ on 1/27/26 at 4:40 p.m. The facility had implemented actions to prevent recurrence prior to the survey therefore, the citation was issued at past non-compliance (PNC).Findings include:R1's admission record dated 4/26/24, identified R1's diagnoses included encephalopathy (any dysfunction of the brain that alters mental state, causing symptoms like confusion), seizure disorder, and generalized weakness.R1's hospital Discharge summary dated [DATE], identified R1's primary admitting diagnoses included status epilepticus, seizure disorder, alcoholic dementia, and metabolic encephalopathy.R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had moderate cognitive impairment, administered anti-seizure medication and was independent for toileting, transfer, and mobility.R1's activity of daily living (ADLs) care plan dated 2/12/25, indicated R1 required anti-seizure medication to be administered as ordered by the provider. Additionally, it directed staff to ensure a position to prevent injury during seizure activity, open airway, and document characteristics. ADLs care plan dated 2/12/25, directed staff to monitor neurological status after any activity for residual impairment and notify the provider of any seizure activity.R1 Physician orders included:-Lacosamide Oral tablet 200 mg. Give 1 tablet by mouth two times a day for uncontrolled seizures (start date 6/17/25.)-Monitor for seizure activity: unusual smells, tastes, sounds, or sensations, Nausea, intense fear and panic, sensation in certain parts of your body, jerky movement in of the arm, leg, or body, weakness and falling to the ground: Every shift (start date 6/16/25) January 2026 Medication Administration Record (MAR) identified R1 did not receive either scheduled dose of Lacosamide oral 200 mg on 1/17/26, 1/18/26, and 1/19/26 (six doses) with notations the medication was not available. Additionally, on 1/20/26 the 8:00 a.m. dose was also not administered. The record identified three different nurses did not administer the doses. In review of R1's record between 1/16/26 through 1/20/26, there was no indication R1's physician was notified nor evident the pharmacy was notified the doses were not administered and/or none available to administer according to the physician order. January 2026 Treatment Administration Record (TAR) identified the physician order to monitor for seizure activity with corresponding checked mark boxes with nurses' initials indicating the task was complete. Review of R1's record which included progress notes did not include the results of the monitoring associated with this task nor was it evident of increased monitoring for signs and symptoms of seizure activity after the prescribed doses of Lacosamide were missed.R1's progress note dated 1/20/26 at 11:31 a.m., indicated when R1 was non-responsive and tremoring, the provider onsite ordered her to be sent to the hospital.R1's hospital admission notes dated 1/20/26 identified R1 was admitted to the intensive care unit (ICU) at the hospital with seizures activity and concern for status epilepticus, requiring intubation on ventilator for airway protection. The note further indicated R1 had been out of Lacosamide (an anti-seizure medication) for the past three days as it had not been available. R1's head computed tomography (CT) scan identified R1 was found to have a thin subdural hemorrhage versus [NAME] thickening (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	01/27/2026

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	along the left cerebral convexityR1's late entry progress note dated 1/20/26 at 1:33 p.m. for 1/16/26 at 1:31 p.m., indicated licensed practical nurse (LPN)-A noticed R1's seizure medication was low so she called and left a voicemail to the provider but did not hear back from the provider before the end of her shift. R1's late entry progress note dated 1/20/26 at 1:30 p.m. for 1/17/26 at 1:31p.m. indicated R1's seizure medication was not delivered, LPN-A called and left a voicemail to the provider. R1's late entry progress note dated 1/20/26 at 1:30 p.m. for 1/19/26, indicated LPN-A left two messages for the provider and did not get a return call back. R1's late entry progress note dated 1/20/26 at 2:15 p.m. for 1/19/26 at 3:58 p.m., indicated staff called the pharmacy to reorder R1's seizure medication which would be delivered on the first run.Attempts were made to interview LPN-A on 1/26/26 at 3:30 pm and again on 1/27/26 at 11:50 a.m., which were not answered, no return phone call was received. During an interview on 1/26/26 at 3:38 p.m., LPN-B stated he cared for R1 the evening shifts of 1/17/26 and 1/18/26. LPN-B stated R1 was supposed to get her seizure medication (Lacosamide 200 mg) two times a day. He could not find the medication in the cart, so he did not give the evening scheduled dose on 1/17/26 and 1/18/26. LPN-B did not notify the pharmacy or the provider or the nurse manager for further directions. LPN-B explained he should have called the pharmacy and the provider but was busy and forgot. LPN-B asserted he did not give any report to the night nurse to follow up and monitor R1 for seizure episodes. Additionally, LPN-B was suspended on 1/20/26 pending the investigation and received re-education regarding medication administration.During an interview on 1/27/26 at 11:04 a.m., LPN-C stated after getting a report on 1/19/26 about anti-seizure medication not available from the day shift nurse, she called the pharmacy to reorder the medication, and the pharmacy confirmed its delivery for that night. LPN-C stated anti-seizure medication arrived as she was leaving the facility. She did not give any report to the night nurse regarding R1 and did not notify the provider, so the anti-seizure medication was not given on 1/19/26. She was terminated on 1/25/26. A packing slip summary dated 1/19/26 indicated R1's Lacosamide 200 mg was delivered on 1/19/26 at 9:00 p.m.During an interview on 1/27/26 at 12:03 p.m., a registered nurse (RN)-A stated she cared for R1 on 1/20/26 in the morning and found R1 very sleepy, difficult to arouse so she determined it was not safe to administer medications which included the anti-seizure medication. RN-A notified the provider onsite of R1's change in condition. RN-A explained she had not been informed R1 had missed three days of anti-seizure medication.During an interview on 1/27/26 at 12:46 p.m., RN-B, unit manager, stated LPN-C shared with her on 1/20/26 about R1 missing anti-seizure medication for three days. After R1 was sent to the hospital, RN-B found 10 anti-seizure tablets (Lacosamide 200 mg) in the medication cart. RN-B expected nurses to contact the pharmacy when a medication was unavailable and notify the provider as well as the nurse manager if doses were not administered; these procedures were not followed in this case. During an interview on 1/26/26 at 3:03 p.m., a pharmacist (PH-A) stated she could not find any electronic request for the seizure medication (Lacosamide 200mg) on 1/17/26 and 1/18/26. The pharmacy had a prescription on file to supply the facility upon request, so there was no need for new script from the provider. PH-A explained that residents who missed an anti-seizure medication should be monitored for seizure episodes to prevent complications such cardiac issues and even stroke. During an interview on 1/27/26 at 10:05 a.m., a nurse practitioner (NP-A) stated she did not have any record about the facility notification regarding the seizure medication not available nor a refill request. NP-A stated on 1/20/26, RN-A alerted her R1 was having change in condition and when she went to the room to evaluate R1, she found R1 actively seizing. NP-A observed three seizures episodes within seven minutes before the emergency medical services (EMS) arrived to transport her to the hospital. NP-A explained the complication for R1 not having her seizure medication (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	01/27/2026

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	could result in brain injury or even death. She expected nursing staff to notify the medical team regarding any seizure medication not available.During an interview on 1/27/26 at 1:17 p.m., the director of nursing (DON) stated when he got the report about anti-seizure medications not administered, the interdisciplinary team initiated an incident investigation. The facility identified R1 missed three days (6 doses) of prescribed seizure medication (Lacosamide 200 mg). R1 experienced a change of condition and was sent to the hospital on 1/20/26. The DON explained staff failed to obtain the medication from the pharmacy resulting in missed doses, did not update the provider when doses were missed. Additionally, nurses did not follow re-order procedure of medications and follow up was not completed to ensure timely delivery of medication. The DON reported they had identified three nurses involved, interviewed, and suspended them pending the investigation. All residents receiving anticonvulsant medications for seizure disorder were identified and reviewed for any missed doses and full house medication administration re-education for nurses and the TMAs (trained medication aide) was initiatedMedication Ordering/Medication Not Available policy dated January 2026 required all nurses and TMAs (Trained Medication Aide) to follow the medication ordering procedure when a medication is running out and/or unavailable. If the medication is down to 3 days or less, the nurse should verify that the medication has been reordered.Medication and treatment orders' policy indicated orders for medication and treatments will be consistent with principles of safe and effective order writing.The facility put the following corrective measures in place and was verified as completed: -LPN-A, LPN-B and LPN-C were suspended pending investigation and re-education was provided on 1/20/26.-The facility reviews their policy and procedure for safe medication and developed a plan to ensure a sufficient supply of medications for residents for timely administration on 1/20/26.-All residents with seizure medications were reassessed to ensure their safety on 1/20/26.-The facility began re-education and competencies test to nursing staff to ensure compliance of medication administration on 1/20/26On 1/26/26 through 1/27/27 staff were interviewed and were able to articulate the ordering procedure when a medication is running out and /or unavailable. This deficient practice is being cited at past Non-compliance.