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	03/03/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to report a change in condition to the provider and family for 1 of 3 residents (R2) when R2 had an acute episode of hypoxemia (low levels of oxygen in the blood characterized by symptoms that may include shortness of breath and bluish lips) during a combined physical and occupational therapy assessment. Findings include: R2's admission Minimum Data Set (MDS) dated [DATE] indicated intact cognition, R2 did not require oxygen or respiratory assistive devices, and had diagnoses that included chronic lung disease. R2's admission Data Collection (nursing assessment) dated 1/28/26 at 3:45 p.m., indicated R2's oxygen saturation rate on 1/28/26 at 2:26 p.m., was 96% on room air with a respiration rate of 18 breaths per minute, normal respirations, and R2 used a continuous positive airway pressure (CPAP) machine (used to treat sleep apnea - a condition where breathing repeatedly stops and starts during sleep). R2's provider orders dated 1/28/26, indicated CPAP machine on at night and for oxygen at 2 liters per nasal cannula to maintain oxygen saturation above 90%. R2's baseline care plan dated 1/28/26, indicated intact cognition and alteration in oxygen/gas exchange with interventions to monitor oxygen saturations as ordered and as needed (PRN), monitor for cyanosis (bluish or discoloration of lips caused by lack of oxygen), monitor and document on respiratory status, administer oxygen as ordered, and keep doctor informed of changes. R2's physical therapy (PT) assessment dated [DATE], and signed at 6:05 p.m., indicated R2 demonstrated signs of respiratory distress, the registered nurse (RN) was immediately informed, and R2 was placed on CPAP. R2's occupational therapy (OT) assessment 1/29/26, signed at 8:13 p.m., indicated R2's oxygen saturations fluctuated significantly with his lips turning blue during the evaluation, nursing was notified, and R2 was placed on CPAP. R2's progress notes from 1/29/26 at 11:52 a.m., to 1/30/26 at 9:17 a.m., lacked indication R2's provider or family were notified of the hypoxic incident. During an interview on 2/26/26 at 11:29 a.m., R2 stated on his second day at the facility (1/29/26), during therapy, he had a hard time breathing, a nurse assessed his oxygen saturation rate, and it was 66%, and the nurse put the CPAP on him as there was no oxygen in the room. During an interview on 2/26/26 at 2:46 p.m., family member (FM)-B stated when she visited R2 the evening of 1/29/26, R2 stated a nurse was in his room earlier because his lips were turning blue. The FM-B asked if nursing checked his oxygen again later, and R2 stated staff had not checked it again. A nurse went to assess R2's vital signs (VS) and stated the oxygen was low, at 89%, but not as low as earlier in the day. FM-B further stated the facility staff had not informed her of the hypoxic event, R2 did. During an interview on 2/27/26 at 11:47 a.m., licensed practical nurse (LPN)-B stated if R2's oxygen rate was at 66%, or 89%, the oxygen rate was low. The nurse should have documented the rate and notified the provider. LPN-B acknowledged the medical record lacked indication the provider was notified. During an interview on 2/27/26 at 2:13 p.m., registered nurse (RN)-B stated if a nurse intervened for a resident's low oxygen rate, the nurse should have notified the provider and the family. During an interview on 3/3/26 at 10:09 a.m., RM-D stated if a resident had a sudden low oxygen saturation, that was considered a change in condition, and a provider and family should have been notified. During an interview on 2/27/26 at 10:38 a.m., the nurse practitioner (NP)-A stated if R2 had (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an episode of O2 saturations of 66% she would have liked to be notified, and the family should have been notified. During an interview on 3/3/26 at 11:53 a.m., the director of nursing (DON) stated she would have expected the nurse to notify R2's provider and family of the change. The Notification of Changes policy dated 3/2024 indicated it is the policy of this facility that changes in a resident's condition or treatment be shared with the resident and/or the resident representative, according to their authority, and reported to the attending physician or delegate (hereafter designated as the physician).

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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and document review, the facility failed to assess and monitor 1 of 3 residents (R2) per the provider orders on admission and failed to comprehensively assess and monitor 1 of 3 residents (R2) after a change in condition when R2 participated in therapy, his lips turned blue and had a significant decrease in oxygen saturation rate. Findings include: R2's admission Minimum Data Set (MDS) dated [DATE] indicated R2 had intact cognition, required no oxygen or respiratory assistive devices, and had diagnoses that included chronic lung disease. R2's baseline care plan dated 1/28/26 indicated intact cognition and an alteration in oxygen/gas exchange with interventions to monitor oxygen saturations as ordered and as needed (PRN), monitor for cyanosis (bluish or discoloration of lips caused by lack of oxygen), monitor and document on respiratory status, administer oxygen as ordered, and keep doctor informed of changes. R2's provider orders indicated the following:Starting 1/28/26 at 3:00 p.m., monitor vital signs every 4 hours for 24 hours for one day through 2/17/26 at 2:15 p.m. Starting 1/28/26 at 3:00 p.m., monitor for pain every shift through 2/17/26 at 2:15 p.m. Starting 1/28/26 at 3:00 p.m., chart the resident's condition in nurse's notes every shift for seven days Starting 1/28/26 at 3:00 p.m., check oxygen saturation levels every shift through 2/17/26 at 2:15 p.m. Starting 1/28/26 at 11:00 p.m., complete a Daily Skilled Note every night shift on Wednesdays and Sundays through 2/17/26 at 2:15 p.m. Starting 1/29/26 at 3:00 p.m., complete a Daily Skilled Note every evening shift on Tuesday, Thursday, and Saturday through 2/17/26 at 2:25 p.m. Starting 1/30/26 at 7:00 a.m., complete a Daily Skilled Note everyday shift on Monday, Wednesday, Friday through 2/17/26 at 2:15 p.m. R2's physical therapy (PT) assessment dated [DATE], and signed at 6:05 p.m., indicated R2 demonstrated signs of respiratory distress, the registered nurse (RN) was immediately informed, and R2 was given the CPAP (continuous positive airway pressure -used to keep the airway open during sleep). R2's occupational therapy (OT) assessment 1/29/26, signed at 8:13 p.m., indicated R2's oxygen saturations fluctuated significantly with lips turning blue during the evaluation, nursing was notified, and R2 was placed on CPAP. R2's oxygen saturation levels were documented in the electronic health record (EHR) as follows:1/28/26 at 2:26 p.m. at 96% on room air (RA)1/28/26 from 3-11 p.m., oxygen saturation levels were not assessed/recorded1/29/26 at 12:42 a.m. at 97% on CPAP 1/29/26 at 4:03 a.m. 93% on RA1/29/26 at 9:51 a.m., 91% per nasal cannula (NC)1/29/26 at 9:53 a.m., 93% on RA1/29/26 at 8:41 p.m., 91% on CPAP1/30/26 at 3:03 a.m., 94% on CPAPR2's oxygen saturation level documentation lacked indication of a decreased saturation level, reported during PT and OT assessments. Further, the record lacked indication of vital signs, which include oxygen saturation rates, were monitored every 4 hours, for 24 hours after admission, as ordered. R2's vital signs records indicated blood pressure, pulse, respirations, and temperature were assessed:1/28/26 at 2:26 p.m.1/29/26 at 12:42 a.m.1/29/26 at 4:03 a.m.1/29/26 at 9:51 a.m. R2's vital sign records indicated R2's pulse and respirations were also assessed on 1/29/26 at 2:28 p.m., but lacked evidence of temperature and blood pressure, or oxygen saturation rate. The records also lacked indication vital signs were assessed every four hours for 24 hours as ordered. R2's January 2026 Treatment Administration Record (TAR) lacked indication of the following:Daily Skilled Notes were completed as ordered on evening shift 1/31/26.Vital signs were entered on the TAR on 1/28/26 at 4:00 p.m. and 8:00 p.m. R2's progress notes R2's progress notes from 1/28/26 at 2:45 p.m., to 9:17 a.m., lacked indication any additional oxygen saturation rates were assessed, and lacked Daily Skilled Notes and nursing assessments on 1/30/26 and 1/31/26. R2's February 2026 TAR lacked indication of the following:Pain assessments every shift as ordered. Staff charted the resident's condition in nurse's notes every shift for seven days (through 2/3/26) as orderedOxygen saturation levels were checked every shift as orderedDaily Skilled Notes were completed as ordered During an interview on 2/26/26 at 11:29 a.m., R2 stated on his second date at the facility, 1/29/26, during therapy, he had a hard time breathing, a nurse assessed his oxygen (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	saturation rate, and it was 66%, and the nurse put the CPAP on him. During an interview on 2/26/26 at 2:46 p.m., FM-B stated when she visited R2 the evening of 1/29/26, R2 indicated a nurse was in his room earlier because his lips were turning blue and FM-B asked if nursing checked his oxygen again later, and R2 stated staff had not checked it again. FM-B went to the nurse's desk to ask for staff to check R2's vital signs, and no one came for about 45 minutes, and then went to ask again, but was told the nurse was on a meal break. A nurse manager went to assess R2's vital signs (VS) and stated the oxygen was low, at 89%, but not as low as earlier in the day. FM-B could not recall who the nurse was who checked R2's VS. FM-B further stated there was no oxygen in R2's room on 1/29/26; it came on 1/30/26. During an interview on 2/27/26 at 11:47 a.m., licensed practical nurse (LPN)-B stated if R2's oxygen rate was at 66%, or 89%, the oxygen rate was low and the nurse who assessed him should have documented the low rate in the progress notes and notified the provider. LPN-B acknowledged the medical record lacked indication the event happened or the provider was notified. LPN-B further acknowledged R2's vital signs were not monitored as ordered, and oxygen saturation levels were not checked as ordered, and daily charting was not completed as ordered. During an interview on 2/27/26 at 2:13 p.m., RN-B stated R2 did not have daily skilled notes for 1/30/26 and 1/31/26, should have had progress notes charted every shift, but did not, and R2's vital signs and oxygen assessments were not performed as ordered. If the resident was not assessed, the resident and family would be concerned about his care. RN-B stated she was not aware R2 had a low oxygen saturation during therapy, but if a nurse intervened because of low oxygen, it should have been charted, and R2 should have had more frequent assessments afterwards, and acknowledged the incident and more frequent assessments were not documented. During an interview on 2/27/26 at 10:38 a.m., the nurse practitioner (NP)-A stated if R2 had an episode of O2 saturations of 66% she would have liked to be notified, and the family should have been notified. The NP-A stated the episode should have been documented if it was not. During an interview on 3/3/26 at 11:53 a.m., the director of nursing (DON) acknowledged R2's medical record lacked documentation of R2's hypoxic event and the nurse's interventions. The DON stated after R2's change in condition nursing staff should have completed an assessment, provided care as needed, called the provider and family, and would have expected further assessment and monitoring but there was no record that occurred. Further, the DON stated she would have expected orders were followed, and care provided per the provider orders. Polices for assessment and monitoring and for following orders as prescribed were requested but not provided.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to sufficiently manage pain for 1 of 3 residents (R2) when R2 reported severe pain and was not provided with pain medications until more than 24 hours later.Findings include: R2's admission Minimum Data Set (MDS) dated [DATE] indicated intact cognition and a diagnosis that included spinal stenosis (narrowing of the spaces within the spine which puts pressure on the nerves and spinal cord) of the cervical (neck) region and required active care at the facility for aftercare for surgery that involved fusion of the spinal bones. R2 received opioid pain medications as needed (PRN), and pain occasionally interfered with activities. R2's baseline care plan dated 1/28/26, indicated intact cognition, pain/comfort issues, with a goal for adequate pain relief, and interventions that included non-medicinal forms of pain relief such as position, rest, and massage, and included pain medications as ordered by the physician. R'2s provider orders dated indicated the following:Dated 1/28/26 at 3:00 p.m., monitor for pain daily, every shift through 2/17/26 at 2:15 p.m.Dated 1/28/26 at 11:30 a.m., acetaminophen 325 milligrams (mg), 2 tablets by mouth every 4 hours as needed for mild painDated 1/28/26 at 11:30 a.m., oxycodone HCl (narcotic pain medication administered for moderate to severe pain), 5 mg, 1 tablet buy mouth every 4 hours as needed for painDated 1/28/26 at 3:00 p.m., use non-pharmacological pain interventions including ice, heated blankets, massage, repositioning, music, essential oils, food/drink, and relaxing/breathing. Document interventions used.R2's January 2026 Medication Administration Record (MAR) indicated the following:acetaminophen was not administered in January, although the progress notes on 1/29/26 at 9:47 p.m., indicated it was administered.Oxycodone was administered for the first time on 1/29/26 at 8:59 p.m. for pain rated as 7/10 and twice on 1/30/26 and 1/31/26 for pain rated between 7-10/10. [The January 2026 MAR indicated R2's pain was rated as 0/10 on 1/30/26 at 9:10 a.m., but during an interview on 2/27/26 at 4:36 p.m., registered nurse (RN)-A stated the pain rating was entered incorrectly and should have been entered as 10/10.]The MAR lacked indication oxycodone was administered again on 1/29/26 at 9:47 p.m., but the progress notes at that time indicated it was administered. R2's January 2026 Treatment Administration Record (TAR) indicated R2's pain was rated as follows:1/28/26 during the 11-7 p.m. shift rated as 7/101/30/26 during the 7-3 a.m. shift rated as 2/10All other shifts through the 11-7 p.m. shift indicated pain was rated as 0/10.The TAR further indicated the only non-medicinal pain intervention offered on 1/28/26 for pain rated as 7/10 was food and drink. R2's January 2026 pain assessment log indicated pain ratings as follows:1/29/26 at 2:41 p.m. rated as 7/101/29/26 at 8:59 p.m. rated as 7/10 R2's progress notes indicated the following:1/28/26 progress notes lacked documentation about pain assessments1/29/26 at 7:53 p.m., indicated a family member was at the nursing desk requesting pain medications for R2. Family reported R2's pain level was rated as 7/10, which meant from experience, it was really meant 9/10 because R2 had, Learned to live through pain. A nurse assessed R2's pain, which R2 rated as 7/10, and the nurse then called the on-call provider to request an oxycodone prescription be sent to the pharmacy so the nurse may pull the medication from the facility's medication bank.1/29/26 at 8:59 p.m., indicated oxycodone 5 mg was retrieved from the mediation bank and administered to R2 for pain.1/29/26 at 9:47 p.m., oxycodone 5 mg was retrieved from the medication bank and administered with acetaminophen and Flexeril (muscle relaxer).1/30/26 at 2:04 a.m., oxycodone 5 mg During an interview on 2/26/26 at 11:29 a.m., with R2 and family member (FM)-A, R2 stated when he arrived at the facility his pain was constant, and would get harder at times, rated as an 8/10 or 9/10. It would get pretty damn hard. During an interview on 2/26/26 at 11:29 a.m., FM-A stated R2 came to the facility after surgery for fused spinal discs, and when R2 arrived, the facility did not have R2's pain medication, oxycodone 5 mg, that was ordered. FM-A stated during a visit with R2 on 1/29/26 around 6:00 p.m., the R2 was shouldn't have had to wait for oxycodone. He was hurting so much R2. FM-A added, he had a terrible ride to the facility, and the (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility did not have pain medication to help with the pain when he arrived.During an interview on 2/26/26 at 1:31 p.m., licensed practical nurse (LPN)-A stated when a resident was newly admitted , the admitting nurse completed a form for the pharmacy to request medications, faxed the form with any required prescriptions to the pharmacy, and then the nurse calls the pharmacy to ensure the pharmacy received the fax. The LPN-A stated the pharmacy delivers medications to the facility twice a day. Additionally, the LPN-A stated residents should not have to wait for pain medications because nurses can get narcotic pain medications from the facility medication bank with an access code provided by a pharmacist and a witness and did not know why R2 waited so long to get pain medication.During an interview on 2/26/26 at 2:47 p.m., FM-B stated when she visited on 1/29/26, R2 had not had pain medications, and a nurse was trying to get them for him. He admitted [DATE] and didn't have pain relief or medication available. FM-B stated R2 reported pain at a rating of 9/10, or 10/10, and didn't want to move around or eat due to the severe pain and had pressed his call light an hour prior to the arrival of family to request pain medications but hadn't gotten them as of the time of the family visit.During an interview on 2/27/26 at 2:13 p.m., RN-B stated she saw R2's FM-A at the nurse's desk on 1/29/26 but didn't normally work at that station. RN-B went with the FM-A and assessed R2's pain, and the FM-A was adamant R2 was uncomfortable and the pain was usually more than R2 stated. R2 rated his pain as 7/10, in his head not his neck, and RN-B told the FM-A she would check to see what R2 had ordered for pain medications. RN-B stated R2's oxycodone was not in the facility because of a miscommunication about the prescription but was able to order the medication from pharmacy. RN-B stated she instructed the unit nurse (she didn't recall who), R2 could have acetaminophen and Flexeril. RN-B stated with pain rated as 7/10, she would not offer non-pharmacological relief first and further stated R2 should have gotten pain relief on 1/28/26 and should not have had to wait until 1/29/26. RN-B did not recall giving another dose previously without charting it. Additionally, RN-B stated when R2 had unmanaged pain, he could have required rehospitalization. The process for obtaining a narcotic prescription was for a nurse to check for the prescription upon admission, and if it is not present, or is not complete, the nurse would call the hospital or the on-call provider to get a prescription. If the resident was not being assessed, or the pain was not managed, the resident and family would be concerned about his care. During an interview on 2/27/26 at 10:38 a.m., the nurse practitioner (NP)-A stated if R2 had pain rated as 7/10 or higher, he would have had pain medications and would not have comfortable. NP-A stated the nurse could have called the pain team for a one-time dose, waiting over 24 hours for pain relief was too long, and NP-A thought oxycodone 5 mg was available in the facility medication bank. NP-A stated she was not notified that the staff couldn't get the pain medication. During an interview on 3/3/26 at 11:53 a.m., during an interview the director of nursing (DON) stated when residents were admitted , they typically came with orders, the facility admitting nurse reviewed the orders, and if pain medications were required but not ordered, the nurse would get an order from the provider. The DON acknowledged there was a disruption in the process for R2 to get pain medications timely, and there continues to be gaps in the process the facility nurses are not following. The DON stated nurses had education about the process, but still had a medication error afterwards, so were still not following the process.The Pain Management protocol dated 3/23/23, indicated a review of each resident's diagnoses and conditions was conducted that commonly cause or predispose to pain, with a review of individual pain upon admission. The staff and provider will identify the location, intensity, frequency, pattern and severity of pain, and observe the resident during rest and movement for evidence of pain. Nursing staff would identify situations or interventions where an increase in pain may be anticipated. The resident's care plan would reflect the pain management needs. If the prescribed medications were not available or there was a delay in obtaining the medication, the provider will be notified, and alternative medications or interventions would be obtained to meet the resident's pain management needs.

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F 0760 Level of Harm - Minimal harm or potential for actual harm 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 verify and accurately transcribe orders for 1 of 3 residents (R1) when a blood pressure medication with conflicting dose and types were prescribed for R1 and then then transcribed incorrectly. Additionally, the facility failed to timely administer prescribed pain medication for 1 of 3 residents (R2) who was admitted post-surgically after a cervical (neck) spinal fusion.Findings include:R1's admission Minimum Data Set (MDS) dated [DATE], indicated intact cognition, with diagnoses that included heart failure, orthostatic hypotension (blood pressure that drops significantly when first sitting up or standing up), and stroke. R1's hospital Discharge summary dated [DATE] indicated R2 was prescribed metoprolol succinate (long-acting type) 50 milligrams (mg) twice daily, in the morning and bedtime. R1's facility orders indicated the following:Metoprolol succinate ER (extended release) 50 mg, give 1 tablet daily by mouth 12/13/25 to 1/16/25 at 8:00 a.m. Metoprolol succinate ER (extended release or long-acting), give 50 mg 1 tablet daily by mouth from 12/12/25 to 1/15/26 at 8:00 p.m. R1's December 2025 Medication Administration Records (MAR) indicated the following:Metoprolol succinate ER 50 mg was administered daily at 8:00 a.m., and at bedtime from 12/12/25 to 12/31/25, with one dose omitted 12/14/25 at bedtime with no reason for the omission documented. R1's cardiology provider note dated 1/15/26, indicated R1 entered the appointment prescribed metoprolol succinate 50 mg once daily and recommendations after the appointment included increasing the metoprolol succinate to 75 mg daily. R1's cardiology provider order from the cardiology clinic dated 1/15/26 indicated increase metoprolol succinate to 75 mg twice daily (BID), contrary to the dose recommended in the cardiology Provider Note. R1's facility orders indicated the following:Metoprolol succinate ER 24 hour sprinkles 25 mg, give 3 tablets by mouth two times a day 1/16/26 to 2/4/26. The progress notes lacked indication facility staff clarified the conflicting cardiology order and cariology provider note from the same visit, or clarified with the cardiologist the discrepancy in dosing with the admitting order from the hospital. R1's provider orders sent from the facility pharmacy to the facility dated 1/30/26 indicated metoprolol succinate ER 50 mg, take 1 tablet once daily. R1's facility orders indicated:Metoprolol succinate ER 24 hour sprinkles 25 mg, give 3 tablets by mouth two times a day 1/16/26 to 2/4/26 Metoprolol tartrate 50 mg, give 1 tablet by mouth daily 1/30/26 to 2/2/26 instead of metoprolol succinateMetoprolol tartrate 50 mg, give 1 tablet by mouth daily 2/3/26 to 2/5/26 The facility orders were clarified and corrected on 2/6/26 to:Metoprolol tartrate 50 mg, give 1 tablet by mouth daily 2/6/26 , instead of metoprolol succinate that was prescribed The progress notes lacked indication nursing staff clarified the conflicting and duplicate orders. R1's January and February MARs indicated both metoprolol succinate 75 mg BID and metoprolol tartrate 50 mg daily were given from 1/30/26 to 2/4/26, and doses of metoprolol succinate were given twice daily from 1/15/26 to 2/4/26 without clarifying the conflicting order of once daily versus twice daily. R1's January 2026 MAR indicated the following:Metoprolol succinate ER 50 mg was administered daily at 8:00 a.m., from 1/1/26 to 1/15/26.Metoprolol succinate ER 50 mg was administered daily at 8:00 p.m., from 1/1/26 to 1/14/26. Metoprolol succinate ER Sprinkle 25 mg, 3 tablets were administered daily at 8:00 a.m., and 4:00 p.m., except one dose was omitted on 1/30/26 at 4:00 p.m. Metoprolol tartrate [wrong form or metoprolol] 50 mg was administered one time at 6 p.m., on 1/30/26. R1's February 2026 MAR indicated the following:Metoprolol tartrate 50 mg was administered at 12:00 p.m. on 2/3/26 and refused on 2/4/26. Metoprolol tartrate 50 mg was administered at 6:00 p.m. on 2/1/26 and 2/2/26. Metoprolol succinate ER Sprinkle 25 mg, 3 tablets were administered at 8:00 a.m. from 2/1/26 to 2/4/26 and 4:00 p.m. from 2/1/26 to 2/3/26. Metoprolol tartrate was administered at 8:00 a.m. from 2/5/25 to 2/20/26. R1's provider progress note dated 2/10/26 at 2:09 p.m., indicated R1 received double the prescribed dose of metoprolol, with repeated symptoms of dizziness. During an interview on 1/26/26 at 8:36 a.m., R1 stated she didn't question her medications when they were administered but felt like she was getting (continued on next page)

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	245187	A. Building B. Wing	03/03/2026

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 - Minimal harm or potential for actual harm Residents Affected - Few	sicker instead of better. R1 stated her cardiology provider told her she was getting the wrong dose of metoprolol, and the nurse practitioner (NP)-A, told her, she had been getting the wrong dose. R1 stated she was supposed to get metoprolol 50 mg once a day, and the dose was increased to 75 mg daily for a while but was getting 75 mg twice daily instead. R1 could not state what dates the changes occurred. During an interview on 2/27/26 at 10:38 a.m., the NP-A stated she remembered talking to R1 about her dizziness and there were duplicate orders for metoprolol which was an error. The NP-A stated she called R1's cardiologist to clarify the orders because R1 was taking metoprolol succinate 75 mg (a long-acting medication to manage blood pressure and heart rate typically given once daily) twice daily and should not have been. The order was changed to metoprolol tartrate (short-acting) 50 mg once daily because that was in error. The NP-A stated R1 did not appear to have severe adverse effects from the medication errors, had no blood pressure variations from the extra doses and no change in her heart rate, only some dizziness and lightheadedness which she had prior to the errors. During an interview on 2/27/26 at 11:47 a.m., licensed practical nurse (LPN)-B stated she noticed in February two doses of metoprolol were in R1's orders, one for 50 mg daily, and one for 75 mg twice daily, and stated R1 expressed concern about the medication dosing. The LPN-B stated she looked at the provider orders for changes and informed registered nurse (RN)-C of her concern. During an interview on 2/27/26 at 3:55 p.m. RN-C stated R1 was on the correct metoprolol dose from 12/12/25 until 12/30/25, but then a nurse received a telephone order from the cardiologist to decrease the medication from 75 mg twice a day to 50 mg once a day but didn't discontinue the 75 mg twice daily order. The process after for when a telephone order was received was to have another nurse and a nurse manager verify the orders, but that had not occurred. The nurses involved in the error were educated about the error and the process. RN-C acknowledged not seeing two different doses ordered by the cardiologist, both metoprolol succinate 75 mg daily and metoprolol succinate 75 mg daily. During an interview on 2/27/26 at 4:36 p.m., RN-A stated the error was when the medication order was entered into the medical record, with the wrong type of metoprolol; tartrate was ordered instead of succinate. RN-A acknowledged not knowing the difference between the two, but educated about the error on 2/26/26, a month after the error occurred. RN-A further acknowledged after the medication order was entered, he should have completed a progress note about the dose change to alert the other nurses but had not. RN-A stated R1 told him she had gotten both doses and had dizziness, which could have occurred as a result of taking more metoprolol than prescribed. Further RN-A stated the 2nd and 3rd verification checks for the telephone order had not occurred, and should have before the medication was administered to the resident but had not. During an interview on 2/27/26 at 1:35 p.m. pharmacist (PH)-A stated metoprolol succinate is an extended-release medication and is typically prescribed once daily. The PH-A stated R1 should not have gotten both metoprolol tartrate 50 mg daily and metoprolol succinate 75 mg twice daily. once dose should have been discontinued when the other started. Getting both doses could cause blood pressure to be too low and could cause dizziness and falls. During an interview on 3/3/26 at 11:53 a.m. the director of nursing stated the education started for R1's medication error on 2/26/26, to teach the difference between metoprolol succinate and metoprolol tartrate. The wrong dose and type would have unintended effects in the blood pressure, with potential for low blood pressure and falls. It was a transcription error that went unnoticed. R2's admission Minimum Data Set (MDS) dated [DATE] indicated R2 had intact cognition, had diagnoses that included spinal stenosis (narrowing of the spaces within the spine which puts pressure on the nerves and spinal cord) of the cervical (neck) region and required active care at the facility for aftercare for surgery that involved fusion of the spinal bones. R2 received opioid pain medications as needed (PRN), and pain occasionally interfered with activities.R2's hospital discharge orders included:Oxycodone 5 mg every 4 hours as needed for pain. Tylenol 325 mg 2 tablets by mouth every 4 hours as needed for mild pain R2's initial admission nursing assessment dated [DATE] at 1:30 p.m., indicated R2 had occasional mild pain in the previous five days. R2's pain evaluation dated 1/28/26, indicated R2 had pain that occasionally affected sleep, (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	therapy activities, and day-to-day activities, and administer Oxycodone 5 mg 1 tablet every 4 hours as needed (PRN) for pain. R2's baseline care plan dated 1/28/26 indicated intact cognition, pain/comfort issues, with a goal for adequate pain relief, and interventions that included non-medicinal forms of pain relief such as position, rest, and massage, and included pain medications as ordered by the physician. R2's provider orders dated indicated the following:1/28/26 at 11:30 a.m., acetaminophen 325 milligrams (mg), 2 tablets by mouth every 4 hours as needed for mild pain1/28/26 at 11:30 a.m., oxycodone HCl (narcotic pain medication administered for moderate to severe pain), 5 mg, 1 tablet by mouth every 4 hours as needed for pain R2's January 2026 MAR indicated the following:acetaminophen was not administered in January, although the progress notes on 1/29/26 at 9:47 p.m. indicated it was administered. Oxycodone was administered for the first time on 1/29/26 at 8:59 p.m. for pain rated as 7/10 and twice on 1/30/26 and 1/31/26 for pain rated between 7-10/10. [The January 2026 MAR indicated R2's pain was rated as 0/10 on 1/30/26 at 9:10 a.m., but during an interview on 2/27/26 at 4:36 p.m., registered nurse (RN)-A stated the pain rating was entered incorrectly and should have been entered as 10/10.]The MAR lacked indication oxycodone was administered again on 1/29/26 at 9:47 p.m., but the progress notes at that time indicated it was administered with acetaminophen and Flexeril (muscle relaxer). R2's progress note dated 1/29/26 at 7:53 p.m., indicated R2's family member requested pain medications for R2, for pain R2 rated as 7/10. The progress note indicated the nurse had to call a provider to request an order for oxycodone 5 mg. The progress notes lack indication the medication was available or administered prior to that date and time. Further the progress notes indicated oxycodone 5 mg was administered on 1/29/26 at 8:59 p.m., and again on 1/29/26 at 9:47 p.m., with acetaminophen and Flexeril for pain management, which was too early according to the every 4 hours as needed time frame in the order. During an interview on 2/26/26 at 11:29 a.m., with R2 and family member (FM)-A, R2 stated when he arrived at the facility his pain was constant, and would get harder at times, rated as an 8/10 or 9/10. It would get pretty damn hard. The FM-A stated R2 did not get pain medications until 1/30/26 but should have on 1/29/26. During an interview on 2/26/26 at 11:29 a.m., FM-A stated R2 came to the facility after surgery for fused spinal discs in his neck, and when R2 arrived the facility did not have R2's pain medication, oxycodone 5 mg, that was ordered. FM-A stated during a visit with R2 on 1/29/26 around 6:00 p.m., R2 was in pain. The FM-A stated, He shouldn't have had to wait for them [pain medications - oxycodone]. He was hurting so much. Further, FM-A stated R2 reported to her he had a terrible ride to the facility, and the facility did not have pain medication to help with the pain when he arrived. During an interview on 2/26/26 at 1:31 p.m., licensed practical nurse (LPN)-A stated when a resident was newly admitted , the process was the admitting nurse completed a form for the pharmacy to request medications, faxed the form with any required prescriptions to the pharmacy, and then the nurse called the pharmacy to ensure the pharmacy received the fax. The LPN-A stated the pharmacy delivers medications to the facility twice a day. Additionally, the LPN-A stated residents should not have to wait for pain medications because nurses can get narcotic pain medication from the facility medication bank with an access code provided by a pharmacist and a witness and did not know why R2 waited so long to get pain medication but it was an error to not have them. During an interview on 2/27/26 at 10:38 a.m., the NP-A stated if R2 had pain rated as 7/10 or higher, he would have had pain medications and would not be comfortable. NP-A stated the nurse could have called the pain team for a one-time dose and waiting over 24 hours for pain relief was too long, and NP-A thought the medication was available in the facility medication bank. During an interview on 3/3/26 at 11:53 a.m., the DON stated the process for obtaining pain medications upon admission was to get the hospital orders, review the orders, and if the orders didn't include required pain medication orders, to get an order from the hospital or the facility provider. The DON acknowledged a disruption in the process for obtaining pain medications upon admission for R2, and there were gaps in the process the nurses had not followed. It sounded like [R2] had pretty severe pain. A Medication Error Policy was requested and not provided.