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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: KLU6
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 **05/22/2018** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12. Total Facility Beds **102** (L18)

13. Total Certified Beds **102** (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
___ 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: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	20	82		
(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 — Kathy Lucas, Unit Supervisor — Date: 05/24/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Douglas S. Larson, Enforcement Specialist — Date: 05/24/2018 (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 **04/30/2018** (L33)

DETERMINATION APPROVAL

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

CMS Certification Number (CCN): 245629 May 23, 2018

Ms. Kristina Umberger, Administrator
The Villa At Osseo
501 Second Street Southeast
Osseo, MN 55369

Dear Ms. Umberger:

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 CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective May 8, 2018 the above facility is certified for:

20 Skilled Nursing Facility/Nursing Facility Beds

82 Nursing Facility II Beds

Your facility's Medicare approved area consists of all 102 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 Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered May 23, 2018

Ms. Kristina Umberger, Administrator
The Villa At Osseo
501 Second Street Southeast
Osseo, MN 55369

RE: Project Number S5629002

Dear Ms. Umberger:

On April 11, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 29, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On May 22, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 21, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 29, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 8, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 29, 2018, effective May 8, 2018 and therefore remedies outlined in our letter to you dated April 11, 2018, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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(L1) **245629**

2. STATE VENDOR OR MEDICAID NO.
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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 **03/29/2018** (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 **102** (L18)
13.Total Certified Beds **102** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With
Program Requirements
Compliance Based On:
____1. Acceptable POC

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
	102			
(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 :
Carlene Lange, NFE - NE II 04/23/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 04/27/2018 (L20)

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

19. DETERMINATION OF ELIGIBILITY
_____ 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)
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3. Both of the Above :

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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

Electronically delivered
April 11, 2018

Ms. Kristina Umberger, Administrator
The Villa at Osseo
501 Second Street Southeast
Osseo, MN 55369

RE: Project Number S5629002

Dear Ms. Umberger:

On March 29, 2018, a standard 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567 whereby corrections are required.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

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 Survey Team
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
Phone: (320) 223-7343
Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 8, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 8, 2018 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 June 29, 2018 (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). This mandatory denial of payments will be based on the

failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 29, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145

St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

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 ______	03/29/2018

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 Lange, Carlene A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements was conducted on 3/26/18 through 3/29/18, during a recertification survey. The facility is not in compliance with the Appendix Z Emergency Preparedness requirements for tag number 0035. The facility's plan of correction (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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	E 000		
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure their emergency preparedness communication plan included a method for	E 035	Facility posted notice in front lobby for public review regarding emergency preparedness plan is in place, where to	5/8/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/20/2018

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

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 ______	03/29/2018

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 035	Continued From page 1 sharing emergency preparedness information with residents and their families or representatives. This had the potential to affect all residents residing in the facility and their families/representatives. Findings include During review of the emergency procedure plan, the plan contained the information required of the regulation, related to communication, with the exception of a process to share information on emergency preparedness with residents their families or resident representatives. During interview, on 3/29/18, at 1:29 p.m. the emergency preparedness policies and procedure manual dated 10/17/17 was reviewed with the administrator and director of maintenance (DM). The policy lacked information on informing residents and their families or representatives on the emergency preparedness plan. At approximately 1:45 p.m. the DM stated we have not shared this information with the residents, their families or representatives.	E 035	find it and that Administrator is available to answer any questions regarding it. Information was also reviewed at resident council on 4/4/18. Staff educated on emergency preparedness notification requirements. Administrator will audit public posting weekly for 4 weeks to ensure availability and then monthly for 3 months. Results will be brought to QAPI to review for further opportunities for improvement. Correction will be completed by May 8th 2018.	
F 000	INITIAL COMMENTS On March 26, 2018-March 29, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom	F 000		

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 ______	**03/29/2018**

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 2 of the first page of the CMS-2567 form. Upon receipt of an acceptable ePOC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.	F 561		5/8/18

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	245629	A. BUILDING ______ B. WING ______	**03/29/2018**

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THE VILLA AT OSSEO	**501 SECOND STREET SOUTHEAST OSSEO, MN 55369**

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F 561	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure bathing frequency preferences were provided for 1 of 2 residents (R61) reviewed for choices. Findings include: R61's quarterly Minimum Data Set (MDS), dated 3/1/18, identified R61 required physical help of one person to help in part of the bathing activity. R61 was cognitively intact. R61's care plan, dated 2/26/18, indicated R61 required physical assist with dressing. The care plan lacked direction related to bathing assistance and bathing preferences. During an interview on 3/26/18, at 1:29 p.m. R61 stated he had not had a shower in 2 weeks. R61 stated staff had approached him 2 weeks ago for a shower when he was in the middle of something. R61 stated he did not want one just then, so the staff said he refused. R61 stated he kept telling staff he wanted a shower and was told "don't have the staff" and "short on people." R61 stated he is scheduled for a shower on Thursdays. R61 stated "You miss your turn you are done for the week." R61 stated "I have to beg for a shower." During an interview on 3/28/18 at 11:31 p.m. R61 stated he had a shower last night. R61 stated he sweats a lot and would like a shower twice a week on Monday and Fridays. R61 stated he had asked staff for more than one shower a week and staff told him "no."	F 561	R 61 was interviewed for bathing preferences and care plan and NAR sheet updated as indicated. All Residents were interviewed for bathing preferences and care plans and NAR sheets updated as indicated. Staff educated on guidelines for bathing preferences; residents will be interviewed for preferences upon admission and reviewed quarterly, annually, and with significant changes. Activities or designee will audit 2 charts a week x 4 weeks and then 5 charts monthly x 3 months. Results will be brought to QAPI to review for further opportunities for improvement. Corrections will be completed by May 8th 2018	

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F 561	Continued From page 4	F 561		

The facility's bath schedule identified R61 was on the the bath schedule one time weekly on Thursday evenings.

Review of R61's progress notes identified the following showers:
3/27/18 (Tuesday) received an evening shower.
3/22/18 (Thursday) Resident refused shower x 3. Wife will give bed bath tomorrow per Resident.
3/15/18 (Thursday) Resident refused shower beginning of shift. Requested shower about 9 p.m.. Offered shower when nursing assistant returned from supper break. Resident refused and went to bed.
3/8/18 (Thursday) Received shower and shampoo with assistance of one staff.
3/1/18 (Thursday) Received shower and shampoo with assistance of one staff.

During an interview on 3/28/18, at 11:02 a.m. registered nurse (RN)-E stated each resident gets one shower a week. Residents are scheduled for a day of the week and either a morning or an evening shower. When asked if a resident can have more than one shower a week RN-E stated "Just one shower." RN-E went onto say that residents can have a bed bath in addition to their weekly shower if they want.

During an interview on 3/29/18, at 9:01 a.m. nursing assistant (NA)-E stated each morning the nurse writes "bath" on the nurse aide assignment sheet, next to the resident's name who is scheduled to receive a shower that shift. NA-E stated if a resident asked her to come back later, she would approach the resident later in the shift to attempt a shower. NA-E stated residents "need to take shower on assigned day." NA-E went onto say other residents are assigned on the other

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F 561	Continued From page 5 days. NA-E stated R61 is assigned a shower in the evening and rarely works evenings. During an interview on 3/29/18, at 1:16 p.m. the director of nursing (DON) stated residents are scheduled for one shower a week. The DON stated if a resident would want more than a weekly shower, staff work on the schedule to accommodate this. The DON stated she was unsure if residents are asked how many showers a week they would like. The DON stated if staff approach a resident for a shower and they are busy like eating, staff should approach 3 times more to offer. "I would want them [staff] to offer again the next shift." The facility's provided an untitled, undated, Self-Determination information that indicated the resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice. "The resident has the right to make choices about aspects of his or her life in the facility that are significant to the the resident."	F 561		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	F 580		5/8/18

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F 580	Continued From page 6 status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 580	R 77 is no longer a resident at the facility.	

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F 580	Continued From page 7 facility failed to notify the responsible party related to vomiting and diarrhea for 1 of 1 residents (R77) reviewed for a change of condition. Findings include: R77's discharge assessment with return anticipated Minimum Data Set (MDS), dated 3/2/18, indicated R77 had short term memory problems and had modified independent cognitive skills for daily decision making, with some difficulty in new situations only. R77's admission record, dated 2/16/18, indicated R77 had weakness and signs and symptoms involving cognitive functions and awareness, and identified family member (F)-A as R77's emergency contact, responsible party, and power of attorney for care and financial. During an interview on 3/26/18, at 2:30 p.m. F-A stated the biggest concern was lack of communication at the facility. F-A stated R77 was admitted to the facility on 2/16/18, and started vomiting and had diarrhea on 2/25/18. F-A stated he was not notified of this until 2/26/18, when the nurse practitioner (NP) called him to say R77 was being transported to the hospital. When he received the phone call from the NP, FM-A stated he left work and went to the hospital emergency department. F-A stated R77 was in a "comatose state," and was severely dehydrated. While he waited with R77 for hospital staff to admit her into the hospital, F-A received a phone call from the facility, stating R77 had been transferred to the hospital. F-A stated he called the facility twice and left two voice messages, asking administrative staff to call him to discuss his frustration with not being notified of R77's change of condition when she started vomiting and had diarrhea, however	F 580	Residents will be reviewed daily by IDT for potential change in condition, including family and physician notification with any changes to the plan of care. Staff educated on guidelines for notification of change in condition; including physician and family notification for changes of condition or care plan. DON or designee will audit 2 charts a week x 4 weeks and then 5 charts monthly x 3 months. Results will be brought to QAPI to review for further opportunities for improvement. Corrections will be completed by May 8th	

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F 580	Continued From page 8 calls were never returned. F-A stated R77 returned to the facility on 3/6/18 after being treated for Norovirus and pneumonia. Review of R77's progress notes from 2/25/18 to 2/27/18 indicated the following: -On 2/25/18, at 6:09 a.m. included, "Resident had nausea and vomiting at 0500 [5:00 a.m.] on NOC [night] shift. Large emesis over bedding and resident. Will continue to monitor." -On 2/25/18, at 2:53 p.m. included, "Patient has had nausea, vomiting, and diarrhea. Encouraging fluids, patient has been in bed most of the day with no appetite..." -On 2/25/18, at 6:18 p.m. included, "No vomiting after drinking ginger ale. Sleeping so far this evening. Has no appetite for food. Will continue to monitor." -On 2/26/18, at 12:43 p.m. a progress note included, "Patient is very weak and lethargic. Confused, not alert to time, place or person." -On 2/26/18, at 1:35 p.m. a progress note included, "Patient did not have diarrhea this morning. Patient did vomit after getting up and out of bed. Patient was not alert and confused. Lethargic and disoriented. Unable to stay sitting up straight. Patient was seen by [NP]. With decision to send to the ER. Patient has been sent to North Memorial. Nephew is aware of condition." During an interview on 3/29/18, at 10:54 a.m. registered nurse (RN)-B stated resident representatives should be notified when residents become sick, and R77's F-A should have been notified when she had nausea, vomiting, and diarrhea on 2/25/18. Review of the facility's policy, Notification of	F 580		

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F 580	Continued From page 9 Changes Guideline, dated 11/28/17, included, "It is the practice of this facility that changes in a resident's condition or treatment are immediately shared with the resident and/or the resident representative, according to their authority, and reported to the attending physician or delegate."	F 580		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would	F 623		5/8/18

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be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental

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F 623	Continued From page 11 disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to send notice of hospital transfers to the Office of the State of Long-Term Care Ombudsman for 5 of 5 residents (R68, R77, R290, R92, R16) who were discharged to the hospital. Findings include: R68's admission record, dated 2/20/18, identified R68 had diagnoses including congestive heart failure, type 2 diabetes, acute respiratory failure with hypoxia (oxygen deficiency), and	F 623	R68, R77, R290, R92, R16 notification of transfers and/or discharges to hospital was submitted to the Office of the State of Long Term Care Ombudsman on 4/3/18. Social Service Director will send discharge and transfers to Ombudsman on a weekly basis and involuntary discharge notices immediately upon issue. Staff educated on discharge notification requirements.	

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F 623	Continued From page 12 hypertension (high blood pressure). R68's admission Minimum Data Set (MDS), dated 3/5/18, identified R68 was cognitively intact. R68's MDS history, reviewed from 2/20/18 to 3/10/18 identified: -R68 had been discharged with return anticipated, on 3/7/18. Review of R68's Progress Notes identified the following: -On 3/7/18, at 4:37 p.m. R68 was in therapy and was transferring from her wheelchair to a bike. R68 passed out and was lowered down to the floor. R68's oxygen saturation was 67-88% on 3 liters of oxygen. Staff called 911 and R68 was transported to the hospital and admitted. There was no evidence the Ombudsman was notified of the transfer. R77's admission MDS, dated 3/19/18, identified R77 was cognitively intact and had diagnoses including anemia, renal insufficiency, and fracture of the femur. R77's MDS history, reviewed from 2/16/18 to 3/13/18, identified: -R77 had been discharged with return anticipated, on 2/26/18. Review of R77's Progress Notes identified the following: -On 2/26/18, at 1:35 p.m. R77 was confused, not alert, lethargic, and disoriented. R77 had vomiting and diarrhea and was unable to stay sitting up straight. R77 was seen by the nurse practitioner and was transported to the hospital and admitted. There was no evidence the Ombudsman was notified of the transfer.	F 623	Administrator will audit all discharge and transfers a week x 4 weeks and then 5 charts monthly x 3 months. Results will be brought to QAPI to review for further opportunities for improvement. Corrections will be completed by May 8th	

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R290's admission record, dated 3/17/18, identified R290 had diagnoses including muscle weakness, left hip fracture, pneumonia, atrial fibrillation (irregular, fast heartbeat). R290's care plan, dated 3/25/18, indicated R290 had confusion and forgetfulness, and sought attention constantly.

Review of R290's Progress Notes identified the following:
-On 3/19/18, at 3:23 p.m. R290 had episode of tachycardia (fast heart rate) with pulse of 130 and low blood pressure. R290 denied chest pain or shortness of breath. R290 was assessed by the nurse practitioner and was transported to the hospital and admitted. There was no evidence the Ombudsman was notified of the transfer.

When interviewed on 3/28/18, at 1:35 p.m. director of admissions stated she spoke to R290's power of attorney and discussed the bed hold policy when she was transported, but had not notified the Ombudsman of the transfer.

R92 progress note identified R92 was discharged from facilty on 12/29/17, at 11:20 a.m. Discharge summary identified R92 was discharged on elderly waiver and needed home care services. Discharge summary included plans for home healthcare services including physical therapy, occupational therapy and registered nursing servers.

During an interview on 3/29/18, at 1:23 p.m. with director of social services (DSS) stated, "I will be honest, I have not reported [to the Ombudsman] since December." DSS stated she was behind in Ombudsman reporting, and verified she had not

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notified the Ombudsman for R68's, R77's, R290's, R16's and R92's transfer to the hospital and/or discharge. DSS stated there was no process in place and there was no policy for notification of the Ombudsman.

R16's Admission Record, dated 3/29/18, identified diagnoses which included Alzheimer's disease and history of falling. The Admission Record further indicated a fractured femur with onset date of 3/5/18.

A progress note, dated 2/28/18, indicated R16 was found by staff on the floor in her room. An ambulance transported R16 via stretcher to the hospital for further evaluation.

A progress note, dated 3/3/18, indicated R16 returned from the hospital.

R16's electronic Census Record indicated R16 was hospitalized 2/28/18 with a return to the facility on 3/3/18.

R16's medical record lacked evidence the ombudsman was notified of R16's transfer to the hospital.

The facility's policy Transfer and Discharge Guideline, dated 11/28/17, indicated "The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman." The policy indicated the resident's physician and facility staff will document in the resident's record: "Date copy of the notice was sent to the representative of the office of the State Long-Term Care Ombudsman and identified state agency per requirements."

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F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident or resident's representative was informed of the bed hold policy at the time of hospitalization for 3 of 4 residents (R68, R77, R16) reviewed for hospitalizations.	F 625	R68 and R77 discharged from the facility. R16 was given a copy of the bed hold policy on 4/18/2018. Bed Hold policy will be provided upon admission to facility and sent with each resident when transferred out or	5/8/18

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Findings include:

R68's admission record, dated 2/20/18, identified R68 had diagnoses including congestive heart failure, type 2 diabetes, acute respiratory failure with hypoxia (oxygen deficiency), and hypertension (high blood pressure). R68's admission Minimum data Set (MDS), dated 3/5/18, identified R68 was cognitively intact.

R68's MDS history, reviewed from 2/20/18 to 3/10/18 identified:
-R68 had been discharged with return anticipated, on 3/7/18.

Review of R68's Progress Notes identified the following:
-On 3/7/18, at 4:37 p.m. R68 was in therapy and was transferring from her wheelchair to a bike. R68 passed out and was lowered down to the floor. R68's oxygen saturation was 67-88% on 3 liters of oxygen. Staff called 911 and R68 was transported to the hospital and admitted. Although there was evidence the bed hold policy was discussed when R68 was admitted to the facility, there was no evidence bed hold information was provided when she was transferred to the hospital.

When interviewed on 3/28/18, at 1:40 p.m. director of admissions (DA) stated, "We talk about bed hold during the admission process so residents are aware of the bed hold policy and have them sign the form," but stated residents or their representative should be notified again when a resident is transferred to the hospital. DA verified there was no bed hold obtained when R68 went to the hospital.

therapeutic leave. Admission Director or designee will follow up with resident or family/representative within 24 hours for bed hold from emergency transfer situations.

Staff educated on Bed hold policy and procedure.

Administrator or designee will audit all transfers weekly x 4 weeks and then 5 transfers month x 3 months. Results will be brought to QAPI to review for further opportunities for improvement.

Correction will be completed by May 8th 2018.

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F 625	Continued From page 17 R77's admission MDS, dated 3/19/18, identified R77 was cognitively intact and had diagnoses including anemia, renal insufficiency, and fracture of the femur. R77's MDS history, reviewed from 2/16/18 to 3/13/18, identified: -R77 had been discharged with return anticipated, on 2/26/18. Review of R77's Progress Notes identified the following: -On 2/26/18, at 1:35 p.m. R77 was confused, not alert, lethargic, and disoriented. R77 had vomiting and diarrhea and was unable to stay sitting up straight. R77 was seen by the nurse practitioner and was transported to the hospital and admitted. There was no evidence bed hold information was provided. When interviewed on 3/28/1:45 p.m. DA stated R77 was transferred to the hospital on 2/26/18 and returned to the facility on 3/6/18. DA verified R77's medical record lacked evidence bed hold information was discussed during the admission process or that a bed hold was provided when she was sent to the hospital. R16's Admission Record, dated 3/29/18, identified diagnoses which included Alzheimer's disease and history of falling. The Admission Record further indicated a fractured femur with onset date of 3/5/18. A progress note, dated 2/28/18, indicated R16 was found by staff on the floor in her room. An ambulance transported R16 via stretcher to the hospital for further evaluation. A progress note, dated 3/3/18, indicated R16	F 625		

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F 625	Continued From page 18 returned from the hospital. R16's electronic Census Record indicated R16 was hospitalized 2/28/18 with a return to the facility on 3/3/18. R16's medical record lacked evidence that R16 or R16's representative was provided bed hold information for R16's hospitalization of 2/28/18. During an interview on 3/29/18, at 9:52 a.m. medical record coordinator (MRC)-D stated she was unable to find bed hold notification in R16's medical record for the 2/28/18 hospitalization. MRC-D stated the administrator was attempting to locate the bed hold information. During an interview on 3/29/18, at 3:01 p.m. the administrator stated she was unable to "physically locate" the bed hold for R16's recent hospitalization. The facility's policy Bed Hold and Return Guideline, undated, indicated "The facility will provide the resident and resident representative a written notice which specifies the duration of the bed-hold policy at the time of transfer for hospitalization or therapeutic leave..." "In cases of emergency transfer, notice at the time of t (sic) transfer means that the facility will send the notice along wit (sic) the necessary paperwork to the receiving setting and the resident representative will receive notice upon transfer." "Documentation of bed hold notice will be completed in the individual medical record."	F 625		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)	F 655		5/8/18

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§483.21 Comprehensive Person-Centered Care Planning
§483.21(a) Baseline Care Plans
§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.
The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be

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F 655 Continued From page 20

administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to ensure a baseline care plan was developed related to properly caring for skin needs and failed to ensure the resident and the resident's representative received a summary of the baseline care plan for 1 of 4 (R60) residents reviewed for pressure ulcers.

Findings include:

R60's 3/1/18 Admission Nursing Evaluation identified a right heel deep tissue injury, which was hard, dark, and measured 3 centimeters (cm) x 2 cm. A left heel deep tissue injury, which was hard, dark, and measured 4 cm x 3 cm. A coccyx open area, which measured 4 cm x 0.5 cm.

R60's admission Minimum Data Set (MDS), dated 3/8/18, indicated R60 required assistance of 2+ staff for bed mobility and transfers. R60 had one stage 2 pressure ulcer and 2 unstageable pressure ulcers. R60 was cognitively intact. R60 was receiving hospice services. R60's Care Area Assessment (CAA), dated 3/13/18, identified pressure ulcers bilaterally to heels and to the sacral/buttocks area. The CAA directed staff to monitor the pressure ulcers weekly and treat the pressure ulcer as ordered. The CAA further directed staff to provide positional changes and to off load R60's heels when in bed. R60 chooses to remain in bed.

F 655

R60¦ s care plan for pressure ulcers was completed on 3/26/18. R60 is currently not a resident at this facility.

Residents admitting will have an initial baseline care plan completed within 48 hours of admission. The baseline care plan will be reviewed with the resident and responsible party within 48 hours of admission. Current residents have been reviewed, baseline care plans completed, and summary provided to resident and their representative.

Staff have been educated on the guidelines for baseline care plans and resident/ family review process.

DON or designee will audit 2 charts a week x 4 weeks and then 6 charts monthly x 3 months. Results will be brought to QAPI to review for further opportunities for improvement.

Corrections will be completed by May 8th 2018.

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R60's physician orders identified:
-3/1/18 " may apply barrier cream to peri-area/scrotum for skin protection every shift."
-3/1/18 order for Cavilon (barrier cream) to left heel twice daily as needed for suspected deep tissue injury.
-3/1/18 order to float R60's heels off the bed at all times due to a suspected deep tissue injury.
-3/1/18 order for a nutritional supplement of vanilla boost every day shift.
-3/6/18 order directed bed rest indefinitely related to hospice patient preference.
-3/9/18 order directed foam adhesive dressing to sacral/coccyx wound every 3 days
-3/9/18 order directed foam adhesive dressing to bilateral heels every 3 days and as needed.

A 3/23/18 Wound Assessment Detailed Report of the coccyx pressure ulcer identified the following:
Stage 2
Periwound criteria: Normal
Wound edge: indistinct
Odor: No
Signs of infection present: No
Dressing present: No
Tissue Types: intact skin 60%, bright pink or red 40%
The PUSH (pressure ulcer score for healing) score increased to 13 (indicating a decline)

A 3/23/18 Wound Assessment Details Report of the right heel pressure ulcer identified the following:
Unstageable: Present upon admission
Periwound Criteria: Normal
Wound edge: distinct and attached
Odor: No
Signs of infection: No
Dressing Present: No

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Continued From page 22

Tissue Type: Purple ecchymosis 100%
Measurements: 3 cm x 3 cm
PUSH score of 9

A 3/23/18 Wound Assessment Details Report of the left heel pressure ulcer identified the following:
Unstageable: Present upon admission
Periwound Criteria: Normal
Wound edge: distinct and attached
Odor: No
Signs of infection: No
Dressing Present: No
Tissue Type: Purple ecchymosis 100%
Measurements 3.5 cm x 4.5 cm
PUSH score 10

The care plan lacked an area related to skin impairment with pressure ulcers and interventions until 3/26/18, when the care plan identified an open area on the coccyx/sacral area and deep tissue injuries to both heels. Interventions included:
-float heel off of bed
-pressure reducing mattress on bed
-turn and reposition every 2 hours.
-evaluate and treat per physicians orders

R60's medical record lacked evidence R60 and R60's representative were provided a summary of the baseline care plan.

During an interview on 3/29/18 at 10:06 a.m. the interim assistant director of nursing (IADON) stated the baseline careplan begins on the day of admission with the Admission Nursing Evaluation electronic form. The IADON reviewed R60's medical record and stated the nurse did not check the boxes needed to initiate a skin and

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F 655	Continued From page 23 pressure ulcer care area on the care plan, but should have. The IADON stated R60's skin and pressure ulcer area were not added to the care plan until 3/26/28. The director of social services (SDD) joined the interview. The SDD stated an electronic care management form is completed within 48 hours of admission, followed by an initial conference with the resident, social services and nursing. The SDD stated she was out the week R60 was admitted and the conference did not occur. The SDD stated baseline care plan was not provided or discussed with the resident. The facility's policy Careplan Standard Guideline, dated 11/28/17, indicated The interdisciplinary team will collect and record data within 24 hours for the admission baseline care plan. The care plan will include the minimum healthcare information necessary to properly care for a resident. "It is the practice of this facility to provide the resident and/or resdient representative with a summary of the baseline care plan. The policy did not identify a timeline for providing the careplan to the resident.	F 655		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent	F 686		5/8/18

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F 686	Continued From page 24 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facilty failed to comprehensively assess and monitor pressure ulcers for 1 of 4 residents (R60) reviewed for pressure ulcers. Findings include: R60's 3/1/18 Admission Nursing Evaluation identified a right heel deep tissue injury, which was hard, dark, and measured 3 centimeters (cm) x 2 cm. A left heel deep tissue injury, which was hard, dark, and measured 4 cm x 3 cm. A coccyx open area, which measured 4 cm x 0.5 cm. The assessment lacked any further information to describe the areas. Physician orders identified a 3/1/18 order " may apply barrier cream to peri-area/scrotum for skin protection every shift." A 3/1/18 order for Cavilon (barrier cream) to left heel twice daily as needed for suspected deep tissue injury. A 3/1/18 order to float R60's heels off the bed at all times due to a suspected deep tissue injury. A 3/1/18 order for a nutritional supplement of vanilla boost every day shift. A 3/6/18 physician order directed bed rest indefinitely related to hospice patient preference. R60's admission Minimum Data Set (MDS), dated 3/8/18, indicated R60 required assistance of 2+ staff for bed mobility and transfers. R60 had one stage 2 pressure ulcer and 2 unstageable pressure ulcers. R60 was cognitively intact. R60 was receiving hospice services. R60's 3/13/18 Care Area Assessment (CAA) identified pressure	F 686	R 60 is no longer a resident in this facility. Residents with pressure ulcers have been assessed; Care plans reviewed and updated as indicated with appropriate treatments applied. Nursing staff will be educated to assess resident¦ s skin status upon admission and apply appropriate intervention to prevent/ treat risks or actual skin impairment. Physicians will be notified on skin impairments upon admit and treatments clarified/ reviewed as indicated. Care plans to be updated with treatment plans and goals. Wounds will be assessed weekly and physician and care plans updated with assessment as indicated until resolved. DON or designee will audit 2 charts a week x 4 weeks and then 6 charts monthly x 3 months. Results will be brought to QAPI t review for further opportunities for improvement. Corrections will be completed by May 8th 2018.	

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F 686	Continued From page 25 ulcers bilaterally to heels and to the sacral/buttocks area. The CAA directed staff to monitor the pressure ulcers weekly and treat the pressure ulcer as ordered. The CAA further directed staff to provide positional changes and to off load R60's heels when in bed. R60 chooses to remain in bed. R60's medical record lacked a comprehensive weekly skin assessment of the coccyx pressure ulcer until 3/9/18, when a 3/9/18 Wound Assessment Detailed Report identified R60's coccyx pressure ulcer. The report revealed the following: Stage 2: Present upon admission Periwound criteria: Normal Wound edge: Indistinct Odor: No Signs of infection present: No Dressing present: No Exudate: Scant and bloody Tissue type: 95% intact skin Measurements 7.5 cm x 2.5 cm. The report identified a "PUSH" (tool for monitoring healing) score of 11. R60's coccyx pressure ulcer lacked a treatment order until 3/9/18, when a physicians order directed: Foam adhesive dressing to sacral/coccyx wound every 3 days and as needed. R60's right heel pressure ulcer lacked a treatment order until 3/9/18, when a physicians order directed: Foam adhesive dressing to bilateral heels every 3 days and as needed. R60's March 2018 electronic Treatment Administration Record indicated completion of pressure ulcer treatments as ordered, as well as	F 686		

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F 686	Continued From page 26	F 686		

implementation of off loading of R60's heels in bed.

A 3/16/18 Wound Assessment Detailed Report of the coccyx pressure ulcer identified the following:
Stage: 2
Periwound criteria: Normal
Wound edge: indistinct
Odor: No
Signs of infection present: No
Dressing present: No
Exudate: Scant and bloody
Tissue Types: 95% intact skin
Measurements 7.5 cm x 3.5 cm
The PUSH score increased to 12 (indicating a decline)

A 3/23/18 Wound Assessment Detailed Report of the coccyx pressure ulcer identified the following:
Stage 2
Periwound criteria: Normal
Wound edge: indistinct
Odor: No
Signs of infection present: No
Dressing present: No
Tissue Types: intact skin 60%, bright pink or red 40%
The PUSH score increased to 13 (indicating a decline)

R60's right and left heel pressure ulcers lacked a comprehensive assessment until 3/23/18, 23 days after identified on the 3/1/18 Nursing Admission Evaluation form.

A 3/23/18 Wound Assessment Details Report of the right heel pressure ulcer identified the following:
Unstageable: Present upon admission

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F 686	Continued From page 27 Periwound Criteria: Normal Wound edge: distinct and attached Odor: No Signs of infection: No Dressing Present: No Tissue Type: Purple ecchymosis 100% Measurements: 3 cm x 3 cm PUSH score of 9 A 3/23/18 Wound Assessment Details Report of the left heel pressure ulcer identified the following: Unstageable: Present upon admission Periwound Criteria: Normal Wound edge: distinct and attached Odor: No Signs of infection: No Dressing Present: No Tissue Type: Purple ecchymosis 100% Measurements 3.5 cm x 4.5 cm PUSH score 10 The care plan lacked an area related to skin impairment with pressure ulcers and interventions until 3/26/18, when the care plan identified an open area on the coccyx/sacral area and deep tissue injuries to both heels. Interventions included: -float heel off of bed -pressure reducing mattress on bed -turn and reposition every 2 hours. -evaluate and treat per physicians orders During constant observation, which began on 3/28/18 at 11:09 a.m. the following was revealed: -11:09 a.m. R60 was sitting up in bed. Wearing bilateral cushioned heel boots. R60 stated he wears the heel boots at all times. R60 stated staff	F 686		

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F 686	Continued From page 28 assist him with moving in bed, but prefers to be on his back, as he gets short of breath. R60 stated he prefers to stay in bed. R60 denied pain. -11:56 a.m. licensed practical nurse (LPN)-E Answered R60's call light. While in the room, LPN-E repositioned R60 slightly to the left side with pillows. During observations on 3/29/18, at 10:26 a.m. LPN-E stated R60's coccyx pressure ulcer dressing was changed overnight. The coccyx pressure ulcer was not observed. Observations of the right and left heel pressure ulcer during a dressing change were as follows: -Left heel: 2 areas. 3.5 cm x 1.5 cm and 1 cm x 0.8 cm. LPN-E stated the area was improving. LPN-E stated the pressure ulcer used to be connected into one larger wound. LPN-E stated the area was hard and brown. Eschar was observed covering the pressure ulcer. -Right heel: 2 areas 2 cm x 2 cm and 1 cm x .3 cm. LPN-E stated the area was improving. LPN-E stated the pressure ulcer used to be connected into one larger wound. Eschar was observed covering the pressure ulcer. During an interview on 3/29/18, at 1:16 p.m. the director of nursing (DON) stated when a pressure ulcer was identified, weekly assessments are completed of the area. The assessment includes a picture, measurements, wound edges and peri-wound assessment. The DON stated the nurse manager was to ensure the pressure ulcer and any skin issues were on the care plan. The DON stated all mattresses were pressure reducing. The DON reviewed R60's medical record and stated R60's pressure ulcers were not monitored weekly. The DON stated the lack of weekly pressure ulcer documentation at the	F 686		

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F 686	Continued From page 29 facility was identified the prior week. Since then, all the pressure ulcers in the building were reviewed to ensure all were assessed. The DON stated she plans to monitor weekly to ensure the assessments are completed. The facility's policy Skin Management Guideline, dated 11/28/17 indicated individual care plans will be developed upon admission, reviewed and updated quarterly and with a change of condition as needed. If a resident is admitted with a pressure ulcer, the physician/NP will be notified weekly wound documentation observation will be completed	F 686		
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 document review, the facility failed to evaluate a fall to determine possible causative factors in order to develop resident centered interventions to minimize the risk of further falls for 1 of 3 residents (R68) who had a fall. Findings include: R68's admission record, dated 2/20/18, identified R68 had diagnoses including congestive heart failure, type 2 diabetes, acute respiratory failure	F 689	R68 incident report was completed and reviewed on 4/20/2018. Residents found on the floor or lowered to the ground will have an incident report completed to evaluate, determine possible causative factors and develop interventions to minimize risks for falls. Staff to be educated on the guidelines related to accidents, hazards, falls and incident reports.	5/8/18

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F 689	Continued From page 30 with hypoxia (oxygen deficiency), abnormalities of gait and mobility, weakness, epilepsy, and hypertension (high blood pressure). R68's admission Minimum Data Set (MDS), dated 3/5/18, identified R68 was cognitively intact, was independent with eating, and required limited assistance with all activities of daily living. R68's care plan, dated 2/22/18, identified R68 was admitted for rehabilitation purposes and was dependent related to physical limitations and weakness. R68 had limited physical ability related to weakness, shortness or breath, and congestive heart failure, used oxygen therapy at all times, and used a cane, walker, or wheelchair for mobility. The care plan also identified R68 was at risk for falls. During an interview on 3/26/18, at 7:14 p.m. R68 stated she was transferring to a bicycle in therapy two to three weeks ago and ended up on the floor. R68 stated she wasn't exactly sure what had happened, but knew that she got her knees caught under the pedals of the bike, so they were sore, and her neck was sore. R68 stated she was transported to the hospital and was admitted. R68 stated she returned to the facility three days later. On 3/27/18, at 3:17 p.m. the administrator stated there was no documentation of R68's fall on the occurrence report provided by the facility, because they did not consider R68's incident a fall, therefore, there was no incident report. During a subsequent interview on 3/28/18, at 1:15 p.m. R68 stated she remembers transferring out of her wheelchair, to the bike, and then remembers waking up on the floor. R68 stated, "I remember my knee hurting and I couldn't catch	F 689	DON or designee will audit 2 charts a week x 4 weeks and then 6 charts monthly x 3 months. Results will be brought to QAPI t review for further opportunities for improvement. Corrections will be completed by May 8th 2018.	

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F 689	Continued From page 31 my breath." R68 stated she had been at an appointment outside of the facility that morning, and she felt really weak. R68 stated, "They think my oxygen tank was either turned off or empty. It was just kind of a weird day. I came back and went to therapy." R68 stated she did some steps first in therapy, and then attempted to transfer to the bike. R68 stated, "The next thing I knew I was on the floor." R68 stated she received three bags of intravenous fluid because she was so dehydrated, and a scan was done of her neck because of the pain she was having. Review of R68's Progress Notes identified the following: -On 3/7/18, at 4:37 p.m. included, "Pt [patient] had an appt [appointment] this morning and when she came back she was taken to the gym to do her PT [physical therapy]. While transferring her from wheelchair to bike, she passed out and was caught and lowered down to the floor. Pt did not hit her head. Vitals were done. Bp [blood pressure] 124/91, P [pulse] 98, O2 sats [oxygen saturation] 67-88 (3 L [liters] O2) and went up to 97% (when put on 6 L O2). BS [blood sugar] 133. 911 was called. Pt responsive before paramedics arrived. Pt was transported to North Memorial Robinsdale. Family called and Pulmonologist also called and informed." -On 3/10/18, at 6:42 p.m. progress notes indicated R68 was readmitted after her hospital stay for syncope episode. R68's fall risk evaluation, completed on 2/20/18, identified R68 was "low risk of fall," had not had a fall anytime in the last 6 months, was on diuretics (for excess fluids) and antihypertensives (treat high blood pressure), and used an assistive device. On 3/10/18, a fall risk evaluation was	F 689		

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completed, which indicated R68 was "low risk of fall," and although R68 had a fall on 3/7/18, the evaluation indicated R68 had not had any falls since admission/entry or reentry, or the prior assessment.

When interviewed on 3/29/18, at 10:42 a.m. registered nurse (RN)-B stated, "If they are on the floor, there should have been an incident report, it should have been discussed, and should have put interventions into place." RN-B stated an investigation should have been completed to determine why it happened, what the resident needed, whether there was possibly equipment failure, if there was anything in the way. In [R68's] case, she collapsed, had a sudden change of condition." RN-B stated, "Do we have the appropriate transfers and such?" RN-B again stated, "There should have been an incident report."

On 3/29/18, at 10:31 a.m. RN-D stated, "[R68] didn't fall, they lowered her to the ground, so we just filled out the note in the progress notes and transfer form. She just went limp. They took her right away." RN-D stated an incident report wasn't completed because it wasn't a fall.

The State Operations Manual - Appendix PP- Guidance for Surveyors for Long term Care, defines a fall as
""Fall" refers to unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force (e.g., resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall. A fall without injury is still a fall. Unless there

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F 689	Continued From page 33 is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred." During an interview on 3/29/18, at 10:50 a.m. director of nursing (DON) stated R68 had a change of condition and was laid on the floor. DON stated an incident report was not done, but should have been. DON stated revisions were not discussed or made to R68's care plan because "It was a change in her medical condition, she desats [saturation of oxygen in blood decreases] with activity, lung capacity is 40%." Review of the facility's policy, Fall Evaluation Safety Guideline, dated 11/28/17, included, "Falling is an unintentional change in position coming to rest on the ground floor or onto the next lower surface. The fall may be witnessed, reported by the resident or an observer or identified when a resident is found on the floor or ground. Falls include any fall regardless which setting it may have occurred. An intercepted fall occurs when the resident would have fallen if he or she or someone else had not caught him or herself. Any failure to maintain an appropriate lying, sitting or standing position resulting in a resident's sudden, unintentional relocation either to the ground or into contact with another object below his or her starting point defines falling." Also identified, Post Fall Action included, team huddle to review a fall, post fall investigation to review medication, vital signs, toileting schedule, changes in mood or behavior, signs and symptoms of infection, increase assistance with ADLs, foot wear, and environment, root cause analysis to determine causal factors of fall, evaluate resident and reevaluate risk, and	F 689		

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F 689	Continued From page 34 evaluate effectiveness of interventions.	F 689		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure food was served at a palatable and appetizing temperature for 7 of 7 residents (R38, R32, R61, R17, R69, R68 and R77) who had concerns with the food temperature. Finding include: During a dining observation on 3/26/18, at 5:03 p.m. the director of dietary (DD) took the temperature of the food that would be served for supper. The tuna sandwiches that were the alternate for the supper meal were temped at 55 degrees Fahrenheit. The DD stated they were not cold enough and placed them in the refrigerator in the dining room. On 3/26/18, at 5:28 p.m. three residents were eating tuna sandwiches. The pan of tuna sandwiches were sitting in a container of ice on the steam table. The DD stated the steam table warms up the sandwiches.	F 804	Food served to the residents will be <40 or >140 degrees. If not within that temperature range they will be out of range for less then 4 hours. Temperatures will be checked and recorded at completion of preparation and at point of service. Production records will be used to ensure adequate portions are produced. Tuna and mayonnaise will be held in refrigerator prior to assembling prepared salads. Room Tray procedure updated to have all 2nd floor room trays transported in a temperature controlled cart. Trays will be limited to 5 at a time to ensure quicker delivery and dietary will notify nursing staff when trays are available. All culinary staff have been educated on proper food assembly procedures, recipe	5/8/18

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F 804	Continued From page 35 On 3/26/18, at 5:34 p.m. the DD took the temp of the tuna sandwiches which were 59 degrees Fahrenheit. On 3/26/18, at 6:02 p.m. the DD went to the refrigerator and took the temperature of the tuna sandwiches and stated the temperature is 53 degrees Fahrenheit. On 3/26/18, at 6:11 p.m. the DD was making peanut butter and jelly sandwiches for R38 in the dining room. An interview on 3/26/18, at 6:27 p.m. the DD stated there was no more BBQ chicken breasts for some of the residents to have. The DD stated there were mashed potatoes, chicken noodle soup or corn if they wanted a hot item. The DD did not offer any other options for hot items. An interview on 3/28/18, at 12:37 a.m. dietary aid (DA)-B stated DA-B made the tuna sandwiches an hour before serving time. DA-B stated the tuna sandwiches were put in the walk in cooler and then brought them to the dining room at 5:00 p.m. DA-B stated the tuna sandwiches were not temped prior to bringing them to the dining room. DA-B stated all the food should be temped prior to bringing the food to the dining room. A review of the service line checklist dated 3/26/18, labeled upstairs and kitchen, lacked documentation related to the temperature of the tuna sandwiches. A review of the tuna salad recipe indicated it contained egg/mayo product. The tuna salad recipe indicated hold cold potentially hazardous	F 804	and production sheets, and HAACP food handling procedures. All staff educated on room tray procedures. Area Director or designee will audit food temperatures and proper food handling procedures 2 meals per week x 4 weeks and 6 meals per month x 3 months. They will also audit 2 room trays on 2nd floor per week x 4 weeks and 6 trays per month x 3 months. Results will be brought to QAPI to review for further opportunities for improvements. Corrections will be completed by May 8th 2018.	

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foods no more than four hours at 41/45 degrees Fahrenheit.

R38's admission record dated 3/28/18, indicated R38's diagnoses included osteoarthritis, muscle weakness, and right artificial knee joint. R38's quarterly Minimum Data Set (MDS) dated 2/8/18, indicated R38's cognition was intact.

During an interview on 3/26/18, at 6:25 p.m. R38 stated dinner was terrible, they ran out of everything and gave me peanut butter and jelly sandwiches.

During an interview on 3/29/18, at 9:45 a.m. R38 stated dinner last night (3/28/18) was bad. R38 stated he had a grilled cheese sandwich with meat that was hard. R38 stated the whole sandwich was cold and R38 had to ask for cold water.

During an observation in the dining room on 3/29/18, at 8:28 a.m. dietary aid-A brought up the food cart with room trays that was covered in plastic wrap, to the second floor and left the food tray cart in the hallway. Dietary aid-A did not tell the second floor staff the food cart with trays was by the nurses station and left the station.

At 8:33 a.m. registered nurse (RN)-A brought the food tray cart down the second floor hallway on the even side of the facility. RN-A passed the food trays to the residents.

At 8:37 a.m. RN-A told nursing assistant (NA)-A we have got to get these trays passed. NA-A assisted with passing food trays.

At 8:46 a.m. with four food trays left on the food

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cart, RN-A called for the DD to come to the second floor with a thermometer.

At 8:50 a.m. the DD took the temperature of the food on the food tray cart. The temperatures were as follows:

frittata (egg dish) 97.5 degrees Fahrenheit
american potatoes 91 degrees Fahrenheit
oatmeal 113 degrees Fahrenheit
milk 53 degrees Fahrenheit
orange juice 52 degrees Fahrenheit

During an interview on 3/29/18, at 8:50 a.m. the DD stated all hot food should be at least 130 Fahrenheit degrees. The DD stated the food was not hot enough or not cold enough for the beverages to serve the residents.

R32's admission MDS dated 8/21/17 indicated diagnosis for arthritis. The admission MDS also indicated R32 was cognitively intact.

During an interview on 3/29/18, at 12:43 p.m. R32 stated the lunch meal room tray food was good today. R32 stated sometimes the food trays for the resident's rooms are cold but today they are not cold because you are here.

R61's quarterly Minimum Data Set (MDS), dated 3/1/18, indicated R61 was independent with eating. R61 was cognitively intact.

R61's care plan, dated 2/26/18 indicated R61 was independent with eating and preferred to eat in his room.

During an interview on 3/26/18, at 1:43 p.m. R61

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F 804 | F 804

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stated "The food was getting cold so much they gave me a thermometer." R61 picked up a food thermometer from his side table. R61 stated he prefers to eat in his room and receives room trays.

During an interview on 3/28/18, at 11:31 a.m. R61 stated the pancakes he received for breakfast were cold.

During observations on 3/28/18 at 12:28 p.m., a cart with lunch trays was located in front of the 2nd floor nursing station. The cart was covered with a plastic covering. Eighteen minutes later, at 12:46 p.m., an unidentified aide brought a lunch tray into R61's room. R61 was sitting in a recliner. The aide set the tray on an overbed table in front of R61 and walked out of the room. On the tray was a mug of coffee and a glass of milk, both covered in plastic wrap. A lid covered a plate on the tray. On the plate was a stuffed green pepper, corn bread, corn, and potato wedges.

Immediately after receiving the tray, R61 removed the cover from the plate and used a thermometer to determine the temperature of the food on the tray. R61 stated he received the thermometer from the dining director (DD.) R61 placed the thermometer in the middle of the green pepper. The thermometer was observed to read at 100 degrees. R61 put the thermometer in the middle of a potato wedge. The thermometer was observed to read at 90 degrees. R61 pushed the thermometer through the plastic wrap and into mug with coffee. The thermometer was observed to read at 100 degrees. R61 pushed the thermometer through the plastic wrap and into the glass of milk. The thermometer was observed to read at 60 degress. A meal card located on the

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tray, next to instructions read "make sure all food is extra hot."

During an interview on 3/29/18, at 9:01 a.m. nursing assistant (NA)-C stated R61 "always says the food is cold." NA-C stated when she brings the tray into R61's room, R61 does not always eat the food right away. NA-C stated she has offered to heat up R61's food, but R61 says "no."

During an interview on 3/29/18, at 12:31 p.m. the DD stated she had spoken to R61 about concerns of cold food. The DD stated R61 had been complaining about cold food for a long time. The DD stated there were times she temped R61's food and it was hot enough. When asked about the thermometer in R61's room, the DD stated she had given R61 the thermometer so he could temp his food. The DD stated the last time she heard R61 had concerns about cold food was about a month ago.

R17's Admission Record, dated 3/29/18, identified diagnoses, which included: Dysphasia (difficulty swallowing), Parkinson's disease, and muscle weakness.

R17's Brief Interview for Mental Status (BIMS), dated 3/14/18, indicated R17 was cognitively intact.

During a resident council meeting, on 3/28/18, at 9:59 a.m. R17 stated "I have yet to get a hot meal out of that kitchen. It is only warm."

R69's Admission Record, dated 3/29/18, identified diagnoses, which included: Dysphagia (difficulty swallowing) and muscle weakness.

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F 804 | F 804

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R69's Brief Interview for Mental Status (BIMS), dated 3/5/18, indicated R69 was moderately cognitively impaired.

During a resident council meeting, on 3/28/18, at 9:59 a.m. R17 was discussing concerns related to the meals at the facility not being hot enough. R69 stated the meals at the facility were not hot.

R68's admission record, dated 2/20/18, identified R68 had diagnoses including congestive heart failure, type 2 diabetes, acute respiratory failure with hypoxia (oxygen deficiency), and hypertension (high blood pressure). R68's admission MDS, dated 3/5/18, identified R68 was cognitively intact.

During an observation on 3/26/18, at 7:07 p.m. R68 was sitting in a chair in her room, with her supper tray in front of her. On the tray, was a grilled cheese sandwich, a small bowl with lettuce, and another small bowl with applesauce. R68 was not actively eating. When asked how her supper tasted, R68 stated, "Yuck. It's cold. Apparently there's a new cook who doesn't know quantity." R68 stated, "The kitchen ran out of the 'special' both last night and tonight. Both nights I ordered the 'special' at 5:10, both nights I got grilled cheese and chocolate mousse pudding." R68 stated she had to ask for the side salad and applesauce tonight. R68 stated, "They should know I eat at 6:00 and then don't eat again until morning. They don't offer a snack in the evening. I'm a diabetic. Six or seven or eight people got grilled cheese, whether they asked for anything else." R68 stated she was lucky to have family that could bring something over for her if she

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needed more to eat. R68 stated, "I have my own stash. Unless you have family to call to bring something over, you are S.O.L."

R68's nutritional assessment, dated 3/1/18, included R68 was on a controlled carbohydrate diet, no added salt, regular texture, and thin liquids. The assessment indicated R68's intake was fair, and 60%.

R68's care plan, dated 3/1/18, identified R68 was independent with eating and had potential nutritional problems, related to obesity, diagnosis of type 2 diabetes and hypertension, and received a therapeutic diet of controlled carbohydrates and no added salt. The care plan also identified interventions, including, "Provide, serve diet as ordered."

R77's admission MDS, dated 3/19/18, identified R77 was cognitively intact and had diagnoses including anemia, renal insufficiency, and fracture of the femur.

R77's care plan, dated 3/6/18, identified R77 required supervision with meals, had dehydration or potential for fluid deficit, and had nutritional problem with greater than 5% weight loss due to inadequate oral intake and recent hospitalization. Interventions included provide and serve diet as ordered and provide feeding/dining assistance as needed.

During an interview on 3/26/18, at 2:30 p.m. R77's family member (FM)-A stated R77's appetite was poor and when he visited recently, R77 was in the dining room, alone at 6:45 p.m., and had only picked at her meal. When he asked why she wasn't eating, R77 complained that her

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food was cold.

During an interview on 3/26/18, at 2:45 p.m. R77 stated, "My lunch was warm today, I almost fell over." R77 stated the food is usually cold when it's delivered from the kitchen, and stated she usually just lets it sit there. R77 stated, "You just have to grin and bear it. It looks good, but it's a little chilly."

During an observation on 3/26/18, at 5:35 p.m. R77 was sitting in her wheelchair, in the dining room, with her head in her hands and her eyes closed. At 5:40 p.m. R77 was given her medications mixed with pudding and was given a Mighty Shake supplement, which she eagerly drank through a straw. At 6:10 p.m. an unidentified staff member started to push R77 back to her room in her wheelchair, when another staff member intervened and stated, "[R77] hasn't eaten yet." R77 was pushed back to the dining room table. At 6:15 p.m. licensed practical nurse (LPN)-A used the telephone at the nurses' station to call the kitchen, and asked for R77's food "STAT." At 6:28 p.m. R77's food was delivered on a tray. The tray contained a grilled cheese sandwich and a small cup of applesauce. R77 said, "That's not what I ordered," but picked up the sandwich and eagerly started to eat it. R77 stated, although she wasn't expecting a grilled cheese sandwich, she was hungry, it was warm, and she was going to eat it.

The facility policy Food Safety Requirements Guideline dated 11/28/17, indicated the danger zone refers to temperatures above 41 degrees Fahrenheit and below 135 degrees Fahrenheit that allow the rapid growth of pathogenic microorganisms that can cause foodborne illness.

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F 804	Continued From page 43 It also indicated the longer food remains in the danger zone, the greater risks for growth of harmful pathogens.	F 804		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow dietary recommendations for 1 of 1 residents (R43) requiring accommodations for food intolerance related to sensitivity to chocolate. Findings Include: R43's Review of progress note, dated 3/12/18, indicates he receives mighty shakes two times daily for poor appetite (weight loss) NO CHOCOLATE as it causes loose stools. R 43's paper dietary slip dated 3/29/18, states allergy to chocolate. R 43's Medication Administration Record dated 3/7/18 documents Mighty Shakes two times a day for poor appetite (weight loss) NO chocolate as it	F 806	LPN B received education regarding honoring resident preference/sensitivity for no chocolate. Residents¦ food preferences/sensitivities will be reviewed and care plans updated as indicated. Staff will be educated regarding honoring food preferences/sensitivities and providing alternatives per resident choices. Preferences/sensitivities will be reviewed upon admission, quarterly, annually and as needed and care plans updated. Dietary Director or designee will audit 2 charts a week x 4 weeks and then 6 charts monthly x 3 months. Results will be brought to QAPI to review for further	5/8/18

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causes loose stools.

R43's Care plan intervention, dated 1/23/18, indicates to provide and serve diet as ordered.

During observation on 3/29/18, 11:45 a.m. R43 was sitting alone at the dining room table for lunch. He was almost finished drinking a shake. There was approximately 10 cc (cubic centimeters) of 90 cc left in his glass. No food has been served yet. R43's shake was chocolate flavor

During an interview, on 3/29/18, at 11:51 a.m. dietary aid (DA)-B stated that licensed practical nurse (LPN)- B served R 43 his chocolate shake. DA-B stated R43 has an allergy to chocolate and it is indicated on the lunch tray tag.

During interview on 3/29/18, at 11:55 a.m. LPN-B stated she served R43 his chocolate shake. LPN-B stated R43 gets diarrhea from chocolate. LPN-B contacted the nurse practitioner at 12:07 and inform her of above. LPN-B did remove the rest of the chocolate mighty shake from R43.

On 3/29/18, at 1:54 p.m. Registered Dietitian (RD-A) stated R43 does not have a true allergy to chocolate, just a sensitivity and the result of the sensitivity is diarrhea. RD-A stated the Nurse practitioner wanted R43's sensitivity under allergies on the dietary slip, so R43 would not receive chocolate and get diarrhea therefore loosing more weight. RD-A stated chocolate is not a true diagnosed allergy.

Review of Food Allergies and Intolerance policy statement revised October 2008 indicated, Residents with food intolerance and allergies will

F 806

opportunities for improvement.

Corrections will be completed by May 8th 2018

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F 806	Continued From page 45 be offered appropriate substitutions for foods they cannot eat.	F 806		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings,	F 842		5/8/18

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F 842	Continued From page 46 law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to maintain an accurate, complete, and readily accessible medical record related to code status for 4 of 4 residents (R38, R43, R77, and R68,) reviewed for advanced directives. Findings include:	F 842	R38, R43, R77, and R 68 medical records regarding code status has been reviewed and reconciled on March 28th 2018 All residents¦ medical records were reviewed and discrepancies regarding	

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R38's admission record dated 3/28/18, indicated R38's diagnoses included osteoarthritis, muscle weakness, and right artificial knee joint. R38's quarterly Minimum Data Set (MDS) dated 2/8/18, indicated R38's cognition was intact.

A review of R38's paper medical record included a Provider Orders for Life Sustaining Treatment (POLST) dated 2/21/18, signed by R38, which directed DNR/do not attempt resuscitation (allow natural death).

A review of R38's electronic medical record, included full code (attempt resuscitation), on the physician orders, printed 3/28/18, and the same on R38's profile.

An interview on 3/28/18, at 1:39 p.m. licensed practical nurse (LPN)-B stated the paper chart and the electronic medical record should be the same for the residents. LPN-B stated R38's most currently dated POLST would be what LPN-B would use for R38 for a code status.

An interview on 3/28/18, at 5:34 p.m. LPN-C stated if the paper chart and the electronic medical record did not match LPN-C would have to go get verification from another nurse as to what the code status was for a resident.

R43's admission MDS, dated 2/20/18, indicated R43 was cognitively intact had a diagnosis of pneumonia, renal insufficiency and hypertension.

R43's care plan, dated 3/26/18, indicated DNR/DNI.

R43's signed physican orders, dated 3/1/18,

F 842

code statuses were clarified and updated on March 28th 2018.

Staff was educated on guidelines for identifying code status and advanced directives upon admission (regardless of POLST). Code status preferences and offering/ follow up of advanced directives will be reviewed with resident and/or family quarterly, annually, and as needed including any updates to the medical record as indicated. Physicians have been educated on guidelines and POLST process, including reconciliation of medical records when POLSTs are initiated.

Social Service or designee will audit 2 charts a week x 4 weeks and then 6 charts monthly x 3 months. Results will be brought to QAPI to review for further opportunities for improvement.

Corrections will be completed by May 8th 2018

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indicated he was DNR/DNI.

R43's Advanced Directive Acknowledgment Form, dated 1/29/18, indicates he has an advanced directive on file. In review of the resident record, there was no advanced directive for R43 in his chart.

During interview on 3/27/18, R43 stated he would like to be resuscitated if he has a heart attack.

On 3/28/18 R43 contained a new signed physician orders changing him to a full resuscitation. In addition, the record contained a signed Code Status Elective Form, dated 3-28-18, changing R43's code status to full resuscitation
R77's admission MDS, dated 3/19/18, identified R77 was cognitively intact and had diagnoses including anemia, renal insufficiency, and fracture of the femur.

Review of R77's paper medical record included an undated POLST, signed by R77's health care agent/power of attorney, which directed, "Attempt Resuscitation/CPR [cardiopulmonary resuscitation]."

Review of R77's electronic medical record, included, "DNAR [do not attempt resuscitation]/DNI [do not intubate]," on the physician's orders, printed 3/28/18, and the same on R77's profile.

When interviewed on 3/28/18, at 10:55 a.m. registered nurse (RN)-B verified R77's paper medical record and electronic medical record had inconsistent directives, and stated, "You would have to treat [R77] like she's a full code then.

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This should have been flagged and verified. It was not followed up on that we can see here." RN-B stated there was no documentation addressing the discrepancy.

R68's admission record, dated 2/20/18, identified R68 had diagnoses including congestive heart failure, type 2 diabetes, acute respiratory failure with hypoxia (oxygen deficiency), and hypertension (high blood pressure). R68's admission MDS, dated 3/5/18, identified R68 was cognitively intact.

Review of R68's paper medical record included POLST signed by R68 on 2/22/18, which indicated R68 desired to have "CPR attempt, provide life sustaining treatment," if she had no pulse or was not breathing. Another POLST signed by R68 on 3/19/18, directed, "DNR/DO NOT ATTEMPT RESUSCITATION (Allow Natural Death)." A handwritten order, dated 3/19/18, directed staff to send the newest POLST to the physician group, but lacked documentation that facility staff addressed the order.

Review of R68's electronic medical record, included, "Full Code" (directing full resuscitation) on the physician orders, printed 3/28/18, and the same on R68's profile. Although R68 had signed a new POLST on 3/19/18 with her wishes to not be resuscitated, the facility failed to change the new directives on the electronic medical record.

When interviewed on 3/28/18, at 9:35 a.m. R68 stated she had decided to change her directives on the POLST after discussion with her family, because if her heart stopped or she stopped breathing, it would not be in her best interest long term to be revived. R68 verified she signed the

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new POLST on 3/19/18, directing staff to not resuscitate if she was without a pulse and was not breathing.

During an interview on 3/28/18, at 10:38 a.m. RN-C stated if a resident determined that they wanted to be resuscitated, their wishes would be honored. If they wished to not have any interventions, that wish would be honored as well. When asked how staff knew what the residents' wishes were, RN-C stated if a resident was found unresponsive and didn't have a pulse, she would stay with the resident and have another staff member check either the paper chart or the computer, whichever was closest, for direction.

On 3/28/18, at 10:44 a.m. RN-D stated each resident's advance directives were in their paper chart and on the electronic medical record. RN-D stated she would go to the paper chart or the computer, whichever was closest, to identify the resident's wishes in an emergency.

On 3/28/18, at 10:46 a.m. admissions director stated when residents were admitted, their advanced directives were discussed and it was important to ensure all sources had the same directives.

During an interview on 3/28/18, at 10:55 a.m. RN-B verified R68 and R77's paper medical records were not consistent with their electronic medical record, which was confusing to the staff, and stated, "In an emergency, staff wouldn't necessarily do the right thing."

Review of the facility's policy, Advance Directives and Care Planning Guidelines, revised 3/2/18, included, "Upon admission, identify if the resident

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F 842	Continued From page 51 has an advance directive and if not, determine if the resident wishes to formulate an advance directive...All advance directive document copies will be obtained and located within the medical record." Also included, "Changes to the resident choices for advance directives will be documented, State specific documents will be updated as necessary, physician orders will be obtained to reflect new choices as applicable and all items will be communicated to staff providing resident care."	F 842		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880		5/8/18

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 ______	03/29/2018

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 880	Continued From page 52 procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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	F 880		

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F 880	Continued From page 53 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 consistent and comprehensive monthly surveillance data was gathered to identify trends and patterns as a way to reduce the spread of illness and infections. This had the potential to affect all 89 residents residing in the facility. In addition, the facility failed to ensure proper hand hygiene and glove usage was provided for 1 of 5 residents (R290) reviewed for personal hygiene. Findings include: February 2018's Monthly Infection Control Logs were reviewed. The logs included heading to document the following information: Resident Name, admit date, unit, type of infection, body site, date of onset, date culture taken, organism, antibiotic resistant (y/n), antibiotic name and start date, Infection definition met (y/n), classification of not infected-community or HAI (hospital acquired infection)acquired, date resolved and if isolated. February 2018's logs identified: 1- gastrointestinal infection due to (c-diff); 6 respiratory infections; 2 yeast infection; 2 urinary tract infections; and 1 skin infection. -All infections lacked documentation of admission date, if infection definition met, classification of infection, date resolved, and if isolated. -Although 10 of the 12 infections identified antibiotic use. The log lacked information of culture information. -The logs lacked documentation of resident symptoms.	F 880	Upon identification of an infection, infection control surveillance will be completed, including reporting and investigation of infections and communicable diseases. Preventative measures will be reviewed and updated as indicated with appropriate staff. NA-D received education regarding infection control techniques, hand washing, and gloving usage. Staff will be educated regarding facility infection prevention and control program, including guidelines regarding infection control process and outcomes based infection control techniques including hand hygiene and glove usage. DON or designee will audit 2 cares a week x 4 weeks and then 6 cares monthly x 3 months to visualize handwashing and appropriate glove use. Results will be brought to QAPI to review for further opportunities for improvement. Corrections will be completed by May 8th 2018	

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THE VILLA AT OSSEO	501 SECOND STREET SOUTHEAST OSSEO, MN 55369

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F 880	Continued From page 54	F 880		

March 2018 Monthly Infection Control logs identified 8 infections. All infections were treated with antibiotics. 1 wound infection, 4 urinary tract infection, 2 skin infections, and 1 respiratory infection.
-All infections lacked documentation if infection definition met, classification of infection, date resolved, and if isolated.
-Although all infections were treated with antibiotics, the log lacked culture information.
-The logs lacked documentation of resident symptoms for 6 of the 8 infections.

The logs lacked trending of infections for February and March 2018.

During an interview on 3/29/18, at 12:59 p.m. the director of nursing (DON) stated she took over tracking and trending resident infections two months ago. The DON stated she does not track infections in real time, but reviews the logs at the end of the month for trends. The DON went on to say February's logs were not reviewed for trends yet and would review March's logs "hopefully next week." After reviewing the logs with the DON, the DON stated the nurses fill out the logs and the logs were missing information.

The facility's policy Infection Control Program, undated, indicated "The infection control program exists to assure a safe, sanitary and comfortable environment for residents and personnel. It is designed to help prevent the development and transmission of disease and infection."
R290's admission record, dated 3/17/18, identified R290 had diagnoses including muscle weakness, left hip fracture, pneumonia, atrial fibrillation (irregular, fast heartbeat).

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F 880	Continued From page 55 R290's care plan, dated 3/25/18, indicated R290 had confusion and forgetfulness, and sought attention constantly. R290's care plan identified R290 required physical assistance for bed mobility, dressing, transfers, oral/dental care, and had an indwelling catheter. During an observation on 3/28/18, at 7:28 a.m. nursing assistant (NA)-D entered R290's room and announced she was going to get her ready for the day. After donning gloves and gathering supplies, NA-D offered R290 choices with clothing and socks. NA-D handed R290 a wet washcloth and directed her to wash her face, and then handed her a towel to dry her face. NA-D raised the bed and told R290 she was going to change her. NA-D unfastened R290's brief and with her gloved right hand, used a disposable wipe to wipe R290's front peri area. NA-D removed the soiled right glove from her right hand, exposing another glove underneath. NA-D assisted R290 to turn to her left side, and used a washcloth to wipe her buttocks. NA-D removed the remaining glove on her right hand and, without performing hand hygiene, took a glove from her pocket and donned another glove on her right hand. NA-D picked up a tube of ointment, applied ointment to R290's bottom, and removed the glove on her right hand and threw it in the trash can. Without performing hand hygiene, NA-D placed a new brief under R290 and assisted her to roll onto her back. NA-D took another glove from her pocket, donned the right hand, and applied ointment to R290's front peri area and between her thighs. Without removing the gloves, NA-D adjusted R290's brief and fastened it, and pulled up her slacks. Still without removing the gloves, NA-D took off R290's gown,	F 880		

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F 880	Continued From page 56 used a wet washcloth to wash her armpits and trunk. NA-D applied ointment under R290's breasts and removed both gloves. Without performing hand hygiene, NA-D took off R290's glasses, assisted to put her shirt on, put her glasses back on, used the remote control to lower the bed and elevate the head of the bed. NA-D tied the plastic bag in the garbage can, pulled the bag out, placed it on the floor, and replaced the plastic bag in the trash can. NA-D picked up the plastic bag from the floor, opened the door to R290's room, and left the room. NA-D returned to R290's room with registered nurse (RN)-D, both donned gloves, and prepared to transfer R290 to the wheelchair with sit to stand lift. After transferring R290, RN-D removed the gloves and used hand sanitizer. NA-D removed gloves, and without performing hand hygiene, pushed R290 into the bathroom, and gave R290 her toothbrush and toothpaste. R290 asked NA-D to find her bottom dentures, which NA-D found on the bedside stand, donned gloves and brushed the bottom denture and placed them in R290's mouth. NA-D removed the gloves, and without performing hand hygiene, picked up the room telephone and dialed the phone and handed it to R290 to place her breakfast order. Still without performing hand hygiene, NA-D then pushed R290 into the hallway and opened the door to the spa room to weigh her. NA-D touched the scale, door handle, and R290's wheelchair before returning R290 to her room. NA-D handed R290 her call light, opened her drapes, and began removing the fitted bottom sheet from R290's bed that had a large brown soiled area. NA-D rolled the sheet and other linens into a ball and placed them onto the floor. NA-D retrieved a plastic bag from the counter in R290's room and with bare hands, put the linen into the bag and tied the bag.	F 880		

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F 880	Continued From page 57 NA-D pushed R290's bedside table in front of her and used a comb to fix her hair. Without performing hand hygiene, NA-D picked up the plastic bag with the soiled linen, carried it out of R290's room, through the hallway, opened a drawer at the receptionist's desk, and obtained a key. NA-D used the key to open the soiled utility room door, threw the bag into a bin, placed the key back into the drawer, and walked to open the door to the spa room. Inside the spa room, NA-D obtained bed linens, walked back to R290's room, and made her bed. NA-D placed the comforter onto R290's bed and realizing it was also soiled, removed the comforter and the pillow cases from the pillows, and threw them all onto the floor. NA-D retrieved a plastic bag from the counter in the room, and with bare hands, picked the linens up off the floor, put them into the bag, and tied the bag. Without performing hand hygiene, R290 picked up the bag from the floor, carried it through the hallway to the receptionist's desk, opened the drawer, obtained the key, closed the drawer, and opened the door to the soiled utility room. NA-D opened the gray bin and threw the plastic bag inside, and then washed her hands in the sink in the soiled utility room. When interviewed on 3/28/18, at 8:31 a.m. NA-D stated, "Most of the time, I just use one glove at a time. I take them off, I wash my hands, I put new gloves on." NA-D verified she had two gloves on her right hand and took one off while providing peri care to R290, and stated, "But that one on is safe." NA-D stated she doesn't usually do that and didn't know why she did during cares today. NA-D stated she did not wash her hands or use hand sanitizer at any time while performing personal cares for R290, when removing gloves, or when leaving her room. NA-D stated she	F 880		

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F 880	Continued From page 58 changed R290's bed linens because they were dirty and when asked if placing the dirty linens on the floor was acceptable, NA-D stated, "Yes, while you get a bag." During an interview on 3/29/18, at 12:16 p.m. registered nurse (RN)-B stated using more than one set of gloves at a time, or double gloving, was not acceptable. RN-B stated the expectation while performing personal cares was for staff to perform hand hygiene when removing gloves, especially during peri care. RN-B stated hand hygiene should always be performed when removing gloves, and before leaving a resident's room. RN-B also stated, soiled linen should be placed in plastic bags, not on the floor. Review of the facility's policy, Hand Hygiene Guideline, dated 11/28/17, included, "To cleanse hands to prevent the spread of potentially deadly infections: To provide a clean and healthy environment for residents, staff and visitors. To reduce the risk to the healthcare provider of colonization or infections acquired from a resident." The policy further directs, "Gloves or the use of baby wipes are not a substitute for hand hygiene."	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a	F 881		5/8/18

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F 881	Continued From page 59 system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement an antibiotic stewardship program. This deficient practice had the potential to affect all 89 residents residing in the facility. Findings include: During a review of the facility's infection control program with the director of nursing (DON) on 3/29/18, at 12:59 p.m. the facility tracking system lacked documentation that an antibiotic stewardship program was utilized. The forms for February 2018 and March 2018 were not complete. The logs included headings to document the following: - "# New cases infected with antibiotics" - "# New cases colonized (not infected) with" -resistant organisms -antibiotic resistant organisms -admission date -unit -culture: date taken, organism, antibiotic resistant (y/n) -community acquired -HAI's (hospital acquired infections) -Date resolved -isolation However the headings were blank for February 2018 and inconsistently documented for March 2018. The DON stated the nurses on the units document the information on the logs. The DON stated there were several areas of data missing. The DON stated the facility has a new evaluation	F 881	DON has been educated on facility Infection Prevention and Control Program, including antibiotic stewardship program and system to monitor antibiotic usage. Staff have been educated on facility infection prevention and control program, including completion of the daily surveillance review completed to identify possible communicable diseases and infections using the Criteria for Infection Report forms. These forms will be reviewed daily by the ICIP to identify any necessary interventions and added to the monthly infection control log for follow up and data collection. Process surveillance audits will be completed 2 x weekly x 4 weeks, and then 4 x monthly. All results from the process surveillance logs will be analyzed and opportunities for improvement identified and reviewed at monthly QAPI meetings. Corrections will be completed by May 8th 2018.	

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F 881	Continued From page 60 form that she is working on getting started using the McGeers criteria (used to evaluate whether or not antibiotic treatment is appropriate for infections). The DON went on to say "I have to train my staff first." The DON stated she tracks and trends at the end of the month, not in real time. The DON stated she would review March's logs "hopefully next week." The facility's policy Antibiotic Stewardship &MDRO's, undated, indicated "Stewardship involves identifying the microbe responsible for disease; selecting the appropriate antibiotic, dosing, route, and duration of antibiotic therapy, and discontinuing antibiotic when they are no longer needed.	F 881		

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

F5629002

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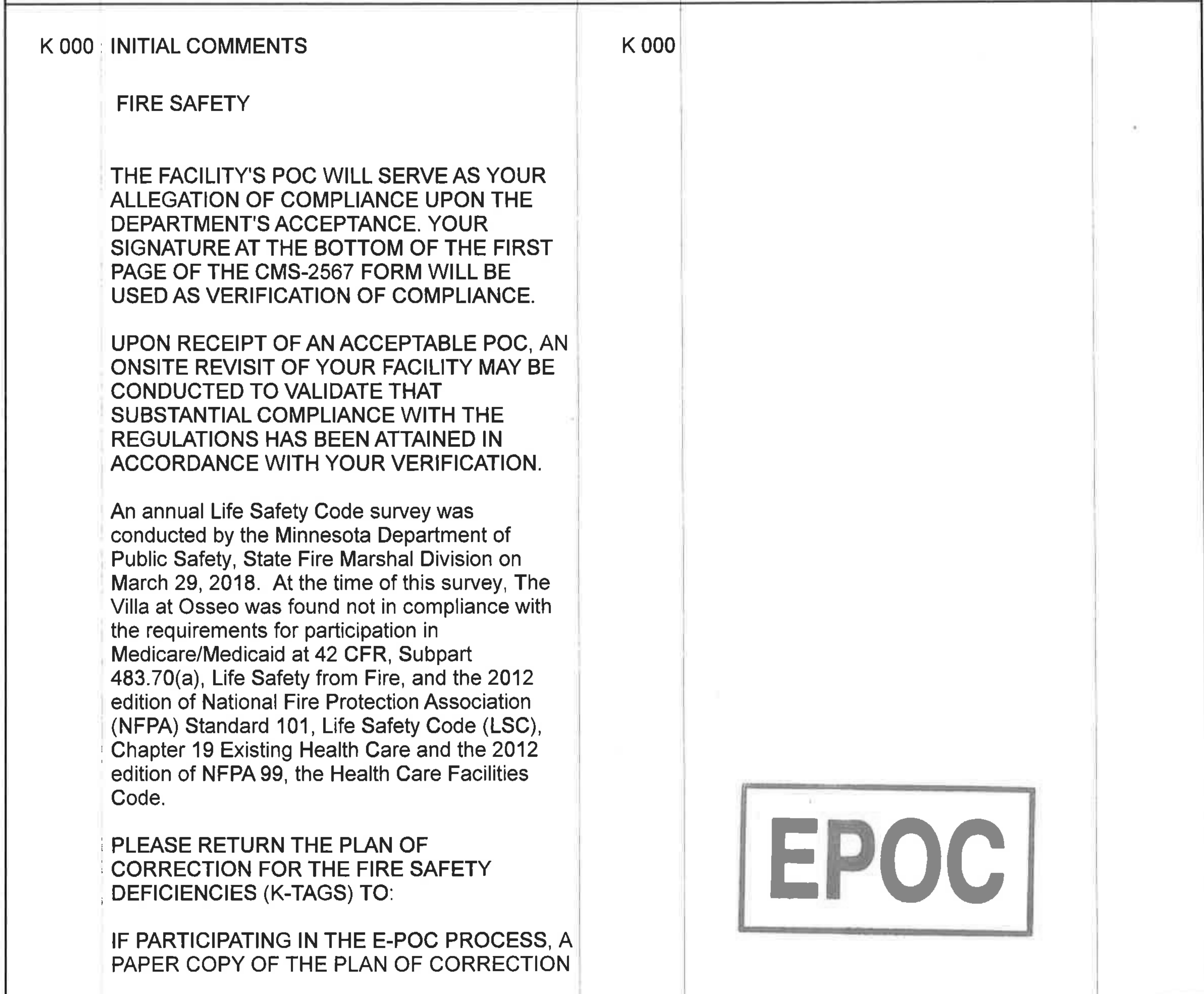
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245629	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA AT OSSEO	501 SECOND STREET SOUTHEAST OSSEO, MN 55369



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K 000	INITIAL COMMENTS FIRE SAFETY 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. An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on March 29, 2018. At the time of this survey, The Villa 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. 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	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 04/20/2018

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

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K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Villa of Osseo is a 2-story building that has been downgraded from construction Type II (222) to 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. 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. On September 24, 2015, a 1-story addition was build of Type V (111) construction. The addition does not have a basement and is fully sprinklered. The addition has a fire alarm system with smoke detection in the resident rooms, corridors and spaces open to the corridor is monitored for automatic fire	K 000		

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K 000	Continued From page 2 department notification. The addition and the existing building are of the same construction type, so the facility will be surveyed as one building. The facility has a capacity of 102 beds and had a census of 89 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is **NOT MET** as evidenced by:	K 000		
K 927 SS=E	Gas Equipment - Transfilling Cylinders CFR(s): NFPA 101 Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) This **REQUIREMENT** is not met as evidenced by: Based on observation and staff interview, transfilling of liquid oxygen was not done within accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen. Transfilling of liquid oxygen is prohibited in patient rooms. 11.5.2.3.1 (NFPA 99) 11.5.2.3.2 (NFPA 99), 11.5.2.2 (NFPA 99). This deficient practice could effect all residents within the smoke compartment.	K 927	On April 10th, 2018, proper exhaust fan was installed by AEM Electric in TCU Oxygen storage room to be able to utilized for transfilling oxygen. Staff educated on transfill room requirements and new location.	5/8/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245629	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**03/29/2018**

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
K 927	Continued From page 3 Findings include: On a facility tour between the hours of 10:00 AM and 2:00 PM on March 29, 2017, it was revealed that the facility was transfilling and storing liquid oxygen cylinders in a tub room, on the second floor. This deficient practice was verified by the Director of Maintenance at the time of discovery.	K 927		