



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 3, 2026

Administrator
THE VILLAS AT ST LOUIS PARK
7500 WEST 22ND STREET
SAINT LOUIS PARK, MN 55426

RE: CCN:245182
Cycle Start Date: February 13, 2026

Dear Administrator:

On February 13, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 426-0175

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued, and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by **May 13, 2026** (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social

Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by **August 13, 2026** (six months after the identification of noncompliance), your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145

St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "H. Zahler". The signature is stylized with a large, looped "H" and a cursive "Zahler".

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
St. Paul, MN 55164-0899
Office: 651-201-4384 | Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245182		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/13/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET , SAINT LOUIS PARK, Minnesota, 55426			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E0000	Initial Comments On 2/9/26 to 2/13/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			E0000			03/31/2026
F0000	INITIAL COMMENTS On 2/9/26 to 2/13/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H51825383C (iQIES# 2730572) H51825384C (iQIES# 2724824) H51825386C (iQIES# 2718827) H51825387C (iQIES# 2669806) H51825389C (iQIES# 2575207) H51825390C (iQIES# 1051933) H51825391C (iQIES# 1051927) H51825392C (iQIES# 1051924) H51825393C (iQIES# 1051920) H51825394C (iQIES# 1051908)			F0000			03/31/2026

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 reverse for further 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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DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

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F0000	Continued from page 1 The following complaints were reviewed with deficiencies cited: H51823201C (iQIES# 2710643) with deficiency cited at F825. H51825385C (iQIES# 2671824) with deficiency cited at F584. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations have been attained.			F0000			
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.			F0550	F-550 Resident Rights/Exercise Rights R 84 has been assisted with removal of chin hair and CP has been updated to include resident's preference All residents have the potential to be affected by deficient practice and have been audited and offered grooming of facial hair any refusal will be documented and Care Planned Nursing staff will be educated on offering grooming as part of ADL's Audits will be conducted 2 x per week for 4 weeks, then weekly for 4 weeks to ensure compliance. Audits to be reviewed in QAPI for review. Corrections will be monitored by Director of Nursing and or Designee		03/31/2026

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F0550 SS = D	Continued from page 2 The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure facial hair was trimmed for 1 of 1 residents (R84) reviewed for dignity. R84's quarterly Minimum Data Set (MDS) dated 1/26/26, included R84 was cognitively intact. R84's diagnoses included arthritis, stroke, and dementia. R84 had impairment to both upper extremities. R84 required substantial to maximum assistance with personal hygiene, which included shaving. During observation on 2/9/26 at 1:30 p.m., R84 was observed with ¼ to ½ inch long white hairs on her chin. R84 had contractures on both of her hands and commented on how she was unable to open her hands because it was too painful. R84's electronic medical record included a note entered by social worker (SW)-A on 2/9/26 at 3:04 p.m., including SW-A offered to have her face shaved, which resident agreed too. During interview on 2/11/26 at 8:14 a.m., SW-A stated she does not do hands on care with residents. SW-A confirmed she noticed R84 had long chin hair and offered to find someone shave it for her. SW-A declined to estimate on the length of the chin hair prior to it being shaved. SW-A stated facial hair preference should have been included in a resident's care plan. During interview on 2/11/26 at 11:42 a.m., nursing			F0550			

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F0550 SS = D	Continued from page 3 assistant (NA)-A stated staff offeres to shave facial hair daily when they are assisting residents with morning grooming. NA-A stated she did not know any female residents who refused to have their face shaved when offered. During interview on 2/11/26 at 11:48 a.m., NA-B confirmed staff assisted with shaving facial hair. NA-B stated she was unaware of R84 refusing to have her facial hair shaved when offered. During interview on 2/11/26 at 12:32 p.m., family member (FM)-A stated R84 would have preferred to have her facial hair removed. During interview on 2/12/26 at 12:01 p.m., R84 confirmed she would have preferred her facial hair to be shaved. During interview on 2/11/26 at 1:03 p.m., director of nursing (DON) stated she expected staff to brush hair, teeth and other basic grooming daily. DON stated she expected nail care to be completed weekly and shaving to be offered weekly. DON expected staff to reapproach if the resident refused and to add a progress note if a resident continued to refuse. Facility policy for activities of daily living dated 3/31/23, included care and services would be person-centered and honor and support each resident's preferences.			F0550			
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure a self-administration of medications assessment was completed to allow residents to safely administer their own medications for 2 of 2 residents (R37, R75) observed with medications at bedside.			F0554	F-554 Resident Self-Admin Meds-Clinically Approp R-75 self-administer assessment complete and appropriate to have Lozenges at bedside to self admin. Nurses involved in leaving medications at bedside without approval for R37 and R75 have been educated All Residents have the potential to be affected by deficient practice and have been audited for self-administration of medications. All Nurses educated on not leaving medications at bed side if no Doctor order and self-administer assessment is not complete and deams them appropriate to		03/31/2026

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F0554 SS = D	Continued from page 4 Findings include: R37's admission record dated 12/4/25, indicated R37 admitted to the facility 12/4/25, and had the following diagnoses: heart failure, chronic kidney disease stage 4, anemia and hypertensive urgency. R37's order summary report dated 2/17/26, included orders for the following medications: Carvedilol 25mg, Ergocalciferol 1.25mg, Furosemide 20mg, Omeprazole 20mg, Sodium bicarbonate 650mg, Lyrica 25mg, Methocarbamol 500mg. The provider signed order summary report lacked an order for self-administration of medications or an order to leave dispensed medications at the bedside. R37's medical record lacked evidence of a self-administration of medication evaluation being completed. During initial resident screening/observation on 2/10/26 at 8:58 a.m., R37 was in room seated on bed with bedside table pushed next to bed. A tray of food was noted on bedside table. A medication cup with approximately 6 unidentified pills/capsules was noted on the food tray. Registered nurse (RN-E) entered room and asked R37 if she was done with her meds. R37 stated she was not but that she would take them. RN-E then picked up the medication cup of unidentified medications and left the room. R37 stated staff 'always leaves my meds here'. During interview on 2/13/26 at 11:28 a.m., Director of Nursing (DON) stated residents who wish to take medications independently needed to have a physician's order and must be assessed as being competent to safely self-administer medications. DON stated staff should never leave medications at the beside for a resident to self-administer without an order or a complete self-administer assessment. DON confirmed R37 did not have an order to self-administer medications and no self-administering assessment had been completed for R37. DON stated she expected staff to confirm a resident had a physician's order and self-administering assessment completed prior to allowing a resident to self-administer medications. DON stated this was important to ensure a resident was taking medications as prescribed and not missing doses or stockpiling medications. R75's quarterly Minimum Data Set (MDS) dated 2/5/26, included R75 was cognitively intact. R75's diagnoses	F0554	Continued from page 4 self-administer medications Audits will be conducted 2 x per week for 4 weeks, then weekly for 4 weeks. Audits will be reviewed in QAPI for compliance. Correction will be monitored by Director of Nursing and or Designee	

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F0554 SS = D	Continued from page 5 included stroke and Barrett’s esophagus with dysplasia (a condition where the lining of the esophagus changes). R75’s order summary report dated 2/13/26, included an order for biotine lozenges per package directions per patient request. Order summary report failed to include an order for self-administration of medications. R75’s self-administration of medication evaluation dated 11/5/25, included a summary that R75 lacked the capacity for self-administration of medications. During observation on 2/9/26 at 4:49 p.m., R75 had throat lozenges in her room on her bedside table. R75 stated her provider was aware she used them and recommended them for her dry mouth. She said her brother currently purchased them and brought them to her. During observation on 2/10/26 at 1:04 p.m., R75 had a biotine lozenge in a white cup on her tray table and two Halls cough drops. R75 stated she had more lozenges in a box in her room. During interview on 2/10/26 at 4:09 p.m., registered nurse (RN)-A confirmed R75 had biotine lozenges in her room and that she was able to take them independently. RN-A stated a resident would need an assessment completed by the nurse manager and an order from a provider prior to keeping medications in their room. During interview on 2/10/26 at 4:16 p.m., nurse manager (RN)-B stated an order was needed from a provider prior to self-administration of medication and a self-administration assessment completed to ensure the resident was safe to manage medications. RN-B confirmed R75 did not have a provider order for self-administration of medication or a current self-administration assessment that stated she was able to manage the medications. During interview on 2/11/26 at 1:20 p.m., director of nursing (DON) stated an assessment needed to be completed prior to a resident self-administering medication. The DON stated an order was also needed from a provider. The DON confirmed the facility was			F0554			

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F0554 SS = D	Continued from page 6 aware R75 was utilizing the biotin lozenges, but a self-administration assessment was not completed. Facility self-administration policy dated February 2024, included a resident who wished to self-administer medications would have a comprehensive assessment to evaluate the cognitive and physical abilities of the resident. The resident would need to be able to store the medication in a safe area that was not accessible to other residents.			F0554			
F0582 SS = D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is			F0582	F-582 Medicaid/Medicare Coverage/Liability Notice R-27 Has discharged from facility. Residents who are on a Medicare Part A stay or Managed A plan have the potential of being affected by the deficient practice. Business office Manager has been educated on providing Notice of Medicare Non-Coverage at least 48 hours prior to end of coverage. Audits will be conducted 2 x per week for 4 weeks then weekly for 4 weeks, Audits will be reviewed in QAPI for compliance. Corrections will be monitored by Business office Manager and or Administrator/ Designee		03/31/2026

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F0582 SS = D	Continued from page 7 transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a Notice of Medicare Non-Coverage (CMS-10123 - NOMNC) was provided at least two days before the end of a Medicare-covered Part A stay for for 1 of 3 residents (R23) whose Medicare covered Part A stay ended. Findings include: R27's Comprehensive Minimum Data Set (MDS) dated 2/16/26, indicated R27 was cognitively intact. R27's Notice of Medicare Non-Coverage (NOMNC) indicated services would end on 1/30/26. However, R27 signed and dated the form on 1/29/26, which was less than two days before the end of Medicare-covered Part A services. R27's electronic health record (EHR) lacked evidence that a NOMNC had been provided to R27 at least two days before the end of the Medicare-covered Part A stay. On 2/12/26 at 11:34 a.m., the business office manager (BOM) verified R27's NOMNC indicated the last covered day was 1/30/26, and R27 signed the NOMNC on 1/29/26. BOM stated the NOMNC should have been provided to the resident three days before the last covered day. On 2/13/26 at 3:09 p.m., the associate administrator stated staff were expected to provide and explain the			F0582			

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F0582 SS = D	Continued from page 8 NOMNC at lease 48 hours before the end of a Medicare-covered Part A stay so residents had adequate time to make decisions regarding their care. The facility's ABN/NOMNC Policy and Procedure, effective 2/20/23, indicated the NOMNC was used for communicating appeal rights and appeal information, and would be completed within 48 hours of being notified of the last covered day for a Medicare/Manage Care primary resident.	F0582			
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels	F0584	F-584 Safe/Clean/Comfortable/Homelike Environment R82 Drawer has been replaced, and appropriate tracks are on the drawers, Closet doors have also been repaired so they close properly. Room is on the model list for new cabinets and drawers. LTC rooms have been audited and plan in place for remodeling of rooms. Maintenance has been educated on repairs done timely and assessing for any safety issues as pertains to environment. Audits will be completed weekly for 4 weeks, then 2x per month for 2 months. Audits will be reviewed in QAPI for Compliance Corrections Monitored by Maintenance/ Administrator and or Designee	03/31/2026	

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F0584 SS = D	Continued from page 9 in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to ensure resident rooms were kept in good working condition for 1 of 2 (R82) reviewed for environment. Findings include: R82's undated face sheet, indicated R82 was admitted on 11/22/2024, and had the following diagnoses: borderline personality disorder, pain, anxiety, insomnia, neuropathy (nerve pain), and depression. Durning the screening process on 2/10/26 at approximately 9:20 a.m., R82 stated their drawers, and closet had been broken for a long time, and they had nowhere to keep their belongings. R82 stated they had reported their concern to the facility social worker, filed maintenance reports and they were still broken. R82 stated the maintenance department had come and tried to fix the issue but were not able to, and it needed to be replaced. Writer observed the drawers and closet in the room, the drawers lacked any pull tracks and when pulled would come out of the cabinet with very little effort, if they were not being held strongly, they would have fallen to the floor. All the drawers shared the same characteristics. Additionally, the closet doors did not close. R82 voiced their frustration of not being able to store anything other than very light weight items in the drawers and having no shelving in the closets to be able to store items, because of this they had to keep their belongings in bags and boxes throughout the room. The Facility work order #12986 dated 9/3/25, indicated maintenance had been requested for R82's room, which stated, "the front of the drawers are coming off, and hooks for hanging". The order was marked as complete on 9/22/25. The facility work order #13074 dated 10/15/25, indicated a maintenance request for R82's room, which		F0584				

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F0584 SS = D	Continued from page 10 stated, "Drawers and cabinets need to be addressed and resolved". The order was marked as complete on 10/17/25. The facility work order #13135 dated 11/19/2025, indicated a maintenance request for R82's room, which stated, "Drawers are unusable-off the track and broken". The order was marked as complete on 11/26/25. On 12/16/2025 at 1:44 p.m., an email chain between the administrator and the director of plant operations of Monarch indicated they were aware of the need for room renovations. On 2/13/26 at 10:02 a.m., the maintenance director (MD) stated they had been aware of the maintenance concerns and request related to the R82's broken drawers and closet. MD confirmed they had attempted to fix the problem however the items were due to be replaced in a remodel of the building; however, they were unable to move forward with the upgrades until it had been approved by upper management. MD confirmed the broken drawers and closet were broken and needed to be replaced, and it was their expectation it would have already been completed. On 2/13/26 at 1:04 p.m., the administrator stated they were aware of the concerns related to the drawers and closet doors in R82's room. The administrator stated their expectation was if drawers or cabinets were broken, they should be addressed right away and was important to protect the safety of the resident. The administrator confirmed they were aware of the plan to update the long-term care unit, however, was unsure of the timeline of the project, and confirmed R82's cabinets should have been fixed as they had been aware of the concern since September of 2025. A facility maintenance policy was requested; however, none were provided.	F0584		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F0657	F-657 Care Plan Timing and Revision R9 Quarterly Care Conference has been scheduled for 3/10/2026 All residents Due for a Quarterly Care Conference will be reviewed to ensure Care conference was scheduled/completed per requirement. Care Conference education will be completed with social	03/31/2026

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F0657 SS = D	Continued from page 11 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to complete regular care conferences for 1 of 1 residents (R9) reviewed for care conferences. Findings include: R9's quarterly Minimum Data Set (MDS) dated 12/2/25, included R9 was cognitively intact. R9's diagnoses included anxiety, depression, bipolar disorder, and schizophrenia. R9's last four care conferences listed in her electronic medical record (EMR) were dated 8/22/24, 2/5/25, 6/15/25 and 11/13/25. During interview on 2/9/26 at 4:58 p.m., R9 stated she does not get invited to quarterly care conferences. During interview on 2/11/26 at 8:14 a.m., social worker (SW)-A stated care conferences were completed quarterly. SW-A stated she contacted families to invite them to the care conference and informed the resident. SW-A stated the care conference would still be completed if the resident and family did not want to	F0657	Continued from page 11 service staff to review the importance of timely care conferences to review any goals/preferences or care concerns. Social service staff have been educated on and will follow facility process to schedule care conferences quarterly, annually and with significant change for all residents that the facility Audits will be conducted weekly for 4 weeks then 2 x per month for 2 months. Audits will be reviewed in QAPI to ensure compliance. IDT will review our care conference tracker attached to our morning meeting template to review residents who need care conferences scheduled to ensure care conferences are being scheduled and completed Corrections will be monitored by Social Services and or Designee	

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F0657 SS = D	Continued from page 12 attend. SW-A stated all care conferences were documented on the care conference assessment form, and a progress note was added with any refusals from the resident and family. SW-A confirmed she was unable to locate any additional notes regarding care conferences for R9 in addition to the ones held 8/22/24, 2/5/25, 6/15/25 and 11/13/25. During interview on 2/11/26 at 1:03 p.m., director of nursing (DON) stated she did not typically attend care conferences. DON stated social work set them up and the nurse managers attended them to review the nursing aspect of care. The DON stated it was important to have these conferences to discuss the care and give the resident and family a regular update. No facility policy for care conferences provided.			F0657			
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to maintain fingernails at a reasonable length for 1 of 4 residents (R84) reviewed for activities of daily living (ADLs). R84's quarterly Minimum Data Set (MDS) dated 1/26/26, included R84 was cognitively intact. R84's diagnoses included arthritis, stroke, and dementia. R84 had impairment to both upper extremities. R84 required substantial to maximum assistance with personal hygiene. During observation on 2/9/26 at 1:30 p.m., R84 was observed having contractures on both of her hands and commented on how she was unable to open her hands because it was too painful. R84's fingernails were long, had uneven, chipping red paint. During interview on 2/11/26 at 11:42 a.m., nursing assistant (NA)-A stated assistance with nail care happened on shower days.			F0677	F-677 ADL Care Provided for Dependent Residents R84 has had her nails cleaned, per resident preferences she wants long nails. Care Plan updated. All Dependent Residents have the potential to be affected by this deficient practice. Dependent residents have been reviewed and appropriate nail care has been completed per resident preferences. Nursing staff has been educated on completing nail care for dependent residents. Audits will be conducted weekly for 4 weeks, then 2 x per month for 4 months. Audits will be reviewed in QAPI for compliance. Corrections will be monitored by Director of Nursing and or Designee		03/31/2026

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F0677 SS = D	Continued from page 13 During interview on 2/11/26 at 11:44 a.m., registered nurse (RN)-C stated residents were offered nail care every shower day. The nurse manager was updated with continued refusals. During interview on 2/11/26 at 12:32 p.m., family member (FM)-A stated she brought up the length of R84's fingernails at the most recent care conference because she was concerned about the length with R84's contractures. R84's last care conference in electronic medical record was dated 1/23/26. During interview on 2/11/26 at 1:03 p.m., director of nursing (DON) stated she expected nail care to be completed weekly. DON expected staff to reapproach if the resident refused and to add a progress note if a resident continued to refuse. DON confirmed R84's nails tend to be long and she has contracted hands which she is unable to open. DON stated all concerns brought forward from a resident or family member should have been addressed in a timely manner. Facility policy for activities of daily living dated 3/31/23, included residents who were unable to carry out ADLs would received necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F0677		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to update the provider with insulin readings outside of parameters for 1 of 1 residents (R101) reviewed for physician parameters.	F0684	F-684 Quality of Care R101 Parameters have been put in for resident's glucose monitoring. Provider has been notified All Residents with Diabetic monitoring have been reviewed and parameters have been put in to assure appropriate glucose monitoring Nurses will be educated on glucose monitoring and parameters and understanding when to notify physician. Audits will be conducted 2x per week for 4 weeks, then weekly for 4 weeks. Audits will be reviewed at QAPI for compliance.	03/31/2026

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F0684 SS = D	Continued from page 14 Findings include: R101's quarterly Minimum Data Set (MDS) dated 1/26/26, included R101 was cognitively intact. R101 had diagnoses of heart failure, diabetes, and traumatic brain injury. R101 received insulin injections 7 out of 7 days. R101's order review report dated 2/11/26, included to check blood sugars three times a day and Lantus SoloStar 100 unit/ml (a long acting insulin used to control blood sugar levels) inject 10 units subcutaneously in the morning. R101's medication administration record (MAR) for 2/1/26 – 2/28/26 included blood sugar readings as follows: 2/9/26 at 1100: 469 2/9/26 at 1700: 415 2/10/26 at 700: 513 2/10/26 at 1100: 466 2/10/26 at 1700: 510 2/11/26 at 700: 539 2/11/26 at 1100: 542 2/11/26 at 1700: 481 R101's standing orders signed 1/8/26, include to notify the provider with two blood glucose readings less than 70 or greater than 400 in a 24 hour time frame and/or change in condition. R101's electronic medical record (EMR) included a progress note dated 2/10/26 at 4:37 p.m., which included the nurse practitioner was updated on the blood sugar reading of 510. No additional updates were noted in R101's EMR. During interview on 2/12/26 at 11:08 a.m., licensed practical nurse (LPN)-B stated blood sugar orders typically have parameters with the order that indicate when the provider should be updated. LPN-B confirmed	F0684	Continued from page 14 Corrections will be monitored by Director of Nursing and or Designee	

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F0684 SS = D	Continued from page 15 R101's blood sugar reading orders did not include parameters on when to update the provider. LPN-B stated she would use her own judgement based on the resident when no parameters were provided. During interview on 2/12/26 at 11:13 a.m., registered nurse manager (RN)-B stated the nurse should follow the parameters included in the order for when to update the provider. The nurse should use the standing orders when no parameters were provided in the order to obtain a blood sugar. RN-B confirmed R101's order for blood sugars did not include parameters on when to update the provider. RN-B confirmed R101's blood sugar readings were elevated, and the provider should have been updated prior to the 2/10/26 update. During interview on 2/12/26 at 2:30 a.m., director of nursing (DON) stated orders should contain parameters on when to update the provider. DON stated it was important to update the provider when readings were outside of parameters so they could address concerns about high or low values. Facility policy for blood sugar parameters not provided.			F0684			
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting,			F0693	F-693 Tube Feeding Mgmt/restore Eating skills R48 Nurse on duty has been educated on the appropriate amount of water flush between each medication administration and has also been educated on the amount after all medications are given. . –R48 TF is flowing properly and is in good working condition. New order in place for water flushes with medication administration. Residents that receive medications via tube have the potential to be affected by this deficient practice. Nurses will be educated on the appropriate amount of water flush between and after medications are received. Audits will be conducted 2 times per week for 4 weeks then weekly for 4 weeks then 1x per month for 2 months. Audits will be reviewed at QAPI for compliance. Corrections will be monitored by Director of Nursing		03/31/2026

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F0693 SS = D	Continued from page 16 dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview the facility failed to ensure gastrostomy tube water flushes with medication administration were provided per physician orders for 1 of 1 residents (R48) reviewed for tube feedings. Findings include: R48's admission Minimum Data Set (MDS) dated 1/17/26 indicated R48 was severely cognitively impaired, dependent on staff for nutrition/hydration needs, medication administration, oral and personal hygiene, and mobility. In addition, R48 had diagnoses of stroke (poor blood flow to a part of the brain causing cell death resulting in parts of the brain to not function properly), hypertension (high blood pressure), diabetes, and a gastrostomy (feeding tube inserted into the stomach). R48's signed order review history report with a provider reviewed date of 2/1/26, indicated an order for facility Standing Orders: May use facility standing orders as signed by provider. The orders also indicated the following medication orders to be administered via gastrostomy tube: Folic Acid 1mg one time a day, Aspirin 81mg one time a day, Metoprolol Tartrate 50mg one time a day, multivitamin 400mcg one time a day, Amlodipine 10mg one time a day, Acetaminophen 500mg three times per day, Miralax 17 grams one time a day. Facility standing orders indicated the following: If a patient has a feeding tube-Medication administration: flush tube with 30mL water before and after administering each medication. Flush with 50mL water after all medications have been administered and upon completion of enteral feeding. R48's care plan indicated a focus of the resident has actual alteration in nutrition and interventions listed as administer medications as ordered. Monitor/document for side effects and effectiveness. The care plan focus/intervention was dated 1/20/26. The care plan lacked a specific focus related to medication administration.			F0693	Continued from page 16 and or Designee		

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F0693 SS = D	Continued from page 17 During observation and interview on 2/11/26 at 8:14 a.m., Registered Nurse (RN)-D entered R48's room to administer medication via gastrostomy tube (GT). R48 was lying in bed with the head of the bed elevated to 30 degrees. R48's GT was connected to her enteral feeding using a feeding pump. RN-D performed hand hygiene and donned personal protective equipment (PPE). RN-D set 8 medication cups containing crushed medications on a counter. RN-D mixed 20mL of water to each medication cup and stirred with spoon. RN-D paused and then disconnected R48's tube feeding from the pump and capped the tube. RN-D used a large piston syringe and drew the crushed medication/water solution from a cup, removed the GT cap and slowly pushed the solution into the GT. RN-D did not administer a 30mL water flush after administering the medication. RN-D then repeated this process until all 8 medications had been administered. RN-D did not administer a 50mL water flush after administering all medications. RN-D reattached R48's enteral feeding and restarted the pump. RN-D confirmed she had not performed a 30mL flush between medications, or a 50mL flush after administering all medications. During interview on 2/13/26 at 10:35 a.m., licensed practical nurse (LPN)-B stated when administering multiple medications via GT you need to flush between each medication and after you have completed all medications. LPN-B was unsure of the amount needed to flush between or after medications and stated a doctor would specify the amount in an order. LPN-B stated this was important to avoid potential interactions of medications or meds getting stuck in the tube. During interview on 2/13/26 at 10:44 a.m., RN-F stated to flush with 15-20mL of water between medications when administering multiple medications via GT. RN-F stated to use the same amount to flush the GT after completing all medications. RN-F stated this was important to avoid clogging the GT and ensure the resident received the medications and they were not sitting in the GT. During interview on 2/13/26 at 11:28 a.m., Director of Nursing (DON) stated a water flush of 15-20mL was required between medications for residents receiving medications via GT. DON stated a final flush was needed after all medication had been administered but she was unsure of the amount needed for the final flush. DON stated her expectation was staff would complete this step with all residents who received medications via	F0693		

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F0693 SS = D	Continued from page 18 GT. DON stated it was important to follow the correct steps of medication administration via GT to ensure the GT did not become clogged and the resident received all meds as prescribed by the provider. Facility policy titled Medication Administration - General Guidelines dated May 2022 lacked specific instructions related to flushes with medication administration via GT. A policy on medication administration via GT was requested but not provided.			F0693			
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure oxygen was administered as ordered for 1 of 1 resident (R38) reviewed for oxygen therapy. R38's quarterly Minimum Data Set (MDS) dated 11/24/25, included R38 was cognitively intact, could understand others and could express ideals and wants. R38's diagnoses include heart failure, multiple sclerosis (a chronic condition that can lead to vision loss, numbness, fatigue and mobility issues), and respiratory failure. R38's summary report dated 2/13/26, included an order for oxygen at 2-3 liters per minute (LPM) via nasal cannula continuously to maintain oxygen saturation at 90% or above. During observation on 2/10/26 at 9:28 a.m., R38 was in her wheelchair at the side of her bed with her feet in footrests. R38's oxygen nasal cannula was hanging off of her right ear and not properly placed in her nostrils. R38 stated she just got back to her room but			F0695	Staff Adjusted oxygen nasal cannula for R38 per physician orders All residents with orders for Oxygen via nasal cannula have the potential to be affected by the deficient practice Education on proper nasal cannula placement per physician orders provided to the nurse and 2 CNAs who were working on the resident's station on 2/10 AM shift. DON or designee to audit 3 residents x2 a week for x4 weeks to ensure proper nasal cannula placement if needed per oxygen saturation parameters Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent Staff to be educated during March "All Staff" Meeting. QAPI committee to review effectiveness of education and audits to determine if the deficiency has been corrected.		03/31/2026

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F0695 SS = D	Continued from page 19 was unsure where she came from. R38 stated she was looking forward to laying down in bed because she was tired but was unable to reach her call light for assistance. On 2/10/26 at 9:35 a.m., business office manager (BOM) entered R38's room. BOM confirmed R38's oxygen nasal cannula was not properly placed in R38's nose and she was unable to reach her call light. BOM stated she would alert a nurse with any medial concerns when answering a call light. On 210/26 at 9:52 a.m., licensed practical nurse (LPN)-A entered R38's room and adjusted R38's nasal cannula to place it over both ears and fitted into her nostrils. LPN-A confirmed R38's oxygen was not properly on when she came into her room and LPN-A was unsure how long R38 was without her oxygen. LPN-A checked R38's oxygen saturation with a reading of 86%. LPN-A confirmed R38 was not showing signs of respiratory distress including gasping, shortness of breath, confusion or cyanosis (blue tint on her lips due to low oxygen). During interview on 2/11/26 at 1:15 p.m., director of nursing (DON) stated the nurse should ensure oxygen was placed correctly and then check oxygen saturations if a resident was found without their oxygen as ordered. The DON stated the nurse should encourage deep breathing and utilize an incentive spirometer if the oxygen was below the ordered level. The nurse should update the provider if the oxygen was unable to be maintained at the ordered level. No policy for call lights provided.	F0695		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide	F0755	All med carts, med rooms and nurse manager offices have been audited and all expired or discontinued medication in those rooms/carts have been destroyed properly. Full med room/med cart audits completed by 3/4/26 Education will be provided to the facility nurses regarding the new process for medication storage, destruction, and reconciliation. Updated facility procedure regarding med destruction/returns; DON/Nurse managers audit all med	03/31/2026

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F0755 SS = D	Continued from page 20 pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to implement a system to monitor stored narcotics and complete controlled substance reconciliation for discontinued medications/discharged residents to prevent potential diversion. Additionally, the facility failed to complete medication reconciliation and medication destruction of non controlled medications that were stored in trash bags and boxes throughout the facility. Findings include: During observation and interview on 2/11/26 at 1:52 p.m., approximately 25 cards containing discontinued/expired medications were noted on a shelf in the Care Coordinators (CC) office located in the transitional care unit. CC stated the medication cards were from residents who had discharged or had their orders changed and the medications needed to be destroyed but she didn't "have any time" to destroy them. During medication storage observation and interview on 2/12/26 at 10:58 a.m., CC stated the facility had previously had two care coordinators who were			F0755	Continued from page 20 carts x1 a week for x1 month to verify compliance and destroy necessary narcotics. QAPI committee to review the effectiveness of our new med return/destruction procedure and to review of audits to determine effectiveness and compliance Nurse Managers/DON will continue to audit med carts and destroy narcotics weekly unless a new process is established in QAPI.		

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F0755 SS = D	Continued from page 21 responsible for medication destruction but that recently one had quit leaving all medication destruction to one staff. CC stated she was doing the work of two people and destroying medications “just isn’t a priority” and she relied on the pharmacy staff to assist in auditing the medication rooms and carts. The following medications for discharged/deceased residents were observed on the transitional care unit (TCU) medication cart #1: 104 capsules of Lyrica 50mg 45 tablets of Oxycodone 5mg 61 tablets of Oxycodone 2.5mg 27 tablets of Percocet 10mg/325mg 2 tablets of Norco 30mg/300mg 8 tablets of Zolpidem 5mg 11 tablets of Tramadol 50mg 10 tabs of Fioricet 50mg/325mg/40mg During medication storage observation on 2/12/26 at 12:05 p.m., the following was observed in the TCU medication room #1: 1 30-gallon clear plastic bag full of non-controlled medication cards for discharge/deceased residents During medication storage observation on 2/12/26 at 12:07 p.m., the following medications for discharged/deceased residents were observed in the TCU medication cart #2: 57 tablets of Oxycodone 5mg 25 tablets of Oxycodone 10mg 37 tablets of Lorazepam 0.5mg 61 tablets of Hydromorphone 2mg 6 tablets of Norco 7.5mg/325mg 8 tablets of Norco 5mg/325mg 11 tablets of Lyrica 100mg			F0755			

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F0755 SS = D	Continued from page 22 9 patches of Belcuca 900mcg 15mL of Hydromorphone 10mcg/mL During medication storage observation on 2/12/26 at 12:17 p.m., the following was observed in the TCU medication room #2: 2 40–45-gallon clear plastic trash bags full of non-controlled medication cards for discharge/deceased residents 2 boxes approximately 12-14 inches high by 20-24 inches long overflowing with non-controlled medication cards for discharge/deceased residents 2 metal boxes approximately 6 inches by 6 inches; box 1 contained 2 bottles of liquid lorazepam, box 2 contained 1 bottle of liquid lorazepam. The metal boxes were inside the unlocked medication refrigerator Documents titled PolarisRX Medication Unit Review dated 9/11/25 indicated the following: Station 1(first floor)- Med room door was not locked, Cart was unlocked; Station 2- (Second floor) Medication room cabinets not secured, discontinued/expired med were not removed from the medication room. Did not indicate who reviewed findings. Documents titled PolarisRX Medication Unit Review dated 10/22/25 indicated the following: Station 1(first floor) – Door to medication room unlocked, lock box in fridge locked but not attached; Station 2 (Second floor)- Lock box in fridge locked but not attached. Did not indicate who reviewed findings. Documents titled PolarisRX Medication Unit Review dated 12/08/25 indicated the following: Station 1(first floor) – Reviewed expired medications with nurse on cart; Nurse informed to remove any discontinued or expired meds, refrigerator lock box locked but not secured. Indicated findings reviewed with Administrator Documents titled PolarisRX Medication Unit Review dated 1/06/26 indicated the following: Station 1(first floor)-medication room door unlocked and propped open, unauthorized drugs or supplies noted; Station 2 (First floor)- medication room unlocked; Station 4 (Second floor)-medication room unlocked; medication cart unlocked. Indicated findings reviewed with Administrator During interview on 2/13/26 at 11:28 a.m., Director of			F0755			

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F0755 SS = D	Continued from page 23 Nursing stated the metal boxes located in the TCU medication room #2 refrigerator contained controlled medications that were required to be double locked and counted. DON stated she was unaware the medication boxes were in the refrigerator and could not locate any documentation indicating the medications had been counted in the required narcotic counts. DON stated the medication carts were routinely monitored by facility staff and audited monthly by a pharmacy consultant. DON stated the most recent pharmacy cart audit was in January 2026 and she had not seen a report for that visit. DON stated she was aware there were medications to be destroyed from discharged/deceased residents and that she had been trying to slowly complete the process since she was hired in the fall of 2025. DON stated she had previously gone through the bagged and boxed medications located in the TCU medication rooms to be sure there were no narcotics but didn't have time to destroy the medications. DON stated when a resident discharged or passed away, she expected staff to package all medications together and put in a locked medication room for destruction as soon as possible. DON stated the overnight nurses assisted with medication destruction, but narcotics were to be destroyed by the unit managers/care coordinators. DON stated this was important to avoid a resident gaining access to excess medications and to reduce the risk of drug diversion. During interview on 2/13/26 at 2:00 p.m., Polaris Pharmacy consultant (PC) stated she completed monthly audits of facility medication carts and medication rooms. PC stated she looked for expired/outdated medications, medication carts/rooms locked, opened date stickers and loose pills in carts. PC stated after each visit a copy of the audit report was reviewed with facility staff, preferably the DON or Administrator (Admin), but would review with floor staff if DON and Admin were unavailable. PC stated a copy of the audit would be electronically shared with the DON, the medical director, Admin, the pharmacy nurse consultant, consulting pharmacist and the director of the Monarch facilities. PC stated if she repeatedly identified a concern, it would be indicated on the audit report as well as addressed in an email to the facility leadership. Facility Policy titled Disposal of Medications and Medication-Related Supplies with a last review date of May 2022 lacked a specific timeline for destruction of discontinued/discharged resident medications.			F0755			
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On			F0756	Addressed recommendations to complete an AIMs assessment for affected resident on 2/10/26.		03/31/2026

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F0756 SS = D	Continued from page 24 CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed follow up on pharmacist recommendations for 1 of 5 residents (R9) reviewed for monthly pharmacist reviews. Findings include:			F0756	Continued from page 24 Full house review of past CP recommendations. Facility is up to date with all CP recommendations/AIMS assessments DON or designee with audit pharmacy recommendations x1 week for x4 weeks QAPI committee to review the effectiveness of CP recommendation audits and track completion/responses for future monthly recommendations in each meeting		

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F0756 SS = D	Continued from page 25 R9's quarterly Minimum Data Set (MDS) dated 12/2/25, included R9 was cognitively intact. R9's diagnoses included anxiety, depression, bipolar disorder and schizophrenia. MDS included R9 was taking antipsychotic medication and antianxiety medication. Review of R9's electronic medical record (EMR) included progress notes from the consultant pharmacist indicating recommendations for the facility on 9/8/25, 10/13/25, 11/9/25, 12/7/25, 1/12/26, and 2/8/26. R9's pharmacy recommendation dated 1/12/26 included a recommendation to complete an AIMS assessment (a tool used to monitor and evaluate side effects of certain medications) with a notation that the recommendation was reissued from November 2025. R9's pharmacy recommendation dated 2/8/26, again included a recommendation to complete an AIMS assessment with a notation it was reissued from November 2025. R9's EMR included an AIMS assessment completed 2/10/26.-after start of survey? - yes During interview on 2/12/26 at 12:04 p.m., consultant pharmacist (CP) stated he reviews resident's monthly to ensure all necessary monitoring was in place, that there were no interactions with medications and that gradual dose reductions were completed. CP confirmed he had requested AIMS assessments be completed on residents and has had to reissue the request because they were not getting completed. During interview on 2/12/26 at 11:22 a.m., registered nurse manager (RN)-B stated she received pharmacist reviews monthly. RN-B confirmed she had received some requests to complete AIMS assessments and had not kept up with the requests. RN-B stated the facility did not have a process for completing the AIMS assessment and only completed the assessment when recommended by the CP. During interview on 2/11/26 at 9:15 a.m., director of nursing (DON) stated the monthly pharmacist review came to her and she passed them on to either the nurse			F0756			

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F0756 SS = D	Continued from page 26 managers or the provider for follow up. DON stated there had been a problem tracking the pharmacist reviews to ensure they were all addressed timely.	F0756		
F0761 SS = E	Facility policy for psychotropic medication dated 5/2025, included an AIMS would be completed semi-annually. Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview the facility failed to ensure medications were properly labeled to prevent medication errors for 4 residents (R48, R56, R109, and R102) observed during review of medication carts. Additionally, the facility failed to permanently affix two lock boxes used for controlled medications in the medication room refrigerator reviewed for medication storage. Findings include:	F0761	Plan of Correction for F0761 (483.45(g)(h)(1)(2)): Facility failed to properly label and store drugs. All med carts and med rooms have been audited to ensure that medications are labeled properly. R48, R56, R109, and R102 medications were reviewed and properly labeled. Lock boxes in the fridges have been removed. New lock boxes have been ordered and will be fastened to the refrigerator. Note: The facility does not have any current ordered narcotics that need to be refrigerated. All med carts and med rooms have been audited to ensure that medications are labeled properly NM and/or DON will audit med carts and med rooms x1 weekly to verify that all medications are ordered properly Lock Boxes will be fastened to fridges and not removed. All nurses to be educated on facility process/MDH regulation to ensure that all medications are properly labeled QAPI committee to review the effectiveness of our new med return/destruction procedure and to review of audits to determine effectiveness and compliance Nurse Managers/DON will continue to audit med carts and destroy narcotics weekly unless a new process is established in QAPI.	03/31/2026

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F0761 SS = E	Continued from page 27 During observation and interview on 2/12/26 at 10:58 a.m., review of transitional care unit (TCU) medication cart was completed. R48 had two Lantus insulin pens which were not clearly marked with open date and expiration dates. Additionally, R56's bottle of prednisolone 1% solution (eye drop) had no open date or expiration date. Care Coordinator (CC) stated all injectable medications as well as eye drops, ear drops, nasal sprays and creams must be labeled with open and expiration dates otherwise staff would not know if the medication were safe to use. CC confirmed the items were not clearly labeled for use. During observation and interview on 2/12/26 at 11:23 a.m., review of long-term (LTC) medication cart station 3 was performed. A blue water cup contained the following: 2 Humalog, 2 Lantus, and 1 Victoza injectable pens; no pharmacy labels were affixed on the pens. Licensed practical nurse (LPN)-D stated she was unsure how to perform the 3 checks. LPN-D confirmed there was no pharmacy label located on the pens to indicate name/dose/route/time. During observation and interview on 2/12/26 at 12:33 p.m., two square locked metal boxes were noted inside the medication refrigerator in med room 2 on the first floor. Director of Nursing (DON) was unable to locate keys for the boxes and requested maintenance to pry open the locked boxes which revealed two bottles of liquid lorazepam intensol in one box and one bottle of liquid lorazepam intensol in the second lock box. During observation and interview on 2/12/26 at 12:43 p.m., review of LTC medication cart station 4 was completed. A Lantus insulin pen for R109 was found to have no pharmacy label. A Lantus insulin pen for R102 was found to have no pharmacy label. LPN-E confirmed there was no pharmacy label located on the pens to indicate dose/route/time. During interview 2/13/26 at 11:28 a.m., DON stated all medications were required to have a pharmacy label affixed with clear dosing instructions for every medication. She went on to say, all insulin pens, eye drops, nasal sprays and creams required an opened date and an expiration date attached to the container. DON stated it was her expectation staff ensured these items were present prior to administering any medications and expected all metal lock boxes use for controlled		F0761				

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F0761 SS = E	Continued from page 28 medication storage to be permanently affixed to a cabinet or refrigerator. DON stated these things were important to ensure residents were not receiving expired medications, to ensure residents were receiving the medications per physician orders, and to reduce the potential of drug diversion. Facility policy titled Medications Storage in the Facility dated May 2022 indicated the following: Certain medications or package types such as multiple dose injectables, and Ophthalmic, once opened require an expiration date shorter than the manufacturer 's expiration date to insure medication purity and potency. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated; the nurse shall place a "date opened" sticker on the medication and enter the date opened and the new date of expiration. The nurse will check the expiration date of each medication before administering it. The policy lacked instructions specific to controlled medication storage.	F0761			
F0825 SS = D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(f), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility	F0825	R95 was evaluated by therapy and was on therapy services until he discharged on 1/28/26 How the facility will identify other residents potentially affected by the same deficient practice Audit all current therapy eligible residents with therapy orders to ensure that therapy services were provided timely Director of therapy or designee will be notified of all new admissions with therapy orders. Therapy staff have been educated on timeliness of evaluation to ensure evaluations are completed within 48 hours of patient admission or order delivery Audit new admissions x2 a week for x4 weeks to verify that therapy services were initiated as ordered. QAPI committee to review therapy metrics to ensure that therapy is evaluating residents within at least 48hrs of admission	03/31/2026	

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F0825 SS = D	Continued from page 29 failed to provide physician ordered physical and occupational therapy (PT and OT) services in a timely manner for 1 of 1 residents (R95) reviewed for rehab services. Findings include: R95's admission minimum data set (MDS) dated 12/22/25, indicated R95 admitted to the facility on 12/22/25 and had the following diagnosis: hypertension (high blood pressure), hyperlipidemia (high levels of fat in blood) and displaced fracture of left tibial spine (broken ankle bones). The MDS also indicated R95 required substantial/maximal assistance with rolling in bed from side to side, sit to stand, chair/bed-to-chair transfers, toilet transfers, and mobility with wheelchair 50 ft. R95's hospital discharge paperwork dated 12/22/25, indicated an order for referral to physical and occupational therapy services. It further indicated R95 would likely need a Transitional Care Unit (TCU) stay, PT/OT post op. R95's historical care plan with a closed date of 2/3/26, indicated R95 had an alteration in mobility and listed interventions to include PT per medical doctor (MD) orders and follow PT instructions. The care plan also indicated R95 was a fall risk and listed interventions to follow PT and OT instructions for mobility function. The care plan indicated an initiated date of 12/29/25. During interview on 2/10/26 at 4:46 p.m., R95's family member (FM-B) stated R95 admitted on 12/22/25 but was not evaluated by PT/OT services until 12/29/25. FM-B stated they asked several staff when therapy would start but were not given a clear answer. FM-B stated on approximately 12/28/25, R95 and FM-B were reportedly advised by TCU care coordinator (CC) that the facility was switching therapy companies. FM-B went on to state later that same day a male who identified himself as therapy staff advised R95 that therapy staff was unaware R95 had been admitted on 12/22/25 and was waiting for therapy services. OT evaluation and plan of treatment note dated 12/29/25 indicated the following: patient presents with impairments in balance, mobility and strength resulting			F0825			

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F0825 SS = D	Continued from page 30 in limitations and/or participation restrictions in the areas of self-care, social life , mobility, general tasks and demands, and domestic life which requires skilled OT services to provision modalities and strengthening, increase safety awareness, increase independence with activities of daily living (ADLs), increase functional activity tolerance and facilitate dynamic standing balance in order to be able to return to prior level of living and return to prior level of skill performance. PT Evaluation and Plan of Treatment assessment record dated 12/29/25, indicated R95 required PT 3 times per week for a duration of 32 days. During interview on 2/11/26 at 10:44 a.m., Certified Occupational Therapy Assistant/Therapy Director (COTA/TD) stated when a resident was admitted with orders for PT or OT, they were seen by therapy staff within 2-3 days. COTA/TD stated it was a goal as a company to see all new residents within 3 days. COTA/TD confirmed R95 was admitted to the facility on 12/22/95 but was not seen by therapy staff until 12/29/25. COTA/TD stated she was unsure why there was a 7-day delay from admission to start of therapy services. There were no notes in R95's medical record that indicated a reason for delay. She went on to state she was unsure if facility staff communicated with R95 on any delays. During interview on 2/13/25 at 10:51 a.m., facility Associate Administrator (AA) stated when a new resident admitted to the facility, the AA was responsible for communication of the new resident's referral information to the care team, which included therapy staff. AA stated it was her expectation that residents who have a referral for therapy services were seen within 48 hours. AA stated it was important to start therapy as soon as possible for better outcomes and to reduce the risk of a negative outcomes like delayed recovery. An untitled facility policy with a published date of 11/18/25 and subtitle of Service Delivery Policies indicated the purpose to standardize the initial of therapy following referral, ensuring timeliness and proper authorization. It went on to indicate new referrals should be evaluated within 24-48 hours and to communicate plans with nursing staff and residents/family.	F0825		

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F0825 F0867 SS = D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(1)-(4)d)(1)(2)(e)(1)-(3)(g)(2)(ii)(iii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to	F0825 F0867	Addressed cross-referenced deficiencies through current 2026 POC's. Repeat tags regarding quality of care, infection control, respiratory care, and resident call light system will be reviewed by IDT. Train committee and review QAPI plan during 3/9/26 meeting Monthly QAPI reviews of all projects; including quality of care, infection control, respiratory care, and resident call system	03/31/2026

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

OMB NO. 0938-0391

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F0867 SS = D	Continued from page 32 ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance.			F0867			

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F0867 SS = D	Continued from page 33 §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the Quality Assurance Assessment and Performance Improvement Plan (QAPI) committee effectively sustained ongoing compliance related to repeat citations from past surveys regarding quality of care, infection control, respiratory care, and resident call system which were also identified during this survey. This had the potential to affect all 92 residents residing in the facility. Findings include: Review of the facility CASPER Report updated 1/14/26, identified the facility was cited at F684 for quality of care on the surveys exited 11/2/23 and 1/9/25. See F684: Based on interview and document review, the facility failed to update the provider with insulin readings outside of parameters for 1 of 1 resident (R101) reviewed for physician parameters. Review of the facility CASPER Report updated 1/14/26, identified the facility was cited at F695 on the survey exited 1/9/25. See F695: Based on observation and interview, the facility failed to ensure oxygen orders were administered as ordered for 1 of 1 resident (R38) reviewed for oxygen therapy.			F0867			

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F0867 SS = D	Continued from page 34 Review of the facility CASPER Report updated 1/14/26, identified the facility was cited at F880 Infection Prevention and Control on the surveys exited 11/2/23 and 1/9/25. See F880: Based on observation, interview and document review the facility failed to ensure infection control measures were maintained when performing wound care for 1 of 1 resident (R61) reviewed for wound care. Review of the facility CASPER Report updated 1/14/26, identified the facility was cited at F919 on the surveys exited 11/2/23 and 1/9/25. See F919: Based on observation and interview, the facility failed to ensure a call light was within reach for 1 of 1 resident (R38) reviewed for call lights. On 2/13/26 at 3:09 p.m., the associate administrator stated previous citations were addressed with facility plan of correction which included audits, and once QAPI determined continued compliance based on audit results, the audits were decreased or suspended, but QAPI still discussed the concerns. The associate administrator stated staff were expected to notify providers per parameters to maintain residents' health, and staff were expected to maintain proper placement of oxygen was important to sustain resident oxygen saturations. Staff were expected to complete hand hygiene between glove changes for infection control, and staff were expected to ensure call lights were within resident reach to prevent potential negative outcomes if not available. The facility's QAPI Plan reviewed 9/25/25, indicated the performance improvement plan (PIP) project, once it has met its goals, will be reviewed in the following quarterly QAPI meeting to ensure the project is being sustained. If the QAPI committee identifies that the PIP project has failed to sustain itself, it will decide what the next steps are to improve and ensure sustainability of the goals. To ensure the PIP project is implemented and effective for sustaining projects, the committees will choose data and measurement tools that directly impact and is effective to meet the goals of the project. The measurements will be reviewed by the committees to ensure it is effective.	F0867			
F0880	Infection Prevention & Control	F0880	R61's wound is at baseline. No s/s of infection was	03/31/2026	

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F0880 SS = D	Continued from page 35 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F0880	Continued from page 35 noted during the deficient practice. Nurse on duty educated and re-trained on proper infection control measures All residents that receive wound care by the nurse with the deficient practice Staff education during “All Staff” meeting March 25th. Nurse manager or designee will audit x2 treatments a week for x4 weeks to ensure education has been effective. QAPI committee to review the effectiveness of staff education and review audits to determine effectiveness and ensure future compliance	

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F0880 SS = D	Continued from page 36 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure infection control measures were maintained when performing wound care for 1 of 1 resident (R61) reviewed for wound care. Findings include: R61's admission Minimum Data Set (MDS) dated 8/24/25, indicated R61's cognition was intact and included diagnoses of pressure ulcer of left buttock-stage 3 (a severe, full-thickness wound extending through the skin to the subcutaneous fat layer, appearing as a deep crater), local infection of the skin and subcutaneous tissue, and morbid obesity. R61's historical care plan with a last review date of 12/5/25, included the following: Focus-resident is currently on Enhanced Barrier Precautions (EBP) relate to wound; Interventions- staff to follow enhanced barrier precautions, staff to don/doff personal protective equipment (PPE) per enhanced barrier precautions when providing high contact care.	F0880		

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F0880 SS = D	Continued from page 37 R61's order review history report signed/dated 2/1/26, indicated the following orders: Buttocks-1) Cleanse with generic wound cleanser 2) Apply skin prep thoroughly 3) Apply collagen to wound bed 4) Apply hydrocolloid dressing over areas 5) Change every 3 days and PRN every day shift related to pressure ulcer of buttock stage 3; and Follow EBP (Enhanced barrier precautions) while providing wound cares and other high contact care activities. During observation on 2/11/26 at 10:04 a.m., registered nurse (RN-D) was observed providing wound care. RN-D donned PPE (gown, gloves and surgical mask) gathered supplies and positioned R61 to lay on his left side exposing his buttocks. RN-D cleansed the wound with wound cleanser and clean 4x4 gauze; removed soiled gloves and applied clean gloves. RN-D did not perform hand hygiene before applying clean gloves. RN-D patted area dry with 4x4 gauze and removed soiled gloves, then applied clean gloves. RN-D did not perform hand hygiene before applying clean gloves. RN-D applied collagen powder into wound bed and calcium alginate, covered wound with hydrocolloid dressing, dated and initialed dressing and removed soiled gloves. RN-D applied clean gloves but did not perform hand hygiene. RN-D applied Vanicream to surrounding tissue, assisted R61 to his back and removed PPE and placed it in trash and then washed hands and exited room. During interview on 2/11/26 at 10:37 a.m., RN-D stated she should perform hand hygiene when entering the room, before applying gloves and when changing gloves. RN-D stated she should wash hands when they were visibly soiled and apply hand sanitizer after removing soiled gloves before applying clean gloves. RN-D stated she believed wearing two pairs of gloves was an acceptable alternative to performing hand hygiene between glove changes. RN-D stated she would remove the outermost glove and believed it was not necessary to perform hand hygiene as she believed the inner gloves would still be clean. During interview on 2/11/26 at 11:02 a.m., licensed practical nurse (LPN-C) stated hand hygiene was performed when you enter a resident room, when changing gloves from dirty to clean and upon exiting room. LPN-C went on to say hand washing should be done if hands were visibly soiled. During interview on 2/11/26 at 1:52 p.m., transitional care unit care coordinator (CC) stated staff should perform hand hygiene going into a resident room,			F0880			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0880 SS = D	Continued from page 38 between glove changes and when exiting a resident room. CC stated wearing two sets of gloves was not an acceptable alternative to hand hygiene when removing soiled gloves. The first set of gloves was basically like your skin. During interview on 2/13/26 at 11:28 a.m., Director of Nursing (DON) stated hand hygiene was completed after using bathroom, when entering or exiting a resident's room and after removing soiled gloves but before applying clean gloves. DON stated wearing two pairs of gloves was not a safe alternative to hand hygiene. DON stated it was her expectation that staff completed hand hygiene by washing hands or using hand sanitizer. DON stated it was important to accurately complete hand hygiene, so you were not introducing new bacteria or germs into an open wound, contaminating dressing supplies and reducing the risk of new or worsening infections with residents. Facility policy titled Infection Prevention and Control Program indicated the facility has established policies and procedures regarding infection control among employees and those with potential direct exposure to blood or body fluids are trained in and required to use appropriate precautions and personal protective equipment.			F0880			
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following:			F0883	R11 received PCV20 Vaccination on 2/23/2026 All residents have the potential to be affected by this deficient practice. All residents' vaccinations have been reviewed and offered pneumococcal Immunization if they are eligible. Nurse Managers have been educated on the importance of reviewing new admissions and yearly for current residents of being offered the vaccination timely. Audits will be completed 1 x per week for new admissions for 4 weeks then monthly for 2 months. Audits will be reviewed in QAPI for compliance. Corrections will be Monitored by Director of Nursing and or Designee		03/31/2026

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F0883 SS = D	Continued from page 39 (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure 1 of 5 residents (R11) was offered, educated and/or provided the pneumococcal vaccination series as recommended by the Centers for Disease Control (CDC), who were reviewed for immunizations. Findings include: A CDC Adult Immunization Schedule by age topic dated 08/07/2025, identified various tables when each (or all) of the pneumococcal vaccinations should be			F0883			

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F0883 SS = D	Continued from page 40 obtained. This identified when an adult over 50 years old had not received the complete series of pneumococcal vaccination (i.e., PPSV23, PCV20 and PCV13) or their history was unknown, then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20), 1 dose of PCV-15, or PCV-21. R11's undated face sheet, indicated R11 was 60 years of age, admitted to the facility on 4/25/2024, and had the following diagnoses: bipolar disorder, post-traumatic stress disorder, weakness, hypertension (high blood pressure) and chronic kidney disease. R11's Minnesota Immunization Information Connection (MIIC) undated report, indicated R1 had received a pneumococcal vaccination on 4/3/2015, it did not indicate which variation. This made R11 eligible for a pneumococcal vaccination. R11's resident vaccine administration consent form signed 10/6/2025, indicated R11 gave consent to receive a Pneumococcal vaccination. R11's medical record lacked any evidence a vaccine was administered. On 2/13/26 at 1:47 p.m., the director of nursing (DON) stated they had offered R11 a vaccination approximately one month ago, but it had not been provided. The DON's expectation was vaccination eligibility was evaluated upon admission to the facility and provided after the resident's status was verified. The DON confirmed R11's vaccination had not been administered. The DON stated the importance of keeping the vaccination status of resident up to date to prevent the risk of respiratory complications. The facility Pneumococcal Policy last revised 2/2024, indicated prior to or upon admission to the facility (within 5 days), all residents will be assessed for current immunization status and eligibility to receive the pneumococcal vaccine. Within 30 days of admission, resident will be offered the vaccine, when indicated.			F0883			
F0919 SS = D	Resident Call System CFR(s): 483.90(g)(1)(2)			F0919	R38 Call light cord unwrapped from bed and assessed to make sure call light clip in place for easy reach when resident is out of bed.		03/31/2026

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F0919 SS = D	Continued from page 41 §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure a call light was within reach for 1 of 1 resident (R38) reviewed for call lights. Findings include: R38's quarterly Minimum Data Set (MDS) dated 11/24/25, included R38 was cognitively intact, could understand others and could express ideals and wants. R38's diagnoses include heart failure, multiple sclerosis (a chronic condition that can lead to vision loss, numbness, fatigue and mobility issues), and respiratory failure. During observation on 2/10/26 at 9:28 a.m., R38 was in her wheelchair at the side of her bed. Feet were in footrests. R38 was leaning to the right, oxygen nasal cannula was out of nostrils. R38 stated she just got back from somewhere but could not remember where. R38 stated she was tired and looking forward to laying down. R38 stated her call light was "somewhere over there" while pointing to the opposite side of her bed. Call light cord was wrapped around bed rail on opposite side of bed and out of reach. On 2/10/26 at 9:35 a.m., business office manager (BOM) was seen entering R38's room. BOM stated she would get a nurse if there were any medical concerns when she answered a call light. BOM confirmed R38's oxygen nasal cannula was not in her nose, and her call light was on the opposite side of her bed, out of reach. BOM left R38's room without moving her call light within her reach. On 2/10/26 at 9:52 a.m., licensed practical nurse	F0919	Continued from page 41 All residents have the potential to be affected by deficient practice. Nursing staff will be educated to make sure call light is within residents' reach before leaving the room. Audits will be conducted 2x per week for 4 weeks then weekly for 4 weeks. Then Monthly for 2 months. Audits will be reviewed in QAPI for compliance. Corrections will be monitored by Director of Nursing/ Administrator and or Designee	

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F0919 SS = D	Continued from page 42 (LPN)-A entered R38's room and adjusted nasal cannula into nose. LPN-A stated she was unsure how long the oxygen was not properly in place. LPN-A check R38's oxygen saturation with a reading of 86%. LPN-A confirmed R38 was not showing any signs of respiratory distress, no gasping, confusion or bluing lips. During interview on 2/11/26 at 8:28 a.m., BOM confirmed R38 was unable to reach her call light the previous day when she was in R38's room. BOM confirmed she left R38's room without ensuring the call light was within reach. BOM stated she informed a nurse at the nurses' station that R38's oxygen nasal cannula needed to be adjusted after she left her room. During interview on 2/11/26 at 1:15 p.m., director of nursing (DON) stated a call light should always be within reach. DON stated every employee should be watching to ensure a call light was within reach. The DON stated if a resident was unable to reach a call light, they were unable to call for help when needed. No policy for call lights provided.			F0919			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245182		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING		(X3) DATE SURVEY COMPLETED 02/10/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ST LOUIS PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 7500 WEST 22ND STREET , SAINT LOUIS PARK, Minnesota, 55426			
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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 02/10/2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, The Villas at St. Louis Park was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:			K0000			03/10/2026

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 reverse for further 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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K0000	Continued from page 1 FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: The Villa at St. Louis Park is a 2-story building with a partial basement. It was built in 1971 and was determined to be of Type II(222) construction. The building has a total of eight separate smoke compartments and is divided into four smoke compartments on each sleeping-floor. The building is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 100 beds and had a census of 93 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:		K0000				
K0372 SS = E Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101		K0372	K0372- Subdivision of Building Spaces- Smoke Barriers Smoke Barrier Near room 101 has been repaired		03/31/2026	

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K0372 SS = E Bldg. 01	Continued from page 2 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.2. These deficient findings could have a patterned impact on the residents within the facility. On 02/10/2026 at 11:02 AM, it was revealed by observation that there was a penetration in the smoke barrier above the smoke barrier doors near the reservation office caused by wires.On 02/10/2026 at 11:06 AM, it was revealed by observation that there was a penetration in the smoke barrier above the smoke barrier doors near resident room 101 caused by wires.An interview with the Interim Administrator, Regional Operations Director, Regional Maintenance Director and the Maintenance Director verified these deficient findings at the time of discovery			K0372	Continued from page 2 Smoke Barriers have been audited throughout the building and no other issues have been noted. Audits will be completed to review compliance of smoke barriers weekly for 4 weeks then Monthly for 4 weeks by Maintenance. Audits will be reviewed in QAPI By Maintenance and IDT team to review Compliance.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 24, 2026

Administrator
THE VILLAS AT ST LOUIS PARK
7500 WEST 22ND STREET
SAINT LOUIS PARK, MN 55426

RE: CCN: 245182

Cycle Start Date: February 13, 2026

Dear Administrator:

On April 8, 2026, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

