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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2R7N

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00733

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245629**
2.STATE VENDOR OR MEDICAID NO.
(L2) **836420100**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE VILLA AT OSSEO**
(L4) **501 SECOND STREET SOUTHEAST**
(L5) **OSSEO, MN** (L6) **55369**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/18/2021** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **03** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **100** (L18)
13.Total Certified Beds **100** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel ___ 6. Scope of Services Limit
___ 3. 24 Hour RN ___ 7. Medical Director
___ 4. 7-Day RN (Rural SNF) ___ 8. Patient Room Size
___ 5. Life Safety Code ___ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
20		80		
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Kathleen Lucas, District Supervisor 08/19/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 08/19/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
03/10/2016
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 19, 2021

CMS Certification Number (CCN): 245629

Administrator
The Villa At Osseo
501 Second Street Southeast
Osseo, MN 55369

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to Medicaid program the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective August 10, 2021 the above facility is certified for:

20 Skilled Nursing Facility Beds

80 Nursing Facility I Beds

Your facility's Medicare approved area consists of all 100 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 19, 2021

Administrator
The Villa At Osseo
501 Second Street Southeast
Osseo, MN 55369

RE: CCN: 245629
Cycle Start Date: June 24, 2021

Dear Administrator:

On August 18, 2021, the Minnesota Department of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2R7N

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00733

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(L1) **245629**
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(L3) **THE VILLA AT OSSEO**
(L4) **501 SECOND STREET SOUTHEAST**
(L5) **OSSEO, MN** (L6) **55369**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/24/2021** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

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To (b) :

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X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
20		80		
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Christine Bodick-Nord HFE - NE II 07/29/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 08/18/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
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03/10/2016
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27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

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06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered

July 13, 2021

Administrator
The Villa At Osseo
501 Second Street Southeast
Osseo, MN 55369

RE: CCN: 245629
Cycle Start Date: June 24, 2021

Dear Administrator:

On June 24, 2021, 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" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Kathleen Lucas, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Office: (320) 223-7343 Mobile: (320) 290-1155

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 24, 2021 (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 24, 2021 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245629	A. BUILDING _____ B. WING _____	C 06/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA AT OSSEO	**501 SECOND STREET SOUTHEAST OSSEO, MN 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
E 000	Initial Comments On June 21 through 24, 2021, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance with this requirement. 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.	E 000		
F 000	INITIAL COMMENTS On June 21 through 24, 2021, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5629057C (MN52340), with a deficiency cited at (F573). The following complaints were found to be UNSUBSTANTIATED: H5629054C (MN73711), H5629055C (MN73668), H5629056C (MN72513), H5629058C (MN50455), H5629059C (MN60201), H5629060C (MN68128), H5629061C (MN63956), H5629062C (MN74066).	F 000		

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

Electronically Signed | 07/21/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245629	A. BUILDING _____ B. WING _____	C 06/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA AT OSSEO	**501 SECOND STREET SOUTHEAST OSSEO, MN 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
F 000	Continued From page 1 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.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		8/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245629	A. BUILDING _____ B. WING _____	C 06/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA AT OSSEO	501 SECOND STREET SOUTHEAST OSSEO, MN 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
F 550	Continued From page 2 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide care in a dignified manner for 1 of 3 residents (R71), whose linens were not replaced in timely manner. Findings include: R71's quarterly minimum data set (MDS) dated 3/4/21, indicated R71 had moderately impaired cognition, and was dependent upon staff for activities of daily living (ADLS) including transfers into bed and for personal cares. R71's medical record indicated diagnoses of abnormality of gait and mobility, displaced fracture of bimalleolar fracture of right lower leg, weakness, unsteadiness on feet, muscle weakness, and dementia and required assistance of one staff to move between surfaces.	F 550	R71 bed was made with clean linen. All residents were audited for properly made beds. Residents who wish to not use bed linens have been care planned. All staff to be educated on resident dignity related to bed linen, timeliness of making beds and what to do if they notice a bed unmade. Director of Nursing or designee will audit 3 bed changes a week for 2 months for timeliness. Results of audits will be reviewed by QAPI committee. Facility will maintain compliance as of August 10th.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245629	A. BUILDING _____ B. WING _____	C 06/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA AT OSSEO	**501 SECOND STREET SOUTHEAST OSSEO, MN 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
F 550	Continued From page 3 During an observation, on 06/21/21 at 02:41 p.m. R71 was observed napping directly on a mattress with no linens. R71 stated the bed was stripped when she got up, around 9 a.m. Further, R71 stated she wanted linens on her bed. R71 stated it made her feel "not important" and "other residents were getting all the attention." During an interview, on 06/24/21 at 08:58 a.m. nursing assistant (NA)-A stated the process for changing bed linens was to strip a bed, ask housekeeping to clean it, wait for the mattress to dry, and then remake the bed. NA-A stated it should take about 30 minutes, or longer if staff were really busy, but that it would not take five hours. NA-A stated the resident was not supposed to sleep on a bed without sheets. Beds were to be remade as soon as possible. During an interview, on 6/24/21 at 10:23 a.m. the administrator stated residents were allowed to lie down upon request, and the bed should be remade before a resident was placed in bed. The administrator expected beds were remade in a reasonable amount of time. However, it was not acceptable for the resident to wait from 9 a.m. until 2:40 p.m. to have linens replaced nor was it acceptable to assist a resident into bed without first replacing the linens. The policy related to dignity was requested but not provided.	F 550		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F 641		8/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245629	A. BUILDING _____ B. WING _____	C 06/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA AT OSSEO	501 SECOND STREET SOUTHEAST OSSEO, MN 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
F 641	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to accurately code the Minimum Data Set (MDS) for 1 of 1 residents (R30) reviewed for accuracy of the MDS. Findings include: R30's face sheet, dated 6/24/21, indicated R30's diagnosis included dementia. R30's admission MDS dated 4/27/21, indicated R30's hearing was adequate, his speech was clear, he was able to make himself understood and was able to understand others. Two sections were not completed. Section C, Cognitive Patterns, each question was left unanswered except question C1310A asking if R20 had evidence of an acute change in mental status. This question was answered with a "0" to indicate "no". Section D, Mood, each question was left unanswered. R30's care plan indicated R30 had mood problems and impaired cognitive function. On 6/24/21, at 8:54 a.m. registered nurse, (RN)-C confirmed she is responsible to ensure completion of the MDS prior to transmitting. If a section is not completed, RN-C needed to update the department responsible for completing the section to ensure completion before transmitting. RN-C confirmed sections C and D were not completed for R30's admission MDS, stating she was aware of this prior to transmitting the MDS. RN-C stated not having enough time to ensure completion and accuracy of all MDS assessments.	F 641	R30 had section 'C - cognitive aptterns' and 'D - mood' completed and care plan updated appropriately. All residents most recent MDS was audited to ensure completion of sections 'C' and 'D'. Sections completed and care plans updated as needed. All staff educated on MDS process and importance of completing each section fully. Administrator or designee will audit 3 MDS' a week for 2 months to ensure compliance. Results of audits will be reviewed by QAPI committee. Facility will maintain compliance as of August 10th.	

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F 641	Continued From page 5 On 6/24/21, at 10:11 a.m. administrator (ADMIN) confirmed it is expected all sections of the MDS are reviewed and completed prior to transmission and sections C and D were not completed for R30's MDS, both sections were signed to indicate completion prior to transmission. ADMIN indicated these sections are necessary to help formulate a personalized plan of care and could have affected the care provided to R30. A facility policy addressing completion of MDS was requested but was not received.	F 641		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide nail care for 1 of 4 residents (R31) who were dependent on staff for assistance with grooming and personal hygiene. Findings included: R31's admission Minimal Data Set (MDS) completed 4/29/21, indicates R31 had diagnoses which included multiple sclerosis, seizure disorder or epilepsy, and was cognitively intact. Further review of MDS, indicated R31 required extensive assistance of two staff members for personal hygiene.	F 677	R31 had nails trimmed and cleaned. Resident has since discharged from facility. All residents had nails trimmed and cleaned. Care plans updated for preferences as appropriate. All staff educated on ADL care related to nail care and honoring resident preferences. Director of Nursing or designee will audit 3 residents nails a week for 2 months to ensure compliance. Results of audits will be reviewed by QAPI committee. Facility will maintain compliance as of August 10th 2021	8/10/21

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F 677	Continued From page 6	F 677		

R31's care plan printed on 6/24/21, indicated R31 had limited physical mobility related to multiple sclerosis, muscle weakness, and required total assist with cares and has actual/potential for an activities of daily living (ADLs) self-care performance deficit. However, R31's care plan does not indicate grooming or personal hygiene preference.

R31's care sheet, for nursing assistant's reference, printed on 6/24/21, indicated R31 required assistance of one staff member for grooming and all ADLs after set up.

On 6/21/21, at 1:45 p.m. R31 was in his room and stated "I wish they would offer to clip my nails. I can't do it myself." R31's nails appeared to look long, uneven and had sharp edges.

On 6/22/21, at 3:09 p.m. R31 was in his room, and nails continued to be long, uneven and had sharp edges. R31 stated "no one has offered me to trim them."

On 6/23/21, at 12:23 p.m. nursing assistant (NA)-C indicated R31 required minimal assistance of one staff member for grooming due to "one of his hands can't quite grab." Further, NA-C stated R31 required minimal assistance of one staff member with combing hair, shaving, and nail clipping. NA-C stated "He can talk. He can let me know. He is verbal about his needs." In addition, NA-C indicated "if they [residents] are not able to let us [staff] know we [staff] know to look and we [staff] will cut them [nails] down and shape them [nails] up."

On 6/23/21, at 1:33 p.m. licensed practical nurse (LPN)- B indicated R31 required assistance by

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F 677	Continued From page 7 staff for grooming. Further, LPN-B stated "shaving, hair combing, and nail clipping we [staff] would do that." LPN-B indicated nails were offered to residents on their scheduled bath day or "the staff will ask, and he would tell us if he needed it done." In addition, LPN-B stated, "I will write him down for nails if he needs them and I will have staff go check with him." On 6/24/21, at 8:37 a.m. Director of Nursing (DON) indicated staff were expected to "be offering it [nail clipping] even if they are cognitively intact, based on resident preference, and would get done when needed." Requested facility policy related to grooming or ADLs, and facility indicated they did not have a policy.	F 677		
F 679 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 record review, the facility failed to provide meaningful activities for 1 of 2 residents (R334), reviewed for activities.	F 679	R334 has discharged from facility. Current activity calendar was passed out to all residents with time and locations of activities. Activity calendar was posted in	8/10/21

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F 679	Continued From page 8 Findings include: R334's admission minimal data set (MDS) completed 6/15/21, indicated R334's diagnoses included cancer, depression and was cognitively intact. Further review of MDS, indicated R334 stated it was very important to her to do her favorite activities. R334's care plan printed on 6/24/21, indicated R334 's leisure preferences are "Resident is a new admission to the TCU [transitional care unit], will continue to monitor. Resident will participate in their Leisure Activities as desired through the Review Period." Further review of care plan, indicated interventions included card/games, computer/video games, having visitors, music, other: TV, pets, puzzles/trivia, reading/magazines R334's activity participation record from 6/9/21, through 6/23/21, lacked evidence that R334 was offered activities of interest as indicated on R334's care plan. Further review of record, indicated R334 participated in arts and crafts on three days, resident was not available one day, resident refused one day, and not applicable another day in addition record lacked evidence that resident was offered the planned activities on the other nine days. Review of June 2021 Villa at Osseo Activity Calendar indicated on 6/21/21, the planned activities were coffee and chat, and dice game. On 6/22/21, the planned activities were coffee and chat, news and stretch, visits with Rosie, Bingo, Reminiscing about Harry Belafonte Songs. On 6/23/21, the planned activities were coffee shop, balloon ball, movie, visits, TCU Leisure	F 679	TCU dining room. Activities staff to complete activities assessment upon admission and quarterly to ensure residents preferences are care planned and met. All staff educated on activities and residents right to participate. Administrator or designee will interview 3 residents a week for 2 months to ensure activities preferences are being met. Results of audit will be reviewed by QAPI committee. Facility will maintain compliance as of August 10th 2021.	

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F 679	Continued From page 9	F 679		

Cart and Visits, and Bingo.

On 6/21/21, at 2:24 p.m. R334 stated "I chose this facility due to the activities, but I have not been invited to any. I heard they have Bingo but have not seen it or been invited to it."

On 6/22/21, at 3:01 p.m. Bingo was being held in the dining room with 10 residents socially distant. R334 was not present.

On 6/22/21, at 3:05 p.m. R334 was sitting in her room, and stated "no activities were offered to me today. They didn't give me a calendar and I was never invited. They came around with a cart last week and asked if I wanted a puzzle on a piece of paper. I really basically get left alone."

On 6/24/21, at 9:26 a.m. activities director (AD) stated in the TCU staff offer the leisure cart "every Wednesday and Friday and visit with people [residents]. No group activities there [in TCU] because I don't have staff. If they [residents] were vaccinated and not in quarantine we invite them over to the long-term care side. We offer activities to everyone." Further, AD stated "she [R334] is not happy to be here. I know she is not going to activities."

On 6/24/21, at 11: 48 a.m. activities assistant (AA)-A indicated "TCU we [staff] have it set up in the evenings with the leisure cart down there. There are books, magazines, puzzles or in room things. TCU gets a calendar with the schedule and they [staff] all know they are welcome to come down as long as they are not in quarantine. Most days I [AA-A] can't get down there [TCU] to invite them [residents], but they are aware." Further, AA-A indicated she invited R334 "last

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F 679	Continued From page 10 Tuesday to Bingo and R334 refused. R334 has not been to any group activities during the day I am not sure about the evenings." AA-A confirmed on 6/23/21, 6/22/21, or 6/21/21, AA-A did not invite R334 to any of the planned activities On 6/24/21, at 12:05 p.m. administrator indicated "TCU we have games and cards. They [residents] have the activities calendar we put on the over the bed table before they admit. With COVID-19 we [staff] have been minimizing activities. Activities [staff] do activities preference on admission. I would expect activities [staff] to invite the residents on the TCU, especially if it is the activity of interest that was mentioned in the assessment that activities [staff] completes with the resident." The policy related to activities was requested but facility failed to provide a copy.	F 679		
F 689 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 record review, the facility failed to ensure call lights were within reach for 2 of 2 residents (R78, R71) reviewed for accidents.	F 689	R78 and R71 had call lights placed within reach. All residents were audited for call light placement and clips were added to call light cords as needed to ensure proper	8/10/21

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F 689	Continued From page 11 Findings include: R78's quarterly Minimum Data Set (MDS) dated 6/3/21, indicated R78 had moderate cognitive impairment and required extensive assistance from two staff for bed mobility, transfers, toilet use and dressing. Required assistance from one staff for locomotion on/off the unit, personal hygiene and eating. Additionally, R78 had upper and lower extremity range of motion impairment on one side and a manual wheelchair for mobility. R78's diagnoses included cerebral infarction (stroke), dysarthria (weakness in the muscles used for speech), morbid obesity, Bell's Palsy (paralysis on one side of the face), dysphagia, cognitive communication deficit, and muscle weakness. During an observation on 6/23/21, at 11:32 a.m. R78 was seated in wheelchair approximately three feet away from call light. R78 stated she would push her call light when she needed help but did not know where it was. When told where call light was located, R78 was unable to propel self in wheelchair to get call light. During an observation on 6/23/21, at 12:18 p.m. R78 was escorted to her room and left seated in wheelchair approximately three feet away from call light. During a subsequent interview on 6/23/21, at 12:18 p.m. trained medication aide (TMA)-A stated R78 would use her call light when she needed assistance and confirmed R78's call light was out of reach. During an interview on 6/24/21, at 9:46 a.m. director of nursing (DON) stated call lights were expected to be accessible to residents, and staff	F 689	placement. Resident preferences to call light placement care planned as appropriate. All staff educated on importance of call light placement and ensuring resident has within reach. Director of Nursing or designee will audit 3 residents a week for 2 months to ensure compliance. Results audit will be reviewed by QAPI committee. Facility will maintain compliance as of August 10 2021.	

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F 689	Continued From page 12	F 689		

were trained to ensure call lights were within reach. Further, DON stated call lights were needed for resident safety.

R78's care plan indicated resident had an ADL self-care deficit due to impaired balance, weakness, and history of cerebral infarction (CI). ADL interventions included assistance of two staff to reposition in bed, check and change in bed and for transfers with hoyer lift, and indicated resident was encouraged to use bell to call for assistance. Further, R78's care plan indicated resident had the potential for acute/chronic pain due to CI and indicated resident was able to call for assistance when in pain. Additionally, R78's care plan indicated R78 had the potential for falls due to impaired balance, weakness, CI and incontinence with an intervention to ensure the call light was within reach, resident was encouraged to use it for assistance, and resident needed prompt response to all requests for assistance.

R78's Care Area Assessment (CAA) dated 6/19/21, indicated R78 had difficulty negotiating the environment, difficulty seeing the television, reading, and recognizing staff due to vision problems. The CAA further indicated R78 had a problem with voice production/low volume.

A PowerPoint training dated 3/9/21, indicated every resident had the right to have a way to ask for help and each resident in the facility was provided a call light. Further, the training indicated it was staffs' responsibility to make sure call lights were always within reach and accessible.

Although a policy related to call lights was requested, none was provided.

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F 689	Continued From page 13	F 689		

R71's quarterly Minimum Data Set (MDS) dated 3/4/21, indicated R71 had moderately impaired cognition, and was dependent upon staff for activities of daily living (ADLS) such as transfers into bed and for personal cares.

R71's face sheet printed 6/24/21, had the following diagnoses: abnormality of gait and mobility, displaced fracture of bimalleolar fracture of right lower leg, weakness, unsteadiness on feet, muscle weakness, and dementia.

R71's plan of care (POC) dated 10/19/20, indicated R71 required the assistance of one staff to move between surfaces and was at risk for falls with an intervention to keep R71's call light within reach.

On 06/21/21, at 02:40 p.m. R71 was observed napping on her bed and R71's call light was wrapped around the connection on the wall out of reach.

On 6/21/21, at 7:24 p.m. R71's was observed sitting in her wheelchair with the call light out of reach, wrapped in the bed covers.

On 6/22/21, at 8:22 a.m. R71's call light was observed to be wrapped around the connection on the wall, out of reach.

On 6/23/21, at 7:23 a.m. R71's call light was wrapped in the bed covers, out of site. When asked if she could reach it, R71 tried to reach the call light and could not.

When interviewed on 6/23/21, at 7:30 a.m. trained medication aide (TMA)-A stated if a call light was wrapped on the wall, it would be

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F 689	Continued From page 14 replaced in reach of the resident. TMA-A stated there was no reason a call light should be wrapped on the wall unless it was placed there to clean or make a bed, and then forgotten. When interviewed on 6/24/21, at 10:23 a.m. the administrator stated call lights should always be in reach or accessible to residents.	F 689		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 761		8/10/21

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F 761	Continued From page 15 Based on observation, and interview, the facility failed to ensure access to medications, including a controlled substance was limited to only authorized staff in 1 of 2 refrigerators used for medication storage. Findings include: On 6/22/21, at 3:10 p.m. registered nurse (RN)-A unlocked the second-floor refrigerator so dietary staff (unnamed) could restock the refrigerator. RN-A returned to the medication cart located out of sight of the refrigerator and did not supervise the dietary staff. RN-A confirmed the drawer in the refrigerator had an emergency medication kit (E-kit) but was not aware if there was a narcotic inside the emergency kit. RN-A checked to ensure the lock was replaced on the refrigerator after the dietary staff finished but did not check the medication in the refrigerator. RN-A confirmed an authorized staff member was not supervising the dietary staff when placing nutritional supplements in the refrigerator. On 6/22/21, at 3:18 p.m. RN-B confirmed the E-kit contained Ativan (a controlled substance), licensed nurses (LPN or RN) and trained medication aids (TMA), assigned to pass medications, carry the key to unlock the second-floor refrigerator. RN-B indicated no other staff should be allowed unsupervised access to the refrigerator. RN-B stated the expected process would be, the nurse would put the nutritional supplements in the refrigerator, or the dietary staff was to be supervised by authorized staff. Unauthorized staff can not be left unsupervised when the refrigerator is unlocked. On 6/23/21, at 2:10 p.m. pharmacy consultant	F 761	All medications stored in 2nd floor refrigerator audited for proper amounts. Facility to separate medications from nutritional supplements in 2 refrigerators to minimize risk. Other unit medication fridges are separate from supplements with medications only stored in it. All staff educated on medication storage and who has proper access, including e-kits and narcotics. Director of Nursing or designee will audit 3 times a week that medications are all stored and locked separately from supplements. Results of audits will be reviewed by QAPI committee. Facility will maintain compliance as of August 10, 2021	

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F 761	Continued From page 16 (PC) stated unauthorized staff should not have access to medications, especially narcotics. Unauthorized staff needed to be supervised when stocking the refrigerator. PC confirmed, the main concern was possible diversion of the narcotic. On 6/24/21, at 10:41 a.m. director of nursing (DON) stated she expected licensed nursing staff have access to the refrigerator used for medication storage. Licensed nursing staff should have been present while the dietary staff had access to the refrigerator and E-kit with narcotics. An undated facility document, Controlled Substance Accountability Guideline, indicated to limit keys and access to medication storage areas and/or facilities to licensed nursing staff and authorized personnel only.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812		8/10/21

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	245629	A. BUILDING _____ B. WING _____	C 06/24/2021

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F 812	Continued From page 17 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dishwashing sanitization was appropriately monitored. Further, the facility failed to ensure food was prepared under sanitary conditions to include 5 of 5 staff (dietary cook (DC)-A, DC-B, DC-C, dietary aide (DA)-B, DA-C) who did not secure their hair with hair nets, and 1 of 1 staff (DC-A) who did not utilize gloves on both hands when handling lettuce, having the potential to affect 81 of 81 residents who were served food from the kitchen. Findings include: During observation, on 6/22/21 at 3:09 p.m. dietary aide (DA)-A was observed not wearing a hair net in the kitchen while chopping lettuce for the noon meal. Upon interview at that time, DA-A stated he did not put a hair net on, and he did not need a hair net because he was not handling food. During observation, on 6/22/21 at 3:10 p.m. DC-A was observed chopping lettuce. DC-A was wearing a glove on his left hand, not the right hand. DC-A was chopping the lettuce with a knife and in his right hand and then picked up the chopped lettuce with both hands to put it in the container for food service. DC-A was not wearing a hair net at the time. Upon interview at the same time, DC-A stated he was supposed to wear a hair net upon entry into the kitchen and wear gloves while doing food prep.	F 812	Ecolab confirmed facility dishwasher was at appropriate chemical level for sanitation. All residents reviewed for symptoms of food borne illness form 6/22 dinner with no concerns. Medical Director updated. All staff educated on proper hair net procedures, food handling related to glove use, and proper dishwasher testing procedure. Dietary Director or designee will audit 3 times a week for 2 months for proper hair net and glove use, as well as proper dishwasher chemical testing. Results of audit will be reviewed by QAPI committee. Facility will maintain compliance as of Aug. 10th 2021	

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F 812	Continued From page 18	F 812		

During observation, on 6/22/21 at 3:10 p.m. DC-B was observed not wearing a hair net in the kitchen while assisting with food preparations for lunch.
Upon interview at the same time, DC-B stated he did not need a hair net because he was bald.

During observation, on 6/23/21 at 3:11 p.m. DA-B was observed not wearing a hair net in the kitchen while preparing food labels for lunch, standing next to food on the preparation table.
Upon interview at the same time, DA-B stated he wears a hair net when he is ready to serve food, no one told him to put one on, but he wears one in the transitional care unit.

During an interview, on 6/23/21 at 8:36 a.m. nutritional services director (NSD) stated hair nets were donned prior to entry into the kitchen by all staff, with no exceptions. NSD pointed to signs on the kitchen doors which stated a hair net was required prior to entry to the kitchen. Further, NSD stated the policy for glove use was to don gloves prior to food preparation when handling food with hands instead of utensils. In addition when asked about the procedure related to checking temperature for dishwasher, the NSD stated the dishwasher temperature and chemical composition was checked after every meal.

During an observation on 6/23/21, 2:09 p.m. DC-C was observed in the kitchen without a hair net while putting away food from lunch.
Upon interview, DC-C stated she was only in the kitchen for a short time and did not need one. DC-C did not don a hair net until prompted by NSD.

During an observation, on 6/23/21 at 11:42 a.m.

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F 812	Continued From page 19	F 812		

of the dishwasher temperature during cycle, the temperature reached 120 degrees Fahrenheit. The dishwasher used a chemical wash.

During an observation and subsequent interview of the dishwashing process, on 6/23/21 at 2:02 p.m. DA-C was observed testing the chemical content of the water during the middle of the wash cycle, with a chemical test strip. NSD did not correct the process to test the water at the end of the cycle when the chemical was present. The test strip was colorless, but DA-C read the strip and rated the composition as between 200-300 parts per million (ppm) and stated the rating was acceptable. Surveyor observed the label on the test strip bottle, and observed the test strips to be expired in November 2019. DA-C stated he did not know the test strips were expired and did not know where to locate more. NSD stated more had been ordered a month prior, Ecolab had been on site two weeks prior and had brought new test strips at that time. The expired test strips were used three times daily and recored as acceptable since the strips had been dropped off by Ecolab.

Upon review of the Ecolab service record dated 6/9/21, the chemical sanitation measured greater than 100 ppm, and the Ecolab representative turned down the chemical dispense to be in compliance at 100 ppm.

During an interview, on 6/23/21 at 3:05 p.m. Ecolab representative stated he was on site two weeks prior and gave NSD the wrong test strips, and did not realize they were expired. Ecolab representative stated the correct process to test the water was to test it at the very end of the rinse cycle after the chemicals were dispensed.

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F 812	Continued From page 20 Further, no chemical would be detected mid-cycle of washing. Ecolab representative tested the water with both an expired test strip and a new test strip and confirmed the expired test strips did not correctly detect the amount of chemical in the wash. However, there currently was the appropriate amount of chemical present for sanitization of dishes. When interviewed on 6/23/21, at 3:05 p.m. with Ecolab present, NSD confirmed the testing was completed at the wrong time during the cycle by dietary staff. When interviewed on 6/24/21, 10:23 a.m. the director of nursing stated she expected kitchen staff to wear hair nets when in the kitchen, and to wear gloves when preparing food. The Machine Washing and Sanitizing Policy and Procedure dated 2017, stated the final rinse of the cycle will be tested with the appropriate test strip. The Dishwashing Machine Operation Policy and Procedure dated 2017, stated in the event the test strip does not show the correct ppm, the dish aid would notify the person in charge and that no reusable small wares including plates, flatware, glasses, cups, and trays will be used for meal service if the dishwashing machine does not meet requirements as indicated by the test strip.	F 812		
F 880 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	F 880		8/10/21

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F 880	Continued From page 21	F 880		

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 §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the

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F 880	Continued From page 22 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 appropriate catheter emptying occurred to prevent cross contamination for 1 of 3 residents (R75) with a catheter. Finding include: R75's annual Minimum Data Set (MDS) dated 3/3/21, indicated R75 had intact cognition. R75 required extensive assist with toileting. R75's diagnosis included neurogenic bladder with chronic indwelling Foley catheter and cerebral vascular accident (CVA).	F 880	R75 was reviewed for any signs or symptoms of infection after 6/23 cares and MD updated of infection control breach. All residents with catheters were reviewed for signs and symptoms of or potential infection. Facility QAPI committee to perform RCA to determine problems that led to deficit practice. Director if Nursing review policies and procedures regarding disinfecting medical equipment and ensured they met CDC guidance for disinfection in health care faciltiies and following disinfectant product	

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F 880	Continued From page 23 During an observation of morning cares on 6/23/21, at 8:40 a.m. nursing assistant (NA)-B had performed morning activities of daily living (ADL's) for R75. NA-B put on gloves and retrieved a urinal out of the bathroom to empty R75's urinary drainage bag into. NA-B took the spout out of the holder on the urinary catheter bag and opened the spout clamp to allow the urine to flow into the urinal. When the urinary catheter bag had drained out NA-B clamp the spout closed and place the spout back in the holder on the urinary catheter bag. During an interview on 6/23/21, at 8:32 a.m. licensed practical nurse (LPN)-A nurse manager (NM) stated the procedure to empty a urinary catheter bag is to wash hands, apply gloves, alcohol swab the spout on the urinary catheter bag, empty the urinary catheter bag, then alcohol swab the spout again and secure on the urinary catheter bag and hang below the level of the bladder, empty urine, then remove gloves and wash hands. When asked if ok not use alcohol wipes LPN-A, NM stated she should have used the alcohol wipe to wipe the spout before and after draining the urinary catheter bag. During an interview on 6/23/21, at 8:36 a.m. NA-B stated she did not use an alcohol wipe to clean the urinary catheter bag spout before or after draining the urinary catheter bag into the urinal. NA-B stated she had looked for them in R75's room, however there were none in the room and she would have to go downstairs to the supply room to get more. NA-B stated she could have left the room to get alcohol wipes. When asked if NA-B could have asked the nurse to bring her some NA-B stated the nurse was supposed to put the alcohol wipes in the room and she was not	F 880	manufacturer directions for use including contact time. All staff responsible for resident care equipment trained on proper disinfection, including following manufacturer guidelines, for medical equipment used within facility. All staff completed post-test for infection control competency and competency specifically related to catheter drainage bag care. Director of Nursing or designee will audit every shift for 1 week and then 3 times a week for 2 months to ensure compliance. Results of audits will be reviewed by QAPI committee. Facility will maintain compliance as of Aug. 10th 2021.	

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F 880	Continued From page 24 going to get them because she was already in R75's room. NA-B stated she should have left the room to get some alcohol wipes. The facility procedure Empty Urinary Drainage Bag, undated indicted to wipe the end of the spout with a disinfectant wipe, clamp spout and replace the spout in the appropriate holder on the drainage bag.	F 880		

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	245629	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/23/2021**

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K 000	INITIAL COMMENTS An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/23/2021. At the time of this survey, The Villa at Osseo was found 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, the Health Care Facilities Code. The Villa of Osseo is a 2-story building that has been determined to be a Type V (111) due to the 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 80 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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