STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245326	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at Roseville	1000 Lovell Avenue Roseville, MN 55113

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) for 2 of 2 residents (R40) reviewed for pressure ulcers, and (R15) reviewed for psychotropic medications. Findings include: The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 user's manual dated 10/2024, identified the intent of section M, Skin Conditions, documented the risk, presence, appearance, and change of pressure ulcers and injuries. Further, it was important to recognize and evaluate each resident's risk factors and identify and evaluate all areas at risk of constant pressure and a complete assessment of skin was essential to an effective pressure ulcer prevention and skin treatment program. The RAI manual directed staff to review the medical record including skin care flow sheets, or other skin tracking forms, nurses' notes, and pressure ulcer injury risk assessments, speak with the treatment nurse and direct care staff on all shifts to confirm conclusions from the medical record review and observations of the resident, examine the resident and determine whether any ulcers, injuries, scars, or non-removable dressings, devices were present. Additionally, pressure ulcer staging was determined by the deepest anatomical stage and if a stageable pressure ulcer had been classified at a higher numerical stage than what was observed it should continue to be classified at the higher numerical stage and pressure ulcers do not heal in a reverse sequence. Stage three and four pressure ulcers fill with granulation tissue that is never as strong as the tissue that was lost and hence is more prone to future breakdown. Clinical standards do not support reverse staging or back staging as a way to document healing as it does not accurately characterize what is occurring physiologically as the ulcer heals. Once a pressure ulcer has healed, it is documented as a healed pressure ulcer at its highest numerical stage and a previously closed pressure ulcer that opens again should be reported at its worst stage, unless currently presenting at a higher stage or unstageable. The State Operations Manual (SOM) provided guidance on pressure ulcer staging that defined the following pressure ulcers/injuries: Stage 1 Pressure Injury is intact skin with localized redness. (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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Stage 2 Pressure ulcer is partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open or ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue (new connective tissue), slough, (non-viable tissue) and eschar (dead tissue) are not present. Stage 3 Pressure Ulcer is a full thickness loss of skin in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and or eschar may be visible but does not obscure the depth of tissue loss. If slough or eschar obscures the wound bed, it is an unstageable pressure ulcer/injury. Stage 4 Pressure Ulcer is a full thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and or eschar may be visible on some parts of the wound bed. Epibole (rolled edges), undermining and or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the wound bed, it is an unstageable pressure ulcer/pressure injury. Unstageable Pressure Ulcer is a full thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. If the slough or eschar is removed, a stage 3 or stage 4 pressure ulcer will be revealed. If the anatomical depth of the tissue damage involved can be determined, then the reclassified stage should be assigned. Deep Tissue Pressure Injury (DTPI) is intact skin with a localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This injury results from intense and or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. Once a deep tissue injury opens to an ulcer, reclassify the ulcer into the appropriate stage. R40's annual MDS dated [DATE], indicated R40 had one or more unhealed pressure ulcers/injuries, 0 stage 1 pressure injuries, one stage 2 pressure ulcer/injury, 0 stage 3 pressure ulcers, 0 stage 4 pressure ulcers, 0 unstageable pressure ulcers with slough or eschar, and 0 unstageable DTPI's. The MDS directed staff to report based on the highest stage of existing ulcers/injuries at their worst; and do not reverse stage. R40's progress notes dated 1/1/25, indicated, R40's pressure ulcer 2 right Achilles-improving. R40's Skin and Wound Evaluation form dated 12/26/24, indicated R40 had a stage two pressure ulcer to the right Achilles that had been present for one week measuring 2.9 centimeters (CM) long by 2.1 cm wide. Further, and contrary to the definition of a stage two pressure ulcer, the note indicated the wound bed contained 70% granulation tissue, 10% slough, and 20% eschar. R40's Skin and Wound Evaluation form dated 1/1/25, indicated R40 had an in-house acquired stage two pressure ulcer to the right Achilles that had been present for one week measuring 4.1 (cm) long by 2.7 cm wide. Further, the note indicated the wound bed contained 80% granulation tissue, 20% slough, and no eschar. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R40's Integrated Wound Care note dated 12/26/24, indicated R40 had a right heel unstageable pressure ulcer. Further, the wound was 2 cm long by 4.7 cm wide, by 0.4 cm deep and contained 10% slough, 20% necrotic tissue, and 70% granulation tissue. R40's Integrated Wound Care note dated 1/2/24, indicated R40 had a right heel unstageable pressure ulcer. Further, the wound was 2.5 cm long, by 4 cm wide by 0.4 cm deep and contained 20% slough, and 80% granulation. During interview on 3/10/25 at 5:18 p.m., R40 stated her heel was painful and pointed to her right heel and stated that was why it was elevated. R40's wheelchair foot rest on the right was pulled down and R40 had a sock on with her right heel resting directly on the foot rest. R40 stated she had a sore on her heel and stated staff usually changed the dressing in the morning, but stated it was changed mid morning on 3/10/25. During interview on 3/12/25 at 12:14 p.m., registered nurse (RN)-A stated he was the MDS coordinator and scheduled the MDS assessments, completed assessments, and made sure everyone completed their sections. RN-A stated he completed sections A, E, G, H, GG, I, J, K, L, M, N, O, P, and S. RN-A stated they were supposed to schedule skin assessments each week and when looking for skin assessments, looked at the Forms in the electronic medical record (EMR). RN-A stated R40 had an Annual MDS on 1/3/25, and when completing the MDS, looked for a skin assessment for 1/3/25, or around that date. RN-A stated they used to have a wound care manager who documented notes directly into progress notes but did not locate notes related to staging during the window for the MDS after reviewing the progress notes. RN-A stated he could not recall where he went to find the stage of the wound and knew it had been a stage two pressure ulcer and stated he used the RAI manual for guidance. RN-A stated according to the RAI manual, a stage two pressure ulcer was the first layer of skin removed and could also be a blister. RN-A further stated a stage two pressure ulcer did not contain slough, eschar, or granulation tissue. RN-A stated he viewed the Wound Evaluation form 1/1/25, for the MDS and stated the form indicated R40 had a stage two pressure ulcer but was staged incorrectly because a stage two pressure ulcer did not have granulation tissue, or slough and stated the MDS would need to be modified. RN-A stated he had been stating that staging of wounds was not being completed correctly and has completed education on staging of wounds. RN-A further stated he looked at wound pictures, but had to be more critical in what he saw and had not been doing that and further added it was important to have correct staging in order to know whether there has been a decline in the pressure ulcer which could indicate the wound was not being managed correctly. During interview on 3/12/25 at 2:14 p.m., the director of nursing (DON) stated she expected documentation align with the provider documentation and the documentation should be accurate. The DON verified the wound documentation note was not accurate for the wound staging according to the wound staging definitions. A policy was requested, however an email from the DON dated 3/12/25 at 3:01 p.m., indicated they utilized the RAI manual dated October 2024 for accuracy of assessments. 49617 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R15's quarterly Minimum Data Set (MDS) dated [DATE] indicated he had intact cognition and identified his diagnoses of anxiety, depression, and bipolar disorder (a mental health condition characterized by extreme periods of elevated mood, or mania, and low mood, or depression). The MDS reported he was taking an antipsychotic medication on a routine basis and indicated a gradual dose reduction (GDR) had not been attempted and there was no physician documentation the GDR was clinically contraindicated. Furthermore, the MDS reported he was not taking an antianxiety medication. R15's active pharmacy orders were reviewed on dated 3/12/25 at 8:12 a.m., and revealed the following orders: - hydroxyzine hydrochloride (HCl) oral tablet 50 milligrams (mg), Give 50mg by mouth two times a day for anxiety, dated 12/15/23. - quetiapine fumarate oral tablet 100mg, Give 100mg by mouth three times a day for depression, dated 7/25/23. R15's medication administration record (MAR) dated 1/25 was reviewed 3/12/25 and reflected the following administered medication orders: - hydroxyzine hydrochloride (HCl) oral tablet 50 milligrams (mg), Give 50mg by mouth two times a day for anxiety, dated 12/15/23. - Seroquel oral tablet (quetiapine fumarate), Give 300mg by mouth at bedtime, dated 10/30/24. R15's care plan dated 7/26/23, identified his use of psychotropic drug medications and his alteration in psychosocial well-being related to his diagnoses of schizophrenia (chronic mental health condition characterized by disruption in thought processes, perceptions, emotions, and social interactions), agoraphobia with panic (anxiety disorder characterized by intense fear of being in situations that might cause panic, or being trapped), and anxiety. A pharmacist's recommendation to prescriber dated 9/16/24, recommended a GDR to R15's psychotropic medications. The prescriber ordered a reduction of his evening Seroquel (quetiapine). A provider progress note dated 11/12/24 indicated under the treatment and plan: no medication changes at this time. GDR attempts are not recommend[sic] at this time due to failed GDR and mental decompensation. Per interview on 3/12/25 at 9:19 a.m., licensed practical nurse (LPN)-A, confirmed R15 was taking hydroxyzine and verified this was an antianxiety medication. Per interview on 3/12/25 at 2:37 p.m., the director of nursing (DON) confirmed R15 was taking an antianxiety medication and had a failed GDR. The DON expected the MDS data to be accurate based on a review of a resident's recent medication list, progress notes, and provider notes. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per interview on 3/12/25 at 2:46 p.m., registered nurse (RN)-A confirmed accountability for completing R15's quarterly MDS dated [DATE]. RN-A verified answering no him taking an antianxiety on the MDS and reviewed his MAR dated 1/25 and stated, I missed the hydroxyzine. Furthermore, RN-A reviewed the provider progress note dated 11/12/24 and the pharmacist's recommendation to prescriber dated 9/16/24 and verified there had been a GDR performed as well as a clinical contraindication to GDR provided. RN-A stated the facility's procedure was to make a modification to erroneous MDS and submit the corrected one. A policy pertaining to MDS accuracy was requested but not received.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on interview and document review, the facility failed to ensure a Level 1 Pre-Admission Screening (PAS) and, if needed, a a Level II Pre-Admission Screening and Resident Review (PASARR) were completed, retained in the medical record, and readily available to ensure continuity of care with mental health needs for 1 of 1 resident (R1) reviewed for PASARR. Findings include: R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 was not considered by the state level II PASRR process to have a serious mental illness and or intellectual disability or a related condition, had intact cognition, and had the following active diagnoses: bipolar disorder and schizophrenia. R1's physician's orders indicated the following order: 12/30/24, aripiprazole (an antipsychotic medication) 2 milligrams (MG) daily, take along with 5 mg for a total dose of 7 mg every day for schizoaffective disorder. 12/30/24, aripiprazole 5 mg daily, take 5 mg along with 2 mg for a total of 7 mg per day. 2/21/25, resident targeted behaviors of yelling, refusal of cares, isolation and interventions to redirect, remove from environment, and see notes, monitor resident for signs and symptoms of medication side effects and notify the physician if noted. R1's History and Physical dated 12/24/24, indicated R1 had active diagnoses of schizoaffective disorder and bipolar 1 disorder. R1's care plan, no date identified, indicated R1 had an alteration in mood and behavior due to bipolar and schizoaffective diagnoses and R1's goals included a stable mood and behavioral state, and R1 would respond to interventions. R1's medical record was reviewed and under a Miscellaneous form in the electronic medical record (EMR), indicated under the heading, PASRR included a document titled, ER [DATE] PAS.pdf The document, was opened and included a Preadmission Screening Referral form. The reason for the referral included two checked boxes indicating managed care, and waiver/AC/ECS. The form indicated the preadmission screen (PAS) was not completed by Senior LinkAge Line and the PAS required action. Further, the form indicated an OBRA Level II and level of care face to face assessment must be completed before nursing home admission. R1's medical record lacked evidence a Level 1 or, if needed, a Level II PASARR had been completed for R1 despite admitting to the nursing home a few months prior and having mental health-related diagnoses (i.e., schizophrenia and bipolar disorder) which could require active treatment. Further, the form lacked a determination of the PAS. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 3/11/25 at 2:01 p.m., the admission coordinator (AC)-E stated she worked at the facility for over two years and her role included requesting preadmission screens through the Senior LinkAge Line. AC-E stated the PAS described what a resident was admitted for and showed the resident's medical and living situation. AC-E viewed R1's chart and initially stated R1 had a PAS, but after opening the form, stated R1 had a referral and the form was not the PAS. AC-E stated no other staff worked on preadmission screenings and verified the PAS were located in the EMR and a PAS would let staff know if a resident needed more than a level one and possibly a level II. AC-E stated R1 would stay at the nursing facility until they could find placement and further stated she would add R1 to her list to find out why she didn't have a PAS and stated it was probably overlooked and R1 should have had a PAS completed before being admitted to the facility. During interview on 3/11/25 at 2:11 p.m., the social services director (SSD) stated she was not a licensed social worker. SSD stated AC-E followed up on the PAS screens and further stated the purpose of the PAS was to help determine services and level II PAS included mental illness diagnoses like schizoaffective disorders would trigger a resident to need a level two PASARR. SSD stated the PAS screenings were supposed to be completed prior to admission and were uploaded into the miscellaneous tab. SSD viewed R1's miscellaneous tab and verified no PAS was uploaded and stated it was important to be completed for the whole team to assess and assist the resident and stated R1 could trigger for a level II PASARR and viewed the form and stated she thought AC-E uploaded the form at this time. SSD viewed a PAS scanned that indicated under a heading, Does the person have a current diagnosis of a mental illness that indicated R1 did not have a mental illness and stated she would ask their consultant if the answer for the question should be documented as yes. During interview on 3/11/25 at 2:22 p.m., AC-E stated she contacted Senior LinkAge right away and stated they never attached the PAS and had just sent the PAS. During interview on 3/11/25 at 2:58 p.m., SSD stated she reviewed the PAS with the consultant and was directed to submit a new PAS with the diagnosis of R1 having mental illness to further determine if R1 needed a Level II PASARR. During interview on 3/12/25 at 11:04 a.m., the director of nursing (DON) stated she expected the PAS to be completed and stated it was important to have the PAS in order to know how to take care of residents and create an individualized care plan. During interview and observation on 3/12/25 at 11:14 a.m., registered nurse (RN)-C viewed R1's paper chart and verified there was no PAS in the paper chart. A care plan with revision history was requested, but was not provided. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy, Pre-Admission Screening (PASSR), dated 6/2023, indicated social services would check for preadmission screening and OBRA Level II requirements and would ensure the initial Pre-Admission Screening results state that the resident meets level of care for purposes of medical assistance payment prior to the resident being admitted to the facility. The initial Pre-Admission Screening must be completed by a medical professional. If the requirements from the initial Pre-Admission Screening cannot be determined, the admission will need to be postponed until the county can complete a face to face assessment and the county can confirm the consumer meets requirements for nursing facility level of care under Medicaid. Upon receipt of the hard copy of the preadmission form(s) from the Senior Linkage Line and or Lead Agency, social services or designated staff person will upload documentation to the resident's medical record. For residents discharging to a nursing facility from the hospital, assisted living, clinic and out of state, before accepting the admission you must receive a copy of the initial PAS from the referring agency which notes that consumer meets criteria for placement.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42586 Based on interview and document review the facility failed to ensure care conferences were completed in a timely manner for 1 of 1 resident (R14) reviewed for care planning. Findings include: R14's annual Minimum Data Set (MDS) dated [DATE], indicated intact cognition and diagnosis of chronic kidney disease. If further indicated R14 required staff assistance with most activities of daily living (ADL) and mobility. During interview on 3/10/25 at 2:53 p.m. R14 stated he couldn't remember if he'd had a care conference or not. R14's progress note dated 8/27/2024, indicated the following: care conference held today with resident. Resident was in a good mood and willing to participate. Interdiciplinary team (IDT) went over cares, nursing needs, therapy, and other questions as needed. Resident had no questions. IDT will continue to assist resident as needed. R14's medical record lacked documentation of a care conference since 8/27/24. During interview on 3/12/25 at 2:53 p.m., the director of social services stated the MDS nurse provided a list of who needed a care conference each month based off of the MDS assessments' schedule. When it was time for a resident to have a care conference she would talk to the team and then schedule it. The director of social services stated they were working on developing a better system in regards to care conferences and they're probably things that have been missed. She also verified the last time R14 had a care conference was on 8/27/25. A facilty policy on care conferences was requested but not received.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on observation, interview, and document review, the facility failed to ensure and identify accurate wound care assessments for 1 of 1 resident (R40) reviewed for pressure ulcers. Findings include: The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 user's manual dated 10/2024, identified the intent of section M, Skin Conditions, documented the risk, presence, appearance, and change of pressure ulcers and injuries. Further, it was important to recognize and evaluate each resident's risk factors and identify and evaluate all areas at risk of constant pressure and a complete assessment of skin was essential to an effective pressure ulcer prevention and skin treatment program. The RAI manual directed staff to review the medical record including skin care flow sheets, or other skin tracking forms, nurses' notes, and pressure ulcer injury risk assessments, speak with the treatment nurse and direct care staff on all shifts to confirm conclusions from the medical record review and observations of the resident, examine the resident and determine whether any ulcers, injuries, scars, or non-removable dressings, devices were present. Additionally, pressure ulcer staging was determined by the deepest anatomical stage and if a stageable pressure ulcer had been classified at a higher numerical stage than what was observed it should continue to be classified at the higher numerical stage and pressure ulcers do not heal in a reverse sequence. Stage three and four pressure ulcers fill with granulation tissue that is never as strong as the tissue that was lost and hence is more prone to future breakdown. Clinical standards do not support reverse staging or back staging as a way to document healing as it does not accurately characterize what is occurring physiologically as the ulcer heals. Once a pressure ulcer has healed, it is documented as a healed pressure ulcer at its highest numerical stage and a previously closed pressure ulcer that opens again should be reported at its worst stage, unless currently presenting at a higher stage or unstageable. The State Operations Manual (SOM) provided guidance on pressure ulcer staging that defined the following pressure ulcers/injuries: Stage 1 Pressure Injury is intact skin with localized redness. Stage 2 Pressure ulcer is partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open or ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue (new connective tissue), slough, (non-viable tissue) and eschar (dead tissue) are not present. Stage 3 Pressure Ulcer is a full thickness loss of skin in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and or eschar may be visible but does not obscure the depth of tissue loss. If slough or eschar obscures the wound bed, it is an unstageable pressure ulcer/injury. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Stage 4 Pressure Ulcer is a full thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and or eschar may be visible on some parts of the wound bed. Epibole (rolled edges), undermining and or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the wound bed, it is an unstageable pressure ulcer/pressure injury. Unstageable Pressure Ulcer is a full thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. If the slough or eschar is removed, a stage 3 or stage 4 pressure ulcer will be revealed. If the anatomical depth of the tissue damage involved can be determined, then the reclassified stage should be assigned. Deep Tissue Pressure Injury (DTPI) is intact skin with a localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This injury results from intense and or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. Once a deep tissue injury opens to an ulcer, reclassify the ulcer into the appropriate stage. R40's 5 day Minimum Data Set (MDS) assessment dated [DATE], indicated diagnoses of anemia, heart failure, peripheral vascular disease, diabetes mellitus, was at risk of developing pressure ulcers, had one stage 2 pressure ulcer that was not present upon admission. Additionally, R40 did not have any stage 1, 3, 4, pressure ulcers or unstageable, or deep tissue injuries. R40's annual MDS dated [DATE], indicated R40 had intact cognition, did not reject care, had anemia, coronary artery disease, heart failure, peripheral vascular disease, diabetes mellitus, one or more unhealed pressure ulcers/injuries, 0 stage 1 pressure injuries, one stage 2 pressure ulcer/injury, 0 stage 3 pressure ulcers, 0 stage 4 pressure ulcers, 0 unstageable pressure ulcers with slough or eschar, and 0 unstageable DTPI's. The MDS directed staff to report based on the highest stage of existing ulcers/injuries at their worst; and do not reverse stage. R40's Optional State Assessment (OSA) dated 1/3/25, indicated R40 required extensive assist with bed mobility, transfers, and toileting. R40's Care Area Assessment (CAA) for pressure ulcers indicated R40 had a stage two pressure ulcer and required partial assistance with lying to sitting, had a foley catheter which could increase the risk for pressure due to the tubing and the pressure ulcer would be addressed in the care plan. R40's care plan undated, indicated R40 had limited physical mobility related to non weight bearing to right lower extremity and interventions included to turn and reposition every 3-4 hours, uses wheelchair and ensure foot peddles are in place. R40's care plan indicated a self care deficit and required assist of one with grooming, bathing, and was encouraged to participate in dressing by placing arms and legs into clothing and staff were to assist with placing and removing socks and shoes. Further, R40's care plan indicated R40 was admitted with a right heel surgical wound and diabetic ulcer and on 3/9/23, had a right heel blister/suspected deep tissue injury and a pressure injury on the right Achilles and interventions included evaluating and treating per physician's orders, evaluate for signs and symptoms of possible infections, was followed by the wound care team weekly, took prostat (a protein supplement), was to be turned and repositioned every 3 to 4 hours, monitor skin during cares, provide a pressure reducing mattress. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R40's physician's orders included the following order: 1/29/25, cleanse right heel wound with generic wound cleanser or Vashe, apply collagen until Santyl arrives, cover with foam dressing, change dressing daily and as needed, inform the provider with any signs or symptoms of infection. Dressings need dates and initials and change daily for wound care. R40's Re-Admission History and Physical note dated 6/11/24, located in the progress notes indicated R40 had an unstageable pressure ulcer to the right heel. R40's Re-Admission History and Physical note dated 6/25/24, located in the progress notes indicated R40 had an unstageable pressure ulcer of the right heel. R40's progress notes dated 1/1/25, indicated, R40's pressure ulcer 2 right Achilles-improving. R40's Skin and Wound Evaluation form dated 11/21/24, indicated R40 had a stage two pressure ulcer to the right Achilles that had been present for one week measuring 2.9 centimeters (CM) long by 2.6 cm wide. Further, and contrary to the definition of a stage two pressure ulcer, the note indicated the wound bed contained 30% granulation tissue, 20% slough, and 50% eschar. R40's Skin and Wound Evaluation form dated 12/3/24, indicated R40 had a stage two pressure ulcer to the right Achilles that had been present for one week measuring 3.6 cm long by 2 cm wide. Further, and contrary to the definition of a stage two pressure ulcer, the note indicated the wound bed contained 60% granulation tissue, and 40% eschar. R40's Skin and Wound Evaluation form dated 12/10/24, indicated R40 had a stage two pressure ulcer to the right Achilles that had been present for one week measuring 3.9 centimeters (CM) long by 2.6 cm wide. Further, and contrary to the definition of a stage two pressure ulcer, the note indicated the wound bed contained 30% granulation tissue, 60% slough, and 10% eschar. R40's Skin and Wound Evaluation form dated 12/17/24, indicated R40 had a stage two pressure ulcer to the right Achilles that had been present for one week measuring 3.1 centimeters (CM) long by 2.0 cm wide. Further, and contrary to the definition of a stage two pressure ulcer, the note indicated the wound bed contained 30% granulation tissue, 60% slough, and 10% eschar. R40's Skin and Wound Evaluation form dated 12/26/24, indicated R40 had a stage two pressure ulcer to the right Achilles that had been present for one week measuring 2.9 centimeters (CM) long by 2.1 cm wide. Further, and contrary to the definition of a stage two pressure ulcer, the note indicated the wound bed contained 70% granulation tissue, 10% slough, and 20% eschar. R40's Skin and Wound Evaluation form dated 1/1/25, indicated R40 had an in-house acquired stage two pressure ulcer to the right Achilles that had been present for one week measuring 4.1 (cm) long by 2.7 cm wide. Further, the note indicated the wound bed contained 80% granulation tissue, 20% slough, and no eschar. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R40's Skin and Wound Evaluation form dated 1/7/25, indicated R40 had a stage two pressure ulcer to the right Achilles that had been present for one week measuring 4.1 centimeters (CM) long by 2.5 cm wide. Further, and contrary to the definition of a stage two pressure ulcer, the note indicated the wound bed contained 90% granulation tissue, and 10% slough. R40's Skin and Wound Evaluation form dated 1/14/25, indicated R40 had a stage two pressure ulcer to the right Achilles that had been present for one week measuring 7.4 cm long by 2.8 cm wide. Further, and contrary to the definition of a stage two pressure ulcer, the note indicated the wound bed contained 90% granulation tissue, 10% slough, and no eschar. R40's Skin and Wound Evaluation form dated 1/21/25, indicated R40 had a stage two pressure ulcer to the right Achilles that had been present for one week measuring 2.4 cm long by 1.3 cm wide. Further, and contrary to the definition of a stage two pressure ulcer, the note indicated the wound bed contained 50% granulation tissue, no slough, and no eschar. R40's Skin and Wound Evaluation form dated 1/28/25, indicated R40 had a stage two pressure ulcer to the right Achilles that had been present for one week measuring 5.5 cm long by 2.4 cm wide. Further, and contrary to the definition of a stage two pressure ulcer, the note indicated the wound bed contained 70% granulation tissue, no slough, and no eschar. R40's Skin and Wound Evaluation form dated 2/6/25, indicated R40 had a stage two pressure ulcer to the right Achilles that had been present for one week measuring 5 cm long by 3.9 cm wide. Further, and contrary to the definition of a stage two pressure ulcer, the note indicated the wound bed contained 70% granulation tissue, 10% slough, and no eschar. R40's Skin and Wound Evaluation form dated 2/13/25, indicated R40 had a stage two pressure ulcer to the right Achilles that had been present for one week measuring 4.5 cm long by 2.7 cm wide. Further, and contrary to the definition of a stage two pressure ulcer, the note indicated the wound bed contained 70% granulation tissue, 10% slough, and 20% eschar. R40's Skin and Wound Evaluation form dated 2/20/25, indicated R40 had an unstageable pressure ulcer to the right Achilles that had been present for one week measuring 4.5 cm long by 2.7 cm wide. Further, and contrary to the definition of a stage two pressure ulcer, the note indicated the wound bed contained 70% granulation tissue, 10% slough, and no eschar. R40's Skin and Wound Evaluation form dated 2/25/25, indicated R40 had an unstageable pressure ulcer to the right Achilles that had been present for one week measuring 4.3 cm long by 2.4 cm wide. Further, and contrary to the definition of a stage two pressure ulcer, the note indicated the wound bed contained 20% granulation tissue, 20% slough, and no eschar. R40's Skin and Wound Evaluation form dated 3/7/25, indicated R40 had an unstageable pressure ulcer to the right Achilles that had been present for one week measuring 4.4 cm long by 2.8 cm wide. Further, and contrary to the definition of a stage two pressure ulcer, the note indicated the wound bed contained 20% granulation tissue, 20% slough, and no eschar. R40's Integrated Wound Care note dated 12/3/24, indicated a right lateral heel unstageable pressure ulcer measuring 3.8 cm long by 2.7 cm wide by 0.3 cm deep with 30% necrotic tissue, 20% eschar, and 50% granulation tissue. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R40's Integrated Wound Care Note dated 12/17/24, indicated a right lateral heel unstageable pressure ulcer measuring 3 cm long by 3.5 cm wide by 0.5 cm deep with 10% necrotic tissue, 30% granulation tissue, and 60% slough. R40's Integrated Wound Care note dated 12/26/24, indicated R40 had a right heel unstageable pressure ulcer. Further, the wound was 2 cm long by 4.7 cm wide, by 0.4 cm deep and contained 10% slough, 20% necrotic tissue, and 70% granulation tissue. R40's Integrated Wound Care note dated 1/2/24, indicated R40 had a right heel unstageable pressure ulcer. Further, the wound was 2.5 cm long, by 4 cm wide by 0.4 cm deep and contained 20% slough, and 80% granulation. R40's Integrated Wound Care note dated 1/2/25, indicated a right lateral heel unstageable pressure ulcer measuring 4 cm long by 2.5 cm wide by 0.5 cm deep with 10% slough and 90% granulation tissue. R40's Integrated Wound Care note dated 1/14/25, indicated a right lateral heel unstageable pressure ulcer measuring 7.3 cm long by 2.8 cm wide by 0.4 cm deep with 10% slough and 90% granulation tissue. R40's Integrated Wound Care note dated 1/21/25, indicated a right lateral heel unstageable pressure ulcer measuring 2.3 cm long by 1.3 cm wide by 0.3 cm deep with 50% necrotic tissue, and 50% granulation tissue. R40's Integrated Wound Care note dated 1/28/25, indicated a right lateral heel unstageable pressure ulcer measuring 5.5 cm by 2.4 cm by 0.3 cm with 30% necrotic tissue and 70% granulation tissue. R40's Integrated Wound Care note dated 2/6/25, indicated a right lateral heel unstageable pressure ulcer measuring 5 cm long by 3.9 cm wide by 0.2 cm deep with 20% necrotic tissue, 70% granulation tissue, and 10% slough. R40's Integrated Wound Care note dated 2/13/25, indicated a right lateral heel unstageable pressure ulcer measuring 4.5 cm long by 2.7 cm wide by 0.2 cm deep with 20% necrotic tissue, 70% granulation tissue and 10% slough. R40's Integrated Wound Care note dated 2/20/25, indicated a right lateral heel unstageable pressure ulcer measuring 4.5 cm long by 2.7 cm wide by 0.2 cm deep with 20% necrotic tissue, 70% granulation tissue and 10% slough. R40's Integrated Wound Care note dated 2/25/25, indicated a right lateral heel unstageable pressure ulcer measuring 4.3 cm long by 2.4 cm wide by 0.2 cm deep with 30% necrotic tissue, 20% granulation, and 20% slough. R40's Integrated Wound Care note dated 3/7/25, indicated a right lateral heel unstageable pressure ulcer measuring 4.4 cm long by 2.8 cm wide by 0.2 cm deep with 30% necrotic tissue, 20% granulation, and 20% slough. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 3/10/25 between 5:16 p.m., and 5:18 p.m., R40 stated she was going to the hospital on 3/11/25 to have an X-RAY of her leg to determine blood flow and further stated her heel was painful and pointed to her right heel and stated that was why it was elevated. R40's wheelchair foot rest on the right was pulled down and R40 had a sock on with her right heel resting directly on the foot rest. R40 stated she had a sore on her heel and stated staff usually changed the dressing in the morning, but stated it was changed mid morning on 3/10/25. During interview on 3/12/25 at 7:52 a.m., R40 stated she had a procedure the day prior to increase the blood flow and help heal her foot. During interview on 3/12/25 at 8:26 a.m., registered nurse (RN)-C stated R40 had a diabetic sore on her heel that was a stage II and had some slough but no eschar. During interview on 3/12/25 at 11:19 a.m., RN-B stated she conducted wound rounds with the nurses weekly and stated the wound assessment was documented under the Skin and Wound in the Forms tab. RN-B stated R40 had an unstageable pressure ulcer on the right Achilles heel. RN-B viewed the 2/13/25, note and verified the wound was documented as a stage two with slough and eschar and stated it could be documented as a stage two because of improvement in the heel. RN-B stated she was not sure if a stage two pressure ulcer presented with eschar and slough and was not sure about the recent staging because sometimes there was improvement in the wound and then the wound comes back. During interview on 3/12/25 at 12:14 p.m., registered nurse (RN)-A stated he was the MDS coordinator and scheduled the MDS assessments, completed assessments, and made sure everyone completed their sections. RN-A stated he completed sections A, E, G, H, GG, I, J, K, L, M, N, O, P, and S. RN-A stated they were supposed to schedule skin assessments each week and when looking for skin assessments, looked at the Forms in the electronic medical record (EMR). RN-A stated R40 had an Annual MDS on 1/3/25, and when completing the MDS, looked for a skin assessment for 1/3/25, or around that date. RN-A stated they used to have a wound care manager who documented notes directly into progress notes but did not locate notes related to staging during the window for the MDS after reviewing the progress notes. RN-A stated he could not recall where he went to find the stage of the wound and knew it had been a stage two pressure ulcer and stated he used the RAI manual for guidance. RN-A stated according to the RAI manual, a stage two pressure ulcer was the first layer of skin removed and could also be a blister. RN-A further stated a stage two pressure ulcer did not contain slough, eschar, or granulation tissue. RN-A stated he viewed the Wound Evaluation form 1/1/25, for the MDS and stated the form indicated R40 had a stage two pressure ulcer but was staged incorrectly because a stage two pressure ulcer did not have granulation tissue, or slough and stated the MDS would need to be modified. RN-A stated he had been stating that staging of wounds was not being completed correctly and has completed education on staging of wounds. RN-A further stated he looked at wound pictures, but had to be more critical in what he saw and had not been doing that and further added it was important to have correct staging in order to know whether there has been a decline in the pressure ulcer which could indicate the wound was not being managed correctly. During interview on 3/12/25 at 12:14 p.m., RN-A stated he spoke with the director of nursing and was told they had documentation the wound was almost healed so it would have been a stage two at that point, and added he did not want to retract anything he said. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 3/12/25 at 1:43 p.m., RN-C changed R40's dressing and completed measurements. RN-C stated R40's wound measured 1 cm long by 2.2 cm wide by 0.1 cm deep. RN-C stated he had training on how to stage wounds previously but not at the facility and stated R40's wound was at a stage three. During interview on 3/12/25 at 2:14 p.m., the director of nursing (DON) stated staff rounded with a wound nurse practitioner who changed orders or made recommendations and staged the wounds and nurses at the facility completed wound assessments and completed the Skin and Wound Evaluation and added if you don't click and change information, the information stays in place in the note. The DON stated R40 admitted with a wound vac (a treatment for the wound) and the wound healed and reopened and added R40 was non compliant and added R40 had an angiogram 3/11/25. The DON stated she expected the provider stage the wound and nursing documentation should align with the provider and should be accurate and verified wound documentation notes were not accurate for the wound staging according to the staging definitions. A care plan with the revision history was requested, but was not provided. A policy, Skin Assessment and Wound Management dated 2/2025, indicated a weekly skin inspection was completed by licensed staff. When a new pressure ulcer is identified the following actions will be taken, notify the provider/treatment ordered, notify the resident representative, complete education with the resident and resident representative including risks and benefits, initiate the skin and wound evaluation, notify the nurse manager/wound nurse.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Based on observation, interview and document review the facility failed to demonstrate safe patient handling to reduce the risk for accidents for 1 of 1 residents (R13) reviewed for safety with mechanical lift assisted transfers. Findings include: R13's annual Minimum Data Set (MDS) dated [DATE], indicated he had intact cognition and was dependent on staff for chair/bed-to-chair transfers. The MDS reported diagnoses of hemiplegia (one-sided weakness) following a cardiovascular accident (CVA, stroke), and hemiplegia (one-sided paralysis). R13's Care Area Assessment for functional abilities dated 12/19/24, indicated he was dependent on staff for transfers. R13's care plan revised 1/3/24, identified his activities of daily living (ADL) self-care deficit and directed staff to provide 2-person assistance using the EZstand. A therapy to nursing communication form dated 5/10/24, indicated R13's transfer status under Transfers: EZ Stand. During interview on 3/10/25 at 4:52 p.m., R13 reported using the EZ Stand for transfers and stated it caused him pain to his ribs and lungs. He stated during some transfers, he would hang there and when he would attempt to tell staff to lower him down because I can't breathe and its pushing on my lungs, staff would tell him to stop hollering at him. During observation and interview on 3/12/25 at 12:54 p.m., nursing assistant (NA)-A and NA-B were in R13's room to transfer him from his wheelchair to his bed. NA-B stood behind the mechanical standing lift with the remote control in hand. NA-A put the lift sling behind R13's back and ensured all the sling loops were fastened to the standing lift. NA-A stated because R13 had weakness to his left side, they would need to make sure he was holding onto the standing lift with his hand properly. After the NAs ensured his feet were secured on the standing lift's platform, NA-B used the remote control to lift R13 from the wheelchair into a semi-upright position. R13 was unable to stand straight up; his knees were bent at approximately 80 degrees while his arms were bent at approximately 90 degrees. He was hanging by both shoulders from the standing lift with the sling behind his back and shoulders. NA-A told NA-B to stop going up and began to move the standing lift over towards R13's bed. The surveyor asked R13 if he was able to stand up any straighter. He attempted and was able to straighten his legs, but his arms remained bent, and his upper extremity posture remained unchanged. NA-A pushed the standing lift over his bed and began to lower R13 onto the bed. R13 stated the transfer felt okay but said if he had to transfer like that repeatedly, he would be in a lot of pain. NA-A stated sometimes R13 would say he did not want to get up or that he was not feeling well, and they would leave him be and notify the nurse. When asked if the observed transfer was safe and positioning was appropriate, NA-A said it was okay because he was able to get into bed, but if he was not okay, they would report that to the nurse. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 3/12/25 at 1:11 p.m., physical therapist assistant (PTA) stated if a resident using a mechanical standing lift was observed using bad posturing, like bowing of the arms out or sort of hanging there, it would be an indication the resident should be evaluated by therapy. PTA expected NAs to report such observations to nurses or nurse managers so it could be passed along to the interdisciplinary team (IDT) to discuss. PTA stated residents struggling to use mechanical standing lifts should be reviewed during IDT so they can get on the therapy caseload for evaluation. PTA stated the residents exhibiting bad posturing techniques during transfers could present risks such cutting off blood flow or circulation to their shoulder joints or risk slipping out of the mechanical standing lift during a transfer. PTA denied being notified of any concerns regarding R13's transfers. During interview on 3/12/25 at 2:30 p.m., the director of nursing (DON) stated a safe mechanical standing lift transfer would be one in which a resident could stand for eight seconds, they could fully hold onto or grasp the lift bars and could come to a complete stand without hanging in the mechanical standing lift. The DON expected if staff observed an unsafe transfer to complete a lift and mobility assessment, change the transfer status and update the care plan accordingly. Finally, the DON expected this to be communicated during morning standup so therapy could get involved. A facility policy pertaining to safe transfers was requested but not received.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Based on observation, interview and document review the facility failed to ensure antifungal medications without an end date were monitored and evaluated for the appropriateness of continued use for 1 of 1 residents (R3) reviewed who were prescribed antifungal medications. Findings include: R3's quarterly Minimum Data Set (MDS) dated [DATE], indicated she was rarely or never understood and identified diagnoses of non-traumatic brain dysfunction, neurosyphilis (a form of syphilis, a sexually transmitted infection, that affects the brain and spinal cord), non-Alzheimer's dementia (a condition that causes a decline in cognitive function, including memory, thinking, language, and problem-solving). The MDS indicated she required two-person extensive assistance with personal and toileting cares. R13's order summary dated 3/13/25, included the order: - Nyamyc external powder 100000 unit/gram (gm) (Nystatin Topical), Apply to abdominal folds topically two times a day for candidiasis, dated 10/28/24 with no end date. R13's medication administration record (MAR) dated 11/24 was reviewed on 3/11/25 and reflected administration of the Nystatin powder as ordered. R13's MAR dated 12/24 was reviewed on 3/11/25 and reflected administration of the Nystatin powder as ordered. R13's MAR dated 1/25 was reviewed on 3/11/25 and reflected administration of the Nystatin powder as ordered. R13's MAR dated 2/25 was reviewed on 3/11/25 and reflected administration of the Nystatin powder as ordered. R13's MAR dated 3/1/25 through 3/10/25 was reviewed on 3/11/25 and reflected administration of the Nystatin powder as ordered. A weekly skin inspection dated 11/5/24, indicated previously noted resident had redness/rash on left lower abdomen folds related to moisture. The inspection indicated treatment is in place. A weekly skin inspection dated 11/12/24, indicated redness/rash on left lower abdomen folds was clearing. A weekly skin inspection dated 11/26/24, indicated slight redness/rash on left lower abdomen folds is clearing. Nystatin applied. A weekly skin inspection dated 12/17/24, indicated skin is intact. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A weekly skin inspection dated 12/24/24, indicated no skin concerns noted, Nystatin applied under adm [sic] folds/groin. During observation on 3/12/25 at 12:45 p.m., licensed practical nurse (LPN)-B was at R3's bedside and assessed her abdominal folds and groin skin. LPN-B confirmed there was no redness and stated her skin was intact. LPN-B stated R3 used to have redness and moisture to this area, but it had cleared now. During interview on 3/12/25 at 12:25 p.m., certified physician assistant (PA-C) confirmed familiarity with R3's care but stated the Nystatin powder order was before my time since PA-C started in December and the order was dated 10/28/24. PA-C stated when treating a true fungal infection, the normal procedure would be to prescribe it with and end date after two weeks and then reassess to determine if it was effective and reconsider the necessity of the topical antifungal and question if it could be an as needed (PRN) order. PA-C stated, if she was continuing on it, I would want to know why. I would probably have stopped [it]. Why would you give something that isn't necessary. During interview on 3/12/24 at 1:41 p.m., registered nurse (RN)-B was not sure if topical antifungals were monitored by the infection preventionist, however, stated nursing staff should be looking for an end date and monitoring for symptoms of improvement or worsening condition. RN-B stated for topical antifungal, like Nystatin powder, if the area was cleared, nursing staff should call the provider to get monitoring orders and consider asking for the medication to be as needed. During interview on 3/12/25 at 2:26 p.m., the director of nursing (DON), also the facility's infection preventionist, stated they did not track topical antifungals in ICAR, a tool used to systematically assess a healthcare facilities infection prevention and control practices. The DON stated because floor nurses were administering the topical Nystatin powder, they would be responsible for assessing the area and were expected to update the provider and ask if the medication order could be re-evaluated once the area had improved. The DON stated the Nystatin powder should have been discontinued once the skin concern improved. Per facility policy titled skin assessment and wound management last revised 2/25, when a significant alteration in skin integrity was noted, staff were directed to notify the provider for treatment orders and perform skin and/or wound evaluations and update the care plan to include interventions. For ongoing skin issues, staff were directed to follow ongoing treatments per provider order and update the provider and care plan as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245326	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at Roseville	1000 Lovell Avenue Roseville, MN 55113

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48065 Based on interview and document review, the facility failed to ensure 1 of the 5 residents (R1) reviewed for immunizations was offered and/or provided the pneumococcal vaccination series as recommended by the Centers for Disease Control (CDC) to help reduce the risk of associated infection(s). Findings include: The CDC's PneumoRecs VaxAdvisor for Vaccine Providers dated 9/12/24, recommended based on R1's age and vaccine history to give a dose of PCV15, PCV20 or PCV21 at least 1 year after the last dose of PPSVR23. Regardless of which vaccine is used (PCV15, PCV20, or PCV21), their pneumococcal vaccinations are complete. R1's Clinical Profile printed on 3/12/25, indicated R1 was [AGE] years old. The immunization record, printed 3/12/25, indicated R1 received a PPSV23 on 1/17/13. R1's electronic medical record (EMR) lacked evidence of shared clinical decision making occurring with the physician for giving one dose of PCV15, PCV20, or PCV21 as it was more than [AGE] years after the previous pneumococcal dose. R26's EMR and paper chart lacked evidence of R1 being offered or receiving any pneumococcal doses or education. During interview on 3/11/25 at 3:33 p.m., R1 stated didn't remember staff talking or offering a pneumococcal vaccine. R1 stated would have accepted a pneumovax vaccine if offered. During interview on 3/12/25 at 11:28 a.m., the infection preventionist/director of nursing (DON) stated besides the duties as the infection preventionist and DON position, had also been fulfilling the nurse manager's duties. DON stated missed auditing R1. DON stated a resident who received the recommended pneumovax vaccination would prevent someone from getting pneumonia, or if they would get pneumonia, the symptoms won't be as severe. Facility's policy titled Pneumococcal Policy dated 2/2024 indicated: It is the practice of the Health Care Facility to offer all residents the pneumococcal vaccines to aid in the prevention of pneumococcal/pneumonia infections. Facility policy indicated the purpose was to follow recommendations of the Advisory Committee on Immunization Practices (ACIP) Centers for Disease Control (CDC) and/or the state Department of Health for prevention of Pneumococcal disease by identifying those residents at risk for Pneumococcal disease and offering Pneumococcal vaccination.