Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 28, 2025

Administrator
THE VILLAS AT RICHFIELD
7727 PORTLAND AVENUE SOUTH
RICHFIELD, MN 55423

RE: CCN: 245492
Cycle Start Date: June 26, 2025

Dear Administrator:

On August 19, 2025, the Minnesota Department(s) 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.

Your request for a continuing waiver involving the deficiency(ies) cited under X at the time of the X standard abbreviated extended survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 24, 2025

Administrator
THE VILLAS AT RICHFIELD

7727 PORTLAND AVENUE SOUTH
RICHFIELD, MN 55423

RE: CCN:245492
Cycle Start Date: June 26, 2025

Dear Administrator:

On June 26, 2025, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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:

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor
Rochester District Office
Health Regulation Division
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727

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 September 26, 2025 (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 December 26, 2025 (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,



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT RICHFIELD	7727 PORTLAND AVENUE SOUTH , RICHFIELD, Minnesota, 55423

(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 6/23/25, through 6/26/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities 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		07/29/2025
F0000	INITIAL COMMENTS On 6/23/25, through 6/26/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited. H54928050C (MN00107405). H54928051C (MN00111520 and MN00111522) 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 has been attained.	F0000		07/29/2025
F0577 SS=C	Right to Survey Results/Advocate Agency Info	F0577	A “Survey Results” sign was placed on the holding	08/07/2025

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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F0577 SS = C	Continued from page 1 CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the facility's survey results were kept in a location readily accessible to all residents and/or visitors who wished to review. This had the potential to affect all 97 residents and/or visitors. Findings include: During an interview with the facility resident council on 6/25/25 at 1:03 p.m., the members stated the survey binder should be in the front lobby of the facility. During interview with R3 on 6/26/25 at 10:55 a.m., R3 stated she had not seen the survey binder in the front	F0577	Continued from page 1 basket of the binder, which remains in our front lobby for easy access. All residents have the potential to be affected if this regulation is not met. The Administrator was re-educated on this requirement, and the identified area has been corrected. Audits will be completed weekly for four (4) weeks, to ensure the survey results are posted and readily available. Audit results will be reviewed at QAPI meetings. Any deficiencies will be identified and corrected at the time of occurrence. Administrator or Designee is the responsible party.	

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F0577 SS = C	Continued from page 2 lobby for a little bit and state it would be nice to know what the facility needs to work on. During observation on 6/26/25 at 11:03 a.m., the facility survey binder was not readily visible nor readily available in the facility lobby without having to ask. During interview on 6/26/25 at 10:38 a.m., administrator confirmed the survey binder was not visible nor easily accessible without having to ask. The administrator located the survey binder in a storage basket with other binders on a higher shelf in the lobby. A policy regarding posting survey results was requested, administrator stated the facility does not have a policy regarding survey results.	F0577		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical	F0656	R18 care plan was reviewed. Geri-sleeve was discontinued from the orders as the resident no longer requires it. Bilateral heel boots were added to the orders to ensure nursing staff check them every shift. A full house audit was conducted to identify residents utilizing skin intervention items. Ensured the skin intervention items are included in both the orders and the care plan for the residents identified. Care planning policy and skin assessment and wound management policy have been reviewed and remain current. Educated clinical leaders to ensure that when entering orders related to a resident’s skin integrity, the corresponding care plan is also updated accordingly, and vice versa. And when an intervention is no longer required, it is removed from both the orders and the care plan. Audits will be completed weekly for four (4) weeks on four (4) residents who have skin interventions to ensure the interventions are being followed and that the intervention is in the resident’s orders and on	08/07/2025

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F0656 SS = D	Continued from page 3 record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure care was provided in accordance with a resident's care plan for 1 of 3 residents (R18) reviewed for non-pressure related skin concerns. Findings include: R18's quarterly Minimum Data Set (MDS) assessment dated 5/29/25, indicated R18 had short- and long-term memory problems, knew location of own room and staff names and faces, and had some difficulty in new situations regarding her cognitive skills for daily decision making. R18 did not have behaviors or rejection of cares. R18 required substantial/maximal to dependent assistance with most activities of daily living (ADLs). R18 was at risk for pressure ulcers. R18's care plan, indicated R18 was at risk for skin alteration related to incontinence, history of recurring redness/rash under breasts and skin folds, poor safety awareness, and history of walking towards doors and walls. The care plan interventions included barrier cream after each incontinent episode, encourage to allow cleansing and drying of skin folds in the morning and bedtime and reapproach if refuses, ensure socks removed carefully and does not stick, assist with nails and toenail care weekly and as needed, heel	F0656	Continued from page 3 their care plan. Audit results will be reviewed at QAPI meetings. Any deficiencies will be identified and corrected at the time of occurrence. DON or designee is the responsible party.	

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F0656 SS = D	Continued from page 4 protectors on while in bed, place a pillow under resident's back when turned and repositioned, turn and reposition every two to three hours and as needed, monitor skin integrity daily during cares and weekly skin inspection by nurse, treat open areas per order, encourage adequate fluid intake, pressure redistribution cushion to wheelchair and chair, low air loss mattress and monitor function every shift, and follow dietary interventions which included supplements as ordered. R18's physician order dated 2/14/24, indicated geri-sleeves (protective sleves) or long sleeves on in the morning and off at bedtime every shift. During observation on 6/25/25 at 7:40 a.m., R18 sat in her wheelchair in the dining area and had short sleeves on and no geri-sleeves. During observation on 6/25/25 at 9:25 a.m., nursing assistant (NA)-A and C assisted R18 to bed and provided peri-cares. R18 had short sleeves on and new geri-sleeves. R18's heels were not floated off the bed with pillows or protective boots. During interview on 6/25/25 at 9:37 a.m., NA-A verified R18 did not have long-sleeves or geri-sleeves on. NA-A stated they were not sure if R18 needed her arms covered. NA-A verified R18's heels were not floated and did not know about protective boots for R18. NA-A stated R18's heels were not an issue and feet did not have skin breakdown. During observation and interview on 6/25/25 at 11:10 a.m., R18 was in bed and observed in short sleeves and no geri-sleeves, and R18's heels were not floated. Registered nurse (RN)-E stated R18 needed her heels floated and verified they were not floated. RN-E found heel protector boots in R18's closet and applied them to R18's feet. During interview on 6/26/25 at 10:37 a.m., the assistant director of nursing (ADON) stated R18 was at risk for pressure ulcers and floating R18's heels were important for pressure ulcer prevention. The ADON stated R18 needed geri-sleeves when she used to bump into doorways and got bruises related to poor safety awareness. During interview on 6/26/25 at 2:01 p.m., the director of nursing (DON) expected staff to follow the care plan. The DON stated geri-sleeves or long sleeves were used to prevent skin tears and bruises.	F0656		

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F0656 SS = D	Continued from page 5 The facility Care Planning policy dated 11/2024, directed staff to use resident's plan of care to provide care or services to the resident. The care plan was to be modified and updated as the condition and care needs of the resident changed.	F0656		
F0679 SS = D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a resident's preferred activities for individual entertainment were available for 1 of 1 resident (R16) reviewed for activities. Finding include: R16's Minimum Data Set (MDS) assessment dated 5/16/25, identified R16 had cognitive impairment and displayed no delusional thinking, with some rejection of cares. R16 was dependent on facility staff for upper and lower body dressing, putting on and removing shoes, and transferring from bed to chair. R16's Evaluation and Social History dated 8/19/24, indicated R16 had no visual or auditory deficits that would impact activity participation, enjoys time with her children, music, and game shows. R16's specific preference to music is old rhythm and blues. Further, R16 was willing to try new activities, actively engages in structured activities of choice, and actively engages in independent activity of choice. R16's care plan dated 11/14/24, indicated R16 had generalized anxiety, major depressive disorder, and obsessive-compulsive disorder. The interventions the facility outlined in this document included: -administer medications as ordered	F0679	R16 had a new TR Eval and Social History Assessment completed. R16 care plan was updated to include her preferred activities. The facility is incorporating music-based activities. Interviews were conducted with all residents capable of completing interviews, to determine if their current activity plan is acceptable to them. Care plans will be updated as needed. Activities, Clinical Leaders, and Social Workers were re-educated on regulation 483.24, including communicating to the activities director any changes the resident would like to their activity plan of care or any recommendations made regarding their activities. Audits will be completed weekly for four (4) weeks by interviewing five (5) residents to determine if their activity preferences are being followed and are acceptable to them. Audit results will be reviewed at QAPI meetings. Any deficiencies will be identified and corrected at the time of occurrence. The Activities Director or Designee is the responsible party.	08/07/2025

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F0679 SS = D	Continued from page 6 -complete PHQ-9 (depression screening) per facility policy -encourage resident to take part in Music Therapy Group events (Bell Choir, Singing Groups, Music in Motion) to stimulate socialization. -Monitor/record/report to MD as needed any changes in mood patterns, signs and symptoms of depression, anxiety, sad mood as per facility behavior monitoring protocols During interview on 6/23/25 at 3:38 p.m., R16 confirmed she likes to listen to music and would be interested in attending music activities or groups. Family stated the facility had not previously had any music-related activities for the resident to attend. Further, the facility staff do not ask the resident if she would like to join a group activity. The activity calendars dated, February 2025, March 2025, April 2025 , May 2025 and June 2025 did not contain any music-related activities or groups. During observation on 6/24/25 at 1:00 p.m., activity director (AD)-A was walking down the hall, gathering residents for a Tuesday Tea Party in the 3rd floor dining room. The AD-A did not enter R16's room to offer to take R16 to the Tea Party. During this observation no other facility staff went into R16's room to alert her to the activity nor offer to take her to the activity. During observation on 6/24/25 at 2:43 p.m., activity director (AD)-A was walking down the hall, gathering residents for Bingo in the 2nd floor dining room. The AD-A did not enter R16's room to offer to take R16 to Bingo. During this observation no other facility staff went into R16's room to alert her to the activity nor offer to take her to the activity. During observation on 6/25/25 at 10:23 a.m., activity director (AD)-A was walking down the hall, gathering residents for a Bible Study in the 2nd floor dining room. The AD-A did not enter R16's room to offer to take R16 to bible study. During this observation no other facility staff went into R16's room to alert her to the activity nor offer to take her to the activity. During observation on 6/25/25 at 12:31 p.m., activity director (AD)-A was walking down the hall, gathering residents for movie in the main activity hall. The AD-A did not enter R16's room to offer to take R16 to the movie. During this observation no other facility staff	F0679		

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F0679 SS = D	Continued from page 7 went into R16's room to alert her to the activity nor offer to take her to the activity. During interview on 6/25/25 at 10:35 a.m., certified nursing assistant (CNA)-C stated the resident was dependent on staff; if she would like to go to an activity, staff would have to assist her. Further, stated the resident should be notified before each activity because she has dementia and wouldn't be able to remember when or what the activity was before the activity. During interview on 6/25/25 at 10:47 a.m., assistant director of nursing (ADON) stated the resident does experience anxiety or depression at times. ADON stated the staff at the facility respond to this anxiety or depression by following the interventions outlined in the care plan. ADON could not list the specific patient-centered music-related intervention for R16. During interview on 6/26/25 at 8:06 a.m., AD-A could not state what R16's personal goals for activity and leisure were. AD-A stated she regularly does rounds on each floor to gather residents to go to activities. AD-A confirmed she did not ask R16 to attend activities on either 6/24/25 or 6/25/25. AD-A stated the facility does not offer music-based activities very often. AD-A stated she was aware R16 had a general anxiety disorder and depression; not knowing about the person-centered intervention to offer music therapy or music-related activities. A facility activity policy was asked for, and not received.	F0679		
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 observation, interview and document review the facility failed to ensure bruises were adequately assessed and monitored for 1 of 1 resident (R92),	F0684	R92 Monitoring orders were entered to ensure that bruises are assessed every shift. Bruise measurements and progress notes have been documented. The care plan was reviewed and updated to include the bruises and the resident's use of anticoagulants. R92 left axilla has resolved. R2 wound on scrotum has been resolved. Received order to discontinue current order for tx with dimethicone. A full house audit was conducted to identify any resident who has any skin impairment including bruises or open area by completing skin assessment. For any bruise or open area observed, ensured that monitoring/treatment orders were entered and that there was documentation including measurement and description of area and that the skin concern is listed in the care	08/07/2025

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F0684 SS = D	Continued from page 8 failed to ensure non-pressure wounds had timely assessment and documentation for 1 of 3 residents (R92), and furthermore failed to implement and/or clarify a wound order after a hospitalization for 1 of 3 residents (R2) reviewed for non-pressure related wounds. Findings include: R92's admission Minimum Data Set (MDS) assessment, dated 6/11/25, indicated intact cognition, did not have delusions or hallucinations, physical, verbal, or other behavioral symptoms, and did not reject care. Further, R92 was dependent on staff for toileting hygiene, lower body dressing, and required substantial to maximal assistance with upper body dressing, personal hygiene, and showering and bathing. R92's diagnoses included cancer, wound infection, diabetes, arthritis, was morbidly obese with a body mass index of 50.0 to 59.9. Furthermore, R92 was at risk for developing pressure injuries, had surgical wounds, and took an anticoagulant (blood thinner). During observation and interview on 6/23/25 between 2:14 p.m., and 2:17 p.m., R92 had bruises bilaterally to the back of her upper arms. R92's right arm had a bruise approximately the size of a grapefruit and the bruise located on R92's left arm went from R92's arm pit area to her elbow and was purple towards the elbow and a faded yellow color on the upper part of R92's left arm. R92 stated they were from her blood thinner shots. R92 stated her camisole stitching rubbed on her and rolled up on her due to her large abdomen and had a sore spot on her left arm pit area. R92's left posterior arm at armpit crease had a small nail head sized open area. An dressing (ABD) pad was tucked in next to the area, but did not cover the open area. R92 stated she didn't want to wear other shirts because she didn't want drainage staining them from her dressings. R92's Physician's Orders form, indicated the following orders: 6/13/25, surgical incision to the right axilla, right breast, cleanse with NS (normal saline) or WC (wound cleanser), pat dry. Cover with a non-adhesive dressing or ABD (dressing type) and secure with tape every day. Monitor for signs and symptoms of infection. 6/6/25, Complete Daily Skilled Note under forms in PCC (Point Click Care-facility electronic medical record). State why the resident is currently being covered for	F0684	Continued from page 8 plan. A full house audit of all resident treatment orders were completed to ensure they are still required. A request to DC order was sent to providers for any no longer required. Clinical leaders were educated to review the comprehensive care plan upon completion of MDS assessments to ensure that the skin-related sections accurately reflect any current skin concerns, including bruising/open area and the resident's risk for bruising. Clinical leaders were educated on if there is any new skin concern documented, to ensure treatment order were entered and entered on care plan. Floor nurses educated to measure and document any observed bruising or skin concerns and to notify the provider of any new or worsening bruises or skin impairment. If a new bruise is observed, to enter a monitoring order including the measurement of the bruise. Nurses were educated to follow treatments order. Four (4) residents will be audited weekly for four (4) weeks by completing a full skin inspection. Each skin inspection will be compared to the corresponding floor nurse's documented skin inspection to ensure accuracy. Any identified bruising will be documented in detail, along with the actions taken in response. Audit results will be reviewed at QAPI meetings. Any deficiencies will be identified and corrected at the time of occurrence. Four (4) residents will be audited weekly for four (4) weeks who were identified as having new bruises or open areas, to ensure that each instance is properly documented. This includes confirming that measurements are recorded, monitoring/treatment orders were entered, and the concern is reflected in the care plan. Audit results will be reviewed at QAPI meetings. Any deficiencies will be identified and corrected at the time of occurrence. Four (4) residents who have active skin treatment orders will be audited weekly for four (4) weeks to ensure the treatment has been followed as ordered and that updates are made to the care plan accordingly. Audit results will be reviewed at QAPI meetings. Any deficiencies will be identified and corrected at the time of occurrence.	

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F0684 SS = D	Continued from page 9 #6 skin issue, #7 infection, #9 diabetes, #13 anticoagulant. 6/8/25, "Monitor for discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle and joint pain, lethargy, bruising, sudden changes in mental status and/or vital signs, SOB [shortness of breath], nose bleeds. 0=No Symptoms, +=See NN (nurse note)". 6/8/25, weekly skin inspection by the licensed nurse. Complete weekly skin inspection in PCC. 6/5/25, enoxaparin sodium (generic for Lovenox) injection solution prefilled syringe 40 milligrams (mg)/0.4 milliliters (ML) inject 0.4 ml subcutaneously every 12 hours for prevention of a blood clot. R92's lacked documentation or treatment instruction for an ABD pad related to the open area and a specific assessment or monitoring for the bruising to R92's upper arms. R92's medication administration record (MAR) and treatment administration record (TAR) dated June 2025, indicated R92 received enoxaparin twice daily at 9:00 a.m., and 9:00 p.m., R92's care plan dated 6/6/25, indicated R92 was diabetic and interventions indicated to check all of her body for breaks in skin per protocol and treat promptly as ordered by the physician. R92's care plan dated 6/12/25, indicated R92 had a potential for alteration in blood formation and coagulation due to use of an anticoagulant and interventions included to monitor and notify the physician for signs and symptoms of bleeding, to monitor for discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle/joint pain, lethargy, bruising, sudden changes in mental status, and or vital signs, SOB, and nose bleeds. R92's care plan dated 6/6/25, indicated R92 had an alteration in skin integrity related to recent surgery and had surgical wounds on the right breast and underarm. Interventions indicated to monitor skin integrity daily during cares and weekly skin inspections by the nurse, treatment to open areas per order, turn and reposition or reminders to offload every 2 to 3 hours and as needed, weekly measurements	F0684	Continued from page 9 DON or designee is the responsible party.	

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F0684 SS = D	Continued from page 10 and assessment of wound. R92's care plan dated 6/6/25, indicated R92 had an alteration in mobility related to generalized weakness and interventions indicated R92 required assist of one with movement in bed and in and out of bed, assist of 2 staff with a Hoyer for all transfers, and R92 could not ambulate. R92's care plan dated 6/6/25, indicated R92 had a self-care deficit, and her sling was to be left under her due to risk of friction and shear. Additionally, R92 had interventions for assist of 1 with grooming, bathing, dressing, was able to dress upper body, and required set up assist with personal hygiene. R92's Skin Evaluation and Skin Risk Factors form dated 6/5/25 at 8:07 p.m., indicated R92 had the following skin conditions: a surgical incision to the right breast measured 3.7 centimeters (cm) long, by 0.3 cm wide, a surgical incision to the right armpit measured 4.2 cm long by 0.5 cm wide. Further, R92 had bruising to the right and left lateral upper arms. The form lacked information regarding and assessment of the coloring of the bruising, size of the bruising or how R92 obtained the bruising. Further the form indicated R92 had the following risk factors that included medications, obesity, and diabetes. R92's Weekly Skin Inspection form dated 6/8/25 at 10:45 p.m., indicated R92 had an open surgical wound on the right breast and all other skin was clear and intact. R92's Weekly Skin Inspection form dated 6/22/25 at 8:44 p.m., indicated it was the nurse's responsibility to evaluate the resident's skin at a minimum of once a week to ensure skin integrity and implement interventions as applicable. The form indicated R92 refused a bath and nail care, however, the form indicated R92 had an open surgical wound on the right breast and all other skin was clear and intact. R92's Skin and Wound Evaluation forms dated 6/24/25 , lacked information R92 had an open area to the left upper posterior arm. R92's Daily Skilled Note dated 6/5/25 at 10:09 p.m., The form lacked an assessment of R92's bruises, or R92 had a bruise.	F0684		

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F0684 SS = D	Continued from page 11 R92's Daily Skilled Note dated 6/6/25 at 1:01 p.m., The form lacked an assessment of R92's bruises or that R92 had a bruise. R92's Daily Skilled Notes dated 6/7/25 at 12:42 p.m., 6/8/25 at 1:03 p.m., 6/9/25 at 12:54 p.m., 6/9/25 at 9:45 p.m., 6/10/25 at 2:03 p.m., indicated R92 was alert and oriented to person, place, and time, did not have behaviors that included resisting care. The form indicated the same check box next to skin issues, and anticoagulant use. Further, the form indicated R92 was free from signs and symptoms of bleeding related to anticoagulant use, and the anticoagulant was administered as ordered. The forms lacked an assessment of R92's bruises or that R92 had a bruise, and further lacked information the bruises identified 6/6/25, had resolved. R92's Daily Skilled Notes dated 6/11/25 at 1:35 p.m., indicated R92 was alert and oriented to person, place, and time, did not have behaviors that included resisting care. The form indicated the same check box next to anticoagulant use. Further, the form indicated R92 was free from signs and symptoms of bleeding related to anticoagulant use, and the anticoagulant was administered as ordered. The form lacked an assessment of R92's bruises or that R92 had a bruise. Further, under a heading, "Resident Response to Treatments & Additional Comments" that indicated R92 did not have bruising or bleeding noted from anticoagulants. R92's MHM Daily Skilled Note dated 6/12/25 at 11:39 a.m., and 6/13/25 at 11:32 a.m., lacked an assessment of R92's bruises or that R92 had a bruise. R92's MHM Daily Skilled Notes dated 6/17/25 at 6:56 p.m., 6/18/25 at 10:23 a.m., 6/19/25 at 9:25 a.m., 6/20/25 at 1:29 p.m., 6/21/25 at 2:11 p.m., 6/23/25 at 11:37 a.m., and 6/24/25 at 1:06 p.m., lacked an assessment of R92's bruises or that R92 had a bruise, and further lacked information the bruises identified 6/6/25, had resolved. R92's Integrated Wound Care note dated 6/17/25, indicated R92 was seen for evaluation of wound sites to the front right axilla and the right breast. Further R92's surgical site on the right axilla was tender due to friction with the edge of the camisole and factors that affected R92's healing included diabetes, cancer,	F0684		

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F0684 SS = D	Continued from page 12 neuropathy, weakness, obesity, and reduced mobility. R92's Integrated Wound Care note dated 6/24/25, indicated R92 was seen for evaluation of the surgical wounds to the front right axilla and the right breast. The note lacked information R92 had a wound to the left upper posterior arm. R92's progress notes were reviewed from 6/5/25, to 6/24/25, and lacked documentation of bruising to arms or an open area assessment of the left upper posterior arm During interview on 6/25/25 at 9:27 a.m., to 9:44 a.m., registered nurse (RN)-B stated skin was assessed and documented weekly, and further stated skin was looked at daily. RN-B stated skin notes were in the Forms tab of their electronic medical record (EMR). RN-B stated they had to report bruising because you need to know how a resident obtained it and then management took pictures of skin issues. RN-B stated open areas had to be documented and if it was new, would utilize standing orders to clean and cover and further stated new bruises or new skin issues had to be assessed and the provider would place orders to either put pads on or keep skin clean and dry. RN-B stated bruises are monitored and when asked how RN-B knew if bruises were changing or getting worse, RN-B stated they would go by orders to monitor the bruise on the MAR or TAR every shift. RN-B stated R92 had wound pictures of R92's sore on her right side, but further stated she did not see any bruising documented and viewed orders and forms and stated there was no documentation of bruising. RN-B opened a Weekly Skin Assessment Form dated 6/8/25, and 6/22/25, and verified there was no documentation of bruising. Further RN-B viewed R92's Daily skin note dated 6/24/25 and verified it lacked information of R92 having a bruise and stated it would not be documented anywhere else. At 9:44 a.m., RN-B verified R92 had bilateral bruising to both arms along with the open area to R92's left arm near her arm pit and stated it had not been documented or measured and stated it should have been. R92 was wearing her tank/camisole again that was rolled up to under her breasts and her arms were exposed. During interview on 6/25/25 at 9:56 a.m., the director of nursing (DON) stated if a resident had a bruise an order needed to be placed to monitor the bruise, and the guardian and physician would be notified and they	F0684		

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F0684 SS = D	Continued from page 13 would complete a risk management form. The DON verified R92 did not have a risk management form. The DON stated a new bruise has color changes of dark red and purple and if a resident was alert and oriented would ask how they got it and would complete an incident analysis and would place a monitoring order and would resolve once the bruises were healed. The DON stated a fresh bruise was a dark purple. The DON stated she would have to review the policy in order to know how staff assessed residents to know whether bruising was getting worse. The DON further stated R92 had diabetes, breast cancer, was obese, and was on a blood thinner and stated the bruise was identified on admission and verified R92's medical record lacked information on the color, shape, or size of R92's bruise identified on 6/5/25. Further, the DON verified R92's chart lacked documentation R92 had an open area to her left arm and stated R92 refused her bath on 6/22/25, and stated there were no further assessments on R92's bruises. When asked about the lack of documentation of bruises in the Daily Skin Notes, the DON stated they would document new bruises. The DON stated she wondered if R92's open area on the left arm pit was from the day prior and verified there were no pictures of the wound on R92's left arm pit. Further, the DON could not explain how staff could identify whether a bruise documented from admission was the same bruise, or if a resident had a new bruise and could not explain how bruises were assessed or documented and stated she would have to check the policy. A late entry note created on 6/25/25 at 11:11 a.m., was entered into R92's progress notes for 6/24/25 at 8:09 a.m., that indicated, "This writer and wound provider access resident armpits noted redness caused by the surgical garment". An additional progress note dated 6/25/25 at 11:44 a.m., was entered into R92's progress notes, "Resident has bruises on her bilateral arms due to anticoagulant use. Redness noted under her right breast and Little open area on the left armpit. Provider updated". During interview on 6/25/25 at 12:18 p.m., nursing assistant (NA)-B stated R92 required a check and change and was alert. NA-B stated R92 could dress her top half after providing the top and further stated they completed skin checks when residents were changed. During interview on 6/26/25 at 11:49 a.m., the DON verified R92's Skin Evaluation and Skin Risk Factors	F0684		

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F0684 SS = D	Continued from page 14 form did not contain measurements for R92's bruises. A policy, Skin Assessment and Wound Management, dated 2/2025, indicated the purpose of the assessment was to provide guidelines for assessing and managing wounds. Further, prevention and identification included implementing preventative skin measures, a skin evaluation and skin risk factors form was completed before initial MDS, annually, and upon significant change. Further, staff would perform routine skin inspections with daily care and nurses were to be notified if skin changes were identified and a weekly skin inspection was completed by licensed staff. Further when a significant alteration in skin integrity is noted such as large or multiple bruising, or other non-pressure related wounds the following actions will be taken: notify the provider, treatment ordered, notify the representative, complete education with the resident including risks and benefits, initiate a skin and wound evaluation, notify the nurse manager, review and update the care plan including interventions. R2 R2's quarterly Minimum Data Set (MDS) assessment, dated 4/29/25, indicated R2 had severe cognitive impairment, no behaviors or rejections of care, and required substantial/maximal to dependent assistance with activities or daily living. R2's diagnoses included peripheral vascular disease, neurogenic bladder, diabetes mellitus, dementia, anxiety, and depression. R2 had an indwelling catheter, was always incontinent of bowel, and was at risk for pressure ulcers. R2's care plan, indicated R2 was at risk for skin alteration related to impaired memory, fragile skin, type one diabetes, peripheral vascular disease, and incontinence. Interventions included occupational therapy to eval (evaluation) and treat for wheelchair positioning, monitor skin integrity daily during cares and weekly skin inspection by nurse, treatment to open areas per order, cue and encourage to turn and reposition every two to three hours and as needed, pressure redistribution mattress to bed, pressure redistribution cushion to wheelchair and chair, and dietary interventions which included to encourage supplements as ordered. R2's physician orders, indicated:	F0684		

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F0684 SS = D	Continued from page 15 -Barrier cream after each incontinent episode and ensure to apply on the scrotum every shift with start date of 9/14/23 . -Wound cares to scrotum with incontinent cleanser (dimethicone active ingredient) and soft dry wipes every shift with start dated of 4/14/25 . R2's progress notes dated 4/7/25 to 6/25/25, indicated R2 was hospitalized on 4/7/25 and returned to the facility on 4/12/25. Progress notes reviewed indicated R2's skin was warm and dry with no open areas. R2's 4/12/25 hospital encounter, directed staff to continue cleansing scrotum with incontinent cleanser (dimethicone active ingredient) and soft dry wipes. R2's June 2025 Medication and Treatment Administration Record (MAR and TAR), indicated staff administered barrier cream every shift. Although R2's wound care orders for his scrotum lacked being identified on the MAR and TAR. During interview on 6/25/25 at 10:46 a.m., nursing assistant (NA)-A stated R2 had skin rashes which appear and heal but skin was clear now. During observation and interview on 6/25/25 at 10:59 a.m., registered nurse (RN)-E stated R2 had a scrotal wound which appeared and cleared. R2's scrotal area had barrier cream and appeared red after the barrier cream was wiped off. RN-E stated R2's scrotum was macerated at times. RN-E reviewed ingredients in the topical products used for R2. Tena Proskin cleansing cream had active ingredients of glyceryl stearates/cetearyl isononanoate. DermaRite PeriGuard ointment had active ingredient of petrolatum. Neither included dimethicone as an active ingredient ordered by provider. During interview on 6/26/25 at 10:37 a.m., the ADON stated R2 had a wound to his scrotum approximately two years ago and no current wound concerns to his scrotal area. The ADON was unsure of where the scrotal wound order with dimethicone came from. During interview on 6/26/25 at 11:00 a.m., licensed practical nurse (LPN)-B stated staff applied barrier	F0684		

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F0684 SS = D	Continued from page 16 cream to R2's scrotum and was not aware of anything else. LPN-B reviewed R2's order for wound care with dimethicone cream and stated the order did not show up on the MAR or TAR. During interview on 6/26/25 at 2:01 p.m., the director of nursing (DON) expected staff to follow orders and clarify orders as needed once residents returned from the hospital. The facility Skin Assessment and Wound Management policy dated 2/2025, directed staff to implement appropriate preventative skin measures and follow ongoing treatments per provider order.	F0684		
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to appropriately assess and help maintain range of motion and prevent possible contracture who had limited functional movement in the right hand for 1 of 2 residents (R16) reviewed for range of motion (ROM). Findings include: R16's Minimum Data Set (MDS) assessment dated 5/16/25,	F0688	R16’s hand was assessed to ensure there was no deficit. A therapy order was obtained to evaluate and treat for contracture. R16 was assessed by therapy and found to have a rigidity and increase tone but not contractures in the digits. R16 does have active ROM and complete FM tasks such as feeding and that PROM order is being completed. A full house audit was conducted by assessing residents’ range of motion to identify any residents with deficits or a decline in range of motion. Ensured that the provider was notified for all identified residents and that an order for referral to therapy was received for evaluation of the deficit. Also ensured that the deficit is noted in the care plan. Educating all nursing staff to ensure that any observed decline or delay in a resident’s range of motion is promptly reported to the provider, with a therapy order requested as appropriate. Staff are also instructed to document the observation and enter a progress note. During MDS assessments, Clinical leaders were educated to assess the resident’s ROM, notify therapy if concerns are noted, and document accordingly. Four (4) residents will be audited weekly for four (4) weeks to assess their range of motion and to ensure appropriate interventions are in place for any identified deficits. If no interventions are present, the audit will ensure that there is a therapy order. Audit results will be reviewed at QAPI meetings. Any	08/07/2025

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F0688 SS = D	Continued from page 17 identified R16 had cognitive impairment and displayed no delusional thinking, with some rejection of cares. Further, R16 required moderate assistance to eat and perform oral hygiene. During observation and interview on 6/23/25 at 3:51 p.m., R16 was resting in bed and her daughter held up R16's right hand and stated she was concerned R16's hand and fingers were becoming more contracted; stating R16 is no longer able to hold silverware or brush her teeth on her own. R16 could previously do those things. During observation on 6/24/25 at 12:40 p.m., R16 had food present and was attempting to feed self. R16 was unable to use the silverware, instead R16 was picking up food with her left index finger and thumb. During interview on 6/25/25 at 10:27 a.m., assistant director of nursing (ADON) stated she does not recall if R16 had a brace for her right hand. ADON stated the importance of a brace for R16 would be to maintain function and prevent loss of range of motion (ROM). During interview on 6/25/25 at 12:33 p.m., physician assistant (PA) confirmed R16 had a contracture of the right hand; stating a physical therapy (PT) consult was ordered in December 2024. PA stated the normal process is the provider team will order the PT consult, once the PT consult is complete, the PT team will make recommendations. Once the provider team has recommendations, they will write PT orders for the resident based on the recommendations. PA confirmed R16 had an Xray of the right hand on 3/12/25, this imaging was limited due to the flexed position of the right hand. PA stated a brace could be important for R16 so that she does not lose any more ROM in her right hand. During interview on 6/25/25 at 12:53 p.m., physical therapy director (PT-D) stated the physical therapy department completed a PT consult on 12/11/24. The consult on this date did not address ROM needs of the right hand; the consult only addressed wheelchair positioning and upper body strengthening. PT-D confirmed the physical therapy department had not seen R16 since December 2024. A facility policy titled Therapy Services Agreement dated 11/17/2019, identified the facility maintains rehabilitation services with a therapy contractor. However, the facility retains responsibility for, and overall supervision of facility residents.	F0688	Continued from page 17 deficiencies will be identified and corrected at the time of occurrence. DON or designee is the responsible party.	
F0697 SS = D	Pain Management	F0697	R296's a pain evaluation has been conducted. The resident's care plan has been reviewed and confirmed as	08/07/2025

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F0697 SS = D	Continued from page 18 CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure timely reassessment after administration of as needed narcotic medication for 1 of 2 residents (R296) reviewed for pain. Findings include: R296's annual Minimum Data Set (MDS) assessment dated 4/10/25, indicated R296 had intact cognition and diagnoses of hypertension, cirrhosis (scarring of liver caused by many diseases and conditions which includes alcohol use disorder), gastro-esophageal reflux disease (condition in which stomach contents move up into the esophagus), viral hepatitis (infection which causes liver inflammation and damage), diabetes mellitus, fracture, anxiety disorder, depression, and chronic obstructive pulmonary disease (condition caused by damage to airways and other parts of the lung). R296 received as needed pain medications. The MDS indicated R296 had pain almost constantly and the pain occasionally effected sleep and interfered with therapy activities and day-to-day activities. R296's care plan, indicated R296 had chronic hip pain and acute lumbar spine fracture, history of substance abuse, and followed by the pain management team. The care plan indicated R296 made statements of "only wanting oxycodone" as pain relief, rated pain at eight or nine out of ten without nonverbal indicators of pain or discomfort, and had a history of opioid abuse. The care plan directed staff to provide nonmedicinal forms of pain relief such as positioning, rest, and massage, administer pain medication as ordered, document on effectiveness of pain medication, encourage R296 to verbalize discomfort, monitor for potential medication side effects related to medication usage. R296's Pain Evaluation dated 6/19/25, indicated R296	F0697	Continued from page 18 up to date. The current pain management plan has been effective per resident. Resident's choice not to be follow by pain management team or ortho treatment. Resident's primary provider is currently managing the resident's pain. A full house audit was conducted to identify residents who received pain PRN medication. Reviewed MAR administration record for the past month to identify if any are documented as ineffective and that provider was notified. Pain management protocol has been reviewed and no changes needed. Education has begun with all licensed nurses to ensure that all pain medications are followed up on within one hour of administration and if pain medication has been identified as ineffective to immediately notify the provider and follow up and document. Audit four (4) residents' pain PRN medication per week for four (4) weeks to ensure the nurse followed up within one hour and if ineffective, to notify the provider and follow provider instructions. Audit results will be reviewed at QAPI meetings. Any deficiencies will be identified and corrected at the time of occurrence. DON or designee to monitor.	

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F0697 SS = D	Continued from page 19 rated his pain at ten out of ten with a verbal description of "moderate". The evaluation indicated R296 complained or showed evidence of pain or possible pain daily. R296's pain treatment included gabapentin 100 milligrams (mg) twice a day and oxycodone 5 mg as needed every six hours. R296's physician order dated 6/19/25 indicated, oxycodone HCl (hydrochloride), opioid painkiller used to relieve moderate to severe pain, 5 milligrams (mg) by mouth every six hours as needed for pain. R296's progress notes, order administration notes, pain scores, and medication administration record dated 6/20/25 through 6/23/25 were reviewed and indicated: -On 6/20/25 at 11:23 a.m., oxycodone was given for "back pain" rated at seven out of ten for pain. At 2:35 p.m., the as needed medication was marked as "effective" and follow-up pain score was zero out of ten. -On 6/20/25 at 8:04 p.m., oxycodone was given for pain rated at two out of ten. On 6/21/25 at 1:40 a.m., the as needed medication was marked as "unknown". No other interventions or notifications were noted. -On 6/21/25 at 5:17 a.m., oxycodone was given for pain rated eight out of ten. At 6:56 a.m., a progress note indicated R296 slept for the most part of the night and requested as needed oxycodone which was given. At 11:36 a.m., the as needed medication was marked as "ineffective" and follow-up pain score was seven out of ten. -On 6/21/25 at 11:40 a.m., oxycodone was given for "back pain" rated at seven out of ten. At 12:54 p.m., a progress note indicated R296 had lower back pain rated at seven out of ten, pain medication was given, and pain was unchanged. No other interventions or notifications were noted. At 4:19 p.m., the as needed medication was marked as "effective" and follow-up pain score was two out of ten. -On 6/21/25 at 6:22 p.m., oxycodone was given for pain rated at three out of ten. At 8:05 p.m., a progress note indicated R296 had no signs or symptoms of pain. At 8:49 p.m., the as needed medication was marked as "effective" and follow-up pain score was two out of ten. -On 6/22/25 at 2:34 a.m., oxycodone was given for pain	F0697		

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F0697 SS = D	Continued from page 20 rated at seven out of ten. At 3:43 a.m., the as needed medication was marked as "effective" and follow-up pain score was zero out of ten. -On 6/22/25 at 9:23 a.m., oxycodone was given for "back pain" rated at seven out of ten. At 12:46 p.m., a progress note indicated R296 had lower back pain rated seven out of ten, pain medication given, and pain unchanged. At 2:04 p.m., the as needed medication was marked as "ineffective" and follow-up pain score was seven out of ten. No other interventions or notifications were noted. -On 6/22/25 at 6:20 p.m., a progress note indicated R296 did not have signs or symptoms of pain. -On 6/22/25 at 9:55 p.m., oxycodone was given for pain rated four out of ten. On 6/23/25 at 5:10 a.m., the as needed medication was marked as "ineffective" and the follow-up pain score was eight out of ten. No other interventions or notifications were noted. -On 6/23/25 at 5:11 a.m., oxycodone was given for pain rated eight out of ten. At 11:57 a.m., the as needed medication was marked as "ineffective" and the follow-up pain score was seven out of ten. No other interventions or notifications were noted. -On 6/23/25 at 12:22 p.m., oxycodone was given for "back pain" rated at seven out of ten. At 5:58 p.m., the as needed medication was marked as "effective" and the follow-up pain score was zero out of ten. During interview on 6/23/25 at 2:29 p.m., R296 stated he struggled with pain to his right side of his abdomen where there was a recent bleed, which led to hospitalization, and chronic back pain from a fracture. R296 stated his pain rated at a seven or eight out of ten. R296 stated he wanted to "run away" from his pain and was unsure his pain would completely "go away". R296 stated nonpharmacological interventions were not effective for his pain. During interview on 6/25/25 at 12:26 p.m., R296 stated his pain was "bad" today from wearing his back brace and transportation to and from an appointment in the morning. R296 stated his back and right abdominal pain was at an eight out of ten when he received as needed pain medication around 11:00 a.m.. R296 stated the nurse had not returned to ask him about the medication effectiveness. R296 stated the pain medication took the "edge off" and rated pain at a six or seven out of ten	F0697		

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F0697 SS = D	Continued from page 21 depending on how much he moved. During interview on 6/25/25 at 1:58 p.m., registered nurse (RN)-C stated R296 complained of pain from his back brace when returned from an appointment and gave him as needed oxycodone around 10:00 a.m.. RN-C stated they had been in R296's room since the oxycodone administration but had not asked him about his pain. RN-C stated R296's pain should be re-assessed within an hour of as needed pain medication administration. RN-C stated staff should attempt other interventions when as needed pain medications were not effective. R296's progress notes, order administration notes, pain scores, and medication administration record dated 6/25/25, indicated R296 received oxycodone for pain rated zero out of ten at 10:21 a.m.. At 4:27 p.m., the as needed medication administration was marked as "effective" and follow-up pain score was zero out of ten. During interview on 6/25/25 at 2:07 p.m., nursing assistant (NA)-D stated R296 asked for his pain medication every six hours and did not look like he was in pain. NA-D stated R296 saw a pain management team weekly who lessened his PRN medication dosing per day but changed back after R296 "screamed and cursed". During interview on 6/26/25 at 10:29 a.m., the assistant director of nursing (ADON) expected staff to follow-up on resident's pain 15 to 30 minutes or up to an hour after PRN pain medication administered. ADON stated staff kept the provider updated about R296's pain management concerns and offered to help R296 change providers. The ADON stated they would educate staff about timely follow-up after PRN medication administration. During interview on 6/26/25 at 2:01 p.m., the director of nursing (DON) expected staff to reassess resident's pain level after or less than thirty minutes from when a PRN pain medication was given. DON stated the reassessment of pain level was important to ensure resident's pain was addressed and to ensure the provider did not need to address resident's continued pain. The facility Pain Management Protocol dated 3/23/23,	F0697		

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F0697 SS = D	Continued from page 22 directed staff to evaluate and report how much and how often residents utilized PRN pain medication. The policy directed staff to reassess residents' pain and related consequences at regular intervals to ensure pain was controlled. The policy directed staff to document effectiveness of interventions for pain and resident's satisfaction with the current level of pain control.	F0697		
F0699 SS = D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to comprehensively assess past trauma and implement individualized care plan interventions utilizing a trauma-informed approach for 1 of 1 (R19) resident reviewed who had post-traumatic stress disorder (PTSD). Findings include: R19's Minimum Data Set (MDS) dated 4/10/25, identified intact cognition, was independent with eating, dressing, toileting, and walking. Diagnosis included depression, schizophrenia, and post-traumatic stress disorder (PTSD). The Care Area Assessment Summary of the MDS for psychosocial well-being was not completed. R19's provider's history and physical note dated 10/9/23 indicated R19 had a diagnosis of schizophrenia, depression, and suicidal ideation. Further, R19 had PTSD due to religious persecution, starvation, and violence suffered in the Sudan; further being complicated by increased life stressors, unspecified psychosis, and alcohol use disorder. Initial review of R19's care plan dated 10/10/23, the focus lacked individualized trauma-informed approaches or interventions and lacked identification of triggers	F0699	Trauma Assessment was completed with R19 and her care plan was updated to include individualized trauma-informed approaches, interventions and identification if triggers to avoid potential re-traumatization. A full house audit was completed by reviewing all residents' trauma assessments to identify which residents are trauma survivors. We will ensure interventions and identification of triggers are care planned to avoid potential re-traumatization. Trauma Informed Care policy was reviewed, and no changes were made. Social Services was educated on the facilities Trauma Informed Care policy and the importance ensuring the information from the assessment is included in the resident's care plan. Audits will be completed weekly for four (4) weeks on three (3) residents who identify as Trauma Survivors to ensure their care plan was updated to include trauma informed approaches, interventions, and identified triggers. Audit results will be reviewed at QAPI meetings. Any deficiencies will be identified and corrected at the time of occurrence. The Social Services Director or Designee is the responsible party.	08/07/2025

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F0699 SS = D	Continued from page 23 to avoid potential re-traumatization. During an interview on 6/24/25 at 2:20 p.m., nursing assistant (NA)-C was not aware of R19's PTSD diagnosis or history, triggers, or patient-centered trauma informed care interventions. During an interview on 6/24/25 at 2:24 p.m., registered nurse (RN)-D stated she was not aware of R19's PTSD diagnosis or history. RN-D stated R19 can become withdrawn, quiet, and refuse to come out of her room at times. RN-D stated she is not aware if these are coping mechanisms related to her PTSD. RN-D reviewed the care plan for R19, confirmed the care plan did have a PTSD care plan. RN-D stated the care plan only stated that R19 had a PTSD diagnosis; the care plan did not specify what the PTSD was from nor what the triggers are. RN-D stated that is why she probably didn't know or remember R19 had PTSD was because the care plan didn't outline anything about R19's PTSD. During interview on 6/25/25 at 10:27 a.m., assistant director of nursing (ADON) stated R19 did have a care plan for PTSD. ADON confirmed the care plan had the following interventions: -referral for psych services as appropriate -staff will utilize trauma informed care when working with resident -connect resident to community services as appropriate -consider past trauma when engaging with resident -Complete PHQ-9 (depression screening) per facility policy and as needed -Notify relevant providers about change in condition or behavior -Encourage collaboration with social services or psych to improve social connections and minimize symptomology ADON confirmed the care plan did not provide detail about R19's PTSD diagnosis or triggers, nor did the care plan outline resident-specific interventions. Per facility policy titled Trauma Informed Care dated	F0699		

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F0699 SS = D	Continued from page 24 2/24/23, residents that have a history of trauma will have goals and interventions added to their care plan to address potential triggers and approaches to minimize or eliminate the effect of the trigger on the resident.	F0699		
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed the ensure residents were free from unnecessary medications for 1 of 2 residents (R25) reviewed for diuretic use. Findings include: R25's admission Minimum Data Set (MDS) assessment, dated 5/21/25, indicated R25 was cognitively intact with no behaviors or delirium. R25 had range of motion to one side of her upper body and required partial to moderate assistance with activities of daily living.	F0757	R25's order was reviewed and requested provider to discontinue since resident has not needed any dose of Torsemide. Received order to discontinue medication and continue with daily weight. Completed medication error form and corrective action. A full house audit was conducted to identify residents receiving oral medication that require parameters to be met prior to administration. Review MAR administration from the past month to Ensure that parameter requirements were followed and if there were not follow then notify provider and complete medication error form. Medication administration policy was reviewed and no changes needed. Education begun with all licensed nurses and TMAs to ensure that weights or any required parameters are obtained and reviewed prior to administering medications. Clinical leaders are also being educated to follow up and notify providers if a resident consistently does not require the medication because the measured parameters fall below the prescribed threshold. Four (4) residents who receive oral medications with parameters will be audited for four (4) weeks to ensure parameters are being followed. Audit results will be reviewed at QAPI meetings. Any deficiencies will be identified and corrected at the time of occurrence. DON or designee to monitor.	08/07/2025

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F0757 SS = D	Continued from page 25 R25 received diuretic medication. R25's diagnosis list included chronic respiratory failure, essential hypertension (high blood pressure), chronic kidney disease, and chronic diastolic congestive heart failure (CHF-heart disease that causes buildup of fluid in the body). R25's care plans included diuretic therapy related to hypertension and congestive heart failure. Interventions included "administer medication as ordered" and potential side effects that included dizziness, postural hypotension (drop in blood pressure with position changes), fatigue, and increased risk of falls. R25's admission orders dated 5/15/25 included torsemide 20 mg (milligrams) tablet for chronic heart failure. For weight 208-216 lbs (pounds)take 40 mg twice a day, for weight greater than 217 lbs take torsemide 80 mg BID. For weight less than 208 lbs, hold torsemide. R25's weight from date of admission on 5/15/25 to 6/25/25 ranged from 183.9 to 198 lbs. R25's medication administration record (MAR) for May and June indicated the following: -Torsemide 40 mg by mouth two times a day for CHF for weight 208-216 lbs. for weight less than 208 hold torsemide. -Torsemide 80 mg by mouth two times a day for CHF for weight greater than 217lbs. For weight less than 208 lbs hold torsemide. Both orders contained a check box in the electronic medical record to document the weight and if the medication was given along with staff initials. The May MAR indicated R25 received the following doses of torsemide: 5/16-120 mg - PM shift. Weight 193.5	F0757		

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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
F0757 SS = D	Continued from page 26 5/18-120 mg - PM shift. Weight 194 5/20-120 mg - PM shift. weight 191.5 5/21-120 mg - PM shift. Weight 192.5 5/28-120 mg - PM shift. Weight 195.5 The June MAR indicated R25 received the following doses of torsemide: 6/3-120 mg - PM shift. Weight 192.5 6/4-120 mg - PM shift. Weight 193 6/8-120 mg - AM and PM shift. Weight 197.5 6/12-120 mg - AM shift Weight 195 6/17-120 mg - PM shift. Weight 195.5 6/18-40 mg - AM shift. Weight 188 6/19-40 mg - AM shift. Weight 184.5 6/20-40 mg - AM shift. Weight 185.5 6/21-40 mg - AM shift and 80mg on PM shift. Weight 183.8 6/22-40 mg - AM shift and 120 mg on PM shift. Weight 184.5 6/23-40 mg - AM shift. Weight 184.5 6/24-40 mg - AM shift. Weight 183.4 6/25-120 mg - AM shift. Weight 183.9 During interview on 6/25/25 at 1:00 p.m., registered nurse (RN)-A stated R25 received torsemide 80 mg and 40 mg for a total of 120 mg the morning of 6/25/25. R25's weight was 183.9. RN-A reviewed the torsemide order and stated, "it doesn't make sense, it's confusing, I should have clarified it". RN-A confirmed the torsemide should have been held based on R25's weight. RN-A stated if the MAR indicated a check mark, the medication was given. If the MAR indicated "5" the medication was held and "9" indicates a progress note was made, and the medication was "probably not given".	F0757		

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

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F0757 SS = D	Continued from page 27 During interview on 6/25/25 at 1:58 p.m., the nurse practitioner (NP) stated resident's weights are reviewed automatically and confirmed R25's weights have been less than 200 since admission. The NP confirmed the order for torsemide and stated R25 should not have received any doses of torsemide since admission. During interview and observation on 6/25/25 at 2:08 p.m., RN-A stated R25 has two cards of torsemide 20mg tablets. Both cards were noted in the medication cart. Both cards contained spots which could house the medication one card had 16 punched out and the other card had 3 punched out. RN-A stated if R25 needed 80 mgs, 4 tablets would be removed and if 40 mg was required, 2 tablets would be given. RN-A stated if tablets were missing from the cards, the medication was given, however there was no way to indicate from the cards what dose or what date R25 received the medication. During an interview on 6/25/25 at 2:25 p.m., the licensed practical nurse (LPN)-A stated a "2" on the MAR indicates refused, "3" indicates a resident is out, "5" means a medication is held, and "9" indicates a nurse's note was made. LPN-A stated she reviews the staff progress notes if a "9", "5", or "3" is documented. If the medication is marked and a note is not made, then it is assumed the medication is given. LPN-A reviewed the torsemide order on R25's June MAR and noted several doses contained "XXX9" (initials of staff protected). LPN-A stated the "xxx9" with the check mark indicated the medication wasn't given because it contained the number 9. It was noted all of R25's medications on those days had "XXX9". When asked if that meant R25 did not receive any of her prescribed medications for those days LPN-A said "no". LPN-A confirmed "XXX9" was the initials of a staff who administered the medication those days. A copy of the electronic medical record staff identifier confirmed "XXX9" identifies the staff member and does not indicate a medication was not given. During interview on 6/26/25 at 9:35 a.m., the director of nursing (DON) stated R25 received torsemide 120 mg on the evening of 6/22/25 however the remaining days the staff reported punching out the medication out of the card, reviewing the weights, and then wasting the medication in the medsafe. A medication destruction record was requested however, the director of nursing stated staff are only required to document wasting narcotic medications, there is no record of other	F0757		

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F0757 SS = D	Continued from page 28 medications wasted. The director of nursing stated she would expect the staff to review R25's weights prior to punching out the medication. She would also expect the staff to correctly document in the MAR if a mediation was given or not. A policy for medication administration was requested but not received.	F0757		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45	F0842	R92 Monitoring orders were entered under the Orders tab to ensure that bruises are assessed every shift. Bruise measurements and progress notes have been documented. The care plan was reviewed and updated to include the bruises and the resident's use of anticoagulants. R92 left axilla has resolved. R25's order was review and requested provider to discontinue since resident has not needed any dose of Torsemide. Received order to discontinue medication and continue with daily weight. Completed medication error form and corrective action. A full house audit was conducted to identify any resident who has any skin impairment including bruises or open area by completing skin assessment. Compare the skin inspection which was completed by the floor nurse to ensure it is documented accurately. A full house audit was conducted to identify residents receiving oral medication that require parameters to be met prior to administration. Review MAR administration from the past month to Ensure that parameter requirements were followed and if there were not follow then notify provider and complete medication error form. Medication administration and skin assessment and wound management were reviewed and no changes needed. Education has begun with all licensed regarding the importance of documenting accurately including skin section of daily skilled noted and weekly skin inspection including measurement and the appearance of bruise or skin concern. Education has begun with all licensed nurses and TMAs to ensure that required parameters are obtained prior to administering oral medications that require them. Also accurately documenting if the medication has been administered or held or refused.	08/07/2025

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F0842 SS = D	Continued from page 29 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medical records were complete and accurately documented for 2 of 2 residents (R92, R25) reviewed.	F0842	Continued from page 29 Four (4) residents will be audited weekly for four (4) weeks by completing visual skin inspections. Each skin inspection and daily skilled note will be compared to the corresponding floor nurse's documented skin inspection to ensure accuracy. Audit results will be reviewed at QAPI meetings. Any deficiencies will be identified and corrected at the time of occurrence. Four (4) residents who receive oral medications with parameters will be visually audited for four (4) weeks to ensure parameters are being followed and accurate documentation was completed. Audit results will be reviewed at QAPI meetings. Any deficiencies will be identified and corrected at the time of occurrence. DON or designee to monitor.	

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F0842 SS = D	Continued from page 30 Findings include: For additional details please see F684 and F757. R92's admission Minimum Data Set (MDS) assessment dated 6/11/25, indicated intact cognition, did not have delusions or hallucinations, physical, verbal, or other behavioral symptoms, and did not reject care. R92's diagnoses included cancer, wound infection, diabetes, and arthritis. Furthermore, R92 was at risk for developing pressure injuries, had surgical wounds, and took an anticoagulant (blood thinner). During observation and interview on 6/23/25 between 2:14 p.m., and 2:17 p.m., R92 had bruises bilaterally to the back of her upper arms. R92's right arm had a bruise approximately the size of a grapefruit and the bruise located on R92's left arm went from R92's arm pit area to her elbow and was purple towards the elbow and a faded yellow color on the upper part of R92's left arm. R92's left posterior arm at armpit crease had a small nail head sized open area. An ABD (dressing) pad was tucked in next to the area, but did not cover the open area. R92's orders were reviewed and lacked documentation or treatment instruction for an ABD pad related to the open area to the left arm pit area. R92's Physician's Orders form, indicated the following orders: 6/6/25, Complete Daily Skilled Note under forms in PCC (facility electronic medical record). State why the resident is currently being covered for #6 skin issue, #7 infection, #9 diabetes, #13 anticoagulant. 6/8/25, "Monitor for … bruising, …. 0=No Symptoms, +=See NN (nurse note)". 6/8/25, weekly skin inspection by the licensed nurse. Complete weekly skin inspection in PCC. R92's record lacked specific assessment and monitoring to bruising to R92's upper arms. R92's orders lacked instruction for treatment to R92's open area to her left upper posterior arm. R92's Skin Evaluation and Skin Risk Factors form dated 6/5/25 at 8:07 p.m., indicated R92 had the following skin conditions: a surgical incision to the right breast that measured 3.7 centimeters (cm) long, by 0.3 cm wide, a surgical incision to the right armpit that	F0842		

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F0842 SS = D	Continued from page 31 measured 4.2 cm long by 0.5 cm wide. Further, R92 had bruising to the right and left lateral upper arms. The form lacked information regarding and assessment of the coloring of the bruising, size of the bruising or how R92 obtained the bruising. Further the form indicated R92 had the following risk factors that included medications, obesity, and diabetes. R92's Skin and Wound Evaluation forms dated 6/6/25, 6/17/25, and 6/24/25 the form dated 6/24/25, lacked information R92 had an open area to the left upper posterior arm. R92's Daily Skilled Note dated 6/5/25 at 10:09 p.m., lacked an further assessment of R92's bruises, or that R92 had a bruise. R92's Daily Skilled Note dated 6/6/25 at 1:01 p.m., lacked an assessment of R92's bruises or that R92 had a bruise. R92's Daily Skilled Notes dated 6/7/25 at 12:42 p.m., 6/8/25 at 1:03 p.m., 6/9/25 at 12:54 p.m., 6/9/25 at 9:45 p.m., 6/10/25 at 2:03 p.m., lacked an assessment of R92's bruises or that R92 had a bruise, and further lacked information the bruises identified 6/6/25, had resolved. R92's Daily Skilled Notes dated 6/11/25 at 1:35 p.m., lacked an assessment of R92's bruises or that R92 had a bruise. Further, under a heading, "Resident Response to Treatments & Additional Comments" that indicated R92 did not have bruising or bleeding noted from anticoagulants. R92's Daily Skilled Note dated 6/12/25 at 11:39 a.m., and 6/13/25 at 11:32 a.m., lacked a check mark in the check box next to anticoagulant use. The form lacked an assessment of R92's bruises or that R92 had a bruise. R92's Daily Skilled Notes dated 6/17/25 at 6:56 p.m., 6/18/25 at 10:23 a.m., 6/19/25 at 9:25 a.m., 6/20/25 at 1:29 p.m., 6/21/25 at 2:11 p.m., 6/23/25 at 11:37 a.m., and 6/24/25 at 1:06 p.m., indicated R92 was alert and oriented to person, place, and time, did not have behaviors that included resisting care. The form indicated the same check box next to skin issues, and anticoagulant use. Further, the form indicated R92 was free from signs and symptoms of bleeding related to anticoagulant use, and the anticoagulant was administered as ordered. The forms lacked an assessment	F0842		

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F0842 SS = D	Continued from page 32 of R92's bruises or that R92 had a bruise, and further lacked information the bruises identified 6/6/25, had resolved. R92's progress notes were reviewed from 6/5/25, to 6/24/25, and lacked documentation of bruising to arms or an open area assessment of the left upper posterior arm. During interview on 6/25/25 at 9:27 a.m., to 9:44 a.m., registered nurse (RN)-B stated R92 had wound pictures of R92's sore on her right side, but further stated she did not see any bruising documented and verified orders and forms and stated there was no documentation of bruising. RN-B indicated the Weekly Skin Assessments and Daily skin note lacked documentation of R92's bruising. At 9:44 a.m., RN-B verified R92 had bilateral bruising to both arms along with the open area to R92's left arm near her arm pit and stated it had not been documented or measured and stated it should have been. During interview on 6/25/25 at 9:56 a.m., the director of nursing (DON) stated if a resident had a bruise an order needed to be placed to monitor the bruise and the guardian and physician would be notified and they would complete a risk management form. DON stated the bruise was identified on admission although verified R92's medical record lacked information on the color, shape, or size of R92's bruise identified on 6/5/25. Further, the DON verified R92's chart lacked documentation R92 had an open area to her left arm and stated R92 refused her bath on 6/22/25, and stated there were no further assessments on R92's bruises. DON stated staff would document new bruises in the Daily Skin Notes. A policy, Skin Assessment and Wound Management, dated 2/2025, indicated the purpose of the assessment was to provide guidelines for assessing and managing wounds. Further, prevention and identification included implementing preventative skin measures, a skin evaluation and skin risk factors form was completed before initial MDS, annually, and upon significant change. Further, staff would perform routine skin inspections with daily care and nurses were to be notified if skin changes were identified and a weekly skin inspection was completed by licensed staff. Further when a significant alteration in skin integrity is noted such as large or multiple bruising, or other non-pressure related wounds the following actions will be taken: notify the provider, treatment ordered, notify the representative, complete education with the	F0842		

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F0842 SS = D	Continued from page 33 resident including risks and benefits, initiate a skin and wound evaluation, notify the nurse manager, review and update the care plan including interventions. A policy was requested, however in an email dated 6/25/25 at 12:01 p.m., the DON indicated the facility did not have a policy regarding complete and accurate documentation. R25 R25's admission Minimum Data Set (MDS) assessment, dated 5/21/25, indicated R25 was cognitively intact with no behaviors or delirium. R25 had range of motion to one side of her upper body and required partial to moderate assistance with activities of daily living. R25 received diuretic medication. R25's care plans included diuretic therapy related to hypertension and congestive heart failure. Interventions included "administer medication as ordered" and potential side effects that included dizziness, postural hypotension (drop in blood pressure with position changes), fatigue, and increased risk of falls. R25's admission orders dated 5/15/25 included torsemide 20 mg tablet for chronic heart failure. For weight 208-216 lbs take 40 mg twice a day, for weight greater than 217 lbs take torsemide 80 mg BID. For weight less than 208 lbs, hold torsemide. R25's medication administration record (MAR) for May and June indicated the following: -Torsemide 40 mg by mouth two times a day for CHF for weight 208-216 lbs. for weight less than 208 hold torsemide. -Torsemide 80 mg by mouth two times a day for CHF for weight greater than 217lbs. For weight less than 208 lbs hold torsemide. Both orders contained a spot to document the weight and a spot to document if the medication was given along	F0842		

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F0842 SS = D	Continued from page 34 with staff initials. The May MAR indicated R25 received torsemide five times weighing under 208 lbs. The June MAR indicated R25 received torsemide 13 times weighing under 208lbs. During interview on 6/25/25 at 1:00 p.m., registered nurse (RN)-A stated R25 received torsemide 80 mg and 40 mg for a total of 120 mg the morning of 6/25/25. R25's weight was 183.9. RN-A confirmed the torsemide should have been held based on R25's weight. During interview on 6/25/25 at 1:58 p.m., the nurse practitioner (NP) stated resident's weights are reviewed automatically and confirmed R25's weights have been less than 200 since admission. The NP confirmed the order for torsemide and stated R25 should not have received any doses of torsemide since admission. During an interview on 6/25/25 at 2:25 p.m., the licensed practical nurse (LPN)-A stated a "2" on the MAR indicates refused, "3" indicates a resident is out, "5" means a medication is held, and "9" indicates a nurse's note was made. LPN-A stated she reviews the staff progress notes if a "9", "5", or "3" is documented. If the medication is marked and a note is not made, then it is assumed the medication is given. LPN-A reviewed the torsemide order on R25's June MAR and noted several doses contained "XXX9" (initials of staff protected). LPN-A stated the "xxx9" with the check mark indicated the medication wasn't given because it contained the number 9. It was noted all of R25's medications on those days had "XXX9". When asked if that meant R25 did not receive any of her prescribed medications for those days LPN-A said "no". LPN-A confirmed "XXX9" was the initials of a staff who administered the medication those days. A copy of the electronic medical record staff identifier confirmed "XXX9" identifies the staff member and does not indicate a medication was not given. During interview on 6/26/25 at 9:35 a.m., the director of nursing (DON) stated she reviewed R25's MAR and spoke to "all the staff". The DON stated R25 received torsemide 120 mg on the evening of 6/22/25 however the remaining days the staff reported punching out the medication out of the card, reviewing the weights, and then wasting the medication in the medsafe. A medication destruction record was requested however, the director of nursing stated staff are only required	F0842		

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F0842 SS = D	Continued from page 35 to document wasting narcotic medications, there is no record of other medications wasted. The director of nursing stated she would expect the staff to review R25's weights prior to punching out the medication. She would also expect the staff to correctly document in the MAR if a mediation was given or not A policy for medication administration was requested but not received.	F0842		
F0880 SS = D	Infection Prevention & Control 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	F0880	R2's catheter bag placement was reviewed, and the location of the bag cover was moved to side of the wheelchair where it is not touching the floor. The resident was assessed and found to be free of any signs or symptoms of infection. A full house audit was conducted to identify residents who utilize catheter. Ensure resident's catheter bag secure and kept off the floor including the protective cover placed on the bed and wheelchair (if applicable) in a location where it can not touch the floor. Begun education with all nursing staff to ensure catheter bag are properly secured and kept off the floor. Four (4) residents with a catheter will be audited weekly for four (4) weeks to ensure the catheter bag is not on the ground. Audit results will be reviewed at QAPI meetings. Any deficiencies will be identified and corrected at the time of occurrence. DON or designee to monitor.	08/07/2025

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F0880 SS = D	Continued from page 36 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. (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 proper placement of catheter bag for 1 of 1 resident (R2) reviewed for catheter use. Findings include: R2's quarterly Minimum Data Set (MDS) assessment dated 4/29/25, indicated R2 had severe cognitive impairment, no behaviors or rejections of care, and required substantial/maximal to dependent assistance with activities or daily living. R2's diagnoses included peripheral vascular disease, neurogenic bladder,	F0880		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT RICHFIELD	7727 PORTLAND AVENUE SOUTH , RICHFIELD, Minnesota, 55423

(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 37 diabetes mellitus, dementia, anxiety, and depression. R2 had an indwelling catheter, was always incontinent of bowel, and was at risk for pressure ulcers. R2's care plan printed, indicated R2 had a suprapubic catheter. Staff were to provide assistance with peri-cares in the morning, at bedtime, and as needed, monitor for signs/symptoms of UTI, monitor catheter output, provide catheter care per policy, change catheter per policy, apply protect cream after each incontinent episode, encourage only and nutritional intake, and monitor bowel movements as they occurred. R2's physician order dated 6/23/25, indicated R2 had a size 16 Fr (French) suprapubic catheter. During observation on 6/23/25 at 12:15 p.m., R2 was sitting in his wheelchair at the end of the hallway in front of the television. R2's catheter bag was on the floor. At 1:00 p.m., R2's catheter bag was still on the floor. At 1:23 p.m., R2's catheter bag was hooked on the back of his wheelchair strap and still touched the floor. During interview on 6/23/23 at 1:24 p.m., nursing assistant (NA)-E verified R2's catheter bag was touching the floor. NA-E stated there was a cover to place R2's catheter bag in, forgot to put the cover on the wheelchair, and believed the cover was in R2's room. During interview on 6/26/25 at 2:01 p.m., the director of nursing (DON) expected catheter bags to be placed inside a cover and off the floor for infection control purposes. The Infection Prevention and Control Program dated 11/2024, directed staff to prevent infection by instituting measures to avoid complications or spread of infection and educating staff and ensuring they adhere to proper techniques and procedures.	F0880		

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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/24/2025. At the time of this survey, The Villas At Richfield 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	K0000		07/28/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245492	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/24/2025

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K0000	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: 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. The Villas At Richfield is a 3 story building with full basement. The building was constructed in 1964 and was determined to be Type II (222) construction. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 105 beds and had a	K0000		

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K0000	Continued from page 2 census of 98 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K0000		
K0321 SS = D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by:	K0321	The identified storage room was equipped with an automatic self-closing device to ensure compliance with NFPA 101 and Life Safety Code Requirements. All Residents have the potential to be affected if this requirement is not met. The Maintenance Director was educated on this requirement, and the identified area has been corrected Audits will be completed weekly for four (4) weeks to ensure all storage room doors remain equipped with functioning self-closing devices. Audit results will be reviewed at QAPI meetings. Any deficiencies will be identified and corrected at the time of occurrence.	08/07/2025

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K0321 SS = D	Continued from page 3 Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 43.7.1.2, 19.3.2.1.2, 19.3.2.1.3, 8.4.3.5, 8.3.3.1, and 7.2.1.8.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/24/2025 at 10:41 AM, it was revealed by observation that the staffing office located in the basement near the stairwell was repurposed as a storage room; however, the door was not equipped with a self-closing device, resulting in it not closing automatically. An interview with the Administrator and the Regional Maintenance Director verified this deficient finding at the time of discovery.	K0321		
K0363 SS = D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke	K0363	The identified Corridor Door obstruction was removed to ensure the door is not held open by any object, in compliance with NFPA 101 and life safety code requirements All Residents have the potential to be affected if this requirement is not met. Staff were re-educated on the requirement that corridor doors must not be held open by any objects, and the identified area has been corrected. Audits will be completed weekly for four (4) weeks to ensure corridor doors are unobstructed and compliant. Audit results will be reviewed at QAPI meetings. Any deficiencies will be identified and corrected at the time of occurrence.	08/07/2025

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K0363 SS = D	Continued from page 4 compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5 and 19.3.6.3.10. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/24/2025 at 10:55 AM, it was revealed by observation that the door to the janitor closet in the basement was being held open with a metal weight. An interview with the Administrator and the Regional Maintenance Director verified this deficient finding at the time of discovery.	K0363		
K0712 SS = C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills	K0712	The process for conducting fire drills has been reviewed to ensure compliance with NFPA 101 and Life Safety code and remains unchanged. All Residents have the potential to be affected if this requirement is not met. The Maintenance Director was educated on the importance of conducting fire drills on all shifts and at varied times, following the facilities Fire Drill Policy and Procedure. Audits will be completed monthly for (3) months to ensure fire drills are completed per regulatory requirements. Audits will be reviewed at QAPI meetings. Any deficiencies will be identified and corrected at the time of occurrence.	08/07/2025

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K0712 SS = C	Continued from page 5 under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/24/2025 between 09:15 AM and 11:45 AM, it was revealed by a review of available documentation that the fire drills conducted during the second shift were not being carried out at varied times. An interview with the Administrator and the Regional Maintenance Director verified this deficient finding at the time of discovery.	K0712		
K0918 SS = F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.	K0918	The process for ensuring emergency generator testing and documentation has been reviewed to ensure compliance with NFPA 101 and Life Safety Code and remains unchanged. All Residents have the potential to be affected if this requirement is not met. The current Maintenance Director, who was on a leave of absence during November 2024, will be re-educated on the facilities generator policy. It is noted that during the time the Maintenance Director has been actively working at the facility, there have been no concerns regarding compliance with this requirement. Audits will be completed monthly for (3) months to ensure generator testing is completed and properly documented. Audit results will be reviewed at QAPI meetings. Any deficiencies will be identified and corrected at the time of occurrence.	08/07/2025

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K0918 SS = F	Continued from page 6 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/24/2025 between 09:15 AM and 11:45 AM, it was revealed by a review of available documentation that at the time of the survey, the facility was unable to provide documentation confirming that the emergency generator was tested in November 2024. An interview with the Administrator and the Regional Maintenance Director verified this deficient finding at the time of discovery.	K0918		