| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245186 | A. Building<br>B. Wing | 04/16/2026 |

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

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to consistently track and monitor dishwasher temperatures for both the wash and rinse cycles, and take timely action to correct the temperatures, for 1 of 1 dishwasher observed. This had the potential to affect all current residents, as well as staff or visitors, who ate food served from dishes and tableware that were cleaned in the dishwasher.Additionally, the facility failed to ensure food items were properly labeled, dated, and stored in the walk-in freezer. The facility also failed to assure that proper hair and beard restraints were used by staff members preparing food within the kitchen. These factors had the potential to impact all residents, staff, and visitors who received food from the kitchen.Findings include: During the initial tour on 4/13/26 at 10:30 a.m., a walkthrough of the dishwashing area was completed. April dishwashing log indicated all temperatures logged with the wash temps of 150 and rinse temps of 180. There were no variations in the temperature range identified. The log for a three-compartment sink identified temperatures were logged at 150 degrees Fahrenheit (F) and the chemical strip results documented were within the desired range. Culinary service director (CSD) stated the equipment was rented. The label identified the company on the front of the machine. On 4/15/26 at 1:22 p.m. dietary aide (DA)-A completed the process of washing dishes. The wash temperature gauge was observed to be 140 degrees (F). The rinse temperature was read at 108 degrees (F). DA-A stated monitoring the temperature was important so the dishes get clean. DA-A stated the temperature was supposed to be 180 degrees F. There were stickers on the front of each gauge which identified Rinse water 120 degrees minimum and Wash water 140 minimum. A sign on the dishwasher indicated a low temp dish machine and directions wash temperature above 120 degrees F. The sign also identified that the low-temp machine depended on chemicals to sanitize the dishes and directed staff to measure with the use of chlorine test paper. The document identified the desired range between 50-100 PPM.DISHWASHING LOG: LOW TEMPERATURE, dated April 2026, included columns labeled wash and PPM for each meal. However, it lacked a spot for rinse temperatures. 4/15/26 noted 130 degrees F for breakfast. However, lacked indication of tracking the noon meal. Further, the April log indicated wash temperatures within the range of 119-130 degrees F and PPM reflected readings between 99-101, with an outlier of 120 on 4/15/26 at breakfast.On 4/15/26 at 2:05 p.m., DA-B stated when the machine was turned on, it would be hot. DA-B stated she was unsure what the required temperature was.On 4/15/26, at 2:07 p.m., DA-A stated the required temperature for the wash cycle was 160 degrees F and 180 degrees F for the rinse cycle. DA-A stated staff were to allow the machine to warm up and check the temperature before anything was run through.January, February and March logs provided were titled DISHWASHING RECORD: HIGH TEMPERATURE. Every entry indicated 150 degrees F under wash column and 180 degrees F under was columns, with no variation. CSD denied any concerns and stated that must be what they were as we watch the temperature closely.On 4/15/26 at 2:22 p.m., review of the test strip bottle indicated numerical options available related to the color of the strips were 10/25/50/100/200 PPM. A review of the test strips was completed with the administrator, with the options clearly displayed. Upon review of the dishwasher log for April, the<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | administrator acknowledged there were multiple entries for 99 and 101. The administrator stated 99 or 101 were not an option to be used. The administrator verified they had not received a new dishwasher between March and April of the present year.On 4/15/26 at 2:36 p.m., a review of test strips was completed with the assistant administrator and CSD. CSD stated the selection of 99 and 101 were the numbers used if it was just a shade of color less than, or greater than, the color designated for the 100. The assistant administrator stated she would have recorded at 100 PPM. The assistant administrator directed attention that the range of the dishwasher temperatures met the specified range outlined on the document on the front of the machine of 120 degrees F as well as the chemical indicator within the desired range of 50-100. However, the labeled temperature gauges indicated Rinse water 120 degrees minimum and Wash water 140 minimum. The assistant administrator stated she was unsure why the gauges were labeled at 140 and 120 but would inquire of this from the service technician. On 4/15/26 at 4:17 p.m., the assistant administrator, CSD, and Regional Consultant-Dietary (RC-D) provided a policy, titled Dishwashing Machine Use, dated 3/10. This was a facility policy, not the manufacturers manual. The policy identified the temperatures required for dishwashers which used hot water for sanitizing and information regarding dishwashing machine chemical sanitizer concentrations and contact time. This graph included the desired range of 50-100 ppm. This policy contained perimeters based on multiple factors which included stationary rack, dual temperature machines or multi-tank, conveyor, multi temperature machines, single tank, conveyor dual temp machines, and for stationary rack, single temperature machines, however, did not specify the specific model of machine currently used. The one-page document on the front of the dishwasher was reviewed with all members, and it was noted although the document identified the temperatures for both the wash and rinse cycles were to be 120 degrees F per this document, the labels on the gauges identified Rinse water 120 degrees minimum and Wash water 140 minimum. RC-D stated she was unaware why gauges on the dishwasher would be labeled this way. On 4/16/26 at 12:42 p.m., the assistant administrator and service technician reviewed the dishwasher. The service technician's manual identified the temperature gauge labels were to be applied on the appropriate gauge to identify: Rinse water 120 degrees minimum and Wash water 140 minimum. Additionally, the product manual identified that the required low temp dishwasher was to have a wash temperature of 140 degrees and a rinse temperature of 120 degrees. The assistant administrator acknowledged the temperature log of April 2026 lacked appropriate wash temperatures of greater than 140 degrees F. Additionally, the log lacked indication of the temperature of the rinse cycle. A review was completed of the current log, to include the lunch reading of 4/15/26 through the current time. It was noted the remaining temps of 4/15/26 failed to meet the required temp of 140 degrees. The morning temperature of 4/16/26 did meet the requirement at 160 degrees.On 4/16/26 at 12:35 p.m., a call was placed to the number provided by the facility for the dishwasher service representative. A message was left with a request for a return phone call, with no call returned. On 4/16/26 at 1:16 p.m., returned to check temperature with CSD. At that time, wash temp was noted to be 140 degrees F., however, the rinse temp was under the 100-degree F. CSD instructed staff to run trays run through, upon running trays through empty for three cycles, the wash temperature was noted to be at 138 degrees F., with the rinse temp at 120 degrees F.On 4/16/26 at 2:58 p.m, DA-A stated sometimes there was a surge from the transformer and that caused the fluctuations of temperatures. Previously DA-A stated the temperatures were to be at 150 and 180 degrees for wash/rinse. Identified with DA-A discrepancy between dishwashing logs. DA-A stated Ok. Now we check it properly. The EcoLab EC-LW Series Conveyors manual, copyrighted 2020, identified the requirements for a low temperature dishwasher were as follows; a wash temperature of 140 degrees F., and a rinse cycle of 120 degrees F. On 4/13/26 at 10:21 a.m., CSD, and assistant Administrator completed a walkthrough in the freezer. A half full 20 pound bag of ice was stored on the floor. This was placed on an empty milk crate so it was off the floor. CSD stated they usually did not use bagged ice and was unsure where this cam from. CSD stated ice, or any items, were not to be stored on the floor of the freezer. The freezer<br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | contents were reviewed, and the following was identified in a stainless steel bin near the entry: *A plastic bag, unsealed and twisted shut, with eight pancakes;*A gallon size bag of breadsticks, undated/labeled;*A package of approximately 8 chicken patties, undated/labeled;*A one gallon bag of sugar cookies, with the notation of either yo or 40, which CSD was unable to decipher, undated/labeled;*Two bags, tied off but not zipper sealed, of approximately one gallon of chocolate chip cookies, located in different areas of the freezer, undated/labeled;*A 5lb bag of fruit, 1/2 full, noted to be unzipped and open to air with the fruit noted to be freezer burnt, undated/labeled; and*A bag with approximately 15 patties, per CSD's estimation, in a bag which was tied shut, but not zip sealed.In addition to the bin by the door, a full, sealed bag of freezer burnt berries, with date [DATE] was also noted within the freezer contents. CSD stated she was unaware if that was 2024, however, acknowledged the berries were freezer burnt. CSD stated the dietary staff were to go through the refrigerators and freezers every Tuesday and Friday when food was delivered. CSD stated the freezer should have been checked the previous Friday, however, commented it was not completed thoroughly enough. CSD stated it was important that items were dated so you knew when it was placed in the freezer, how long it was in the freezer, and when it should be used/disposed by. CSD stated using food outside of this range could make people potentially sick. On 4/15/26 at 2:36 p.m., reviewed status of undated/unlabeled food items found in the freezer during the initial kitchen tour. The administrative assistant acknowledged food was to be labeled and dated when stored, and assured food items found unlabeled/undated were disposed of. The facility policy, titled Refrigerators and Freezers, revised 12/14, indicated all food was to be appropriately dated to ensure proper rotation by expiration dates. The policy identified that Use by dates were to be completed with expiration dates on prepared food in the refrigerators, however, lacked this direction for prepared food in freezers. The policy went on to identify the supervisors were responsible to ensure food items in the freezers were not expired or beyond perish dates. The facility policy, Food Receiving and Storage, last reviewed 10/17, identified the for the food items kept in the nursing units all residents' foods must contain the name, the item, and the use by date, however, the policy direction lacked direction as to food stored in the primary freezer in the kitchen.Initial tour on 4/13/26 at 10:21 a.m., was completed culinary service director (CSD) and two dietary assistants (DA)'s A and B. DA-A and DA-B were wearing hair bonnets. However, did not constrain their hair properly.On 4/15/26 at 1:45 p.m., CSD stated all dietary staff should be wearing both hairnets/bonnets and beard masks to prevent food from going into the food being served to others. A review of the facility policy, titled Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices, dated 10/17, identified the food and nutrition services employees will follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness. The policy identified hair nets or caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils and linens. |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on documentation and interview, the facility failed to ensure residents were informed of and consented to medications prescribed and given for mental health intervention for 1 of 5 residents (R53) review for unnecessary medication review. Findings include: R53's Face Page indicated the following diagnoses: schizoaffective disorder - unspecified, bipolar disorder - current episode mixed - uncomplicated, anxiety disorder - unspecified and insomnia - unspecified. R53's admission Minimum Data Set (MDS) dated [DATE] indicated R53 was cognitively intact, moderate depression, received partial - minimal assistance with activities of daily living, and substantial - maximal assistance with lower extremity dressing and care. A review of R53's Care Area Assessment (CAA) for Psychotropic Drug Use dated 3/24/26, indicate R53 had taken in the last seven days, medications with the following classifications: antipsychotic, anti-depressant and antianxiety. A review of R53's Hospital Discharge summary dated [DATE], indicated the following medications to be continued at the facility: 1, Clonazepam 0.5 milligrams (mg) 1 tablet by mouth daily at bedtime - benzodiazepine used to treat panic disorder and certain seizure disorders 2. divalproex ER - antiseizure medication - 500 mg capsules, take three capsules by mouth at bedtime3. divalproex ER - antiseizure medication - 250 mg take one capsule by mouth at bedtime4. olanzapine - anti-psychotic - 20 mg, take one tablet orally at bedtime5. trazadone - antidepressant - 150 mg, take one tablet orally at bedtime In review of R53's Physician orders section in Point-Click Care (facility electronic medical record) printed 4/16/26, indicated the physician's diagnoses for the five medications being ordered: clonazePAM Oral Tablet 0.5 MG (Clonazepam) Give 0.5 mg by mouth at bedtime for Anxiety Divalproex Sodium ER Oral Tablet Extended Release 24 Hour (Divalproex Sodium) Give 1750 mg by mouth at bedtime related to SCHIZOAFFECTIVE DISORDER, UNSPECIFIED OLANZapine Oral Tablet (Olanzapine) Give 20 mg by mouth at bedtime related to SCHIZOAFFECTIVE DISORDER, UNSPECIFIED traZODone HCl Oral Tablet (Trazodone HCl) Give 150 mg by mouth at bedtime for chronic insomnia In a review of R53's Informed Consent For Required Medications dated 3/24/26, signed off by care manager (CM)-A and R53, listed only clonazepam and trazadone as medications the facility educated resident on for consent. The diagnoses listed for these two medications were for anxiety and insomnia. Check marks were in place for education and consent for anti-anxiety, antidepressant and antiepileptics (seizure medications). R53's form failed to document:the Divalproex Sodium ER after checking the antiepileptic box, check off the antipsychotic box andlist R53 received Olanzapine (an antipsychotic medication). The assessment / consent form instructed the user to review and list the following medication classifications educated on and consented to: anti-anxiety, antidepressant, Anti-psychotics, sedative/hypnotics, antihistamines, antiepileptics, melatonin/other and simulants. During interview on 4/16/26 at 8:29 a.m., care manager (CM)-A reviewed R53's consent form and current physician orders. CM-A stated she should have listed R53's Depakote ER and Olanzapine as being medications R53 was educated and consented to. CM-A stated she forgot to mark the box that R53 received an anti-psychotic, Olanzapine. CM-A stated the form should include all medications and the categories listed on the form.In an interview on 4/16/266 at 9:53 a.m., the director of nursing (DON) reviewed R53's consent form and physician orders. DON stated the form lacked documentation R53 received Olanzapine and Depakote ER. DON stated was her expectation staff reviewed physician orders, made sure medications matched the classifications the form indicated, be listed on the form, educated the resident, and document consent received. A review of the facility's policy entitled: Psychotropic Medication Use Policy (last dated 5/2025) documented the following:6. Consent: Provide the resident/resident representative with information on the medication, indication, dose, side effects, adverse consequences and goal of treatment.a. Obtain informed consent from the resident and/or resident representative and document education, information regarding the medication indication and directions for use, side effects and potential adverse consequences, risks and benefits of the<br>(continued on next page) |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | medication and resident choice.b. The residents and/or responsible party will be notified regarding changes.c. Psychotropic medications will be reviewed quarterly at resident care conferences. |

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| F 0636<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, document review, and interview, the facility failed to comprehensively assess residents scoring high on a PHQ-9 (an assessment to determine someone's depression) for 1 of 1 resident (R53) in the samplewho displayed signs and symptoms of moderate depression. Findings include: R53's Face Page indicated the following diagnoses: schizoaffective disorder - unspecified, bipolar disorder - current episode mixed - uncomplicated, anxiety disorder - unspecified and insomnia - unspecified. R53's admission Minimum Data Set (MDS) dated [DATE], indicated cognitively intact, moderate depression, received partial - minimal assistance with activities of daily living, and substantial - maximal assistance with lower extremity dressing and care. A review of R53's Care Area Assessment (CAA) for Psychosocial Well-Being dated 3/27/26, indicated Yes to the statement: Little interest or pleasure in doing things, and indicated the facility would be adding this to R53's care plan, with the overall objective being: improvement, slow and minimize decline, maintain current level of functioning and minimize risks. The form further indicated: Is a referral to another discipline warranted? No. A review of R53's CAA for Mood State dated3/27/26, indicated response of Yes to the statement Thoughts that you would be better off dead, or hurting yourself in some way. No further information was documented on this CAA. During multiple observations during survey 4/13/26 through 4/16/26, R53 was not observed out of his room. Their room door was either opened only a crack or closed. R53 usually sat in his wheelchair, watched TV with the volume down low. In review of R53's Patient Health Questionnaire (PHQ-9, used to determine the level of someone's mood / depression) dated 3/18/26, scored 17, indicated R53 was experiencing Moderately Severe depression. The score was assessed from the following responses: Little interest or pleasure in doing things - 12-14 days YesFeeling down, depressed, or hopeless - 12-14 days YesTrouble falling asleep - YesPoor appetite or overeating - 2-6 days YesFeeling bad about yourself - YesMoving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual - 12-14 days YesThoughts that you would be better off dead, or of hurting yourself in some way - 12-14 days YesSocial Isolation - marked as always A review of R53's comprehensive care plan printed 4/16/26, indicated the following: Alteration in mood and behavior [related to] loss of independence. Resident has a [history] of suicidal thoughts. States talking with staff helps him. Agreed to see [ Associated Clinic of Psychology]. R53's electronic medical record lacked evidence the facility comprehensively assessed resident's history of suicidal thoughts.Interview on 4/16/26 at 9:00 a.m., social worker (LSW)-A reviewed R53's PHQ-9, stated the facility should have conducted a Suicide Prevention Assessment with the PHQ-9 score of 17. R53 was experiencing Moderately Severe depression. In further review of R53's medical record, SW-A stated she was unable to find where resident had been offered ACP (Associated Clinic of Psychology - a mental health counseling service). SW-A stated that they offer it to all residents upon admission and was unable to see where it was documented the services had been offered to R53.On 4/16/26 at 9:53 a.m., the director of nursing (DON) reviewed R53's medical records. Their expectation was to complete a suicide prevention assessment with a score of 17 on the PHQ-9, Facility needed to be able to monitor for concerns related to self-harm. DON stated she was unable to find documentation R53 was offered ACP services. DON stated it was the facility's expectation ACP was offered to ALL residents being admitted to the facility, regardless of mental health status.In review of the facility policy, entitled: Suicide Prevention Policy last revised 11/2023, indicated the following:Policy Interpretation and Implementation1. question 9 on the PHQ-9 or a resident is exhibiting any of the following behaviors, they shall be assessed by an IDT member for suicide risk.Examples include the following observable behaviors:a. Suicidal ideationb. Withdrawal from usual activitiesc. Social isolationd. Detailed plan for suicidee. Signs of depressionf. Farewells to friends and family membersg.<br>(continued on next page) |

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| F 0636<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Giving away personal belongingsh. Obvious suicidal messagesi. Feelings of hopelessness/helplessnessj. Putting affairs in orderk. Sudden increase of energy after severe depressionl. Increased feeling of euphoria2. The Unit Nurse and/or person in charge must be notified immediately if a resident is expressing these behaviors or states wanting to harm themselves or commit suicide. The unit nurse will assess the situation to gather additional information and determine the course of action.3. If the resident states they have a plan, refuses to share if they do have a plan or have made any physical attempts to harm themselves, resident will be placed on 1:1 supervision and the administrator or director of nursing will be notified.4. The Suicide Prevention interview must be completed.5. If determined to be at risk, a room search will be completed to look for potential dangers that would allow the resident to harm themself. See Room Search Policy/ Alternate care items will be provided as indicated (i.e.: call bell)6. Update the Interdisciplinary team including administrator, director of nursing and social services.7. Contact the physician regarding the outcome of the suicide prevention assessment. Request recommendations for further medical evaluation and/or referral to a counselor or psychiatric practitioner. 8. If necessary, obtain physicians order such as medication or hospitalization to keep the resident safe.9. Determine the need for ongoing interventions per physician orders.10. Update care plan with appropriate interventions and notify the staff.11. Notify family members or responsible party regarding the resident's condition. |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to request a screening in follow up for a new diagnosis of mental illness identified after admission for 1 of 1 resident (R12) reviewed for Preadmission Screening and Resident Review (PASRR).Findings include:R12's admission Record printed 4/17/26, identified admission on [DATE], diagnoses included diabetes mellitus (a disease which impacts the way a body uses sugar (glucose)), anemia (a disorder of the blood), hyperlipidemia (elevated level of cholesterol in the blood) , history of transient ischemic attacks (known as little strokes), cerebral infarction (stroke) without residual deficits (paralysis or weakness), and symptoms and signs involving cognitive functioning (thought processes) and awareness. R12 did not have any diagnosis of mental health conditions upon admission to the facility. The admission Record also indicated R12 was diagnosed with unspecified schizophrenia (a mental health disease) on 2/17/22.A review of the Initial Pre-admission Screening (PAS) results, or PASRR) completed on 12/6/21, identified R12's anticipated nursing home admit date was 12/6/21, and R12 was anticipated to have a stay of less than 30 days. The PASRR identified R12 had no major mental disorder.The Psych Treatment Plan and Updates dated 2/4/22, identified diagnostic impressions of adjustment disorder, unspecified (a strong reaction to stress or trauma which can affect thoughts, behaviors, or emotions). A subsequent note of 2/17/22, indicated effective 2/17/22, R12's diagnostic impressions updated on that date identified other specified schizophrenia spectrum and other psychotic disorder. The treatment plan recommended the treatment team reviewed R12's medical treatment for possible pharmacological treatment for delusions with Paranoia. A review of R12's Progress Notes from 2/1/22, identified tentative discharge plan was to move to an Assisted Living facility (ALF). The narrative notes of 2/11/22, identified a conversation was held with ACP and identified R12 appeared delusional and had scattered thought processes. The note identified ACP was to continue to follow and provide recommendations. On 2/22/22, the narrative noted identified discharge plans changed from desire to discharge to ALF to remain in a long-term care setting. A review of the documents through 4/1/22 lacked indication of outreach for a follow up PASRR due to newly diagnosed mental health illness.A review of resident medical record was completed and was found to have lacked documentation regarding a referral for a subsequent screen following new diagnosis on 2/17/22.During interview on 4/15/26 at 10:16 a.m., Licensed Social Worker (LSW)-A stated when a new diagnosis of mental illness was received, a referral was made to have an updated PASRR completed. LSW-A reviewed the medical record and acknowledged an updated Level II (more detailed screen) had not been completed and should have been. LSW-A stated R12 continued to reside in house and continued to be followed by ACP. LSW-A stated the purpose of an updated screen was for recommendations, and a review of their history.On 4/16/26 at 1:52 p.m., the director of nursing (DON) stated the PASRR was initially obtained prior to resident's admit to the facility. DON stated if there were newly diagnosed mental health illnesses after admission, the expectation was social services followed up to obtain necessary screening.A facility policy for referral process for Level II PASRR assessment for mental health illness diagnosed following admission to the facility was requested but not received. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to coordinate services for 1 of 1 resident (R56) evaluated for hospice services. Findings include:R56's admission Record printed 4/17/26, identified admission on [DATE], diagnoses included: pneumonitis (pneumonia-a infection of the lungs which may cause productive cough, fever, chills, and difficulty breathing) due to inhalation of food and vomit, Alzheimer's disease (a progressive neurodegenerative disorder which primarily affected memory, thinking, and behavior), multiple cardiac related diagnoses, chronic kidney disease-stage four (severe, irreversible damage of the kidneys), and oropharyngeal phase dysphagia (a disease which caused problems with swallowing). The admission Record identified R56 was enrolled in hospice.R56's Hospice Certification and Plan of Care identified R56 was enrolled in hospice effective 4/7/26, with the top three diagnoses listed on the plan identified as Alzheimer's disease with late onset, dementia with anxiety, and dysphagia. The plan of care for R56 included skilled nurse visits for symptom management two times a week and additional visits available as needed. R56 was scheduled for home health aide visits three times a week to assist with activities of daily living and personal care needs. Additional services provided by hospice included medical social worker, chaplain, and music therapy.On 4/13/26 at approximately 12:00 p.m., R56 was resting in bed, with head elevated approximately 60-degrees. R56 was being assisted to eat by a female visitor, identified as a visiting agency (VA)-U. Family member (FM)-A was sitting to the bedside. FM-A requested a call was placed to FM-B to obtain information regarding R56, as she was more familiar with cares provided.During phone call on 4/13/26 at 2:02 p.m., FM-B stated family had contracted with a support agency to assure R56 received the necessary care. FM-B stated these services were contracted for 14 hours a day and were in place to provide assist with personal cares.Progress notes dated 4/9/26, identified visiting agency was present, however, the document lacked indication as to what their role was, what their qualifications were, how often they were there and length of visit, if they were contracted services, and if so, by whom.On 4/14/26 at 4:38 p.m., FM-A and FM-C were present with R56 in his room. R56 was observed resting quietly in bed, under covers, with head of bed elevated at approximately 30-degree angle. At this time, a staff member from visiting agency was in the room. FM-C stated he was aware the facility could not have continuous staff in R56's room, however, he was unsure what level of care was expected from facility staff. FM-C stated cares had not occurred from nursing facility staff unless family had requested them. FM-C expressed concerns as to what would happen if R56 was restless and called out and family was not there. FM-A stated often the staff response to R56's calling out was to shut the door. Further, family had experienced long wait times when requesting comfort medications.On 4/15/26 at 8:31 a.m., FM-A arrived and was updated by LPN-A regarding morphine administration to R56 to maintain comfort. After family interaction, LPN-A acknowledged visiting agency was in the room at this time, and family had contracted with this service to sit at bedside to ensure R56 was not alone. LPN-A stated the staff from visiting agency assured R56 was comfortable, provided oral care as needed, and assured that he remained safe in bed. LPN-A stated visiting agency had assisted facility staff with turning and positioning R56. LPN-A stated she was not aware what level of training agency staff had received. LPN-A stated hospice and visiting agency staff provided services above and beyond basic cares provided by facility. They don't take away what we do, they just give them extra care. LPN-A stated this was the first time she was aware of visiting agency presence in the facility. LPN-A stated the visiting agency staff had been present all week.On 4/15/26 at 3:59 p.m., R56 was resting in bed, under covers, on his right side, and the bed slightly elevated to a 30-degree angle. Visiting agency staff (VA-B) was in R56's room. VA-B stated both FM-A and FM-C were in today to spend time. VA-B stated nursing staff have provided her with assist to turn, reposition, and provide incontinent care on three occasions. On 4/16/26 at 12:05 p.m., LSW-A stated R56 was enrolled in hospice and received supportive care from<br>(continued on next page) |

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| | 245186 | A. Building<br>B. Wing | 04/16/2026 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | hospice throughout his stay. LSW-A stated family members were here frequently; however, she was unaware of any other services in place. Upon learning of visiting agency prescence, LSW-A looked online and identified this was a home care agency. LSW-A stated residents should not need home care services in a long-term care setting. LSW-A stated she was unaware family members had contracted privately with an outside agency for provision of care for R56.During interview on 4/16/26 at 12:10 p.m., certified nursing assistant (CNA)-B stated CNA-B stated the visiting agency requested help for management of soiled linen and requested fresh linen and briefs. CNA-B stated VA-B provided hands on care for R56 and facility staff helped VA-B to turn, reposition, and provide incontinent care.On 4/16/26, at 12:14 p.m., registered nurse (RN)-B stated R56 received hospice services, as well as services from a visiting agency. RN-B stated the visiting agency provided assist with PCA (personal care attendants) cares (provision of personal cares, including turning, repositioning, etc.) and sought facility staff assistance to help as needed. RN-B stated the services were private services contracted by the family. RN-B stated visiting agency was a home health care agency, however stated she was unaware of the qualifications of the agency staff members providing care, although acknowledged caregivers who provide personal care must be certified. Upon review of R56's care plan, RN-B identified the care plan lacked indication of this service in place.During interview on 4/16/26 at 1:56 p.m., the director of nursing (DON) stated although she was aware the visiting agency was present in the facility, contracted by the family, she was unaware the agency staff were providing personal cares. DON stated it was her understanding the agency was there for companionship. DON stated the visiting agency staff should not have been feeding the resident or providing personal care and was unaware of the level of training by the visiting agency staff and their qualifications to provide care. DON stated the facility was being paid to provide direct care services for R56. DON stated she had reached out to hospice to inquire of this service, however, had not spoken with family about implementation of services. DON stated the facility had not generally allowed personal attendants/outside contracted agencies to provide care within the facility, and to do so would have required a contract in place which would have included their scope of service.A facility policy was requested for coordination of care, however, was unavailable. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>Based on observation, interview, and document review, the facility failed to ensure residents were free of medication errors of less than 5% for 1 of 3 residents (R66) observed for medication administration resulting in an 8% error rate.Findings include:R66 was observed on 4/15/26 at 8:20 a.m., during a medication pass. Registered nurse (RN)-A set up oral medications for R66 which included gabapentin (prescription medication used to treat nerve pain) 100 milligrams (mg) tablet. RN-A administered R66's medications. Upon review of R66's electronic medication record (EMR) was unable to locate an order for gabapentin for R66. On 4/15/26 at 11:16 a.m., RN-A stated R66 had previously taken gabapentin 200mg but had been decreased to 100mg. RN-A reviewed EMR, stated they was unable to locate an order for gabapentin for R66, RN-A stated had found an order for pregabalin (a nerve pain medication) 100mg by mouth three times daily. R66 did not receive her ordered pregabalin during medication pass at 8:20 a.m. On 4/15/26 at 11:20 a.m., R66's EMR indicated Gabapentin 200 mg three times daily order had been discontinued 2/3/26. Pregabalin 100mg twice daily was ordered 4/2/26, the pregabalin order was then changed to three times daily on 4/7/26. On 4/15/26 at 2:28 p.m., care manager licensed practical nurse (LPN)-B stated R66's gabapentin was discontinued on 2/3/26. LPN-B was not sure why the medication remained in the medication cart. The expectation was for the medication be removed from the medication cart when it was discontinued to decrease risk of medication error. On 4/15/26 at 3:17 p.m., director of nursing (DON) stated best practice was to remove discontinued medications from the medication cart. The expectation was for overnight nurses to audit the medication carts on a rotating weekly basis and remove discontinued medications. DON reviewed R66's medication cards of gabapentin, and acknowledged the medication was filled on 2/1/26. DON stated upon review of R66's medication cards, orders and pregabalin-controlled medication sign out pages, it had appeared R66 had received several doses of gabapentin instead of the ordered pregabalin between 2/3/26 and 4/15/26. On 4/16/26 at 8:00 a.m., consultant pharmacist (CP)-A stated medications should be removed as soon as possible from the medication cart after the medication was discontinued. CP-A stated to receive gabapentin instead of pregabalin was a medication error. However, this was not considered a significant medication error due to them being similar drugs. Facility Medication and Treatment orders policy dated 2/2024, was provided however the policy lacked direction as to the removal of discontinued medications. Facility policy regarding medication administration was requested, however, none was provided. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure complete and accurate medical records for 1 of 1 resident (R13) reviewed for mental health practitioner visits.Findings include: R13's quarterly minimum data set (MDS) dated [DATE], indicated R13 was independent in decision making, had the ability to understand others, and make self-understood. Diagnoses included anxiety, depression, schizophrenia, and post-traumatic stress disorder (PTSD). Facility progress note dated 9/24/25, included social work met with R13 to discuss barriers and goals of care. Progress note included R13 had a therapist he worked with. No additional information on therapists included. R13's electronic medical record (EMR) failed to include name of therapist, date of appointments, after visit summaries or additional information regarding mental health care. During interview on 4/14/26 at 5:54 p.m., health unit coordinator (HUC) stated after visit summaries were placed in the resident's hard chart if they have not been scanned into the EMR. HUC confirmed there was no record of visits in the resident's hard chart or EMR. During interview on 4/14/26 at around 6:00 p.m., director of nursing (DON) stated R13's guardian assisted him to appointments and had not always bring back an after-visit summary. DON stated the facility should have followed up with the therapist to collect the information. The DON stated she was unsure if the facility had attempted to follow up for after visit summaries for the mental health visits. During interview on 4/15/26 at 8:35 a.m., HUC stated the facility did not currently have access to the therapist notes but had reached to the providing facility and requested after-visit notes. Facility policy for mental health notes requested and not provided. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement proper precautions for 2 of 3 residents (R16, R64) reviewed for contact precautions.<br><br>Findings include:<br><br>R16's quarterly minimum data set (MDS) dated [DATE], included an admission date of 10/29/25. R16's diagnoses included multidrug-resistant organism [(MDRO) a bacteria that is resistant to at least 3 antibiotics and is contagious].<br><br>During observation on 4/16/26 at 8:38 am, R16 had a sign indicating he was on enhanced barrier precautions (EBP). R16's care plan with last review date of 2/17/26, included R16 had a current infection of staphylococcal with interventions to use isolation precautions per protocol.<br><br>R16's care plan with last review date of 2/17/26, included R16 had a current infection of staphylococcal with interventions to use isolation precautions per protocol.<br><br>A review of R64's care plan initiated 3/31/26, identified R65 was admitted to the facility on [DATE], with medical diagnoses which included type one diabetes mellitus (a disease where the body was unable to properly manage blood sugar and required insulin), a malignant neoplasm (a cancerous growth) of the tongue, dysphagia (difficulty swallowing), and moderate protein calorie malnutrition, and gastrostomy status (surgically created opening into the stomach, with a feeding tube in place for nutrition, hydration, and medication delivery). The care plan also identified R64 experienced alteration in elimination related to foley catheter (indwelling catheter (tube) which goes directly into the bladder for drainage) and was on enhanced barrier precautions (EBP).<br><br>The Centers for Disease Control, FAQ's about EBP Precautions in Nursing Homes dated 6/28/24, identified EBP as an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO, as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices).<br><br>During observation and interview on 4/15/26 at 8:21 a.m., nursing assistant (NA)-A and NA-B provided personal cares for R64. NA-A and NA-B wore gloves, however, no gowns. R64's room had signage to indicate EBP. NA-A and NA-B assisted R64 with dressing. Including handling of urinary bag, threaded it through the pant leg and adjusted the tubing. Further, NA-A and NA-B assisted to place shirt on R64 and adjusted it over the feeding tube site. R64 was turned and repositioned on to side to adjust clothing. Resident was positioned into a back lying position, with pillow adjusted. Once resident was positioned, the catheter bag was placed into the bed bag for privacy. Upon completion of cares, NA-B removed gloves and disposed of them. NA-B stated she should have worn a gown to avoid of the potential spread of infections to both resident and others. NA-A gathered garbage and carried it the soiled utility room. After disposing of garbage, gloves were removed and disposed. Hand hygiene was performed. NA-A stated they were supposed to wear gown as it was important to prevent infection.<br><br>During interview on 4/16/26 at 10:03 a.m., infection preventionist (IP) confirmed R16 had a diagnosis of MRSA and should have been on contact precautions. IP stated they used infection control signs<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | from the Center for Disease Control and Prevention (CDC). The sign for contact precautions from the CDC included staff must put on gloves and gown before entering the room.<br><br>During observation and interview on 4/16/26 at 11:06 a.m., IP confirmed the sign outside R16's room was for enhanced barrier precautions (EBP), which was not the same as contact precautions. IP confirmed the EBP sign was the incorrect sign for R16.<br><br>Facility policy for contact precautions dated 7/31/23, included MDRO infections should be considered for residents who have them and a proper personal protective equipment (PPE) should be used when entering the resident's room. |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** During interview and record review, the facility failed to ensure all residents were offered and up to date on immunizations for 2 of 5 residents (R60, R69) reviewed for immunizations.Findings include:A CDC Pneumococcal Vaccine Timing for Adults feature dated 3/15/2023, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over [AGE] years old had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after [AGE] years old. R60's admission minimum data set (MDS) dated [DATE], included an admission date of 1/29/26 and a date of birth of [DATE]. R60's diagnosis included Parkinson's Disease (a progressive disease that could lead to tremors, stiff muscles, slow movement and balance issues), anxiety, and depression. R60's electronic medical record (EMR) included the following pneumonia and influenza vaccines:PCV13 given 11/10/16PPSV23 given 6/20/14Influenza given 10/20/22During interview on 4/16/26 at 10:00 a.m., infection preventionist (IP) stated every resident's immunization status was reviewed upon admission and necessary immunizations were offered. This was a shared task involving the director of nursing (DON), IP, and nurse managers. IP confirmed R60 should have been offered PCV20 and influenza vaccines. IP confirmed there was not a document in R60's electronic medical record (EMR) stating he wished to refuse the PCV20 and influenza vaccines. R69's quarterly MDS dated [DATE], included an admission date of 12/17/25 and a date of birth of [DATE]. R69's diagnoses included debility, heart failure, respiratory failure, and malnutrition.R69's EMR failed to include any documentation of immunizations received or signed declinations for immunizations. During interview on 4/16/26 at 10:00 a.m., infection preventionist (IP) confirmed R69 did not have any record of immunizations received or declinations in his EMR. IP was unsure why R69 had not received any immunizations or education regarding immunizations. Facility policy for influenza dated 11/2025, included vaccination is the primary method for managing influenza and the facility would follow recommendations of the CDC and Minnesota Department of Health for influenza vaccinations. Facility policy for pneumococcal dated 2/2024, included the facility would identify those at risk for pneumococcal disease and offer the pneumococcal vaccination by following the current CDC recommended immunization schedule. |