Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 18, 2024

Administrator
The Villas at Osseo LLC
501 Second Street Southeast
Osseo, MN 55369

Re: Reinspection Results
Event ID: MYYQ12

Dear Administrator:

On October 1, 2024, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 22, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 18, 2024

Administrator
The Villas at Osseo LLC
501 Second Street Southeast
Osseo, MN 55369

RE: CCN: 245629
Cycle Start Date: August 22, 2024

Dear Administrator:

On September 13, 2024, we notified you a remedy was imposed.

On October 1, 2024, October 3, 2024, and October 16, 2024 (LSC), the Minnesota Departments of Health and Public Safety completed a revisits to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 11, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 22, 2024, did not go into effect. (42 CFR 488.417 (b))

In our letter of September 13, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 22, 2024, due to denial of payment for new admissions. Since your facility attained substantial compliance on October 11, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 3, 2024

Administrator
The Villas at Osseo, LLC
501 Second Street Southeast
Osseo, MN 55369

RE: CCN: 245629
Cycle Start Date: September 3, 2024

Dear Administrator:

On August 22, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester MN, 55901
Email: Lisa.Krebs@state.mn.us
Office: (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by November 22, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by February 22, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates

specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245629	A. BUILDING _____ B. WING _____	C 08/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 8/19/24 through 8/22/24 a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 8/19/24 through 8/22/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H56297161C / MN 00104566 HE1177124C / MN 00098706 HE1177262C/ MN 00105944 H56297203C / MN 00105861 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/12/2024

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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F 000	Continued From page 1 validate substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 550		9/24/24

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F 550	Continued From page 2 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to utilize professional interpretive services for 1 of 1 residents (R66) reviewed for oral communication. Findings include: R66's Quarterly Minimum Data Set (MDS) dated 6/5/24, included diagnosis of psychotic disorder, post traumatic stress disorder, anxiety disorder, and stroke. R66 was cognitively intact. R66 was listed as having pain frequently. R66's order summary report dated 8/22/24, included contact information for Burg Interpreter Services. Order included phone number, pin number for access, resident spoke Ukrainian, and to utilize as needed. R66's care plan dated 7/11/24, included resident has a risk for alterations in behavior due to trauma and PTSD. Care plan included to communicate via interpreter and to consider past trauma when engaging with the resident. Care plan included R66's primary language was Russian and to utilized translator app on phone to communicate. During interview on 8/19/24 at 5:01 p.m., R66 stated the facility did not utilize the professional interpreter service. R66 stated the facility only	F 550	F550 -The process for satisfying this requirement has been reviewed and revised as needed, to ensure the facility develops and implements processes and procedures to utilize professional interpreter services as needed. -R66 and like residents residing in the facility had the potential to be affected. -R66 was provided with professional interpreter services. -Monarch Healthcare Management invested in an electronic interpretation device to assist with current/future language barriers. -All necessary VAO staff will be educated on utilizing interpreter services per the Residents care plan - Audits will be completed to ensure compliance with this requirement. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Administrator or designee is the	

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F 550	Continued From page 3 utilized her personal cell phone for translation and she preferred to not have to use her personal phone. During observation on 8/20/24 at 1:03 p.m., licensed practical nurse (LPN)-C was providing wound care to R66 with assistance from nursing assistant (NA)-B. R66 became tearful multiple times during wound care, speaking in foreign language and pointing in attempt to communicate. R66 stated "pain, pain" multiple times. R66 did attempt to communicate via Google translate on personal cell phone, but Google translate was unable to translate correctly. On 8/20/24 at 1:29 p.m., LPN-C and NA-B attempted to utilize Google translator application on R66's personal cell phone but were unable to utilize the application effectively. Neither staff offered to call Burg Translator service. R66's face was red and she was visibly crying. LPN-B entered R66's room to attempt to provide comfort and communicate with resident. LPN-B stated, "I don't understand" and walked out of the room without offering to contact the professional interpreter service. R66 was heard crying after LPN-B left her room. During interview on 8/20/24 at 1:30 p.m., LPN-B stated the interpreter would have been utilized if R66 had not calmed down or if staff were not able to understand what she was trying to communicate. LPN-B stated R66 preferred to utilize Google translator application on her phone. LPN-B stated it had been a month to a month and a half since she had utilized Burg interpreter services. R66 continued to audibly cry during interview with LPN-B without communication	F 550	responsible party. -Corrective Action will be completed on or before 9/24/2024.	

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F 550	Continued From page 4 intervention from LPN-B or other staff. During interview on 8/21/24 at 8:09 a.m., director of nursing (DON) stated he spoke with R66 almost every day. He stated he utilized Google translator. The DON stated he would have expected the professional translator service to be utilized if R66 was upset and her phone was not working to translate. During observation on 8/21/24 at 10:37 a.m., NA-C and LPN-A were providing incontinence care and assistance with dressing for R66. Both staff were attempting to communicate without an interpretive device by speaking in English and using hand gestures. R66 was observed getting agitated with the volume of voice increasing and hand gestures becoming more pronounced. At 10:42 a.m., R66 was crying. Neither staff had offered to contact professional translator services. R66's was handed her phone but phone translator application was unable to translate effectively and R66 firmly set phone down. R66 again became upset, speaking loudly in foreign language when staff attempt to put an incontinence brief on her. R66 first spoke in a foreign language then stated in English "not clean." R66 cleaned herself with a disposable wipe. R66 continued to speak in foreign language without comprehension from staff. Staff stated in English "it's ok." At 11:05 a.m., LPN-A stated "I don't know what she is saying." Professional translator services were not offered. At 11:07 a.m., LPN-A held up two shirts for R66 to choose between. R66 again became visibly upset and was handed her phone. R66 attempted to utilize translator application on her phone without success. R66 was aggressively hitting on glass portion of her phone and set the phone down	F 550		

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F 550	Continued From page 5 again. R66 yelled "pain, pain" in English. Staff told her in English to use her phone. R66 stated in English "don't understand." Staff did not offer to contact professional translator service. During interview on 8/21/24 at 11:16 a.m., LPN-A stated she did not feel it was necessary to utilize the professional translator because she knew R66 was in pain. LPN-A stated she only utilized the interpreter service if she was not able to communicate or understand what R66 wanted. During interview on 8/21/24 at 11:26 a.m., NA-C stated she was not informed how to communicate with R66 prior to working with her. NA-C stated this was her first day because she was a traveling NA. NA-C stated it would have been helpful to have been given some instructions on how to effectively communicate with R66. On 8/21/24 at 11:33 a.m., an attempt was made to interview R66 on cares received, but was prevented by the director of nursing (DON) entering R66's room and closing her door. During interview on 8/21/24 at 3:04 p.m., R66 stated utilizing the professional language translator service would have reduced her frustration. R66 stated she did not think the staff would utilize the service even after she requested it due to the wait time to connect with translator because staff were always in a hurry. Facility Interpreter Policy dated 2/2024 included residents and family members with limited English proficiency are provided services free of charge with BURG Translation service.	F 550		
F 623 SS=D	Notice Requirements Before Transfer/Discharge	F 623		9/24/24

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F 623	Continued From page 6 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 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,	F 623		

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F 623	Continued From page 7 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 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.	F 623		

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F 623	Continued From page 8 §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 document review, and interview the facility failed to ensure a written notification of transfer and/or discharge was sent to the office of the Ombudsman for 1 of 4 (R30) reviewed for hospitalization and/or discharge. Findings include: R 30's significant change Minimum Data Sset (MDS) dated 6/28/24, indicated R30's diagnoses included: high blood pressure, renal insufficiency (poorly functioning kidneys), diabetes, cerebral vascular accident (CVA) (stroke), aphasia (difficulty understanding or expressing words), hemiplegia (weakness of one side of the body), anxiety, depression, and chronic obstructive pulmonary disease (COPD) (long-term obstruction of airways). R30's census list dated 8/22/24, indicated R30	F 623	F623 -Facility failed to ensure a written notification of transfer and/or discharge was sent to the Office of Ombudsman for 1 resident (R30) who was hospitalized from 5/5/24-5/10/24 with provider orders. -Residents who are hospitalized, and/or are discharged involuntarily have the potential to be affected if this requirement is not met. -Social Services Director faxed the Resident Report from 1/1/24-5/31/24 of Facility-Initiated Discharges/Transfers to the Ombudsman's Office on 8/22/24. This report included R30's transfer to the hospital.	

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	245629	A. BUILDING _____ B. WING _____	C 08/22/2024

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F 623	Continued From page 9 was hospitalized from 5/5/24 through 5/10/24. R30's medical record lacked evidence a written notification of transfer/discharge was sent to the office of the Ombudsman for long term care. On 8/22/24 at 10:32 a.m., the administrator approached surveyor and provided a list of ombudsman notifications from January through May which had been sent in on 8/22/24. The administrator stated they had understood one instance may have been missed and they had sent in a list to make sure they were all completed. On 8/22/24 at approximately 1:00 p.m., social service director (SS)-A stated they were responsible for creating a report from point click care (PCC), and then sending a copy to the office of the Ombudsman each month. SS-A stated they had used a discharge report but had realized not all appropriate residents were pulling up on the report in May of this year, so they changed to another report. SS-A confirmed there was no notification sent for R30 and it was important to complete this notification as the ombudsman was an advocate for the residents. On 8/2/24 at 1:59 p.m., the administrator confirmed no notification was sent to the office of the ombudsman for R30 and it was important to provide all resources and advocates to the residents. The policy Bed-Holds and Returns last updated 2/2023, indicated copies of notices for emergency transfers must be sent to the ombudsman.	F 623	-All necessary VAO staff were educated on Monarchs Facility-Initiated Discharge or Transfer Policy and the Care Providers Required Transfer and Discharge Notification Decision Tree. -Social Services Team received instructions on how to correctly run the report on PCC that is sent to the OOLTC monthly. - Audits will be completed to ensure compliance with this requirement. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2)	F 644		9/24/24

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F 644	Continued From page 10 §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a level II preadmission screening and resident review (PASARR) was completed for 1 of 1 residents (R25) residents reviewed with a serious mental illness diagnosis. Findings include: R25's quarterly Minimum Data Set (MDS) dated indicated R25 had diagnoses to include anxiety disorder and schizophrenia (a chronic and sever mental disorder that affects how a person thinks, feels, and behaves). R25's medical record revealed a level I PASARR was completed on 5/12/23 prior to admission and indicated a PASARR level II was required before	F 644	F644 -The process for satisfying this requirement has been reviewed and revised as needed, to ensure the facility develops and implements processes and procedures for coordination of PASARR and assessments on all Residents. -Social Services has contacted R25□s lead agency to schedule and complete an OBRA Level 2 Assessment. -Residents residing in the facility that have a diagnosis of a mental disorder or intellectual disability have the potential to be affected if this requirement is not met.	

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F 644	Continued From page 11 R25 admitted to a nursing facility. No level II PASARR was found. During interview on 8/22/24, at 8/:49 a.m. social worker (SW)2 stated the normal process included having a level II PASARR completed prior to admission. SW-2 stated she had not had any communication with the lead agency regarding a level II PASARR in several months and it was inappropriate to not have it completed prior to admission. During interview on 8/22/24, at 9:43 a.m. the administrator stated the social services team would request the level II screening, if required, prior to admission. administrator stated it was the responsibility of the social services department to ensure this process was completed. administrator went on to say she expected social services staff to have continued and regular contact with the lead agency until the process was complete and waiting months between contact or follow up was unacceptable. administratorN stated it is important to have the level II completed prior to admission to ensure the facility had the proper resources available to meet a resident's individual needs. A policy related to PASARR was requested but not provided.	F 644	-All residents have been reviewed to ensure Level 1 pre-admission screenings were completed and, if needed, a Level 2. -All necessary VAO staff were educated on the requirements of the PASARR screening and OBRA level 2 assessment. - Audits will be completed to ensure compliance with this requirement. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. - Social Services Director or designee is the responsible party. - Corrective action will be completed on or before 10/11/2024.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical	F 688		9/24/24

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F 688	Continued From page 12 condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, facility failed implement interventions to prevent further development of decreased range of motion and ability for 2 of 2 residents (R17, R51) reviewed for positioning and mobility. Findings include: R17's significant change Minimum Data Set (MDS) dated 7/5/24, included a primary diagnosis of Parkinson's disease (a progressive neurological condition). R17's MDS included limited range of motion (ROM) on both upper and lower extremities and dependent for mobility. R17's admission record printed 8/22/24, included diagnosis of contracture of the left ankle and foot. During observation on 8/19/24, R17's feet were noted to not be resting on the wheelchair foot pedals. R17's left foot was noticeably turned inward. No brace or positioning device was observed.	F 688	F688 -The process for satisfying this requirement has been reviewed and revised as needed, to ensure the facility develops and implements processes and procedures to increase resident ROM or mobility status or prevent further avoidable reduction of ROM and mobility. -R17 and R51□s comprehensive care plans and tasks were reviewed and revised as needed to ensure appropriate range of motion programs are in place. -The plan of care for Residents with range of motion programs were reviewed and revised as needed. -All necessary VAO staff have been re-educated on Range of Motion and Mobility programs and appropriate documentation.	

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F 688	Continued From page 13 R17's physical therapy discharge summary dated 6/12/24, included recommendation R17 would benefit from daily stretches. A functional maintenance program was established, and staff were trained. R17's Order summary report dated 8/22/24, included an order to ensure the restorative ROM program was completed every shift. R17's care plan last reviewed 6/3/24, included an intervention to complete ROM on left and right ankles including flexion/eversion holding for 5 minutes and completing 10 repetitions. R17's Follow up Question Report dated 8/20/24, included a task of passive ROM for left and right ankles and passive ROM daily of both arms and hands. The task was documented on a total of 17 times during the date range of 8/1/24 and 8/20/24. The ROM task was marked as complete on 3 dates. All other dates were documented as "Not Applicable." Two dates did not include documentation. During interview on 8/22/24 at 8:40 a.m., care coordinator licensed practical nurse (LPN)-A stated charting for a restorative program should be check weekly. LPN-A confirmed the documentation for R17 was mostly "not applicable." She would have expected the nursing assistant (NA)s to report to the nurse that the task was not being completed and the nurse to follow up. She would have expected the nurse to put a progress note in R17's chart. R51's annual MDS dated 6/28/24, included a primary diagnosis as multiple myeloma (a cancer that forms in a type of white blood cells) and	F 688	-Audits will be completed to ensure compliance. Audit results will be reviewed at QAPI, with any deficient practice corrected at the time of occurrence. -Administrator or designee is the responsible party. -Corrective action will be completed on or before 09/24/2024.	

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F 688	Continued From page 14 arthritis. R51's needed substantial assistance coming to a standing position from sitting in a chair. During interview on 8/19/24 at 4:25 p.m., R51 stated she was supposed walk with her walker and brace daily, but it was not being offered. R51 denied ever refusing to walk if it was offered. R51's Order Summary Report dated 8/22/24, included staff were to assist resident with restorative program of assisting the resident to walk with her walker, brace on her right leg, and wheelchair following. Report failed to include an order to assist R51 with daily standing. R51's care plan last reviewed 7/8/24, included an intervention to follow physical therapy (PT) and occupational therapy (OT) instructions for mobility function. R51 was to walk 50-100 feet with assistance of one staff member, walker, and wheelchair to follow three times per week. R51's Physical therapy discharge Summary dated 8/12/24, included recommendation R51 stand daily. R51's task documentation for how the resident walked in the corridor on the unit dated 8/20/24, included 40 responses between the dates of 8/1/24 and 8/20/24. 37 of the 40 responses were marked as "not applicable," one was marked as "independent," and two were marked as "limited assistance." During interview on 8/21/24 at 1:33 p.m., NA-A stated it would be listed on a resident's care plan if they were to have either range of motion exercises or walking. NA-A stated it would be	F 688		

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F 688	Continued From page 15 documented in the resident's chart when the task was completed. "Not applicable" would be selected if the task was not done. During interview on 8/22/24 at 10:59 a.m., NA-B stated she would document "refuse" if a resident refused a task. During interview on 8/22/24 at 8:46 p.m., LPN-A confirmed there was an order for R51 to have her brace put on when she walked. LPN-A confirmed she was not able to find the therapy recommendation for R51 to stand daily. She stated therapy typically gave a hand off report sheet which was then used to update the resident's care plan and tasks when a resident was discharged from therapy. LPN-A stated they were unable to find documentation regarding recommendations from therapy. During interview on 8/22/24 at 11:11 a.m., director of nursing (DON) confirmed most responses for both R17 and R51 were "not applicable." The DON confirmed the available responses for staff to select were "Yes, "No," "resident not available," "resident refused" and "not applicable." The DON confirmed that the answer of "not applicable" should have been followed up within a week if not sooner to find out why the task was not being completed. The DON stated R51's standing recommendation was not relayed from therapy and therefore not started. He stated typically therapy gaves a written recommendation that was treated as an order and should have been started immediately. During an interview on 8/22/24 at 12:55 p.m., therapy director confirmed R17 had passive range of motion ordered and R51 was discharged	F 688		

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F 688	Continued From page 16 from therapy with a recommendation for daily standing. She would have wanted to be informed of the task not being completed after a week or two so further evaluation could have been completed. The therapy director stated it was important to complete both tasks to prevent further decline and to maintain quality of life. Facility policy for restorative nursing services dated July 2017, indicated residents will receive restorative nursing care to promote safety and independence.	F 688		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements.	F 851		9/24/24

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F 851	Continued From page 17 The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to submit complete and/or accurate data for staffing information based on payroll and other	F 851	F851 -The process for satisfying this	

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F 851	Continued From page 18 verifiable data during 1 of 1 quarter (Quarter 2) reviewed, to the Centers for Medicare and Medicaid Services (CMS), according to specifications established by CMS. Findings include: Review of the Payroll Based Journal (PBJ) Casper Report 1705D identified the facility had excessively low weekend staffing during the second quarter of the fiscal year 2024, which included dates between January 1st to March 30th. Review of daily staff schedules and facility staffing report during quarter 2 indicated adequate levels of staff on weekends. Therefore, the data submitted in the PBJ to CMS was inaccurate. During interview on 8/22/24 at 4:41 p.m. the administrator stated the facility staffing levels did not change from weekdays to weekends. administrator stated contracted staff did not show up on the facility staffing plan as regular staff hours but show up as contracted hours and thus caused the staffing report to be inaccurate. Facility policy related to PBJ reporting was requested but not provided.	F 851	requirement has been reviewed and revised as needed, to ensure the facility submits complete and accurate direct care staffing information for payroll-based journal (PBJ) to CMS. -All VAO staff responsible for collecting and submitting staffing information have been educated on the facility PBJ policy and procedure. -PBJ data will be reviewed by Administrator prior to uploading to ensure accuracy. -Once PBJ is submitted, the Administrator or Designee will ensure it is approved by CMS. -Administrator or Designee is the responsible party. -Corrective Action will be completed on or before 09/24/2024.	

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/21/2024. At the time of this survey, The Villas At Osseo was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 09/12/2024

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 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Villas at Osseo is a 2-story building that has been determined to be a Type V (111) due to wood joist and plywood floors in some of the linen closets. It has a partial basement and is fully fire sprinkled. On September 24, 2015, a 1-story addition was also determined to be a Type V (111) construction. The addition does not have a basement and is fully sprinkled. The facility has a fire alarm system with smoke detection in resident	K 000		

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 _____	**08/21/2024**

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

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K 000	Continued From page 2 rooms, corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility will be surveyed as one building. The facility has a capacity of 100 beds and had a census of 82 at the time of the survey.	K 000		
K 355 SS=D	The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install fire extinguishers per NFPA 101 (2012 edition), Life Safety Code sections 19.3.5.12 and 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 6.1.3.8.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 08/21/2024 at 10:57 AM, it was revealed by observation that the fire extinguisher in the dining room was mounted higher than the maximum 5 feet. An interview with the Maintenance Director verified	K 355	K355 During a walk through on 8/21/24, it was identified that the fire extinguisher in the dining room was mounted higher than the maximum 5 feet. -In the event of an emergency, failure to meet this regulation could have a patterned impact on the residents within the facility. -Maintenance Director has been educated to the requirement. -The fire extinguisher was moved to be mounted below the maximum 5 feet.	8/21/24

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K 355	Continued From page 3 this deficient finding at the time of discovery.	K 355	-Audit was complete on 8/21/24 on all facility fire extinguishers to ensure compliance. -Maintenance Director or designee is the responsible party. -Corrective action was complete on 8/21/24.	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.1, and 8.5.2.2. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 08/21/2024 at 10:31 AM, it was revealed by	K 372	K372 During a walk through on 8/21/24, it was identified that the smoke barrier on first floor near resident room 110 is not complete from outside wall to outside wall. -In the event of an emergency, failure to meet this regulation could potentially have a widespread impact and affect all	10/11/24

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K 372	Continued From page 4 observation that the smoke barrier on the first floor near resident room 110 is not complete from outside wall to outside wall. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 372	occupants of the facility. -Maintenance Director has been educated to the requirement. -Monarch Healthcare Management is obtaining bids from contractors / service providers to correct this deficiency area. - Installation dates to meet the needs of this requirement are pending availability of contractors / service providers. - Contractors / Service providers have been on-site to evaluate the service needs and provide quotes. -Upon completion of necessary upgrades and replacements, necessary audits will be completed to ensure compliance. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Maintenance Director or designee is responsible party	
K 711 SS=C	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the	K 711		8/21/24

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K 711	Continued From page 5 basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire safety plan per NFPA 101 (2012 edition), Life Safety Code, section 19.7.2.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/21/2024 between 09:00 AM and 11:15 AM, it was revealed by a review of available documentation that the fire safety plan that was provided at the time of the survey did not include the Transmission of alarms to fire department. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 711	K711 Based on review of documentation on 8/21/24, the facility failed to implement a fire safety plan per NFPA 101, section 19.7.22. -In the event of an emergency, failure to meet this regulation could have a widespread impact on the residents within the facility. -Maintenance Director has been educated to the requirement -The facility fire safety plan was revised to include the transmission of alarms to the fire department. -Maintenance Director or designee is the responsible party. - Corrective action was complete on 8/21/24.	
K 741 SS=D	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions:	K 741		10/11/24

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K 741	Continued From page 6 (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to implement the smoking policy per NFPA 101 (2012 edition), Life Safety Code, section 19.7.4. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 08/21/2024 at 10:54 AM, it was revealed by observation that in the smoking area there was a trash can that had discarded cigarettes in it along	K 741	K741 During a walk through on 8/21/24, it was identified that the facility failed to implement a smoking policy per NFPA 101, section 19.7.4 -In the event of an emergency, failure to meet this regulation could have a patterned impact on the residents within the facility. -Maintenance Director has been educated	

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K 741	Continued From page 7 with trash and other combustibles. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 741	to the requirement. -A metal container with a self-closing cover which ashtrays can be emptied into was purchased to be utilized on the smoking patio. -Audits will be completed to ensure compliance. Audit results will be reviewed at QAPI, with any deficient practice corrected at the time of occurrence. -Maintenance Director or designee is the responsible party. -Corrective action will be completed on or before 10/11/2024	
K 930 SS=D	Gas Equipment - Liguid Oxygen Equipment CFR(s): NFPA 101 Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to safely store liquid oxygen per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.7.4. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 08/21/2024 at 10:50 AM, it was revealed by observation that there was one liquid oxygen	K 930	K930 -During a walk through on 8/21/24, it was identified that the facility failed to safely store liquid oxygen per the NFPA 99, section 11.7.4. There was one liquid oxygen container being stored in the second-floor nurses' office. -In the event of an emergency, failure to meet this regulation could have an isolated	10/11/24

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K 930	Continued From page 8 container being stored in the second floor nurses office. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 930	impact on the residents within the facility. -All necessary VAO staff were educated on the requirements for storing liquid oxygen. -The liquid oxygen container was immediately removed from the nurse's office and stored in the appropriate location. -All necessary VAO staff were educated on the requirements for storing liquid oxygen. -Audits will be completed to ensure compliance. Audit results will be reviewed at QAPI, with any deficient practice corrected at the time of occurrence. -Maintenance Director or designee is the responsible party. -Corrective action will be completed on or before 10/11/2024.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 4, 2024

Administrator
The Villas at Osseo, LLC
501 Second Street Southeast
Osseo, MN 55369

Re: State Nursing Home Licensing Orders
Event ID: MYYQ11

Dear Administrator:

The above facility was surveyed on August 19, 2024, through August 22, 2024, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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

Please feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00733	A. BUILDING: _____ B. WING _____	C 08/22/2024

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/19/24 through 8/22/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT IN compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed with NO deficiencies cited: H56297161C / MN 00104566 HE1177124C / MN 00098706 HE1177262C/ MN 00105944 H56297203C / MN 00105861 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the	2 000		

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2 000	Continued From page 2 Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, facility failed implement interventions to prevent further development of decreased range of motion and ability for 2 of 2 residents (R17, R51) reviewed for positioning and mobility.	2 895	CORRECTED	10/11/24

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2 895	Continued From page 3 Findings include: R17's significant change Minimum Data Set (MDS) dated 7/5/24, included a primary diagnosis of Parkinson's disease (a progressive neurological condition). R17's MDS included limited range of motion (ROM) on both upper and lower extremities and dependent for mobility. R17's admission record printed 8/22/24, included diagnosis of contracture of the left ankle and foot. During observation on 8/19/24, R17's feet were noted to not be resting on the wheelchair foot pedals. R17's left foot was noticeably turned inward. No brace or positioning device was observed. R17's physical therapy discharge summary dated 6/12/24, included recommendation R17 would benefit from daily stretches. A functional maintenance program was established, and staff were trained. R17's Order summary report dated 8/22/24, included an order to ensure the restorative ROM program was completed every shift. R17's care plan last reviewed 6/3/24, included an intervention to complete ROM on left and right ankles including flexion/eversion holding for 5 minutes and completing 10 repetitions. R17's Follow up Question Report dated 8/20/24, included a task of passive ROM for left and right ankles and passive ROM daily of both arms and hands. The task was documented on a total of 17 times during the date range of 8/1/24 and 8/20/24. The ROM task was marked as complete	2 895		

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

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2 895	Continued From page 4 on 3 dates. All other dates were documented as "Not Applicable." Two dates did not include documentation. During interview on 8/22/24 at 8:40 a.m., care coordinator licensed practical nurse (LPN)-A stated charting for a restorative program should be check weekly. LPN-A confirmed the documentation for R17 was mostly "not applicable." She would have expected the nursing assistant (NA)s to report to the nurse that the task was not being completed and the nurse to follow up. She would have expected the nurse to put a progress note in R17's chart. R51's annual MDS dated 6/28/24, included a primary diagnosis as multiple myeloma (a cancer that forms in a type of white blood cells) and arthritis. R51's needed substantial assistance coming to a standing position from sitting in a chair. During interview on 8/19/24 at 4:25 p.m., R51 stated she was supposed walk with her walker and brace daily, but it was not being offered. R51 denied ever refusing to walk if it was offered. R51's Order Summary Report dated 8/22/24, included staff were to assist resident with restorative program of assisting the resident to walk with her walker, brace on her right leg, and wheelchair following. Report failed to include an order to assist R51 with daily standing. R51's care plan last reviewed 7/8/24, included an intervention to follow physical therapy (PT) and occupational therapy (OT) instructions for mobility function. R51 was to walk 50-100 feet with assistance of one staff member, walker, and wheelchair to follow three times per week.	2 895		

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2 895	Continued From page 5 R51's Physical therapy discharge Summary dated 8/12/24, included recommendation R51 stand daily. R51's task documentation for how the resident walked in the corridor on the unit dated 8/20/24, included 40 responses between the dates of 8/1/24 and 8/20/24. 37 of the 40 responses were marked as "not applicable," one was marked as "independent," and two were marked as "limited assistance." During interview on 8/21/24 at 1:33 p.m., NA-A stated it would be listed on a resident's care plan if they were to have either range of motion exercises or walking. NA-A stated it would be documented in the resident's chart when the task was completed. "Not applicable" would be selected if the task was not done. During interview on 8/22/24 at 10:59 a.m., NA-B stated she would document "refuse" if a resident refused a task. During interview on 8/22/24 at 8:46 p.m., LPN-A confirmed there was an order for R51 to have her brace put on when she walked. LPN-A confirmed she was not able to find the therapy recommendation for R51 to stand daily. She stated therapy typically gave a hand off report sheet which was then used to update the resident's care plan and tasks when a resident was discharged from therapy. LPN-A stated they were unable to find documentation regarding recommendations from therapy. During interview on 8/22/24 at 11:11 a.m., director of nursing (DON) confirmed most responses for both R17 and R51 were "not applicable." The	2 895		

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2 895	Continued From page 6 DON confirmed the available responses for staff to select were "Yes, "No," "resident not available," "resident refused" and "not applicable." The DON confirmed that the answer of "not applicable" should have been followed up within a week if not sooner to find out why the task was not being completed. The DON stated R51's standing recommendation was not relayed from therapy and therefore not started. He stated typically therapy gaves a written recommendation that was treated as an order and should have been started immediately. During an interview on 8/22/24 at 12:55 p.m., therapy director confirmed R17 had passive range of motion ordered and R51 was discharged from therapy with a recommendation for daily standing. She would have wanted to be informed of the task not being completed after a week or two so further evaluation could have been completed. The therapy director stated it was important to complete both tasks to prevent further decline and to maintain quality of life. Facility policy for restorative nursing services dated July 2017, indicated residents will receive restorative nursing care to promote safety and independence. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for limited range of motion/ambulation to assure they are receiving the necessary treatment/services to prevent further limitation in range of motion. The director of nursing or designee, could conduct random audits of the delivery of care to ensure appropriate care and services are implemented. The results of the audits could be brought to the	2 895		

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2 895	Continued From page 7 quality assurance committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure tuberculosis (TB) screening was completed for 3 of 5 residents (R23, R51, R66) reviewed for TB testing. Findings include:	21426	CORRECTED	10/11/24

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21426	Continued From page 8 The Centers for Disease Control (CDC) guidelines for preventing the transmission of mycobacterium tuberculosis in Health Care Settings, 2005, directed that all residents and staff must receive a baseline TB screening should consist of an assessment for TB risk factors and history, assessment for current symptoms of active TB, and testing for the presence of infection with mycobacterium tuberculosis. R23's quarterly Minimum Data Set (MDS) dated 6/4/2024, indicated an admission date of 7/18/2012 and diagnoses included: high blood pressure, hyperlipidemia (high cholesterol), anxiety, depression, and schizophrenia. R51's annual MDS dated 6/28/24, indicated an admission date of 4/18/23 and diagnoses included: cancer, anemia (low iron in the blood), high blood pressure, gastroesophageal reflux disease (GERD) (acid reflux), renal insufficiency (poorly functioning kidneys, diabetes, hyponatremia (low salt in the body), arthritis, malnutrition, and depression. R66's quarterly MDS dated 6/5/24, indicated an admission date of 5/30/24 and diagnoses included: anemia, wound infections, cerebrovascular accident (stroke), paraplegia (loss of feeling/use of part of one's body), malnutrition, anxiety, psychotic disorder, and post traumatic stress disorder (PTSD). R23, R51, and R66's medical records lacked evidence of a screening for TB symptoms. On 8/22/24, the director of nursing (DON)(O)-A stated when a resident was admitted to the facility	21426		

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21426	Continued From page 9 they were supposed to be screened and tested for TB. The DON expected orders to be entered into point click care (PCC), symptom screening, then testing and documentation with education when necessary. The DON confirmed R23, R51, and R66 did not have a TB screening completed and it had been missed or lost. The DON stated it was important to complete the screening to prevent the spread of a contagious disease. SUGGESTED METHOD OF CORRECTION: The infection control nurse (ICN), director of nursing (DON) and/or designee should review policies and procedures related to the screening and testing for tuberculosis for residents and/or employees (staff). Facility staff could be educated on the TB regulations, symptom screening, and the two-step Mantoux process. The ICN, DON and/or designee could audit resident admissions and/or staff new hires as well as current residents and/or staff records to ensure compliance. The ICN, DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21426		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.	21805		10/11/24

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21805	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to utilize professional interpretive services for 1 of 1 residents (R66) reviewed for oral communication. Findings include: R66's Quarterly Minimum Data Set (MDS) dated 6/5/24, included diagnosis of psychotic disorder, post traumatic stress disorder, anxiety disorder, and stroke. R66 was cognitively intact. R66 was listed as having pain frequently. R66's order summary report dated 8/22/24, included contact information for Burg Interpreter Services. Order included phone number, pin number for access, resident spoke Ukrainian, and to utilize as needed. R66's care plan dated 7/11/24, included resident has a risk for alterations in behavior due to trauma and PTSD. Care plan included to communicate via interpreter and to consider past trauma when engaging with the resident. Care plan included R66's primary language was Russian and to utilized translator app on phone to communicate. During interview on 8/19/24 at 5:01 p.m., R66 stated the facility did not utilize the professional interpreter service. R66 stated the facility only utilized her personal cell phone for translation and she preferred to not have to use her personal phone. During observation on 8/20/24 at 1:03 p.m.,	21805	CORRECTED	

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21805	Continued From page 11 licensed practical nurse (LPN)-C was providing wound care to R66 with assistance from nursing assistant (NA)-B. R66 became tearful multiple times during wound care, speaking in foreign language and pointing in attempt to communicate. R66 stated "pain, pain" multiple times. R66 did attempt to communicate via Google translate on personal cell phone, but Google translate was unable to translate correctly. On 8/20/24 at 1:29 p.m., LPN-C and NA-B attempted to utilize Google translator application on R66's personal cell phone but were unable to utilize the application effectively. Neither staff offered to call Burg Translator service. R66's face was red and she was visibly crying. LPN-B entered R66's room to attempt to provide comfort and communicate with resident. LPN-B stated, "I don't understand" and walked out of the room without offering to contact the professional interpreter service. R66 was heard crying after LPN-B left her room. During interview on 8/20/24 at 1:30 p.m., LPN-B stated the interpreter would have been utilized if R66 had not calmed down or if staff were not able to understand what she was trying to communicate. LPN-B stated R66 preferred to utilize Google translator application on her phone. LPN-B stated it had been a month to a month and a half since she had utilized Burg interpreter services. R66 continued to audibly cry during interview with LPN-B without communication intervention from LPN-B or other staff. During interview on 8/21/24 at 8:09 a.m., director of nursing (DON) stated he spoke with R66 almost every day. He stated he utilized Google translator. The DON stated he would have	21805		

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21805	Continued From page 12 expected the professional translator service to be utilized if R66 was upset and her phone was not working to translate. During observation on 8/21/24 at 10:37 a.m., NA-C and LPN-A were providing incontinence care and assistance with dressing for R66. Both staff were attempting to communicate without an interpretive device by speaking in English and using hand gestures. R66 was observed getting agitated with the volume of voice increasing and hand gestures becoming more pronounced. At 10:42 a.m., R66 was crying. Neither staff had offered to contact professional translator services. R66's was handed her phone but phone translator application was unable to translate effectively and R66 firmly set phone down. R66 again became upset, speaking loudly in foreign language when staff attempt to put an incontinence brief on her. R66 first spoke in a foreign language then stated in English "not clean." R66 cleaned herself with a disposable wipe. R66 continued to speak in foreign language without comprehension from staff. Staff stated in English "it's ok." At 11:05 a.m., LPN-A stated "I don't know what she is saying." Professional translator services were not offered. At 11:07 a.m., LPN-A held up two shirts for R66 to choose between. R66 again became visibly upset and was handed her phone. R66 attempted to utilize translator application on her phone without success. R66 was aggressively hitting on glass portion of her phone and set the phone down again. R66 yelled "pain, pain" in English. Staff told her in English to use her phone. R66 stated in English "don't understand." Staff did not offer to contact professional translator service. During interview on 8/21/24 at 11:16 a.m., LPN-A stated she did not feel it was necessary to utilize	21805		

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21805	Continued From page 13 the professional translator because she knew R66 was in pain. LPN-A stated she only utilized the interpreter service if she was not able to communicate or understand what R66 wanted. During interview on 8/21/24 at 11:26 a.m., NA-C stated she was not informed how to communicate with R66 prior to working with her. NA-C stated this was her first day because she was a traveling NA. NA-C stated it would have been helpful to have been given some instructions on how to effectively communicate with R66. On 8/21/24 at 11:33 a.m., an attempt was made to interview R66 on cares received, but was prevented by the director of nursing (DON) entering R66's room and closing her door. During interview on 8/21/24 at 3:04 p.m., R66 stated utilizing the professional language translator service would have reduced her frustration. R66 stated she did not think the staff would utilize the service even after she requested it due to the wait time to connect with translator because staff were always in a hurry. Facility Interpreter Policy dated 2/2024 included residents and family members with limited English proficiency are provided services free of charge with BURG Translation service. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to ensure residents dignity is being maintained. The facility could update policies and procedures, educate staff on these changes, and audit to ensure resident(s) dignity are maintained. The results of	21805		

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21805	Continued From page 14 these audits will be reviewed by the quality assurance committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		