



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 17, 2026

Administrator

THE VILLAS AT OSSEO LLC

501 SECOND STREET SOUTHEAST

OSSEO, MN 55369

RE: CCN: 245629

Cycle Start Date: September 3, 2026

Dear Administrator:

On September 3, 2026, a survey was completed at your facility by the Minnesota Department(s) 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:

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

Office: (320) 223-7300 Mobile: (320) 426-0175

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public

Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by December 3, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 3, 2027 (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,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health

P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 17, 2026

Administrator
THE VILLAS AT OSSEO LLC
501 SECOND STREET SOUTHEAST
OSSEO, MN 55369

Re: State Nursing Home Licensing Orders

Event ID: 2851C0-H1

Dear Administrator:

The above facility survey was completed on September 3, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

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

Office: (320) 223-7300 Mobile: (320) 426-017

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/03/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(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 8/31/26 through 9/03/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			E0000			09/25/2026
F0000	INITIAL COMMENTS On 8/31/26 through 9/3/26, a standard recertification survey (S5629018) was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed, NO deficiencies were cited. 264084708 - H56293907C H56293905C/IQIES# 3156272 H56293859C/IQES# 3170663 H56293907C/IQIES# 3093008 H56293908C/IQES# 3066291 H56293909C/IQES# 3063489 H56293911C/IQES# 3036972 H56293912C/IQES# 2654010 H56293961C/IQES# 3040016 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			F0000			

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: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/03/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(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
F0000	Continued from page 1 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			09/25/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff had access to a resident's locked door for 1 of 1 resident (R85) reviewed for accidents and hazards. Findings include: R85's quarterly Minimum Data Set (MDS) dated 7/16/26, indicated no cognitive impairment, no behaviors, was independent with walking and personal cares. Diagnoses include schizoaffective disorder and major depressive disorder. R85's care plan dated 7/7/26, included R85's behavior of locking herself in her room and self-isolating; care plan failed to include how staff would access her room in case of emergency when the door was locked. On 8/31/26 at 3:20 p.m., nursing assistant (NA)-A confirmed R85's door was always locked whether in or out of her room. NA-A shrugged her shoulders when asked how staff would access R85's room in the event of an emergency. NA-A stated staff would just knock and R85 would open the door. On 8/31/26 at 3:25 p.m., NA-B stated R85 had her			F0689	F689 – Free of Accident Hazards/Supervision/Devices The process for satisfying this requirement has been reviewed and revised as needed to ensure the facility develops and implements processes and procedures for Locks on Resident Room Doors, consistent with Minnesota Rules Parts 4658.4110 and 4658.5005, which require a written facility policy addressing the use of locks on resident bedroom doors and require that all bedroom door locks permit exit from the room by simple operation without a key, and that all locks be openable with a master key located at each nurses' station. Residents residing in the facility who have locks on their room door have the potential to be affected if this requirement is not met. All resident room doors were checked to ensure the facility is aware of resident rooms with locks on their door. Care plans were reviewed and revised for residents found to have locks on their room door, to reflect the presence of the lock and staff access requirements. All necessary VAO staff were trained on the facility's room lockout policy and procedures. In accordance with state statute, this training specifically focused on identifying residents with secured doors and ensuring immediate access to the master key during an emergency. Audits will be completed to verify staff knowledge of and access to master keys for locked resident room doors 3x weekly for 2 weeks, 2x weekly for 2 weeks, 1x weekly for 1 week and monthly thereafter. Audit		09/25/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/03/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(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
F0689 SS = D	Continued from page 2 own key to lock and unlock her door. When asked how staff would access the locked door, NA-B stated he would get the key from the nurse's desk. On 8/31/26 at 3:30 p.m., R85 returned to her room and used a key to unlock her door. On 9/1/26 at 9:30 a.m., nurse manager registered nurse (RN)-A, stated staff should knock twice on R85's door and R85 would unlock it. In addition, RN-A stated maintenance, nurse managers and director of nursing (DON) had a key to access R85's room. RN-A further stated there was a locked box outside of the administrator and DON offices that could be accessed in case of emergency. RN-A confirmed the code to lock box was not readily available and staff would have to call the on-call administrator to receive the code. On 9/1/26 at 9:36 a.m., licensed practical nurse (LPN)-A stated a spare key was located in the maintenance department on the lower level. LPN-B was also present and stated there was no spare key near the nurse's desk and had only been aware a key was located in the maintenance department. LPN-B confirmed this would be a concern in an emergency as the maintenance department was located on the lower level of the building. On 9/1/26 at 11:13 a.m., NA-B retrieved a key to R85's door from his personal backpack at the nurse's desk. NA-B stated he had been provided a key by maintenance when he started working at the facility. On 9/1/26 at 11:23 a.m., DON stated he had been aware R85 kept her door locked. DON stated the triple zero ("000") key would open R85's door and was located on a key ring for each medication cart and also at the nurse's desk. DON had retrieved LPN-B's key ring and verified the "000" key was present. DON had been unable to locate the key that should have been located at the nurse's desk. DON stated he was surprised staff were unaware of the location of the keys and expected they knew. DON expected this information was included on R85's care plan. On 9/1/26 at 12:27 p.m., corporate nurse consultant (RN-B) stated she placed a key for R85's door handle lock in a drawer at the nurse's desk today. The key was observed in a drawer and had been wrapped in paper that was taped and stapled shut and was identified as "key room 108" in red ink. RN-B stated an order had been placed in the electronic health record (EMR) indicating nursing			F0689	Continued from page 2 results will be reviewed at the facility's QAPI committee, with any deficient practice identified corrected at the time of occurrence. The Administrator or Designee is the responsible party. Corrective action will be completed on or before 9/25/26.		09/25/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/03/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(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
F0689 SS = D	Continued from page 3 staff were to check the nurse's desk for the location of “000” key each shift. On 9/1/26 at 12:32 p.m., RN-A had been aware R85 kept door locked. RN-A had been unaware staff did not know where to find the key to open R85's door. RN-A stated staff could call maintenance to open the door, however, was unaware if maintenance was in the building 24/7. RN-A confirmed the order had been placed in the EMR by RN-B because “everyone needs reminders”. RN-A stated she was not aware of any training provided to new staff or agency staff regarding unlocking R85s door in an emergency. On 9/2/26 at 10:14 a.m., administrator confirmed staff should have been aware of the location of keys, adding that information had been added to the care plan 9/1/26. Administrator stated this should have been covered during new employee orientation and would now be added to the checklist. Administrator confirmed it was a concern staff did not know where the key was located to access R85's room in case of an emergency. Facility Locks on Resident Room Doors policy dated 9/1/26, included the facility permits the use of privacy locks on resident room doors provided they comply with federal regulations. Under no circumstances may a lock require a key, tool, passcode, or complex combination to unlock from the inside. Master keys capable of unlocking all resident rooms must be stored at the nurse's desk at all times and the charge nurse must carry a key to ensure immediate emergency entry. Residents are to be assessed for cognitive status, safety awareness and physical capabilities and it must be explicitly documented in the care plan. No policy had been available prior to State surveyor identifying the concern.			F0689			09/25/2026

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/03/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(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
20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/31/26 through 9/3/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Nursing Home Licensure. NO licensing orders were issued. The following complaints were reviewed, H56293905C/IQIES# 3156272			20000			09/25/2026

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/03/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(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
20000	Continued from page 1 H56293859C/IQES# 3170663 H56293907C/IQIES# 3093008 H56293908C/IQES# 3066291 H56293909C/IQES# 3063489 H56293911C/IQES# 3036972 H56293912C/IQES# 2654010 H56293961C/IQES# 3040016 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			20000			09/25/2026
21665	Physical Environment CFR(s): MN Rule 4658.1400 A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff had access to a resident's locked door for 1 of 1 resident (R85) reviewed for accidents and hazards. Findings include: R85's quarterly Minimum Data Set (MDS) dated 7/16/26, indicated no cognitive impairment, no behaviors, was independent with walking and personal cares. Diagnoses include schizoaffective disorder and major depressive disorder. R85's care plan dated 7/7/26, included R85's behavior of locking herself in her room and self-isolating; care plan failed to include how staff would access her room in case of emergency when the door was locked.			21665	CORRECTED.		09/25/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/03/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(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
21665	Continued from page 2 On 8/31/26 at 3:20 p.m., nursing assistant (NA)-A confirmed R85’s door was always locked whether in or out of her room. NA-A shrugged her shoulders when asked how staff would access R85’s room in the event of an emergency. NA-A stated staff would just knock and R85 would open the door. On 8/31/26 at 3:25 p.m., NA-B stated R85 had her own key to lock and unlock her door. When asked how staff would access the locked door, NA-B stated he would get the key from the nurse’s desk. On 8/31/26 at 3:30 p.m., R85 returned to her room and used a key to unlock her door. On 9/1/26 at 9:30 a.m., nurse manager registered nurse (RN)-A, stated staff should knock twice on R85’s door and R85 would unlock it. In addition, RN-A stated maintenance, nurse managers and director of nursing (DON) had a key to access R85's room. RN-A further stated there was a locked box outside of the administrator and DON offices that could be accessed in case of emergency. RN-A confirmed the code to lock box was not readily available and staff would have to call the on-call administrator to receive the code. On 9/1/26 at 9:36 a.m., licensed practical nurse (LPN)-A stated a spare key was located in the maintenance department on the lower level. LPN-B was also present and stated there was no spare key near the nurse’s desk and had only been aware a key was located in the maintenance department. LPN-B confirmed this would be a concern in an emergency as the maintenance department was located on the lower level of the building. On 9/1/26 at 11:13 a.m., NA-B retrieved a key to R85’s door from his personal backpack at the nurse’s desk. NA-B stated he had been provided a key by maintenance when he started working at the facility. On 9/1/26 at 11:23 a.m., DON stated he had been aware R85 kept her door locked. DON stated the triple zero (“000”) key would open R85’s door and was located on a key ring for each medication cart and also at the nurse’s desk. DON had retrieved LPN-B’s key ring and verified the “000” key was present. DON had been unable to locate the key that should have been located at the nurse’s desk. DON stated he was surprised staff were unaware of the location of the keys and expected they knew. DON expected this information was included on R85’s care plan.			21665			09/25/2026

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/03/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(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
21665	Continued from page 3 On 9/1/26 at 12:27 p.m., corporate nurse consultant (RN-B) stated she placed a key for R85’s door handle lock in a drawer at the nurse’s desk today. The key was observed in a drawer and had been wrapped in paper that was taped and stapled shut and was identified as “key room 108” in red ink. RN-B stated an order had been placed in the electronic health record (EMR) indicating nursing staff were to check the nurse's desk for the location of “000” key each shift. On 9/1/26 at 12:32 p.m., RN-A had been aware R85 kept door locked. RN-A had been unaware staff did not know where to find the key to open R85’s door. RN-A stated staff could call maintenance to open the door, however, was unaware if maintenance was in the building 24/7. RN-A confirmed the order had been placed in the EMR by RN-B because “everyone needs reminders”. RN-A stated she was not aware of any training provided to new staff or agency staff regarding unlocking R85s door in an emergency. On 9/2/26 at 10:14 a.m., administrator confirmed staff should have been aware of the location of keys, adding that information had been added to the care plan 9/1/26. Administrator stated this should have been covered during new employee orientation and would now be added to the checklist. Administrator confirmed it was a concern staff did not know where the key was located to access R85’s room in case of an emergency. Facility Locks on Resident Room Doors policy dated 9/1/26, included the facility permits the use of privacy locks on resident room doors provided they comply with federal regulations. Under no circumstances may a lock require a key, tool, passcode, or complex combination to unlock from the inside. Master keys capable of unlocking all resident rooms must be stored at the nurse’s desk at all times and the charge nurse must carry a key to ensure immediate emergency entry. Residents are to be assessed for cognitive status, safety awareness and physical capabilities and it must be explicitly documented in the care plan. No policy had been available prior to State surveyor identifying the concern. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could ensure staff are educated on policies and procedures to keep residents safe. The DON or designee could identify all residents at risk for harm as a vulnerable adult and update/implement measures to keep each			21665			09/25/2026

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/03/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(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
21665	Continued from page 4 resident safe. In addition, the facility could care plan those measures for each resident involved and/or at risk. The DON or designee could perform measurable audits to ensure all care plans are updated and interventions consistently implemented. Results of those audits could go to the Quality Assurance Performance Improvement (QAPI) for determination of compliance and the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21665			09/25/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 09/01/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(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
K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on 9/1/2026. At the time of this survey, The Villas at Osseo 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			09/27/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 09/01/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(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
K0000 Bldg. 01	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. Building Info: The Villas at Osseo is a 2-story building that has been determined to be a Type V (111) due to wood joist and plywood floors in some of the linen closets. It has a partial basement and is fully fire sprinklered. On September 24, 2015, a 1-story addition was also determined to be a Type V (111) construction. The addition does not have a basement and is fully sprinklered. The facility has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility will be surveyed as one building. The facility has a capacity of 100 beds and had a census of 92 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:			K0000			09/27/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 09/01/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(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
K0761 SS = F Bldg. 01	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 9/1/2026 between 9:15 AM and 12:45 PM, it was revealed by a review of available documentation that at the time of the survey the facility was unable to provide a fire door inspection report that included an inventory of the fire doors and identified the specific inspection criteria evaluated for each door. An interview with the Administrator, Regional Maintenance Director, and the Maintenance Director verified this deficient finding at the time of discovery.			K0761	K0761 Maintenance, Inspection & Testing – Doors: -On 9/1/26 it was revealed by a review of available documentation that at the time of the survey the facility was unable to provide a fire door inspection report that included an inventory of the fire doors and identified the specific inspection criteria evaluated for each door. -In the event of an emergency, all occupants have the potential to be affected if this regulation is not met. -The Maintenance Director completed a fire door inspection on 9/1/2026 that included an inventory of the fire doors and identified the specific inspection criteria evaluated for each door. This report was placed in the Life Safety Binder. -The Maintenance Director will complete a fire door inspection annually, per regulation, with the inventory and inspection criteria documented for each door. The inspection due date will be tracked on the facility's preventive maintenance calendar. -Completion of the annual fire door inspection will be verified through QAPI review to ensure the report is completed, documented, and filed as required. -Maintenance Director or Designee is the responsible party. -Corrective action will be completed on or before 9/30/26.		09/30/2026
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing			K0918	K0918 Electrical Systems - Essential Electric System Maintenance and Testing: -On 9/1/26 it was revealed by a review of available documentation that at the time of the survey the documentation provided did not clearly demonstrate		09/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 09/01/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(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
K0918 SS = F Bldg. 01	Continued from page 3 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. 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, 8.4.2.1, and 8.4.2.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 9/1/2026 between 9:15 AM and 12:45 PM, it was revealed by a review of available documentation that the facility has two emergency generators; at the time of the survey the documentation provided did not clearly demonstrate that inspections and testing had been completed for both generators. An interview with the Administrator, Regional Maintenance Director, and the Maintenance Director verified this deficient finding at the time of discovery.			K0918	Continued from page 3 that inspections and testing had been completed for both generators. -In the event of an emergency, all occupants have the potential to be affected if this regulation is not met. - The facility has updated its generator testing and inspection documentation to clearly identify which generator each inspection/test pertains to. The facility will ensure that inspection and testing is completed and documented for both generators in accordance with applicable regulatory requirements. -Documentation will be verified through monthly QAPI review to ensure the generator logs clearly identify which generator each test log corresponds to. -The Maintenance Director or Designee is the responsible party. -Corrective action will be completed on or before 9/30/26.		09/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 09/01/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(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
K0232 SS = E Bldg. 01	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain egress corridors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, 19.2.3.4, and 7.1.10.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 9/1/2026 at 11:05 AM, it was revealed by observation that on the second floor, outside the Director of Nursing's office, a desk was observed in the corridor near the exit stairway. The desk was not securely attached to the floor or wall. An interview with the Administrator, Regional Maintenance Director, and the Maintenance Director verified this deficient finding at the time of discovery.			K0232	K0232 Aisle, Corridor, or Ramp Width: -On 9/1/2026 at 11:05 AM, it was revealed by observation that on the second floor, outside the Director of Nursing's office, a desk was observed in the corridor near the exit stairway. The desk was not securely attached to the floor or wall. -In the event of an emergency, failure to meet this regulation could have a patterned impact on the residents within the facility. -This desk was removed from the corridor near the exit stairway. -The Maintenance Director conducted a walk-through of all corridors and exit pathways on both floors to identify any other unsecured furniture or equipment that could obstruct egress width in the event of an emergency. -Audits will be completed of corridors and exit pathways for unsecured furniture/equipment 3x weekly for 2 weeks, 2x weekly for 2 weeks, 1x weekly for 1 week and monthly thereafter. Audit results will be reviewed at the facility's QAPI committee, with any deficient practice identified corrected at the time of occurrence. -Maintenance Director or Designee is the responsible party. -Corrective action will be completed on or before 9/30/26.		09/30/2026
K0920 SS = E Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips			K0920	K0920 Electrical Equipment - Power Cords and Extension Cords: -On 9/1/2026 it was revealed by observation that room 224 and 205 had extension cords in use in their room. -In the event of an emergency, this could have a patterned impact on the residents within the facility. -The extension cords in room 224 and 205 were immediately removed.		09/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 09/01/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(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
K0920 SS = E Bldg. 01	Continued from page 5 for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, section 400.8. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 9/1/2026 at 11:13 AM, it was revealed by observation that there was an extension cord being used in resident room 224 near the window. 2. On 9/1/2026 at 11:27 AM, it was revealed by observation that an extension cord was being used in resident room 205. An interview with the Administrator, Regional Maintenance Director, and the Maintenance Director verified these deficient findings at the time of discovery.			K0920	Continued from page 5 -Room 224 and 205 were offered and provided with an approved power strip. -Facility Residents and Staff were educated on extension cords being prohibited in the facility. -Maintenance Director will audit a random selection of resident rooms for extension cords 3x weekly for 3 weeks, 2x weekly for 2 weeks, 1x weekly for 1 week and monthly thereafter. Audit results will be reviewed at QAPI with any deficient practice corrected at the time of occurrence. -Maintenance Director or Designee is the responsible party. -Corrective action will be completed on or before 9/30/26.		09/30/2026
K0221 SS = D Bldg. 01	Patient Sleeping Room Doors CFR(s): NFPA 101 Patient Sleeping Room Doors Locks on patient sleeping room doors are not permitted unless the key-locking device that restricts access from the corridor does not restrict egress from the patient room, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5. 18.2.2.2, 19.2.2.2, TIA 12-4			K0221	K0221 Patient Sleeping Room Doors: -On 9/1/2026 at 11:39 AM, it was revealed by observation that the door to Resident Room 108 was equipped with a locking device that was operated from inside the room. The locking device restricted egress from the resident room, and not all staff members were able to readily unlock the door. -In the event of an emergency, failure to meet this regulation could have an isolated impact on the residents within the facility.		09/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 09/01/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(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
K0221 SS = D Bldg. 01	Continued from page 6 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain patient sleeping room doors per NFPA 101 (2012 edition), Life Safety Code, section 19.2.2.2.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 9/1/2026 at 11:39 AM, it was revealed by observation that the door to Resident Room 108 was equipped with a locking device that was operated from inside the room. The locking device restricted egress from the resident room, and not all staff members were able to readily unlock the door. An interview with the Administrator, Regional Maintenance Director, and the Maintenance Director verified this deficient finding at the time of discovery.			K0221	Continued from page 6 -The facility developed and implemented processes and procedures for Locks on Resident Room Doors, consistent with Minnesota Rules Parts 4658.4110 and 4658.5005, which require a written facility policy addressing the use of locks on resident bedroom doors and require that all bedroom door locks permit exit from the room by simple operation without a key, and that all locks be openable with a master key located at each nurses' station. -All resident room doors were checked to ensure the facility is aware of resident rooms with locks on their door. -The maintenance director changed the resident door lock to a lock that meets requirements per NFPA 101 (2012 edition) 19.2.2.2.2. -All necessary VAO staff were trained on the facility's room lockout policy and procedures. In accordance with state statute, this training specifically focused on identifying residents with secured doors and ensuring immediate access to the master key during an emergency. -Audits will be completed to verify staff knowledge of and access to master keys for locked resident room doors 3x weekly for 2 weeks, 2x weekly for 2 weeks, 1x weekly for 1 week and monthly thereafter. Audit results will be reviewed at the facility's QAPI committee, with any deficient practice identified corrected at the time of occurrence. -Maintenance Director or Designee is the responsible party. -Corrective action will be completed on or before 9/30/26.		09/30/2026
K0324 SS = D Bldg. 01	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:			K0324	K0324 Cooking Facilities: 1. On 9/1/2026 between 9:15 AM and 12:45 PM, it was revealed by a review of available documentation that the kitchen fire suppression system inspection reports dated January 5, 2026, and July 2, 2026, both documented that the appliance piping was not correctly positioned due to a change in the appliance and indicated that the piping needed to be repositioned. At the time of the survey, there was no		09/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 09/01/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(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
K0324 SS = D Bldg. 01	Continued from page 7 * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the kitchen hood suppression system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.1 and 9.2.3, and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, sections 4.1.3.1, 12.1.2.3, and 12.1.2.3.1. These deficient findings could have an isolated impact on the residents within the facility. Findings include: 1. On 9/1/2026 between 9:15 AM and 12:45 PM, it was revealed by a review of available documentation that the kitchen fire suppression system inspection reports dated January 5, 2026, and July 2, 2026, both documented that the appliance piping was not correctly positioned due to a change in the appliance and indicated that the piping needed to be repositioned. At the time of the survey, there was no documentation available demonstrating that the required corrective work had been completed. 2. On 9/1/2026 between 9:15 AM and 12:45 PM, it was revealed by observation that the stove in the kitchen did not have an approved method in place to ensure the appliance is returned to its designated, approved location after cleaning. An interview with the Administrator, Regional Maintenance Director, and the Maintenance Director verified these deficient findings at the time of discovery.			K0324	Continued from page 7 documentation available demonstrating that the required corrective work had been completed. 2. On 9/1/2026 between 9:15 AM and 12:45 PM, it was revealed by observation that the stove in the kitchen did not have an approved method in place to ensure the appliance is returned to its designated, approved location after cleaning. -In the event of an emergency, failure to meet this regulation could have an isolated impact on the residents within the facility. -The maintenance director removed the shelf, so the appliance piping was no longer blocked; a photo was sent to Summit Fire Protection to provide clearance documentation proving that the piping is not blocked and is correctly positioned. Once documentation is received, this will be placed in the Life Safety Binder. -The kitchen floor will be marked to ensure the appliance is returned to its designated and approved location after cleaning. -The kitchen fire suppression system inspection reports will be reviewed at QAPI to ensure corrective work has been completed in a timely manner. -The maintenance director or designee is the responsible party. -Corrective action will be completed on or before 9/30/26.		09/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 09/01/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(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
K0353 SS = D Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2.1.1.1 and 5.2.1.1.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 9/1/2026 at 11:46 AM, it was revealed by observation that there was paint on the sprinkler located near the TCU stairwell on the first floor. An interview with the Administrator, Regional Maintenance Director, and the Maintenance Director verified this deficient finding at the time of discovery.			K0353	K0353 Sprinkler System - Maintenance and Testing: -On 9/1/2026 at 11:46 AM, it was revealed by observation that there was paint on the sprinkler located near the TCU stairwell on the first floor. -In the event of an emergency, failure to meet this regulation could have an isolated impact on the residents within the facility. -Summit Fire Protection has been contacted to provide a proposal for draining the system and replacing the sprinkler head near the TCU stairwell. -Maintenance Director observed facility sprinkler heads to identify if paint was on any other sprinkler heads. -The sprinkler head replacement to meet the needs of this requirement is pending vendor availability. Upon completion of this replacement, necessary audits will be completed to ensure compliance. Audit results will be reviewed at QAPI with any deficient practice corrected at the time of occurrence. -Maintenance Director or designee is the responsible party.		10/07/2026
K0363 SS = A Bldg. 01	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors			K0363			09/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 09/01/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(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
K0363 SS = A Bldg. 01	Continued from page 9 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 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 9/1/2026 at 11:16 AM, it was revealed by observation that the door to resident room 210 would not latch due to metal hangers on the top of the door. The hangers were removed at the time of survey.			K0363			09/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 09/01/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(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
K0363 SS = A Bldg. 01	Continued from page 10 An interview with the Administrator, Regional Maintenance Director, and the Maintenance Director verified this deficient finding at the time of discovery.			K0363			09/30/2026