STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245186	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at Brookview	7505 Country Club Drive Golden Valley, MN 55427

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. (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
	245186	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at Brookview	7505 Country Club Drive Golden Valley, MN 55427

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 0554 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 ensure residents were comprehensively assessed for self-administration of medications for 1 of 1 resident (R27) reviewed for self-administration of medication. Findings include:R27's diagnosis report printed 7/2/25, include Type 2 diabetes mellitus, dermatitis (characterized by inflammation and irritation of skin), other prurigo (skin disorder characterized by intensely itchy spots on the skin) and bipolar disorder.R27's annual Minimum Data Set (MDS) dated [DATE], indicated R27's cognition was intact. R27's behaviors did not include rejection of care and there was not a noted change in R27's behaviors since last MDS dated . R27 required staff assistance with ADLs.R27's care plan, last reviewed 6/29/25, included direction to administer medications per orders. R27's care plan lacked direction for R27 to self-administer medication or indication of R27 being assessed for self-administration of medication.R27's provider progress note dated 6/16/25, did not include an order for lidocaine 4% (four percent) gel or an order for self-administration of medication.R27's electronic health record (EHR) failed to include an assessment for self-administration of medication.During observation and interview on 6/29/25 at 7:23 p.m., container of Tylenol lidocaine 4% noted in a basket on R27's bedside table. Container was not under other items. R27 stated she used the medication for shoulder pain, she applied this medication on her own.During observation on 6/30/25 at 8:48 a.m., registered nurse (RN)-D brought medications to R27, in her room. RN-D set the medication cup on R27's bedside table, next to the basket with the Tylenol lidocaine 4% visible in the basket. RN-D assisted R27 to take medications and with fluids for the medications. RN-D left R27's room without asking R27 about the Tylenol lidocaine 4% and left it in the basket.During observation on 7/1/25 at 7:53 a.m., container of Tylenol lidocaine 4% remained in a basket on R27's bedside table. Container was on top of other items in the basket, with no items on top of it.During interview, record review and observation on 7/1/25 at 1:10 p.m., RN-C stated a resident would need to be assessed prior to self-administering medications, an order would be in the resident's record and the medication would be listed on the resident's medication administration record (MAR) with specific instructions regarding the self-administration of the medication. RN-C reviewed R27's orders and MAR then verified there was no order for Tylenol lidocaine 4% or for self-administration of medication in R27's MAR. RN-C then verified location of Tylenol lidocaine 4% set on top of items in the basket on R27's bedside table. RN-C left R27's room and left the Tylenol lidocaine in R27's room.During interview on 7/1/25 at 1:26 p.m., nurse manager (NM)-A stated the nurse managers are responsible for completing self-administration of medication assessments. Any resident who desired to self-administer medications is expected to be assessed first to ensure appropriate use of the medication. An order would be obtained from the resident's provider and placed in the resident's EHR and visible in the resident's MAR. NM-A stated R27's family had a history of sneaking medication to R27. NM-A expected the medication was removed from R27's room upon discovering it. NM-A was not aware R27 had Tylenol lidocaine 4% in her room, no one told me about it.During interview on 7/2/25 at 10:07 a.m. regional nurse consultant (RNC) stated the facility has a policy, but we can't control what family brings into the room. RNC expected if staff noticed a medication in a resident's room, that staff did something about it. If the medication as seen by a staff member, RNC expected the medication was removed from the room and the nurse manager was made aware. RNC stated it was important for the facility and the resident's provider to be aware of all medications a resident is taking as there could be adverse effects.A facility policy for self-administration of medication was requested but was not provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245186	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at Brookview	7505 Country Club Drive Golden Valley, MN 55427

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
	245186	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at Brookview	7505 Country Club Drive Golden Valley, MN 55427

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 observation, interview and record review the facility failed to ensure nursing rehabilitation services were provided for 1 of 1 residents (R7) who was care planned for passive range of motion (ROM).Findings include:R7's quarterly Minimum Data Set (MDS) dated [DATE], indicated R7 diagnoses of end stage renal disease, altered mental status, muscle weakness, right below the knee amputation and Parkinsonism. R7's MDS further indicated resident was moderately cognitively impaired, and required assist of 1-2 staff for all activities of daily living (ADLs). R7's care plan (print date [DATE]), indicated R7 had Alteration in mobility related to [end stage renal disease]. R7's care plan further documented the provision of NURSING REHAB: Passive ROM to upper and lower extremities - 10 [repetitions] to each joint or as tolerated.During multiple observations, from [DATE] - [DATE] (when not attending dialysis), was observed laying in his bed (sleeping or watching TV). Meals were brought to R7's room, where after set up by staff, fed self. In review of R7's Point of Care section (nursing assistant documentation tool of cares provided) of Point Click Care (PCC - electronic medical record) the ROM section was review and the following was documented:[DATE] -Provided two daysResident Not Available six daysThe reminder were documented as Not Applicable. [DATE] -Provided five daysResident Refused one dayResident Not Available five daysThe reminder were documented as Not Applicable. [DATE] -Provided 6 daysThe reminder were documented as Not Applicable. [DATE] -Documented as Not Applicable.During interview on [DATE] at 9:42 a.m., director of therapy services / physical therapy assistant (PTA) stated physical therapy (PT) only evaluated R7 after his admission in November of 2024. However occupational therapy (OT) did work with resident until R7 plateaued and was taken off of the case load. A functional Maintenance Plan (FMP) was provided to the nursing department for continued passive range of motion for R7. An interview on [DATE] at 8:54 a.m., licensed practical nurse (LPN)-A stated she was unaware of any resident on the 2nd floor who received nursing rehab, only the therapy department work with resident on this floor. An interview on [DATE] at 9:00 a.m., nursing assistant (NA)-A, stated the only resident on the south wing of the 2nd floor, who received nursing rehab ROM was R48. During interview on [DATE] at 9:08 a.m., 2nd floor care manager (RN)-A stated R7 was to receive daily range of motion (ROM), and was to be documented in Point of Care. RN-A stated it appeared the facility staff need to be educated either to the ROM program, or how to correctly document the activity. RN-A confirmed R7's ROM program is not being run as written. An interview on [DATE] at 10:25 a.m., interim director or nursing / corporate nurse consultant (Interim DON) stated he knew there were residents in the facility receiving nursing rehab, but due to being and interim, referred questions to the assistant director or nursing (ADON). During interview on [DATE] at 10:26 a.m., ADON and Interim DON reviewed R7's ROM documentation. ADON stated last January they facility went through all resident in the facility to see who would benefit from nursing rehab, beside residents with recommendation from the therapy department. When R7's Point of Care was updated for passive ROM, it appeared Point Click Care (PCC) program auto populated R7's ROM program to be implemented every shift. However, that did not explain staff documentation of Not Applicable. ADON verified current documentation buy facility staff indicated R7's passive ROM program was not being run.An interview on [DATE] at 10:30 a.m., PTA provided a screening of R7's current ROM, performed this morning, which indicated there has been no lost of ROM since R7 was last seen by the therapy department. A facility policy for Nursing Rehab services was request, with the following policy received (last updated [DATE]):Activities of Daily Living (ADLs)/Maintain Abilities PolicyINTENT: 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.PROCEDURE:1. 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.2. The facility will ensure a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living.3. The facility will provide care and services for the following activities of daily living: a. Hygiene-bathing, dressing, grooming, and oral care. b. Mobility-transfer and ambulation, including

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245186	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at Brookview	7505 Country Club Drive Golden Valley, MN 55427

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245186	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at Brookview	7505 Country Club Drive Golden Valley, MN 55427

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 0677 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 nail care was completed for 1 of 2 residents (R27) who were reviewed for being dependent on staff for activities of daily living (ADLs).Findings include:R27's diagnosis report printed 7/2/25, include Type 2 diabetes mellitus, dermatitis (characterized by inflammation and irritation of skin), other prurigo (skin disorder characterized by intensely itchy spots on the skin) and bipolar disorder.R27's annual Minimum Data Set (MDS) dated [DATE], indicated R27's cognition was intact. R27's behaviors did not include rejection of care and there was not a noted change in R27's behaviors since last MDS dated . R27 required staff assistance with ADLs.R27's care plan included diagnosis methicillin-resistant staphylococcus aureus (MRSA) (bacteria that is resistive to many antibiotics, making infections difficult to treat) to R27's skin. Staff were instructed to educate R27 regarding the importance of hand washing, to remind R27 to wash hands immediately after activities of daily living (ADLs), care tasks and activities. Also, in R27's care plan, it was noted R27 had open lesions due to scratching. Facility document, MHM Weekly Skin Inspection V-5 for R27 completed 6/2/25, 6/9/25 and 6/16/25, noted R27's fingernails and toenails did not require trimming at time of the inspections.R27's nursing progress notes reviewed 6/4/25-6/30/25. Nursing progress notes lacked information of R27's refusal of nail care or refusal to allow assistance with cleaning underneath nails.During observation on 6/30/25 at 8:58 a.m., R27's fingernails on both hands were one-quarter to one-half inch long with unknown dark, brown substance underneath all nails.During observation on 7/1/25 at 7:53 a.m., R27 was noted to have several long, interrupted, scabbed and open areas on her right leg from above the knee to her mid-thigh. R27's nails on both her hands were one-quarter to one-half inch long with unknown dark, brown substance underneath all nails.During observation on 7/2/25 at 11:28 a.m., R27 was not seen scratching during conversation with surveyor. When R27 returned to watching television, she immediately started scratching both her upper arms. R27's nails on both hands were noted to be one-quarter to one-half inch long with unknown dark, brown substance underneath all nails.During interview on 7/1/25 at 12:51 p.m. nursing assistant (NA)-B stated nail care, including cutting nails, for residents with diabetes was completed by licensed staff (nurses). The instruction for nail care was found on the care sheets. Nurses should be aware of the information on the care sheets. NA-B would let the nurse know if a resident's nails needed to be cut. If a resident needed dirt or other substance cleaned out from under their nails, the nursing assistants were responsible for this. NA-B stated, if a resident refused to have their nails cleaned, he would let the nurse know. NA-B was not able to recall the last time he attempted to clean under R27's fingernails.During observation and interview on 7/1/25 at 1:10 p.m., registered nurse (RN)-B stated nurses complete nail care for diabetics weekly on the resident's bath day. Nursing assistants were responsible for cleaning under fingernails between bath day. If a resident refused, the nursing assistants alert the nurse it would be charted in the progress notes. RN-B was not aware of R27 refusing to have her fingernails cut or to have them cleaned. RN-B observed R27's fingernails and verified they needed to be cut and the presence of dark, brown substance under each fingernail. RN-B stated the length of R27's fingernails and the unknown substance underneath R27's fingernails were a concern because R27 had a history of scratching and skin infections.During interview on 7/1/25 at 1:26 p.m., nurse manager (NM)-A state R27 had a diagnosis of dermatitis and was, constantly scratching. R27 had a history of refusing to allow her fingernails to be cut and to have them cleaned. NM-A expected staff to continue to offer and refusals were documented in the progress notes. NM-A verified the lack of documentation in the progress notes regarding R27's refusals, referring to a progress note written on 6/4/25 by NM-A, R27 allowed NM-A to cut her toenails, but refused to allow her fingernails to be cut. NM-A stated that was the last time NM-A attempted to cut and clean R27's fingernails and toenails. NM-A had not looked at R27's fingernails or toenails since that date.During interview on 7/2/25 at 8:41 a.m., NM-A reported she observed R27's fingernails on 7/1/25 after interview with surveyor. NM-A confirmed, R27's fingernails needed to be cleaned. NM-A expected nursing assistants and/or nurses to attempt this. NM-A stated it was important to keep R27's fingernails cut and clean due to R27's scratching her skin and R27's history of skin infections. During interview on 7/2/25 at 10:07 a.m., regional nurse consultant (RNC)-A stated he expected nail care, including cutting and cleaning underneath, was offered when needed. It was important to maintain cut and clean nails to prevent possible infection. RNC-A expected refusals were documented in the progress notes.A facility policy for nail care was requested but was not received.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245186	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at Brookview	7505 Country Club Drive Golden Valley, MN 55427

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure skin abrasions were adequately assessed and monitored for 1 of 1 resident (R27) reviewed for non-pressure related skin concerns.Findings include:R27's diagnosis report printed 7/2/25, include Type 2 diabetes mellitus, dermatitis (characterized by inflammation and irritation of skin), other prurigo (skin disorder characterized by intensely itchy spots on the skin) and bipolar disorder.R27's annual minimum data set (MDS) dated [DATE] indicated no current skin concerns. R27 had intact cognition. R27 had no behavior concerns and there was no change in behavior since last MDS.R27's care plan included diagnosis methicillin-resistant staphylococcus aureus (MRSA) (bacteria that is resistive to many antibiotics, making infections difficult to treat) to R27's skin. Staff were instructed to educate R27 regarding the importance of hand washing, to remind R27 to wash hands immediately after activities of daily living (ADLs), care tasks and activities and to monitor skin integrity. Also, in R27's care plan, it was noted R27 had open lesions on R27's clavicle (collar bone) and right forearm due to scratching.Facility document, MHM Weekly Skin Inspection V-5 indicated the following:- 6/2/25- Resident has multiple scabbed area. NO new skin issues noted.- 6/9/25- Skin intact- 6/16/25- No new skin condition noted- 6/30/25- No new skin condition not ed [educated] todayR27's provider progress note dated 6/16/25 noted, Patient does have pruritic and itching all over the place. She does have abrasions from itching at this time cannot tell but does not appear to be any scabies. Note also indicated no changes to current plan of care.R27's nursing progress notes reviewed 6/4/25-6/30/25. Nursing progress notes lacked information of R27's open lesions to right lower extremity (RLE) knee to thigh.During observation on 6/30/25 at 8:59 a.m., R27 was noted to have several open and scabbed over lesions on RLE knee to thigh.During interview on 7/1/25 at 7:53 a.m. R27 stated, It itched so I scratched it, motioning with her hand to the lesions on RLE. It's been that way for a while, at least a week.During interview and observation on 7/1/25 at 12:51 p.m., nursing assistant (NA)-B stated any new or existing skin concerns were reported to the nurse. NA-B observed R27's RLE then reported the open lesions were new, not noted earlier today. The scabbed lesions had been there during cares a few days prior. NA-B stated he reported the skin lesions to the nurse.During interview and observation on 7/1/25 at 1:10 p.m., registered nurse (RN)-B verified the open and scabbed lesions on R27's RLE, knee to thigh. RN-B stated she was not aware of the lesions on R27's RLE prior to today, but RN-B had not worked with R27 for the past few days. RN-B stated expecting nursing assistants to make the nurses aware of all open and scabbed areas, regardless of how new or old the areas appeared.During interview on 7/1/25 at 1:26 p.m., nurse manager (NM)-A stated she was aware R27 had lesions on her clavicle and right forearm. NM-A was not aware R27 had new and scabbed lesions on her RLE. NM-A reviewed progress notes and skin inspection completed 6/20/25 and confirmed no documentation was noted regarding the new and scabbed skin lesions.During interview on 7/2/25 at 8:41 a.m., NM-A stated she observed R27's skin on 7/1/25 after interview with surveyor. NM-A reported updating R27's provider after her observation. NM-A expected nurses to monitor skin daily and with weekly skin check. NM-a stated the scabbed lesions were more than a couple days old and R27's provider should have been updated sooner than 7/1/25. R27 had a history of skin infections, including MRSA. Not updating the provider timely of the skin lesions could lead to more skin infections.During interview on 7/2/25 at 10:07 a.m. regional nurse consultant (RNC) stated he expected skin checks were completed weekly and as needed. New areas of concern were reported to the nurse manager and the resident's provider at the time they were found.A facility policy on non-pressure related skin concerns was requested but was not received.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245186	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at Brookview	7505 Country Club Drive Golden Valley, MN 55427

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure recommended dental services were provided for 1 of 2 residents (R13) reviewed for dental services.Findings include:R13's quarterly minimum data set (MDS) dated [DATE], indicated R13 was cognitively intact, and was independent with activities of daily living. R13 had diagnosis of protein-calorie malnutrition.R13's dental care assessment area (CAA) dated 2/18/25, indicated R13 was edentulous (having no teeth) which can put resident at risk for nutritional deficits. When interviewed on 6/29/25, at 2:27 p.m. R13 stated he had no teeth, had waited a long time for them but had not received them and was not aware of what was happened with getting his dentures. A dental visit note dated 10/24/24, indicated R13 had previously declined to start denture fabrication process because he believed he would be discharged within a few weeks. Dental group spoke with social worker who reported he was on the list for a new placement, believed he would be discharged by end of year. If something changed and patient would be here long-term, could start denture fabrication. the note identified action required by nursing home staff: Patient is expected to discharge by the end of the year, per discussion with social worker. Not indicated to start dentures if there was not enough time to complete the procedure. If circumstances changed and patient will definitively be here for at least 6-7 months, let us know, and we would start denture making process.When interviewed on 7/01/25, at 3:36 p.m. social services (SS)-A stated she did not have direct contact with dental service, did not update dental service that resident had not discharged by the end of the year.When interviewed on 7/02/25, at 8:16 a.m. medical record director (MRD) stated R13 was on the list to have a annual dental exam on 7/8/25 but was not sure if the dentures would be addressed. MRD was unable to locate any documentation that dental group was updated that R13 had not discharged by the end of the year. When interviewed on 7/02/25, at 8:30 a.m. licensed practical nurse (LPN)-A stated R13 had mentioned multiple times he was waiting for dentures, he did not like having no teeth. When interviewed on 7/02/25, at 11:09 a.m. administrator stated social services covered dental service during admission and at care conferences, and medical records was responsible to schedule appointments.A facility policy and/or procedure on dental services was requested, however, none was provided.