STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245492	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at Richfield	7727 Portland Avenue South Richfield, MN 55423

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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview, and document review, the facility failed to ensure the facility's survey results were kept in a location readily accessible to all residents and/or visitors who wished to review. This had the potential to affect all 97 residents and/or visitors.Findings include:During an interview with the facility resident council on 6/25/25 at 1:03 p.m., the members stated the survey binder should be in the front lobby of the facility. During interview with R3 on 6/26/25 at 10:55 a.m., R3 stated she had not seen the survey binder in the front lobby for a little bit and state it would be nice to know what the facility needs to work on. During observation on 6/26/25 at 11:03 a.m., the facility survey binder was not readily visible nor readily available in the facility lobby without having to ask. During interview on 6/26/25 at 10:38 a.m., administrator confirmed the survey binder was not visible nor easily accessible without having to ask. The administrator located the survey binder in a storage basket with other binders on a higher shelf in the lobby. A policy regarding posting survey results was requested, administrator stated the facility does not have a policy regarding survey results.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure care was provided in accordance with a resident's care plan for 1 of 3 residents (R18) reviewed for non-pressure related skin concerns. Findings include:R18's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R18 had short- and long-term memory problems, knew location of own room and staff names and faces, and had some difficulty in new situations regarding her cognitive skills for daily decision making. R18 did not have behaviors or rejection of cares. R18 required substantial/maximal to dependent assistance with most activities of daily living (ADLs). R18 was at risk for pressure ulcers.R18's care plan, indicated R18 was at risk for skin alteration related to incontinence, history of recurring redness/rash under breasts and skin folds, poor safety awareness, and history of walking towards doors and walls. The care plan interventions included barrier cream after each incontinent episode, encourage to allow cleansing and drying of skin folds in the morning and bedtime and reapproach if refuses, ensure socks removed carefully and does not stick, assist with nails and toenail care weekly and as needed, heel protectors on while in bed, place a pillow under resident's back when turned and repositioned, turn and reposition every two to three hours and as needed, monitor skin integrity daily during cares and weekly skin inspection by nurse, treat open areas per order, encourage adequate fluid intake, pressure redistribution cushion to wheelchair and chair, low air loss mattress and monitor function every shift, and follow dietary interventions which included supplements as ordered.R18's physician order dated 2/14/24, indicated geri-sleeves (protective sleves) or long sleeves on in the morning and off at bedtime every shift.During observation on 6/25/25 at 7:40 a.m., R18 sat in her wheelchair in the dining area and had short sleeves on and no geri-sleeves.During observation on 6/25/25 at 9:25 a.m., nursing assistant (NA)-A and C assisted R18 to bed and provided peri-cares. R18 had short sleeves on and new geri-sleeves. R18's heels were not floated off the bed with pillows or protective boots. During interview on 6/25/25 at 9:37 a.m., NA-A verified R18 did not have long-sleeves or geri-sleeves on. NA-A stated they were not sure if R18 needed her arms covered. NA-A verified R18's heels were not floated and did not know about protective boots for R18. NA-A stated R18's heels were not an issue and feet did not have skin breakdown.During observation and interview on 6/25/25 at 11:10 a.m., R18 was in bed and observed in short sleeves and no geri-sleeves, and R18's heels were not floated. Registered nurse (RN)-E stated R18 needed her heels floated and verified they were not floated. RN-E found heel protector boots in R18's closet and applied them to R18's feet.During interview on 6/26/25 at 10:37 a.m., the assistant director of nursing (ADON) stated R18 was at risk for pressure ulcers and floating R18's heels were important for pressure ulcer prevention. The ADON stated R18 needed geri-sleeves when she used to bump into doorways and got bruises related to poor safety awareness. During interview on 6/26/25 at 2:01 p.m., the director of nursing (DON) expected staff to follow the care plan. The DON stated geri-sleeves or long sleeves were used to prevent skin tears and bruises.The facility Care Planning policy dated 11/2024, directed staff to use resident's plan of care to provide care or services to the resident. The care plan was to be modified and updated as the condition and care needs of the resident changed.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure a resident's preferred activities for individual entertainment were available for 1 of 1 resident (R16) reviewed for activities.Finding include:R16's Minimum Data Set (MDS) assessment dated [DATE], identified R16 had cognitive impairment and displayed no delusional thinking, with some rejection of cares. R16 was dependent on facility staff for upper and lower body dressing, putting on and removing shoes, and transferring from bed to chair.R16's Evaluation and Social History dated 8/19/24, indicated R16 had no visual or auditory deficits that would impact activity participation, enjoys time with her children, music, and game shows. R16's specific preference to music is old rhythm and blues. Further, R16 was willing to try new activities, actively engages in structured activities of choice, and actively engages in independent activity of choice.R16's care plan dated 11/14/24, indicated R16 had generalized anxiety, major depressive disorder, and obsessive-compulsive disorder. The interventions the facility outlined in this document included:-administer medications as ordered-complete PHQ-9 (depression screening) per facility policy-encourage resident to take part in Music Therapy Group events (Bell Choir, Singing Groups, Music in Motion) to stimulate socialization.-Monitor/record/report to MD as needed any changes in mood patterns, signs and symptoms of depression, anxiety, sad mood as per facility behavior monitoring protocolsDuring interview on 6/23/25 at 3:38 p.m., R16 confirmed she likes to listen to music and would be interested in attending music activities or groups. Family stated the facility had not previously had any music-related activities for the resident to attend. Further, the facility staff do not ask the resident if she would like to join a group activity. The activity calendars dated, February 2025, March 2025, April 2025 , May 2025 and June 2025 did not contain any music-related activities or groups.During observation on 6/24/25 at 1:00 p.m., activity director (AD)-A was walking down the hall, gathering residents for a Tuesday Tea Party in the 3rd floor dining room. The AD-A did not enter R16's room to offer to take R16 to the Tea Party. During this observation no other facility staff went into R16's room to alert her to the activity nor offer to take her to the activity.During observation on 6/24/25 at 2:43 p.m., activity director (AD)-A was walking down the hall, gathering residents for Bingo in the 2nd floor dining room. The AD-A did not enter R16's room to offer to take R16 to Bingo. During this observation no other facility staff went into R16's room to alert her to the activity nor offer to take her to the activity.During observation on 6/25/25 at 10:23 a.m., activity director (AD)-A was walking down the hall, gathering residents for a Bible Study in the 2nd floor dining room. The AD-A did not enter R16's room to offer to take R16 to bible study. During this observation no other facility staff went into R16's room to alert her to the activity nor offer to take her to the activity.During observation on 6/25/25 at 12:31 p.m., activity director (AD)-A was walking down the hall, gathering residents for movie in the main activity hall. The AD-A did not enter R16's room to offer to take R16 to the movie. During this observation no other facility staff went into R16's room to alert her to the activity nor offer to take her to the activity.During interview on 6/25/25 at 10:35 a.m., certified nursing assistant (CNA)-C stated the resident was dependent on staff; if she would like to go to an activity, staff would have to assist her. Further, stated the resident should be notified before each activity because she has dementia and wouldn't be able to remember when or what the activity was before the activity.During interview on 6/25/25 at 10:47 a.m., assistant director of nursing (ADON) stated the resident does experience anxiety or depression at times. ADON stated the staff at the facility respond to this anxiety or depression by following the interventions outlined in the care plan. ADON could not list the specific patient-centered music-related intervention for R16. During interview on 6/26/25 at 8:06 a.m., AD-A could not state what R16's personal goals for activity and leisure were. AD-A stated she regularly does rounds on each floor to gather residents to go to activities. AD-A confirmed she did not ask R16 to attend activities on either 6/24/25 or 6/25/25. AD-A stated the facility does not offer music-based activities very often. AD-A stated she was aware R16 had a general anxiety disorder and depression; not knowing about the person-centered intervention to offer music therapy or music-related activities. A facility activity policy was asked for, and not received.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure bruises were adequately assessed and monitored for 1 of 1 resident (R92), failed to ensure non-pressure wounds had timely assessment and documentation for 1 of 3 residents (R92), and furthermore failed to implement and/or clarify a wound order after a hospitalization for 1 of 3 residents (R2) reviewed for non-pressure related wounds.Findings include: R92's admission Minimum Data Set (MDS) assessment, dated 6/11/25, indicated intact cognition, did not have delusions or hallucinations, physical, verbal, or other behavioral symptoms, and did not reject care. Further, R92 was dependent on staff for toileting hygiene, lower body dressing, and required substantial to maximal assistance with upper body dressing, personal hygiene, and showering and bathing. R92's diagnoses included cancer, wound infection, diabetes, arthritis, was morbidly obese with a body mass index of 50.0 to 59.9. Furthermore, R92 was at risk for developing pressure injuries, had surgical wounds, and took an anticoagulant (blood thinner). During observation and interview on 6/23/25 between 2:14 p.m., and 2:17 p.m., R92 had bruises bilaterally to the back of her upper arms. R92's right arm had a bruise approximately the size of a grapefruit and the bruise located on R92's left arm went from R92's arm pit area to her elbow and was purple towards the elbow and a faded yellow color on the upper part of R92's left arm. R92 stated they were from her blood thinner shots. R92 stated her camisole stitching rubbed on her and rolled up on her due to her large abdomen and had a sore spot on her left arm pit area. R92's left posterior arm at armpit crease had a small nail head sized open area. An dressing (ABD) pad was tucked in next to the area, but did not cover the open area. R92 stated she didn't want to wear other shirts because she didn't want drainage staining them from her dressings. R92's Physician's Orders form, indicated the following orders: 6/13/25, surgical incision to the right axilla, right breast, cleanse with NS (normal saline) or WC (wound cleanser), pat dry. Cover with a non-adhesive dressing or ABD (dressing type) and secure with tape every day. Monitor for signs and symptoms of infection. 6/6/25, Complete Daily Skilled Note under forms in PCC (Point Click Care-facility electronic medical record). State why the resident is currently being covered for #6 skin issue, #7 infection, #9 diabetes, #13 anticoagulant. 6/8/25, Monitor for discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle and joint pain, lethargy, bruising, sudden changes in mental status and/or vital signs, SOB [shortness of breath], nose bleeds. 0=No Symptoms, +=See NN (nurse note). 6/8/25, weekly skin inspection by the licensed nurse. Complete weekly skin inspection in PCC. 6/5/25, enoxaparin sodium (generic for Lovenox) injection solution prefilled syringe 40 milligrams (mg)/0.4 milliliters (ML) inject 0.4 ml subcutaneously every 12 hours for prevention of a blood clot. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R92's lacked documentation or treatment instruction for an ABD pad related to the open area and a specific assessment or monitoring for the bruising to R92's upper arms. R92's medication administration record (MAR) and treatment administration record (TAR) dated June 2025, indicated R92 received enoxaparin twice daily at 9:00 a.m., and 9:00 p.m., R92's care plan dated 6/6/25, indicated R92 was diabetic and interventions indicated to check all of her body for breaks in skin per protocol and treat promptly as ordered by the physician. R92's care plan dated 6/12/25, indicated R92 had a potential for alteration in blood formation and coagulation due to use of an anticoagulant and interventions included to monitor and notify the physician for signs and symptoms of bleeding, to monitor for discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle/joint pain, lethargy, bruising, sudden changes in mental status, and or vital signs, SOB, and nose bleeds. R92's care plan dated 6/6/25, indicated R92 had an alteration in skin integrity related to recent surgery and had surgical wounds on the right breast and underarm. Interventions indicated to monitor skin integrity daily during cares and weekly skin inspections by the nurse, treatment to open areas per order, turn and reposition or reminders to offload every 2 to 3 hours and as needed, weekly measurements and assessment of wound. R92's care plan dated 6/6/25, indicated R92 had an alteration in mobility related to generalized weakness and interventions indicated R92 required assist of one with movement in bed and in and out of bed, assist of 2 staff with a Hoyer for all transfers, and R92 could not ambulate. R92's care plan dated 6/6/25, indicated R92 had a self-care deficit, and her sling was to be left under her due to risk of friction and shear. Additionally, R92 had interventions for assist of 1 with grooming, bathing, dressing, was able to dress upper body, and required set up assist with personal hygiene. R92's Skin Evaluation and Skin Risk Factors form dated 6/5/25 at 8:07 p.m., indicated R92 had the following skin conditions: a surgical incision to the right breast measured 3.7 centimeters (cm) long, by 0.3 cm wide, a surgical incision to the right armpit measured 4.2 cm long by 0.5 cm wide. Further, R92 had bruising to the right and left lateral upper arms. The form lacked information regarding and assessment of the coloring of the bruising, size of the bruising or how R92 obtained the bruising. Further the form indicated R92 had the following risk factors that included medications, obesity, and diabetes. R92's Weekly Skin Inspection form dated 6/8/25 at 10:45 p.m., indicated R92 had an open surgical wound on the right breast and all other skin was clear and intact. R92's Weekly Skin Inspection form dated 6/22/25 at 8:44 p.m., indicated it was the nurse's responsibility to evaluate the resident's skin at a minimum of once a week to ensure skin integrity and implement interventions as applicable. The form indicated R92 refused a bath and nail care, however, the form indicated R92 had an open surgical wound on the right breast and all other skin was clear and intact. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R92's Skin and Wound Evaluation forms dated 6/24/25 , lacked information R92 had an open area to the left upper posterior arm. R92's Daily Skilled Note dated 6/5/25 at 10:09 p.m., The form lacked an assessment of R92's bruises, or R92 had a bruise. R92's Daily Skilled Note dated 6/6/25 at 1:01 p.m., The form lacked an assessment of R92's bruises or that R92 had a bruise. R92's Daily Skilled Notes dated 6/7/25 at 12:42 p.m., 6/8/25 at 1:03 p.m., 6/9/25 at 12:54 p.m., 6/9/25 at 9:45 p.m., 6/10/25 at 2:03 p.m., indicated R92 was alert and oriented to person, place, and time, did not have behaviors that included resisting care. The form indicated the same check box next to skin issues, and anticoagulant use. Further, the form indicated R92 was free from signs and symptoms of bleeding related to anticoagulant use, and the anticoagulant was administered as ordered. The forms lacked an assessment of R92's bruises or that R92 had a bruise, and further lacked information the bruises identified 6/6/25, had resolved. R92's Daily Skilled Notes dated 6/11/25 at 1:35 p.m., indicated R92 was alert and oriented to person, place, and time, did not have behaviors that included resisting care. The form indicated the same check box next to anticoagulant use. Further, the form indicated R92 was free from signs and symptoms of bleeding related to anticoagulant use, and the anticoagulant was administered as ordered. The form lacked an assessment of R92's bruises or that R92 had a bruise. Further, under a heading, Resident Response to Treatments & Additional Comments that indicated R92 did not have bruising or bleeding noted from anticoagulants. R92's MHM Daily Skilled Note dated 6/12/25 at 11:39 a.m., and 6/13/25 at 11:32 a.m., lacked an assessment of R92's bruises or that R92 had a bruise. R92's MHM Daily Skilled Notes dated 6/17/25 at 6:56 p.m., 6/18/25 at 10:23 a.m., 6/19/25 at 9:25 a.m., 6/20/25 at 1:29 p.m., 6/21/25 at 2:11 p.m., 6/23/25 at 11:37 a.m., and 6/24/25 at 1:06 p.m., lacked an assessment of R92's bruises or that R92 had a bruise, and further lacked information the bruises identified 6/6/25, had resolved. R92's Integrated Wound Care note dated 6/17/25, indicated R92 was seen for evaluation of wound sites to the front right axilla and the right breast. Further R92's surgical site on the right axilla was tender due to friction with the edge of the camisole and factors that affected R92's healing included diabetes, cancer, neuropathy, weakness, obesity, and reduced mobility. R92's Integrated Wound Care note dated 6/24/25, indicated R92 was seen for evaluation of the surgical wounds to the front right axilla and the right breast. The note lacked information R92 had a wound to the left upper posterior arm. R92's progress notes were reviewed from 6/5/25, to 6/24/25, and lacked documentation of bruising to arms or an open area assessment of the left upper posterior arm (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/25/25 at 9:27 a.m., to 9:44 a.m., registered nurse (RN)-B stated skin was assessed and documented weekly, and further stated skin was looked at daily. RN-B stated skin notes were in the Forms tab of their electronic medical record (EMR). RN-B stated they had to report bruising because you need to know how a resident obtained it and then management took pictures of skin issues. RN-B stated open areas had to be documented and if it was new, would utilize standing orders to clean and cover and further stated new bruises or new skin issues had to be assessed and the provider would place orders to either put pads on or keep skin clean and dry. RN-B stated bruises are monitored and when asked how RN-B knew if bruises were changing or getting worse, RN-B stated they would go by orders to monitor the bruise on the MAR or TAR every shift. RN-B stated R92 had wound pictures of R92's sore on her right side, but further stated she did not see any bruising documented and viewed orders and forms and stated there was no documentation of bruising. RN-B opened a Weekly Skin Assessment Form dated 6/8/25, and 6/22/25, and verified there was no documentation of bruising. Further RN-B viewed R92's Daily skin note dated 6/24/25 and verified it lacked information of R92 having a bruise and stated it would not be documented anywhere else. At 9:44 a.m., RN-B verified R92 had bilateral bruising to both arms along with the open area to R92's left arm near her arm pit and stated it had not been documented or measured and stated it should have been. R92 was wearing her tank/camisole again that was rolled up to under her breasts and her arms were exposed. During interview on 6/25/25 at 9:56 a.m., the director of nursing (DON) stated if a resident had a bruise an order needed to be placed to monitor the bruise, and the guardian and physician would be notified and they would complete a risk management form. The DON verified R92 did not have a risk management form. The DON stated a new bruise has color changes of dark red and purple and if a resident was alert and oriented would ask how they got it and would complete an incident analysis and would place a monitoring order and would resolve once the bruises were healed. The DON stated a fresh bruise was a dark purple. The DON stated she would have to review the policy in order to know how staff assessed residents to know whether bruising was getting worse. The DON further stated R92 had diabetes, breast cancer, was obese, and was on a blood thinner and stated the bruise was identified on admission and verified R92's medical record lacked information on the color, shape, or size of R92's bruise identified on 6/5/25. Further, the DON verified R92's chart lacked documentation R92 had an open area to her left arm and stated R92 refused her bath on 6/22/25, and stated there were no further assessments on R92's bruises. When asked about the lack of documentation of bruises in the Daily Skin Notes, the DON stated they would document new bruises. The DON stated she wondered if R92's open area on the left arm pit was from the day prior and verified there were no pictures of the wound on R92's left arm pit. Further, the DON could not explain how staff could identify whether a bruise documented from admission was the same bruise, or if a resident had a new bruise and could not explain how bruises were assessed or documented and stated she would have to check the policy. A late entry note created on 6/25/25 at 11:11 a.m., was entered into R92's progress notes for 6/24/25 at 8:09 a.m., that indicated, This writer and wound provider access resident armpits noted redness caused by the surgical garment. An additional progress note dated 6/25/25 at 11:44 a.m., was entered into R92's progress notes, Resident has bruises on her bilateral arms due to anticoagulant use. Redness noted under her right breast and Little open area on the left armpit. Provider updated. During interview on 6/25/25 at 12:18 p.m., nursing assistant (NA)-B stated R92 required a check and change and was alert. NA-B stated R92 could dress her top half after providing the top and further stated they completed skin checks when residents were changed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/26/25 at 11:49 a.m., the DON verified R92's Skin Evaluation and Skin Risk Factors form did not contain measurements for R92's bruises. A policy, Skin Assessment and Wound Management, dated 2/2025, indicated the purpose of the assessment was to provide guidelines for assessing and managing wounds. Further, prevention and identification included implementing preventative skin measures, a skin evaluation and skin risk factors form was completed before initial MDS, annually, and upon significant change. Further, staff would perform routine skin inspections with daily care and nurses were to be notified if skin changes were identified and a weekly skin inspection was completed by licensed staff. Further when a significant alteration in skin integrity is noted such as large or multiple bruising, or other non-pressure related wounds the following actions will be taken: notify the provider, treatment ordered, notify the representative, complete education with the resident including risks and benefits, initiate a skin and wound evaluation, notify the nurse manager, review and update the care plan including interventions. R2 R2's quarterly Minimum Data Set (MDS) assessment, dated 4/29/25, indicated R2 had severe cognitive impairment, no behaviors or rejections of care, and required substantial/maximal to dependent assistance with activities or daily living. R2's diagnoses included peripheral vascular disease, neurogenic bladder, diabetes mellitus, dementia, anxiety, and depression. R2 had an indwelling catheter, was always incontinent of bowel, and was at risk for pressure ulcers. R2's care plan, indicated R2 was at risk for skin alteration related to impaired memory, fragile skin, type one diabetes, peripheral vascular disease, and incontinence. Interventions included occupational therapy to eval (evaluation) and treat for wheelchair positioning, monitor skin integrity daily during cares and weekly skin inspection by nurse, treatment to open areas per order, cue and encourage to turn and reposition every two to three hours and as needed, pressure redistribution mattress to bed, pressure redistribution cushion to wheelchair and chair, and dietary interventions which included to encourage supplements as ordered. R2's physician orders, indicated: -Barrier cream after each incontinent episode and ensure to apply on the scrotum every shift with start date of 9/14/23 . -Wound cares to scrotum with incontinent cleanser (dimethicone active ingredient) and soft dry wipes every shift with start dated of 4/14/25 . R2's progress notes dated 4/7/25 to 6/25/25, indicated R2 was hospitalized on [DATE] and returned to the facility on 4/12/25. Progress notes reviewed indicated R2's skin was warm and dry with no open areas. R2's 4/12/25 hospital encounter, directed staff to continue cleansing scrotum with incontinent cleanser (dimethicone active ingredient) and soft dry wipes. R2's June 2025 Medication and Treatment Administration Record (MAR and TAR), indicated staff administered barrier cream every shift. Although R2’s wound care orders for his scrotum lacked being identified on the MAR and TAR. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/25/25 at 10:46 a.m., nursing assistant (NA)-A stated R2 had skin rashes which appear and heal but skin was clear now. During observation and interview on 6/25/25 at 10:59 a.m., registered nurse (RN)-E stated R2 had a scrotal wound which appeared and cleared. R2's scrotal area had barrier cream and appeared red after the barrier cream was wiped off. RN-E stated R2's scrotum was macerated at times. RN-E reviewed ingredients in the topical products used for R2. Tena Proskin cleansing cream had active ingredients of glyceryl stearates/cetearyl isononanoate. DermaRite PeriGuard ointment had active ingredient of petrolatum. Neither included dimethicone as an active ingredient ordered by provider. During interview on 6/26/25 at 10:37 a.m., the ADON stated R2 had a wound to his scrotum approximately two years ago and no current wound concerns to his scrotal area. The ADON was unsure of where the scrotal wound order with dimethicone came from. During interview on 6/26/25 at 11:00 a.m., licensed practical nurse (LPN)-B stated staff applied barrier cream to R2's scrotum and was not aware of anything else. LPN-B reviewed R2's order for wound care with dimethicone cream and stated the order did not show up on the MAR or TAR. During interview on 6/26/25 at 2:01 p.m., the director of nursing (DON) expected staff to follow orders and clarify orders as needed once residents returned from the hospital. The facility Skin Assessment and Wound Management policy dated 2/2025, directed staff to implement appropriate preventative skin measures and follow ongoing treatments per provider order.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to appropriately assess and help maintain range of motion and prevent possible contracture who had limited functional movement in the right hand for 1 of 2 residents (R16) reviewed for range of motion (ROM). Findings include:R16's Minimum Data Set (MDS) assessment dated [DATE], identified R16 had cognitive impairment and displayed no delusional thinking, with some rejection of cares. Further, R16 required moderate assistance to eat and perform oral hygiene. During observation and interview on 6/23/25 at 3:51 p.m., R16 was resting in bed and her daughter held up R16's right hand and stated she was concerned R16's hand and fingers were becoming more contracted; stating R16 is no longer able to hold silverware or brush her teeth on her own. R16 could previously do those things. During observation on 6/24/25 at 12:40 p.m., R16 had food present and was attempting to feed self. R16 was unable to use the silverware, instead R16 was picking up food with her left index finger and thumb. During interview on 6/25/25 at 10:27 a.m., assistant director of nursing (ADON) stated she does not recall if R16 had a brace for her right hand. ADON stated the importance of a brace for R16 would be to maintain function and prevent loss of range of motion (ROM).During interview on 6/25/25 at 12:33 p.m., physician assistant (PA) confirmed R16 had a contracture of the right hand; stating a physical therapy (PT) consult was ordered in December 2024. PA stated the normal process is the provider team will order the PT consult, once the PT consult is complete, the PT team will make recommendations. Once the provider team has recommendations, they will write PT orders for the resident based on the recommendations. PA confirmed R16 had an Xray of the right hand on 3/12/25, this imaging was limited due to the flexed position of the right hand. PA stated a brace could be important for R16 so that she does not lose any more ROM in her right hand.During interview on 6/25/25 at 12:53 p.m., physical therapy director (PT-D) stated the physical therapy department completed a PT consult on 12/11/24. The consult on this date did not address ROM needs of the right hand; the consult only addressed wheelchair positioning and upper body strengthening. PT-D confirmed the physical therapy department had not seen R16 since December 2024.A facility policy titled Therapy Services Agreement dated 11/17/2019, identified the facility maintains rehabilitation services with a therapy contractor. However, the facility retains responsibility for, and overall supervision of facility residents.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure timely reassessment after administration of as needed narcotic medication for 1 of 2 residents (R296) reviewed for pain.Findings include: R296's annual Minimum Data Set (MDS) assessment dated [DATE], indicated R296 had intact cognition and diagnoses of hypertension, cirrhosis (scarring of liver caused by many diseases and conditions which includes alcohol use disorder), gastro-esophageal reflux disease (condition in which stomach contents move up into the esophagus), viral hepatitis (infection which causes liver inflammation and damage), diabetes mellitus, fracture, anxiety disorder, depression, and chronic obstructive pulmonary disease (condition caused by damage to airways and other parts of the lung). R296 received as needed pain medications. The MDS indicated R296 had pain almost constantly and the pain occasionally effected sleep and interfered with therapy activities and day-to-day activities. R296's care plan, indicated R296 had chronic hip pain and acute lumbar spine fracture, history of substance abuse, and followed by the pain management team. The care plan indicated R296 made statements of only wanting oxycodone as pain relief, rated pain at eight or nine out of ten without nonverbal indicators of pain or discomfort, and had a history of opioid abuse.The care plan directed staff to provide nonmedicinal forms of pain relief such as positioning, rest, and massage, administer pain medication as ordered, document on effectiveness of pain medication, encourage R296 to verbalize discomfort, monitor for potential medication side effects related to medication usage. R296's Pain Evaluation dated 6/19/25, indicated R296 rated his pain at ten out of ten with a verbal description of moderate. The evaluation indicated R296 complained or showed evidence of pain or possible pain daily. R296's pain treatment included gabapentin 100 milligrams (mg) twice a day and oxycodone 5 mg as needed every six hours. R296's physician order dated 6/19/25 indicated, oxycodone HCl (hydrochloride), opioid painkiller used to relieve moderate to severe pain, 5 milligrams (mg) by mouth every six hours as needed for pain. R296's progress notes, order administration notes, pain scores, and medication administration record dated 6/20/25 through 6/23/25 were reviewed and indicated:-On 6/20/25 at 11:23 a.m., oxycodone was given for back pain rated at seven out of ten for pain. At 2:35 p.m., the as needed medication was marked as effective and follow-up pain score was zero out of ten.-On 6/20/25 at 8:04 p.m., oxycodone was given for pain rated at two out of ten. On 6/21/25 at 1:40 a.m., the as needed medication was marked as unknown. No other interventions or notifications were noted.-On 6/21/25 at 5:17 a.m., oxycodone was given for pain rated eight out of ten. At 6:56 a.m., a progress note indicated R296 slept for the most part of the night and requested as needed oxycodone which was given. At 11:36 a.m., the as needed medication was marked as ineffective and follow-up pain score was seven out of ten.-On 6/21/25 at 11:40 a.m., oxycodone was given for back pain rated at seven out of ten. At 12:54 p.m., a progress note indicated R296 had lower back pain rated at seven out of ten, pain medication was given, and pain was unchanged. No other interventions or notifications were noted. At 4:19 p.m., the as needed medication was marked as effective and follow-up pain score was two out of ten.-On 6/21/25 at 6:22 p.m., oxycodone was given for pain rated at three out of ten. At 8:05 p.m., a progress note indicated R296 had no signs or symptoms of pain. At 8:49 p.m., the as needed medication was marked as effective and follow-up pain score was two out of ten.-On 6/22/25 at 2:34 a.m., oxycodone was given for pain rated at seven out of ten. At 3:43 a.m., the as needed medication was marked as effective and follow-up pain score was zero out of ten.-On 6/22/25 at 9:23 a.m., oxycodone was given for back pain rated at seven out of ten. At 12:46 p.m., a progress note indicated R296 had lower back pain rated seven out of ten, pain medication given, and pain unchanged. At 2:04 p.m., the as needed medication was marked as ineffective and follow-up pain score was seven out of ten. No other interventions or notifications were noted. -On 6/22/25 at 6:20 p.m., a progress note indicated R296 did not have signs or symptoms of pain.-On 6/22/25 at 9:55 p.m., oxycodone was given for pain rated four out of ten. On 6/23/25 at 5:10 a.m., the as needed medication was marked as ineffective and the follow-up pain score was eight out of ten. No other interventions or notifications were noted.-On 6/23/25 at 5:11 a.m., oxycodone was given for pain rated eight out of ten. At 11:57 a.m., the as needed medication was marked as ineffective and the follow-up pain score was seven out of ten. No other interventions or notifications were noted.-On 6/23/25 at 12:22 p.m., oxycodone was given for back pain rated at seven out of ten. At 5:58 p.m., the as needed medication was marked as effective and the follow-up pain score was zero out of ten. During interview on 6/23/25 at 2:29 p.m. R296 stated he struggled with pain to his right side of his abdomen where there was a recent bleed, which

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to comprehensively assess past trauma and implement individualized care plan interventions utilizing a trauma-informed approach for 1 of 1 (R19) resident reviewed who had post-traumatic stress disorder (PTSD).Findings include:R19's Minimum Data Set (MDS) dated [DATE], identified intact cognition, was independent with eating, dressing, toileting, and walking. Diagnosis included depression, schizophrenia, and post-traumatic stress disorder (PTSD). The Care Area Assessment Summary of the MDS for psychosocial well-being was not completed.R19's provider's history and physical note dated 10/9/23 indicated R19 had a diagnosis of schizophrenia, depression, and suicidal ideation. Further, R19 had PTSD due to religious persecution, starvation, and violence suffered in the Sudan; further being complicated by increased life stressors, unspecified psychosis, and alcohol use disorder.Initial review of R19's care plan dated 10/10/23, the focus lacked individualized trauma-informed approaches or interventions and lacked identification of triggers to avoid potential re-traumatization. During an interview on 6/24/25 at 2:20 p.m., nursing assistant (NA)-C was not aware of R19's PTSD diagnosis or history, triggers, or patient-centered trauma informed care interventions.During an interview on 6/24/25 at 2:24 p.m., registered nurse (RN)-D stated she was not aware of R19's PTSD diagnosis or history. RN-D stated R19 can become withdrawn, quiet, and refuse to come out of her room at times. RN-D stated she is not aware if these are coping mechanisms related to her PTSD. RN-D reviewed the care plan for R19, confirmed the care plan did have a PTSD care plan. RN-D stated the care plan only stated that R19 had a PTSD diagnosis; the care plan did not specify what the PTSD was from nor what the triggers are. RN-D stated that is why she probably didn't know or remember R19 had PTSD was because the care plan didn't outline anything about R19's PTSD.During interview on 6/25/25 at 10:27 a.m., assistant director of nursing (ADON) stated R19 did have a care plan for PTSD. ADON confirmed the care plan had the following interventions:-referral for psych services as appropriate-staff will utilize trauma informed care when working with resident-connect resident to community services as appropriate -consider past trauma when engaging with resident-Complete PHQ-9 (depression screening) per facility policy and as needed-Notify relevant providers about change in condition or behavior-Encourage collaboration with social services or psych to improve social connections and minimize symptomologyADON confirmed the care plan did not provide detail about R19's PTSD diagnosis or triggers, nor did the care plan outline resident-specific interventions.Per facility policy titled Trauma Informed Care dated 2/24/23, residents that have a history of trauma will have goals and interventions added to their care plan to address potential triggers and approaches to minimize or eliminate the effect of the trigger on the resident.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed the ensure residents were free from unnecessary medications for 1 of 2 residents (R25) reviewed for diuretic use. Findings include: R25's admission Minimum Data Set (MDS) assessment, dated 5/21/25, indicated R25 was cognitively intact with no behaviors or delirium. R25 had range of motion to one side of her upper body and required partial to moderate assistance with activities of daily living. R25 received diuretic medication. R25's diagnosis list included chronic respiratory failure, essential hypertension (high blood pressure), chronic kidney disease, and chronic diastolic congestive heart failure (CHF-heart disease that causes buildup of fluid in the body). R25's care plans included diuretic therapy related to hypertension and congestive heart failure. Interventions included administer medication as ordered and potential side effects that included dizziness, postural hypotension (drop in blood pressure with position changes), fatigue, and increased risk of falls. R25's admission orders dated 5/15/25 included torsemide 20 mg (milligrams) tablet for chronic heart failure. For weight 208-216 lbs (pounds)take 40 mg twice a day, for weight greater than 217 lbs take torsemide 80 mg BID. For weight less than 208 lbs, hold torsemide. R25's weight from date of admission on [DATE] to 6/25/25 ranged from 183.9 to 198 lbs. R25's medication administration record (MAR) for May and June indicated the following: -Torsemide 40 mg by mouth two times a day for CHF for weight 208-216 lbs. for weight less than 208 hold torsemide. -Torsemide 80 mg by mouth two times a day for CHF for weight greater than 217lbs. For weight less than 208 lbs hold torsemide. Both orders contained a check box in the electronic medical record to document the weight and if the medication was given along with staff initials. The May MAR indicated R25 received the following doses of torsemide:5/16-120 mg - PM shift. Weight 193.55/18-120 mg - PM shift. Weight 1945/20-120 mg - PM shift. weight 191.55/21-120 mg - PM shift. Weight 192.55/28-120 mg - PM shift. Weight 195.5 The June MAR indicated R25 received the following doses of torsemide:6/3-120 mg - PM shift. Weight 192.56/4-120 mg - PM shift. Weight 1936/8-120 mg - AM and PM shift. Weight 197.56/12-120 mg - AM shift Weight 1956/17-120 mg - PM shift. Weight 195.56/18-40 mg - AM shift. Weight 1886/19-40 mg - AM shift. Weight 184.56/20-40 mg - AM shift. Weight 185.56/21-40 mg - AM shift and 80mg on PM shift. Weight 183.86/22-40 mg - AM shift and 120 mg on PM shift. Weight 184.56/23-40 mg - AM shift. Weight 184. 56/24-40 mg - AM shift. Weight 183.46/25-120 mg - AM shift. Weight 183.9 During interview on 6/25/25 at 1:00 p.m., registered nurse (RN)-A stated R25 received torsemide 80 mg and 40 mg for a total of 120 mg the morning of 6/25/25. R25's weight was 183.9. RN-A reviewed the torsemide order and stated, it doesn't make sense, it's confusing, I should have clarified it. RN-A confirmed the torsemide should have been held based on R25's weight. RN-A stated if the MAR indicated a check mark, the medication was given. If the MAR indicated 5 the medication was held and 9 indicates a progress note was made, and the medication was probably not given. During interview on 6/25/25 at 1:58 p.m., the nurse practitioner (NP) stated resident's weights are reviewed automatically and confirmed R25's weights have been less than 200 since admission. The NP confirmed the order for torsemide and stated R25 should not have received any doses of torsemide since admission. During interview and observation on 6/25/25 at 2:08 p.m., RN-A stated R25 has two cards of torsemide 20mg tablets. Both cards were noted in the medication cart. Both cards contained spots which could house the medication one card had 16 punched out and the other card had 3 punched out. RN-A stated if R25 needed 80 mgs, 4 tablets would be removed and if 40 mg was required, 2 tablets would be given. RN-A stated if tablets were missing from the cards, the medication was given, however there was no way to indicate from the cards what dose or what date R25 received the medication. During an interview on 6/25/25 at 2:25 p.m., the licensed practical nurse (LPN)-A stated a 2 on the MAR indicates refused, 3 indicates a resident is out, 5 means a medication is held, and 9 indicates a nurse's note was made. LPN-A stated she reviews the staff progress notes if a 9, 5, or 3 is documented. If the medication is marked and a note is not made, then it is assumed the medication is given. LPN-A reviewed the torsemide order on R25's June MAR and noted several doses contained .9 (initials of staff protected). LPN-A stated the xxx9 with the check mark indicated the medication wasn't given because it contained the number 9. It was noted all of R25's medications on those days had .9. When asked if that meant R25 did not receive any of her prescribed medications for those days LPN-A said no. LPN-A confirmed .9 was the initials of a staff who administered the medication those days. A copy of the electronic medical record staff identifier confirmed .9 identifies the staff member and does not indicate a medication was not given. During interview on 6/26/25 at 9:35 a.m., the

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure medical records were complete and accurately documented for 2 of 2 residents (R92, R25) reviewed. Findings include: For additional details please see F684 and F757. R92's admission Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, did not have delusions or hallucinations, physical, verbal, or other behavioral symptoms, and did not reject care. R92's diagnoses included cancer, wound infection, diabetes, and arthritis. Furthermore, R92 was at risk for developing pressure injuries, had surgical wounds, and took an anticoagulant (blood thinner). During observation and interview on 6/23/25 between 2:14 p.m., and 2:17 p.m., R92 had bruises bilaterally to the back of her upper arms. R92's right arm had a bruise approximately the size of a grapefruit and the bruise located on R92's left arm went from R92's arm pit area to her elbow and was purple towards the elbow and a faded yellow color on the upper part of R92's left arm. R92's left posterior arm at armpit crease had a small nail head sized open area. An ABD (dressing) pad was tucked in next to the area, but did not cover the open area. R92's orders were reviewed and lacked documentation or treatment instruction for an ABD pad related to the open area to the left arm pit area. R92's Physician's Orders form, indicated the following orders: 6/6/25, Complete Daily Skilled Note under forms in PCC (facility electronic medical record). State why the resident is currently being covered for #6 skin issue, #7 infection, #9 diabetes, #13 anticoagulant. 6/8/25, Monitor for … bruising, …. 0=No Symptoms, +=See NN (nurse note). 6/8/25, weekly skin inspection by the licensed nurse. Complete weekly skin inspection in PCC. R92's record lacked specific assessment and monitoring to bruising to R92's upper arms. R92's orders lacked instruction for treatment to R92's open area to her left upper posterior arm. R92's Skin Evaluation and Skin Risk Factors form dated 6/5/25 at 8:07 p.m., indicated R92 had the following skin conditions: a surgical incision to the right breast that measured 3.7 centimeters (cm) long, by 0.3 cm wide, a surgical incision to the right armpit that measured 4.2 cm long by 0.5 cm wide. Further, R92 had bruising to the right and left lateral upper arms. The form lacked information regarding and assessment of the coloring of the bruising, size of the bruising or how R92 obtained the bruising. Further the form indicated R92 had the following risk factors that included medications, obesity, and diabetes. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R92's Skin and Wound Evaluation forms dated 6/6/25, 6/17/25, and 6/24/25 the form dated 6/24/25, lacked information R92 had an open area to the left upper posterior arm. R92's Daily Skilled Note dated 6/5/25 at 10:09 p.m., lacked an further assessment of R92's bruises, or that R92 had a bruise. R92's Daily Skilled Note dated 6/6/25 at 1:01 p.m., lacked an assessment of R92's bruises or that R92 had a bruise. R92's Daily Skilled Notes dated 6/7/25 at 12:42 p.m., 6/8/25 at 1:03 p.m., 6/9/25 at 12:54 p.m., 6/9/25 at 9:45 p.m., 6/10/25 at 2:03 p.m., lacked an assessment of R92's bruises or that R92 had a bruise, and further lacked information the bruises identified 6/6/25, had resolved. R92's Daily Skilled Notes dated 6/11/25 at 1:35 p.m., lacked an assessment of R92's bruises or that R92 had a bruise. Further, under a heading, Resident Response to Treatments & Additional Comments that indicated R92 did not have bruising or bleeding noted from anticoagulants. R92's Daily Skilled Note dated 6/12/25 at 11:39 a.m., and 6/13/25 at 11:32 a.m., lacked a check mark in the check box next to anticoagulant use. The form lacked an assessment of R92's bruises or that R92 had a bruise. R92's Daily Skilled Notes dated 6/17/25 at 6:56 p.m., 6/18/25 at 10:23 a.m., 6/19/25 at 9:25 a.m., 6/20/25 at 1:29 p.m., 6/21/25 at 2:11 p.m., 6/23/25 at 11:37 a.m., and 6/24/25 at 1:06 p.m., indicated R92 was alert and oriented to person, place, and time, did not have behaviors that included resisting care. The form indicated the same check box next to skin issues, and anticoagulant use. Further, the form indicated R92 was free from signs and symptoms of bleeding related to anticoagulant use, and the anticoagulant was administered as ordered. The forms lacked an assessment of R92's bruises or that R92 had a bruise, and further lacked information the bruises identified 6/6/25, had resolved. R92's progress notes were reviewed from 6/5/25, to 6/24/25, and lacked documentation of bruising to arms or an open area assessment of the left upper posterior arm. During interview on 6/25/25 at 9:27 a.m., to 9:44 a.m., registered nurse (RN)-B stated R92 had wound pictures of R92's sore on her right side, but further stated she did not see any bruising documented and verified orders and forms and stated there was no documentation of bruising. RN-B indicated the Weekly Skin Assessments and Daily skin note lacked documentation of R92’s bruising. At 9:44 a.m., RN-B verified R92 had bilateral bruising to both arms along with the open area to R92's left arm near her arm pit and stated it had not been documented or measured and stated it should have been. During interview on 6/25/25 at 9:56 a.m., the director of nursing (DON) stated if a resident had a bruise an order needed to be placed to monitor the bruise and the guardian and physician would be notified and they would complete a risk management form. DON stated the bruise was identified on admission although verified R92's medical record lacked information on the color, shape, or size of R92's bruise identified on 6/5/25. Further, the DON verified R92's chart lacked documentation R92 had an open area to her left arm and stated R92 refused her bath on 6/22/25, and stated there were no further assessments on R92's bruises. DON stated staff would document new bruises in the Daily Skin Notes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245492	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at Richfield	7727 Portland Avenue South Richfield, MN 55423

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy, Skin Assessment and Wound Management, dated 2/2025, indicated the purpose of the assessment was to provide guidelines for assessing and managing wounds. Further, prevention and identification included implementing preventative skin measures, a skin evaluation and skin risk factors form was completed before initial MDS, annually, and upon significant change. Further, staff would perform routine skin inspections with daily care and nurses were to be notified if skin changes were identified and a weekly skin inspection was completed by licensed staff. Further when a significant alteration in skin integrity is noted such as large or multiple bruising, or other non-pressure related wounds the following actions will be taken: notify the provider, treatment ordered, notify the representative, complete education with the resident including risks and benefits, initiate a skin and wound evaluation, notify the nurse manager, review and update the care plan including interventions. A policy was requested, however in an email dated 6/25/25 at 12:01 p.m., the DON indicated the facility did not have a policy regarding complete and accurate documentation. R25 R25's admission Minimum Data Set (MDS) assessment, dated 5/21/25, indicated R25 was cognitively intact with no behaviors or delirium. R25 had range of motion to one side of her upper body and required partial to moderate assistance with activities of daily living. R25 received diuretic medication. R25's care plans included diuretic therapy related to hypertension and congestive heart failure. Interventions included administer medication as ordered and potential side effects that included dizziness, postural hypotension (drop in blood pressure with position changes), fatigue, and increased risk of falls. R25's admission orders dated 5/15/25 included torsemide 20 mg tablet for chronic heart failure. For weight 208-216 lbs take 40 mg twice a day, for weight greater than 217 lbs take torsemide 80 mg BID. For weight less than 208 lbs, hold torsemide. R25's medication administration record (MAR) for May and June indicated the following: -Torsemide 40 mg by mouth two times a day for CHF for weight 208-216 lbs. for weight less than 208 hold torsemide. -Torsemide 80 mg by mouth two times a day for CHF for weight greater than 217lbs. For weight less than 208 lbs hold torsemide. Both orders contained a spot to document the weight and a spot to document if the medication was given along with staff initials. The May MAR indicated R25 received torsemide five times weighing under 208 lbs. The June MAR indicated R25 received torsemide 13 times weighing under 208lbs. During interview on 6/25/25 at 1:00 p.m., registered nurse (RN)-A stated R25 received torsemide 80 mg and 40 mg for a total of 120 mg the morning of 6/25/25. R25's weight was 183.9. RN-A confirmed the torsemide should have been held based on R25's weight. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/25/25 at 1:58 p.m., the nurse practitioner (NP) stated resident's weights are reviewed automatically and confirmed R25's weights have been less than 200 since admission. The NP confirmed the order for torsemide and stated R25 should not have received any doses of torsemide since admission. During an interview on 6/25/25 at 2:25 p.m., the licensed practical nurse (LPN)-A stated a 2 on the MAR indicates refused, 3 indicates a resident is out, 5 means a medication is held, and 9 indicates a nurse's note was made. LPN-A stated she reviews the staff progress notes if a 9, 5, or 3 is documented. If the medication is marked and a note is not made, then it is assumed the medication is given. LPN-A reviewed the torsemide order on R25's June MAR and noted several doses contained .9 (initials of staff protected). LPN-A stated the xxx9 with the check mark indicated the medication wasn't given because it contained the number 9. It was noted all of R25's medications on those days had .9. When asked if that meant R25 did not receive any of her prescribed medications for those days LPN-A said no. LPN-A confirmed .9 was the initials of a staff who administered the medication those days. A copy of the electronic medical record staff identifier confirmed .9 identifies the staff member and does not indicate a medication was not given. During interview on 6/26/25 at 9:35 a.m., the director of nursing (DON) stated she reviewed R25's MAR and spoke to all the staff. The DON stated R25 received torsemide 120 mg on the evening of 6/22/25 however the remaining days the staff reported punching out the medication out of the card, reviewing the weights, and then wasting the medication in the medsafe. A medication destruction record was requested however, the director of nursing stated staff are only required to document wasting narcotic medications, there is no record of other medications wasted. The director of nursing stated she would expect the staff to review R25's weights prior to punching out the medication. She would also expect the staff to correctly document in the MAR if a mediation was given or not A policy for medication administration was requested but not received.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure proper placement of catheter bag for 1 of 1 resident (R2) reviewed for catheter use.Findings include: R2's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R2 had severe cognitive impairment, no behaviors or rejections of care, and required substantial/maximal to dependent assistance with activities or daily living. R2's diagnoses included peripheral vascular disease, neurogenic bladder, diabetes mellitus, dementia, anxiety, and depression. R2 had an indwelling catheter, was always incontinent of bowel, and was at risk for pressure ulcers. R2's care plan printed, indicated R2 had a suprapubic catheter. Staff were to provide assistance with peri-cares in the morning, at bedtime, and as needed, monitor for signs/symptoms of UTI, monitor catheter output, provide catheter care per policy, change catheter per policy, apply protect cream after each incontinent episode, encourage only and nutritional intake, and monitor bowel movements as they occurred. R2's physician order dated 6/23/25, indicated R2 had a size 16 Fr (French) suprapubic catheter. During observation on 6/23/25 at 12:15 p.m., R2 was sitting in his wheelchair at the end of the hallway in front of the television. R2's catheter bag was on the floor. At 1:00 p.m., R2's catheter bag was still on the floor. At 1:23 p. m., R2's catheter bag was hooked on the back of his wheelchair strap and still touched the floor. During interview on 6/23/23 at 1:24 p.m., nursing assistant (NA)-E verified R2's catheter bag was touching the floor. NA-E stated there was a cover to place R2's catheter bag in, forgot to put the cover on the wheelchair, and believed the cover was in R2's room. During interview on 6/26/25 at 2:01 p.m., the director of nursing (DON) expected catheter bags to be placed inside a cover and off the floor for infection control purposes. The Infection Prevention and Control Program dated 11/2024, directed staff to prevent infection by instituting measures to avoid complications or spread of infection and educating staff and ensuring they adhere to proper techniques and procedures.