DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services Midwest Division of Survey and Certification Chicago Regional Office 233 North Michigan Avenue, Suite 600 Chicago, IL 60601-5519



National Provider Identifier (NPI): 1972947851 CMS Certification Number (CCN): 245629

June 24, 2016

Kristi Umberger, Administrator The Villa at Osseo, LLC d/b/a The Villa at Osseo 501 2nd Street SE Osseo, MN 55369-1603

Dear Ms. Umberger:

The Centers for Medicare & Medicaid Services has accepted your request to participate as a skilled nursing facility in the Medicare program (Title XVIII of the Social Security Act). Your effective date of participation is March 10, 2016. A copy of the completed agreement is enclosed for your records.

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Your National Provider Identifier (NPI) is your primary identifier for all health insurance billing. The NPI should be entered on all forms and correspondence relating to the Medicare program. In addition, you have been assigned the CMS Certification Number (CCN) shown above; please provide it when contacting this office, when contacting the State agency, or any time it is requested. The National Government Services has been authorized to process your Medicare claims.

When you make general inquiries to your fiscal intermediary (FI) and/or Medicare Administrative Contractor (MAC), you will be prompted to give either your provider transaction access number (PTAN) or CCN. These identification numbers are used as authentication elements when inquiring about beneficiary- and claim-specific information. When prompted for your PTAN, give your CCN.

This agreement covers the 20 Medicare Certified beds. Please be sure that patients are advised upon admission of those beds certified for Medicare coverage.

This Medicare certification is contingent upon compliance with Office for Civil Rights (OCR) requirements. If OCR approval is not obtained, reimbursement will be recouped as of the effective date of this provider agreement. You will be contacted again only if the necessary approval is not granted by the OCR.

If you are dissatisfied with the effective date of Medicare participation indicated above, you may request that the determination of the effective date be reconsidered. The request must be submitted in writing to this office within 60 days of the date you receive this notice. The request

for reconsideration must state the issues or the findings of fact with which you disagree and the reasons for disagreement.

Regulations at 42 CFR 489.18 require that providers notify CMS when there is a change of ownership. Therefore, you must notify this office promptly if there is a change in your legal status as owner of this facility. You should also report to the State agency any changes in staffing, services, or organization which might affect your certification status.

We welcome your participation and look forward to working with you in the administration of the Medicare program. If you have any questions, please contact Mrs. Charlotte A. Hodder, RN, BSN, CRRN, Certification Specialist at (312) (352-5169) or me, at (312) (353-1502).

Sincerely, IULKA J. Bom Tamika J. Brown

Program Representative Long Term Care Certification & Enforcement Branch

Enclosure

cc: Minnesota Department of Health Minnesota Department of Human Services National Government Services Stratis Health MN-Office of LTC Ombudsman

DEPARTMENT OF HEALTH AN			ID CEDTIFIC			MEDICARE & MEDICAID SERVICES
					VD TRANSMITTAL E SURVEY AGENCY	ID: 2Q10 Facility ID: 00733
I. MEDICARE/MEDICAID PROVIDER NO.(LI) INITIAL		3. NAME AND ADD (L3) THE VILLA	RESS OF FACILI			4. TYPE OF ACTION: 1(L8) 1. Initial 2. Recertification
2. STATE VENDOR OR MEDICAID		(L4) 501 SECON		DUTHEAS		3. Termination 4. CHOW
NO.(L2) 836420100	·····	^(L5) OSSEO, MN	1		(L6) 55369	5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF OWNE	RSHIP	7. PROVIDER/SUPI	PLIER CATEGOR		<u>3</u> (L7)	8. Full Survey After Complaint
(L9)	(T 3 1)	01 Hospital	05 HHA	09 ESRD	22 CLIA	
6. DATE OF SURVEY 03/10/16 8. ACCREDITATION STATUS:	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/11D	14 CORF 15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC	(2.10)	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31
2 AOA 3 Other			CODTEED 10			
11. LTC PERIOD OF CERTIFICATION From (a) :		10.THE FACILITY I A. In Compliance			And/Or Approved Waivers Of Th	a Following Requirements
То (b):		Program Req			2. Technical Personnel	6. Scope of Services Limit
		Compliance	Based On:		3. 24 Hour RN	7. Medical Director
12.Total Facility Beds	100	1. A	eceptable POC		4. 7-Day RN (Rural SNF) 8. Patient Room Size
13. Total Certified Beds	102 102	B Not in Comr	liance with Program		5. Life Safety Code	9. Beds/Room
13. Iolal Connice Deas	102		nd/or Applied Wain		* Code: A *	(L12)
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MEETS	
18 SNF 18/19 SNF 20	19 SNF 82	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (1.38)	(L39)	(L42)	(L43)			
17. SURVEYOR SIGNATURE	being forwar	ded to CMS and Date :	-	to correc	18. STATE SURVEY AGENCY A	CDL
Timothy Rhonemus - H				(L19)	Colleen B. Leach, Cen	tification Specialist 11/15/2016
 DETERMINATION OF ELIGIBILITY <u>X</u> I. Facility is Eligible to Parti 	cipate		PLIANCE WITH (ITS ACT:	CIVIL		ccial Solvency (HCFA-2572) 1 Interest Disclosure Stmt (HCFA-1513) :
2. Pacility is not Eligible	(L21)					
22. ORIGINAL DATE	23. LTC AGREEN	IENT 2	4. LTC AGREEM	ENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNINC	DATE	ENDING DAT	ſE	<u>YOLUNTARY</u>	00 INVOLUNTARY
03/10/2016					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbursen	•
25. LTC EXTENSION DATE:	27. ALTERNATIV	VE SANCTIONS			03-Risk of Involuntary Termination	OTHER
	A. Suspension	1 of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change 00-Active
(L27)	B. Rescind St	spension Date:	(L.44)			00-2011/0
			(L45)			
28. TERMINATION DATE:	2	29. INTERMEDIARY/C	CARRIER NO.		30. REMARKS	ttoCV/S/RO
	(L28)			(L31)	Asa	an Email notification. ached in ACO.
31. RO RECEIPT OF CMS-1539		32. DETERMINATION	OF APPROVAL D	ATE		
	(1.32)	05/20/2016		(1.33)	DETERMINATION APPR	OVAL

00733

DEPARTMENT OF HEALTH AND	HUMAN	SERVICES			CENTERS FOR ME	EDICARE & MEDICAID SERVICES
	MEDIO	CARE/MEDICAI	D CERTIFICA	ATION A	ND TRANSMITTAL	ID: WWW3
	PART I	- TO BE COMP	LETED BY TI	HE STAT	E SURVEY AGENCY	Facility ID: 00733
I. MEDICARE/MEDICAID PROVIDER NO. (L1) Initial		3. NAME AN (L3 THE VILLA (L4) 501 SECONI	AT OSSEO		LITY	4. TYPE OF <u>1</u> (L8) 1. Initial 2.
2.STATE VENDOR OR MEDICAID N (L2 836420100	0.	(1.5) OSSEO, MN		1112/4.91	(L6) 55369	3. Termination 4. CHOW
						5. Validation 6. Complaint 7. On-Site Visit 9. Other
 5. EFFECTIVE DATE CHANGE C (L9 6. DATE OF 03/10/2016 		7. PROVIDE 01 Hospital 02	R/SUPPLIER 05 HHA 06 prtf	09 ESRI 10 NF	<u>.02.</u> (L7) D 13 PTIP ^{22 CLIA} 14 CORF	8. Full Survey After
	_ (L10)	03	07 X-Ray	11	15 ASC	FISCAL YEAR ENDING (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08	12 RHC	16	12/31
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS:	:		lana
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of The	e Following Requirements:
То (b):			Requirements		2. Technical Personnel	6. Scope of Services Limit
		Complian	ce Based On:		3. 24 Hour RN	7. Medical Director
12.Total Facility Beds 20) (L18)	1. /	Acceptable POC		4. 7-Day RN (Rural SNF)	8. Patient Room Size
	(1.17)	B. Not in Cor	mpliance with Progra	am	5. Life Safety Code	9. Beds/Room
13.1 otal Certified Beds 20		1	and/or Applied Wai		* Code: A	(L12)
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
20						
(L37) (L38)	(1.39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMARKS (IF	APPLICABI	E SHOW LTC CANCE	ELLATION DATE)	<u> </u>		
See Attached Remarks						
				·		
17. SURVEYOR SIGNATURE	T II 02	Date :			18. STATE SURVEY AGENCY A	APPROVAL Date:
Timothý Rhonemus – HF	E II 03	/10/16			Colleen B. Leach, Certi	fication Specialist 03/14/2016
				(L19)		(L20)
PART I	I - TO BI	E COMPLETED	BY HCFA RE	GIONAL	OFFICE OR SINGLE STA	ATE AGENCY
19. DETERMINATION OF ELIGIBILITY			PLIANCE WITH	CIVIL	21. 1. Statement of Finan	
1. Facility is Eligible to Participate		RI	GHTS ACT:		 Ownership/Control Both of the Above 	Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible						
	(L21)					
22. ORIGINAL DATE 23. L	IC AGREEN	IENT 2	4. LTC AGREEM	ENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DATI	E	VOLUNTARY00	
01/01/1975					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	L41)		(L25)		02-Dissatisfaction W/ Reimburseme	nt 06-Fail to Meet Agreement
25. LTC EXTENSION DATE: 27. 4	ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	OTHER
Α	. Suspensio	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(1.27)			(L44)			00-Active
(LLI) E	 Rescind Su 	spension Date:				
			(L45)			
28. TERMINATION DATE:	29). INTERMEDIARY/	CARRIER NO.		30. REMARKS	
28. TERMINATION DATE:	29). INTERMEDIARY/(CARRIER NO.		Sen	t to CMS / (RO)
28. TERMINATION DATE:). INTERMEDIARY/0	CARRIER NO.	(L31)	Sen As a	nn Email notification.
). INTERMEDIARY/(CARRIER NO.	(L31)	Sen As a	
	28)	 INTERMEDIARY/0 DETERMINATION 0 			Sen As a	nn Email notification.

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DEPARTMENT OF HEALTH AND	HUMAN SERVICES	CENTERS FOR MEDICARE & MEI	DICAID SERVICES
	MEDICARE/MEDICAID CERTIFICATION AND 7	TRANSMITTAL	ID: WWW3
	PART I - TO BE COMPLETED BY THE STATE SU	RVEY AGENCY	Facility ID: 00733
C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS		

CCN: Initial

An initial certification survey completed on March 10, 2016, found The Villa at Osseo in compliance with health and life safety code requirements for Long Term Care Facilities. Certification is recommended effective March 10, 2016 since all requirements are met.

Attached are the following documents: Health CMS-2567, Life Safety Code CMS-2567, CMS-2786R and crucial data extract, CMS-671, CMS-672, CMS-1561, HHS690, Office of Civil Rights Information Packet, Transfer Agreement, CMS-855 including the approval letter from National Government Services dated February 8, 2016.

(CMS is aware that the LSC survey was completed prior to the approval of the CMS 855)



Protecting, Maintaining and Improving the Health of Minnesotans

03/14/2016

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

Re: Initial Certification Survey

Dear Ms. Umberger:

An initial Medicare survey was completed at your facility on March 10, 2016 for the purpose of assessing compliance with Federal certification regulations. At the time of the initial Medicare survey, the survey team from the Minnesota Department of Health, Health Regulation Division, were pleased to find that your facility was in full compliance with Federal certification regulations.

The Department will recommend certification to be effective as of the date of the survey.

Enclosed is your copy of the Federal Form CMS-2567 indicating your facility's compliance with the Federal regulations.

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

Thank you for your cooperation.

Sincerely,

Colleen B. Leach

Colleen B. Leach, Certification Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health Telephone: (651)201-4117

Enclosure cc: Licensing and Certification File

		AND HUMAN SERVICES				FORM /	03/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE	
			B. WING			03/1	10/2016
NAME OF F	PROVIDER OR SUPPLIER	1			T ADDRESS, CITY, STATE, ZIP CODE		
THE VILL	A AT OSSEO				ECOND STREET SOUTHEAST EO, MN 55369		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROD DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	тя	F	000			
	department perforr survey using the Tr The Villa at Osseo added 20 bed TCU facility has been fo the requirements o	6, surveyors from this ned an Initial Certification raditional Survey process, at to federally certify a newly No beds were added. The und to be in compliance with f 42 CFR Part 483, Subpart B, for Long Term Care Facilities.					
		IDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE		TITLE	<u></u>	(X6) DATE

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.

		AND HUMAN SERVICES				FORM	03/15/2016 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G 02 - THE VILLA OF OSSEO	(X3) DATE COM	E SURVEY PLETED
		24E117	B. WING	i		09/:	24/2015
NAME OF F	PROVIDER OR SUPPLIER		·		STREET ADDRESS, CITY, STATE, ZIP CODE		
THE VILI	A AT OSSEO				501 SECOND STREET SOUTHEAST OSSEO, MN 55369		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	I IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	TS	ĸ	000	D		
	by the Minnesota D State Fire Marshal 2015. At the time o Osseo, Southwest in substantial comp for participation in I Subpart 483.70(a), 2000 edition of Nat Association (NFPA Code (LSC), Chap The Villa of Osseo building with no ba II(000) construction separation from ex This facility will be because of the exis The facility is fully s fire alarm system v detection and spac monitored for auto notification.	ty Code Survey was conducted Department of Public Safety, Division on September 24, if this survey, The Villa of Wing addition was found to be Diance with the requirements Medicare/Medicaid at 42 CFR, Life Safety from Fire, and the tional Fire Protection) Standard 101, Life Safety ter 18 New Health Care. , Southwest Wing is a 1-story sement the construction Type h. The facility has a 2-hr tisting 2-story nursing home. surveyed as 2 buildings sting and new building. sprinklered. The facility has a with full corridor smoke ces open to the corridors that is matic fire department eapacity of 20 beds and had a at the time of the survey.					
	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					ND TRANSMITTAL E SURVEY AGENCY		C45Z lity ID: 00733
I. MEDICARE/MEDICAID PROVIDER N (L1) 24E117 2.STATE VENDOR OR MEDICAID NO. (L2) 836420100	0.	(L3) THE VILLA	D STREET SOUT		(L6) 55369	 Termination Validation 	<u>2 (</u> L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9)		01 Hospital	PPLIER CATEGORY 05 HHA	09 ESRD	<u>10</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After Comple	9. Other aint
6. DATE OF SURVEY 04/14/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DAT 12/31	TE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b):		10.THE FACILITY A. In Complia Program Re Compliance	nce With quirements		And/Or Approved Waivers Of Th 2. Technical Personnel 3. 24 Hour RN	e Following Requirements: 6. Scope of Services 7. Medical Director	
12.Total Facility Beds 13.Total Certified Beds	102 (L18)20 (L17)	X B. Not in Com	Acceptable POC pliance with Program and/or Applied Waive		4. 7-Day RN (Rural SNF 5. Life Safety Code * Code: B *) 8. Patient Room Size 9. Beds/Room (L12)	
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF	19 SNF 20	ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38) 16. STATE SURVEY AGENCY REMARK This revis		(L42) SHOW LTC CANCELI ted 5/11/2016.	*				
17. SURVEYOR SIGNATURE	HFE NE II	Date :	05/10/2016	(L19)	18. STATE SURVEY AGENCY AI		Date: 05/11/2016 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RE	GIONAL	OFFICE OR SINGLE STAT	FE AGENCY	
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Part 2. Facility is not Eligible			IPLIANCE WITH CI TTS ACT:	WIL	 Statement of Finance Ownership/Control Both of the Above : 	Interest Disclosure Stmt (HCFA-15	13)
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	24. LTC AGREEME	NT	26. TERMINATION ACTION:	(L30))
OF PARTICIPATION 01/01/1975	BEGINNING	DATE	ENDING DATE		<u>VOLUNTARY</u> <u>0</u> 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme	05-Fail to Meet F	Health/Safety
(L24) 25. LTC EXTENSION DATE: (L27)	(L41) 27. ALTERNATIVI A. Suspension o B. Rescind Sus	of Admissions:	(L25) (L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	ent 06-Fail to Meet A <u>OTHER</u> 07-Provider Stat 00-Active	-
28. TERMINATION DATE:	20	. INTERMEDIARY/C	(L45)		30. REMARKS		
2. TEMARUTONDALE.	(L28)		. addin 100.	(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (OF APPROVAL DAT	Е	Posted 05/20/2016 Co.		
	(L32)			(L33)	DETERMINATION APPRO	OVAL	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

		ICARE/MEDICA						D: C45Z
MEDICARE/MEDICAID PROVIDER NO (L1) 24E117 2.STATE VENDOR OR MEDICAID NO. (L2) 836420100 5. EFFECTIVE DATE CHANGE OF OWN).	 T - TO BE COMI NAME AND ADI (L3) THE VILLA. (L4) 501 SECOND (L5) OSSEO, MN PROVIDER/SUP 	DRESS OF FACILI AT OSSEO D STREET SOUT	TY THEAST		55369	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation 7. On-Site Visit	2 (L8) 2. Recertification 4. CHOW 6. Complaint 9. Other
(L9)	LKSIIII	01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA	8. Full Survey After Co	mplaint
6. DATE OF SURVEY 04/14/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING 12/31	DATE: (L35)
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12.Total Facility Beds 13.Total Certified Beds	20 (L18)20 (L17)	X B. Not in Comp	cceptable POC pliance with Program and/or Applied Waiv			y RN (Rural SNF) Safety Code B *	8. Patient Room 5 9. Beds/Room (L12)	Size
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF (L37) (L38)	19 SNF 20 (L39)	ICF (L42)	IID (L43)		15. FACILITY M 1861 (e) (1) or		(L15)	
16. STATE SURVEY AGENCY REMARK								
17. SURVEYOR SIGNATURE	HEE NIE H	Date :	05/10/2016			VEY AGENCY API		Date:
Jennifer Bahr,		BE COMPLETEI		(L19)			ogram Specialis	<u>st</u> 05/11/2016 (L20)
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Part 2. Facility is not Eligible		20. COM	PLIANCE WITH C		21. 1. S 2. C	tatement of Financi	al Solvency (HCFA-2572) nterest Disclosure Stmt (HCF/	A-1513)
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEM	ENT	26. TERMINAT	ION ACTION:	(L30)
OF PARTICIPATION 01/01/1975	BEGINNING	DATE	ENDING DAT	E	VOLUNTARY 01-Merger, Closu 02-Dissatisfaction	00 re h W/ Reimbursemer	05-Fail to M	<u>'ARY</u> eet Health/Safety eet Agreement
(L24) 25. LTC EXTENSION DATE: (L27)	(L41) 27. ALTERNATIVI A. Suspension o B. Rescind Sus	of Admissions:	(L25) (L44)		03-Risk of Involu 04-Other Reason f	ntary Termination	OTHER	Status Change
28. TERMINATION DATE:	29	. INTERMEDIARY/C	(L45) ARRIER NO.		30. REMARKS			
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	DETERMINATION C	OF APPROVAL DA	TE	Posted 05/2	20/2016 Co.		
	(L32)			(L33)	DETERMINA	TION APPRO	VAL	

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: C45Z PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00733 1. MEDICARE/MEDICAID PROVIDER NO. 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: 2 (L8) (L3) THE VILLA AT OSSEO (L1) 24E117 1. Initial 2. Recertification (L4) 501 SECOND STREET SOUTHEAST 2.STATE VENDOR OR MEDICAID NO. 3. Termination 4. CHOW 836420100 (L6) 55369 (L2) (L5) OSSEO, MN 5. Validation 6. Complaint 7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 1 (L7) 8. Roll Survey After Complaint (L9) 01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA 6. DATE OF SURVEY 04/14/2016 (L34) 02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF FISCAL YEAR ENDING DATE: (L35) 8. ACCREDITATION STATUS: _ (L10) 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 0 Unaccredited I TJC 04 SNF 08 OPT/SP 12 RHC 16 HOSPICE 12/31 2 AOA 3 Other 11. .LTC PERIOD OF CERTIFICATION 10. THE FACILITY IS CERTIFIED AS: From (a): A. In Compliance With And/Or Approved Waivers Of The Following Requirements: ____ 2. Technical Personnel ____ 6. Scope of Services Limit То (b) :-Program Requirements Compliance Based On: _____ 3, 24 Hour RN ____ 7. Medical Director ____1. Acceptable POC 4. 7-Day RN (Rural SNF) ____ 8 Patient Room Size 12 Total Facility Beds 20 (L18) ____ S. Life Safety Code ____ 9. Beds/Room 20 (LI7) 13.Total Certified Beds X B. Not in Compliance with Program Requirements and/or Applied Waivers: (L12) * Code: B* 14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 18 SNF 18/19 SNF 19 SNF ICF ШD 1861 (e) (1) or 1861 (j) (1): (L15) 20 (1.37) (L38) (L39) (1.43) (L42)

- i i

 17. SURVEYOR SIGNATURE
 Date :
 18. STATE SURVEY AGENCY APPROVAL
 Date:

 Jennifer Bahr, HFE NE II
 05/10/2016
 Kate JohnsTon, Program Specialist
 05/11/2016

 PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY
 (L20)

 19. DETERMINATION OF ELIGBELITY
 20. COMPLIANCE WITH CIVIL
 21.
 1. Statement of Financial Solvency (HCFA-2572)

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

1. Facility is Eligible to P	articipate	RIGHTS ACT:		 Ownership/Control Interest Both of the Above : 	Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible	(L21)			-	<u> </u>
22. ORIGINAL DATE	23. LTC AGREEMENT	24. LTC AGREEMEN	Г	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING DATE	ENDING DATE		VOLUNTARY 00	INVOLUNTARY
01/01/1975				01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(1.41)	(L25)		02-Dissatisfaction W/ Reimbursement	06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIVE SANCTION	S		03-Risk of Involuntary Termination	OTHER
	A. Suspension of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)	B. Rescind Suspension Date;	(L44)			00-Active
		(IA5)			
28. TERMINATIONDATE:	29, INTERMED	IARY/CARRIER NO.		30, REMARKS	
	(L28)		(L31)		
31. RO RECEIPT OF CMS-1539	32. DETERMINA	ATION OF APPROVAL DATE			
	(L32) S-1	20-2019	(L33)	DETERMINATION APPROVAL	2 Car



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 5910 April 27, 2016

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

RE: Project Number SE117025

Dear Ms. Umberger:

On April 14, 2016, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - 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;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - 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 a "F" tag), i.e., the plan of correction should be directed to:

Jessica Sellner, Unit Supervisor Minnesota Department of Health St. Cloud B Survey Team Licensing & Certification Health Regulation Division Midtown Square 3333 West Division, #212 St. Cloud, Minnesota 56301 Telephone: (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 24, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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 Villa At Osseo April 27, 2016 Page 3

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,
- Include signature of provider and date.

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

If an acceptable PoC 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 PoC 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 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

The Villa At Osseo April 27, 2016 Page 4 VERIFICATION OF SUBSTANTIAL 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. 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 July 14, 2016 (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

The Villa At Osseo April 27, 2016 Page 5 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 October 14, 2016 (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 Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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 444 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525 The Villa At Osseo April 27, 2016 Page 6

Feel free to contact me if you have questions.

Sincerely,

Yate Compton

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		RECEIVED COMPLETED	
<u></u>		24E117	B. WING		AAAV . 0 9618 04/	MAN 0 2016 04/14/2016	
	ROVIDER OR SUPPLIER A AT OSSEO			STREET ADDRESS, CITY, STAT 501 SECOND STREET SOUT OSSEO, MN 55369			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S P (EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETIO DATE	
F 000	INITIAL COMMENTS	;	F 00				
	as your allegation of Department's accepta bottom of the first pag be used as verificatio Upon receipt of an ac revisit of your facility validate that substant regulations has been	ance. Your signature at the ge of the CMS-2567 form will n of compliance. cceptable POC an on-site		appoint	Jac aller Mar		
F 248 SS=D	of activities designed the comprehensive as		F 24	able to communica An activity assessr with resident's fan and care plan was will be brought to	dependent and not ate needs or wishes. nent was completed nily on April 27 th 2016 updated. Resident attend activities that f he is awake. One-		
	by: Based on observation review the facility faile assess and implement of 4 residents (R50) re addition, the facility fa activity opportunities of of 4 residents (R75, R	is not met as evidenced n, interview and document ed to comprehensively it meaningful activities for 1 eviewed for activities. In iled to provide sufficient during weekend hours for 2 (37) reviewed who indicated n activities provided on the		from once a week Residents who are able to communica were reviewed for programming. Ser been added to the May for residents from them.	nsory activities have activity calendar for who may benefit		
	R50's annual Minimur 3/15/16, identified R50	n Data Set (MDS) dated) had severe cognitive			ed on April 26 th 2016 t and care plan was staff working the		

Any deterency statement ending with an asterisk by 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.

ATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
		24E117	B. WING	·	04/44/0040	
	ROVIDER OR SUPPLIER	ATEMENT OF DEFICIENCIES	5 C	TREET ADDRESS, CITY, STATE, ZIP CODE 01 SECOND STREET SOUTHEAST DSSEO, MN 55369	04/14/2016	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIC	
F 248	impairment and had diagnosis including Alzheimer's disease.		F 248	is going on that day and offer to	attend.	
	dated 3/22/16, indicat pleasure in doing thin issues which resulted participation, and had The CAA indicated R4 in structured activities is laid down in betwee one on one visit from R50's care plan for an identified R50 was de "emotional, intellectua needs," and listed inte staff to converse with cares; provide with ac resident of any change activities; thank reside function; the res [resid in-room visit and activ of room events; the re assistance/escort to a resident's preferred ac	in reduced activity functional mobility deficits. 50, "Is not able to participate or communicate. Resident on meals and is on a weekly activities staff members." Activities dated 4/13/16, bendent for meeting I, physical and social rventions including, "All resident while providing tivities calendar, notify es to the calendar of nt for attendance at activity ent] needs 1:1 bedside/ ties is unable to attend out sident needs ctivity functions; and the tivities are: resident enjoys oping of feet and hands,		F37 was interviewed on April 22 th for activity interest and care plan updated. Activity staff working t weekends will inform resident of is going on that day and offer to a Residents were interviewed in re- to activity enjoyment and to give on what can be offered. At resid council May 4 th 2016, residents w asked about what activities they enjoyed, which they didn't care for what else they would like to see offered. 2 hours were added to a staff on Saturdays starting May 1 to ensure more group activities co be offered. Staff education will be completed May 24 th .	a was he what attend. gards ideas ent vere or and activity st 2016 ould	
	a.m. and 3:30 p.m., R chair, being assisted ir eating, or observed lyin At 1:37 p.m. while lying	ng in his bed in his room. j in bed, music was heard 0's room. R50 was not		All residents will have an activity assessment completed quarterly. Resident attendance at activities continue to be tracked. Resident decreased activity attendance wil reported to QA monthly.	will s with	

Facility ID: 00733

If continuation sheet Page 2 of 20

.

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TID	LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:				IPLETED
		24E117	B. WING		04	1/14/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	Ξ	
THE VILL	A AT OSSEO			501 SECOND STREET SOUTHEAST OSSEO, MN 55369		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
	R50 was observed ir Following the noon n sleeping in his room evening, at 7:38 p.m. and NA-K began R50 with cares, and assis During interview on 4 stated she talks with for bed or taking him stated this was some residents; there was R50 pertaining to act During interview on 4 stated R50 pertaining to act During interview on 4 stated R50 did not go meals staff just put hi thought R50 slept mor resident rarely respon needs known. A review of the facility March 2016, listed act sewing, coffee shop, game, Rosary, fitness and protestant religio fitness club, manicure activities from Januar indicated music offeri including hymn sings,	n 4/12/16, at 12:47 p.m., n the 1st floor dining room. neal, R50 was observed at 2:12 p.m. The same ., nursing assistants (NA)-J D's evening routine, providing ting him into bed. 1/12/16, at 7:47 p.m. NA-H R50 when getting him ready to meals, however, she thing she did with all nothing special she did with	F 24		ace May 24 th	
	with Ernest." A review of the facility records for R50 from indicated a daily, one	r's recreation participation January through April 2016, -to-one visit recorded for were no other structured				

PRINTED: 04/27/2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/27/2016 FORM APPROVED

JENIER	S FOR MEDICARE &	MEDICAID SERVICES					<u>O. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUC			E SURVEY PLETED
		24E117	B. WING	<u></u>		04	/14/2016
AME OF PF	ROVIDER OR SUPPLIER			STREET ADD	RESS, CITY, STATE, ZIP CODE		
				501 SECONE	D STREET SOUTHEAST		
HE VILLA	A AT OSSEO			OSSEO, MI			
(X4) ID	SI IMMARY ST	ATEMENT OF DEFICIENCIES	10			271011	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO ROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 248 Continued From page	- 3	F	040				
			F	248			
	participation records.	Even though R50 liked					
	participation records i	the care plan, the					
	outside music activity o	onered.					
		non-no-no-free free					
	A review of nursing p	our our stand and the stand of		l			
	weekly, one-to-one vis	016, indicated R50 had a					
	ADION AND AND AND AND AND AND AND AND AND AN	isit on the following dates:					
	12/31; 1/7; 1/15; 1/22	; 1/28; 2/14; 2/19; 2/26; 3/4;					
	3/11; 3/18; 3/26; 4/1;	and 4/8.					
ים	During interview on A	/13/16, at 11:44 a.m. the					
	activities director (AD) stated the focus for DE0					
	activities director (AD) stated the focus for R50 was 1:1 visits which were completed by her or						
	Volunteer staff on a w	eekly basis. The AD stated					
	she had known P50 f	or about three years, and					
	B50's condition had r	emained about the same,	ł				
	however R50 used to	be brought out to activities.					
	AD stated R50 no lon	gor wont to activities					
	herause it upont his a	pouse (who also lived at the					
	facility) when she say	w R50 at an activity and R50					
	no longer roopanized	his spouse. In addition to	r r				
	1.1 visite the AD stat	ed R50 enjoyed music,					
	however if R50 was l	aying down as he often did,					
	staff would not awake	n him. The AD also stated					
	in the past she would	bring R50 out to hear the					
	player plano, and also	when entertainers came					
1	out, but acknowledge	d it was hard, "especially at					
	a change of shiff" to a	et him out. The AD stated			*		
	now he has a music C	D player for his room, but					
	said she did not know	the last time R50 was out					
1	at a music event. The	AD further stated R50's					
1	routine "includes a lot	of sleep" and "we stop and					
5	see him, and all the re	esidents" and give a					
	greeting. The AD ack	nowledged R50's initial					
1	activity assessment w	as completed 2/2/10		1		i	
	subsequent activity as	sessments for the MDS					
1.8	subsequent activity assessments						
v	vere completed in the	computer_The AD sold on				1	
V	were completed in the	computer. The AD said an ent was completed "last					

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULT	PLE CONSTRUCTION		NO. 0938-039 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:		3		MPLETED
		24E117	B. WING			04/14/2016
NAME OF PI	RÓVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
	A AT OSSEO			501 SECOND STREET SOUTHEAS OSSEO, MN 55369	Т	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETION DATE
	addressed R50's press In a follow up interview the AD stated "we wo one-to-one visits," but frequency of those vis staff would be comple individualized activity could benefit more fro "how that could be a p R75's annual MDS da very important to R75 favorite activities. R75 2/4/16, indicated R75 impairments and inclu depression. R75's last comprehens was dated 3/24/14, ind encouragement to com residents interests incl library cart, music, wal making, outdoor game cards, poetry, nails, co booking, outings, word R75's care plan dated was dependent on stat and social needs, and preferred activities that demanding cognitive ta	ware of a more sement that evaluated and sent activity needs. w on 4/14/16, at 1:06 p.m., uld continue with R50's certainly could increase the sits. The AD also stated ting a more comprehensive assessment to see if R50 m activity stimulation, and bart of his plan." ted 8/25/16, indicated it was to participate in her 's quarterly MDS dated had moderate cognitive ded a diagnosis of sive activity assessment dicated R75 needed ne to activities, and the uded spiritual, gardening, king, art, baseball, jewelry es, indoor games, reading, ooking, baking, scrap I find books, and puzzles. 11/16/15, indicated R75 ff for meeting emotional directed staff R75 t did not involve overly asks, and to engage her in	F 24	18		
t	o family.	/12/16, at 12:41 p.m. R75				
s	stated there were no a	ctivities on Saturday's and				

If continuation sheet Page 5 of 20

PRINTED: 04/27/2016

CENTER		AND HUMAN SERVICES & MEDICAID SERVICES				F	NTED: 04/27/20 ORM APPROVE
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION	(X3) I	NO. 0938-039 DATE SURVEY COMPLETED
		24E117	B. WING_				04/14/2016
NAME OF F	PROVIDER OR SUPPLIER	····		STRE	EET ADDRESS, CITY, STATE, ZIP CODE		0 // 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/
	A AT OSSEO			501 \$	SECOND STREET SOUTHEAST		
	AAT 03320			oss	EO, MN 55369		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 248	Continued From page 5		F	248			
		o do for her at the facility.					
	a.m. R75 stated she	nterview on 4/14/16, at 8:47 e doesn't do anything on it was not by her choice, she o activities provided.					
	weekends indicated weekend activities for activity on 3/12/16, a	ation Record reviewed for R75 did not participate in any or February, attended a music and attended church on nths reviewed, R75 did not					
	was cognitively intac	dated 3/29/16, indicated R37 ct, had a diagnosis of cated it was very important to e activities.					
	included past interes	vity assessment which sts, current activity w the activity department was					
	to assist the resident that was meaningful	ed 6/13/14, directed the staff t with a program of activities and of interest to R75, no specific direction to staff rests.					
	stated the facility did on the weekends and	n 4/11/16, at 11:20 a.m. R37 n't have anything for activities d it was "very boring" on y's. R37 further stated " They					

Facility ID: 00733

If continuation sheet Page 6 of 20

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		TE SURVEY MPLETED
		24E117	B. WING		0	4/14/2016
NAME OF P	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	s	TREET ADDRESS, CITY, STATE, ZIP COD		
THE VILL	A AT OSSEO		l l	01 SECOND STREET SOUTHEAST DSSEO, MN 55369		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 248	R37's February and I Participation Record did not participate in weekends. The facili	March 2016 Recreation for weekends indicated R37	F 248			
	indicated on each Sa activities offered to th visits and mail every alternating activity of and/ or dictionary. Th at 1:00 p.m. or 1:30 p p.m. with no activities the day. Sunday's the scheduled with the ex- included four activities Sunday Service or Hy and then alternating a coffee and treats, dice game. The activities v a.m. 11:00 a.m. and 3					
	indicated that on each two activities offered t included visits and ma one other alternating a singers, yahtzee and a activities were schedu p.m. or 2:15 p.m. with the rest of the day. Each three activities schedu	il every Saturday and then activity of Easter craft, triniti				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 24E117 B. WING 04/14/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **501 SECOND STREET SOUTHEAST** THE VILLA AT OSSEO **OSSEO, MN 55369** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 248 Continued From page 7 F 248 manicures. The activities were scheduled at 10:00 a.m., 10:45 a.m. and 3:00 p.m. or 3:30 p.m. most of the days. Monday through Friday's included on average eight activities a day at varying times of the morning, afternoon and evening most days. Review of the activity calendar for April 2016, indicated that there were only two activities offered on Saturdays, visits and mail and then one other activity which alternated between spring flower craft, bingo,arts and crafts and yahtzee. The activities were scheduled at 1:00 p.m. and 2:00 p.m. or 2:30 p.m. with no activities scheduled for the rest of the day. Each Sunday there were only three activities scheduled which included Sunday service and visits with Jada each Sunday and then alternating activities of golf, spring cleaning, dice and manicures. The activities were scheduled at 10:00 a.m., 10:45 a.m. and 3:30 p.m. Monday through Friday's included on average eight activities a day at varying times of the morning, afternoon and evening most days. When interviewed on 4/14/16, at 9:07 a.m. NA-B stated the activity staff was only here for a few hour on the weekends and there wasn't much for activities on the weekends. When interviewed on 4/14/16, at 9:14 a.m. licensed practical nurse (LPN)-A stated on weekends there were not a lot of activities provided. When interviewed on 4/14/16, at 9:45 a.m. activity assistant (AA)-B stated some residents have complained there isn't anything to do on the weekends, and activity staff was only scheduled

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00733

If continuation sheet Page 8 of 20

PRINTED: 04/27/2016

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	0. 0938-039 SURVEY LETED
		24E117	B. WING	_		044	4410040
NAME OF P	ROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE	04/	14/2016
					01 SECOND STREET SOUTHEAST		
THE VILL	A AT OSSEO				DSSEO, MN 55369		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ÌD	<u> </u>	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 248	Continued From pag	e 8	F	248			
		day on the weekends and	Г Г	240			
	had requested more	hours on the weekends but sn't enough hours to be					
F 323 SS=D	stated she was only a day of the weekend f for activities was bas census. The AD state complain of the lack of but had made availab watch if they are bore on the weekends are The facility policy Qua Determination and Pa indicated residents sh to engage in their pre- basis. 483.25(h) FREE OF A HAZARDS/SUPERVI The facility must ensu- environment remains as is possible; and ea	of activities on the weekends ble DVD's for residents to ed. AD stated the activities to be more self directed. ality of Life- Self articipation dated 10/09, hall be provided assistance ferred activities on a routine ACCIDENT SION/DEVICES ure that the resident as free of accident hazards	F	323	R28 has had no negative outcomes from the assist rail placed on bed. bed was reassessed for safety. He perimeter mattress was replaced v regular flat mattress and a second was place to secure mattress from	Her r vith a rail	
	This REQUIREMENT by: Based on observation review, the facility fail assess the safe use o	is not met as evidenced n, interview and document ed to comprehensively of a perimeter mattress with n did not meet FDA (Federal			sliding – the maximum gap is now An audit of all beds with an assist r was performed by Administrator to ensure no others exceeded the FD, recommendation of 4.75". Facility Administrator updated poli regarding use of side rails to ensure	rail D A Cy	

Facility ID: 00733

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If continuation sheet Page 9 of 20

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				/ APPRO\)0938-0:
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA · IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		24E117	B. WING		04/14/2016	
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE VILL	A AT OSSEO			01 SECOND STREET SOUTHEAST DSSEO, MN 55369		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES				
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETI DATE
F 323	Continued From page	9	F 323	there is no gap larger than 4.75'	' when	
	Drug Administration)			rails are placed on bed and mat		
	for accidents and haz	residents (R28) reviewed ards related to a large gap		secured.		
	between the mattress	s and grab bar.		Staff will be educated on bed sa	•	
	Findings include:			assist rail guidelines by May 24 th	ו י	
		nge Minimum Data Set		All beds will be audited by main	tenance	
		identified R28 had moderate		for safety on a month basis for 3	3	
	cognitive impairment, assistance from staff			months. Results of audit and po	licy will	
		s of one side of the body),		be reviewed at QA.		
				Facility will be in compliance Ma	ay 24 th	
	During observation or bed had a perimeter r	n 4/11/16, at 1:27 p.m. R28's mattress and metal grab rail		2016.		
	(used to help with bec	mobility) which was fixed				
	to the bed frame. R28	8's mattress moved easily				
	when slight pressure	was applied to it, which				
	between the grab bar	approximately 5-6 inches) and mattress.				
		Jse of Side Rails dated				
	falls and demonstrate	8 had a recent increase in d a loss of balance at times.				
	The evaluation identifi	ied R28 used the mobility				
	(grab) bar, "To assist v					
		ne evaluation did not identify ssed for the safe use of the				
		neter mattress that resulted				
	in a large gap betweer	n the mobility rail and				
		cause entrapment if R28 bed by herself and was				
	unable too.	ed by hersen and was				
	R28's care plan dated	2/12/16, identified R28 had				
	an activities of daily liv	ving (ADL) self performance				
		to make positional changes Occasionally able to get in				
	m bed independently.	occasionally able to get in				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TPLE CONSTRUNG			E SURVEY IPLETED
		24E117	B. WING			0	1/14/2016
NAME OF P	ROVIDER OR SUPPLIER		I	STREET ADI	DRESS, CITY, STATE, ZIP CODE		14/2010
	A AT OSSEO			501 SECON	ID STREET SOUTHEAST		
	1			OSSEO, M	IN 55369		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC ROSS-REFERENCED TO THE APPI DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 323	Continued From page	<u>> 10</u>	E C	202			
	and out of bed, but ge	enerally needs staff to assist fer out of bed and walk to	F3				•
	"NAR reported that @ sitting on her buttocks apparent injuries note the note identified star	d, denies pain." Further, ff, "Reminded [R28] to call transfers. Call light in place.					
	guidance for Bed Syst Assessment and Guid Entrapment, issues 3/ for facilities to reduce with side/assist rails, w serious injury. The gui patients as those who memory, sleeping, incouncontrolled body mov out of bed unsafely wit included, the gap, "bet mattress." The FDA re	ug Administration (FDA) rem Dimensional ance to Reduce 10/06, included information entrapment risk of patients which may result in death or dance identified vulnerable have problems with ontinence, pain or /ements, or those who get thout assistance. Zone 3 ween the rail and commended this space be s), a space where a head					
 	move over on the fram between the fixed grab mattress. NA-C pushe mattress and stated it, 'Not a good thing." Fu	-C observed R28's pressure to it causing it to e exposing a large gap rail and perimeter d on R28's perimeter "Slides easily" and was, urther, NA-C stated					
r	maintenance should se ped frame so it doesn't	cure the mattress to the slide.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00733

If continuation sheet Page 11 of 20

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 24E117 B. WING 04/14/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **501 SECOND STREET SOUTHEAST** THE VILLA AT OSSEO OSSEO, MN 55369 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG **REGULATORY OR LSC IDENTIFYING INFORMATION)** CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 323 | Continued From page 11 F 323 During interview on 4/13/16, at 8:08 a.m. licensed practical nurse (LPN)-B observed R28's bed and pressed on the mattress which exposed a large gap between the fixed grab rail and perimeter mattress. LPN-B measured the gap between the mattress and grab rail bar and stated it was, "5 inches." LPN-B stated having a large gap in between the fixed rail and mattress was, "Probably not very safe," because R28, "Could roll into there [the large gap] and get hurt." Further, LPN-B stated R28 would at times attempt to self transfer out of her bed on her own, and she would see if a new mattress could be provided. During interview on 4/13/16, at 1:28 p.m. the director of nursing (DON) stated she was unaware of the large gap created by R28's mattress and fixed grab rail, so it had never been assessed to see if it was safe for R28 to use, "I couldn't assess it if I was unaware." Further, the DON stated she did not feel the large gap created by the perimeter mattress and fixed grab rail was an entrapment hazard because the grab bar was not a full side rail. A facility Proper Use of Side Rail policy dated October 2010, identified, "The Resident will be checked periodically for safety r/t [related to] side rail use. When side rail use is appropriate, the facility will assess the space between the mattress and side rails to reduce the risk for entrapment (the amount of safe space may very, depending on the type of bed and mattress being used)." F 364 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, F 364 SS=D PALATABLE/PREFER TEMP FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00733

If continuation sheet Page 12 of 20

PRINTED: 04/27/2016

	DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIÄ IDENTIFICATION NUMBER:		E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
		24E117	B. WING		04/14/2016
NAME OF PRO	VIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	04/14/2010
THE VILLA	AT OSSEO			501 SECOND STREET SOUTHEAST DSSEO, MN 55369	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO
E f v r t t T b l r r f c c F R 2 in D 4, m st t s t t t t t t t t t t t t t t t	bod prepared by metil alue, flavor, and appre- alatable, attractive, a emperature. This REQUIREMENT y: Based on observation eview, the facility faile bods were served col- esidents (R41) observ- ottage cheese. indings include: 41's quarterly Minimu (11/16, identified R41 hpairment. uring observation of the learn table was in use roganoff, noodles, ar as sitting on top of the ble which contained p elted crushed ice, an e/water was a clear of anges, and a 5 lbs (p ottage cheese which a xture. At 12:25 p.m.	s and the facility provides nods that conserve nutritive earance; and food that is nd at the proper is not met as evidenced a, interview, and document ed to ensure refrigerated d and palatable for 1 of 1 ved who received warm and Data Set (MDS) dated had severe cognitive the lunch meal service on R41 was seated in the be served her meal. A e which contained beef ad vegetables. A container e left side of the steam pooled water and partially d sitting inside the pool of ontainer of mandarin pound) white container of appeared to have a watery cook (CK)-A walked to begin serving meals.	F 364		hrown g the ents or e d sure es. 016, udit minded ns neal sk for od to d in

Facility ID: 00733

If continuation sheet Page 13 of 20

		& MEDICAID SERVICES	······			O. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY IPLETED
		24E117	B. WING		04	1/14/2016
AME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HE VILL	A AT OSSEO			501 SECOND STREET SOUTHEAST OSSEO, MN 55369		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
	scooping servings of mandarin oranges of serving bar. Dietary the plate with the co- oranges and served a table. The survey temperature of the co- remained uncovered checked the tempera- stated it was 60.9 de would obtain a new of to serve the resident During interview on a stated she didn't like that day because it co- stated it had a, "Kinco- stated it had a, "Kinco- stated it had a, "Kinco- stated nobody offere food since it had bee When interviewed or stated cottage chees below [degrees]," in a freshness." Further, R41 a new plate of co- they observed the sur- registered dietician (f should be served, "N cheese was served wo of a sour taste" which means."	K-A picked up a plate, if the cottage cheese and on it before setting it on the manager (DM)-A picked up ittage cheese and mandarin it to R41 who was seated at or requested CK-A check the cottage cheese which d on the steam table. CK-A ature of the cottage cheese, agrees Fahrenheit, and she container of cottage cheese is. 4/12/16, at 12:36 p.m. R41 the cottage cheese served didn't, "Taste right." R41 d of sour taste to it," and d to get her a new plate of an served. h 4/12/16, at 1:13 p.m. DM-A the should be served at, "40 or order to, "Guarantee DM-A stated the staff offered ottage cheese, but only after inveyor speaking to the	F 364	⁴ Facility will be in compliant 2016.	e May 24 th	

F

DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 24E117 B. WING 04/14/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST THE VILLA AT OSSEO **OSSEO, MN 55369** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 371 Continued From page 14 The cottage cheese found at improper F 371 F 371 483.35(i) FOOD PROCURE F 371 temperature was immediately thrown SS=E STORE/PREPARE/SERVE - SANITARY away. The facility must -R41 was monitored and had no (1) Procure food from sources approved or considered satisfactory by Federal, State or local negative outcome from receiving the authorities: and cottage cheese. No other residents (2) Store, prepare, distribute and serve food were observed to have GI issues or under sanitary conditions negative outcomes from cottage cheese. Staff will be educated on proper procedures for temping food and This REQUIREMENT is not met as evidenced by: setting up the serving area to ensure Based on observation, interview, and document food stays at proper temperatures. review, the facility failed to ensure refrigerated foods were held and served at or below 41 Food temps will be taken at each meal degrees to reduce the risk of potential food borne to ensure safe zone - any food found in illness for 1 of 1 residents (R41) observed to receive warm cottage cheese. This had potential the danger zone will be immediately to affect 8 of 8 residents observed during the thrown away. Audits will be review by same meal service who were served cottage QA monthly. cheese. Findings include: Facility will be in compliance May 24th 2016. R41's quarterly Minimum Data Set (MDS) dated 2/11/16, identified R41 had severe cognitive impairment. During observation of the lunch meal service on 4/12/16, at 12:23 p.m. R41 was seated in the main dining with approximately six to eight other residents who were waiting to be served their meals. A steam table was in use which contained beef stroganoff, noodles, and vegetables. A container was sitting on top of the left side of the

FORM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 15 of 20

PRINTED: 04/27/2016

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		NO. 0938-039 ATE SURVEY MPLETED
		24E117	B. WING			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE		04/14/2016
THE VILL	A AT OSSEO			501 SECOND STREET SOUTH OSSEO, MN 55369		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
	partially melted crush- ice was a clear contai and a 5 lbs (pound) w cheese which was ap appeared to have a w cook (CK)-A walked b begin serving meals. thermometer from a p steam table and check stroganoff, and vegets check any of the temp including the cottage of plate, scooping serving and mandarin oranges the serving bar. Dieta up the plate with the c mandarin oranges and seated at a table. The check the temperature which remained uncov CK-A checked the tem cheese, and stated it w Fahrenheit.	ntained pooled water and ed ice, and sitting inside the ner of mandarin oranges, hite container of cottage proximately half full and atery texture. At 12:25 p.m. ehind the steam table to She removed a lastic container behind the ked the temperature of the ables, however did not eratures of the cold items, cheese. CK-A picked up a gs of the cottage cheese s on it before setting it on ry manager (DM)-A picked ottage cheese and d served it to R41 who was e surveyor requested CK-A of the cottage cheese tered on the steam table. perature of the cottage vas 60.9 degrees	F3	371		
	nad melted, and the co been kept cold to ensu					
5	stated she immediately sottage cheese after it emperature was 60.9 c stated she didn't feel th	was identified the				

If continuation sheet Page 16 of 20

		ND HUMAN SERVICES MEDICAID SERVICES			FO	ED: 04/27/20 RM APPROVE
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY MPLETED
		24E117	B. WING			414 410040
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		4/14/2016
THE VILL	A AT OSSEO			501 SECOND STREET SOUTHEAS OSSEO, MN 55369	ST	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN C	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETIO DATE
F 465 SS=D	which would help ens in the products before When interviewed on registered dietician (F kept in the, "Temperal extended periods sho could potentially be, " residents who might h cottage cheese would risk for foodborne illne An undated Food Prejidentified, "The 'dange temperatures is betwee degrees Fahrenheit." promotes the rapid gro microorganisms that of The policy identified so hazardous foods," incl melon, eggs, milk, yog and directed staff to m [degrees] or below" identified food service food if it cannot be deto temperature was above 483.70(h)	"40 [degrees] or below," "ure, "Bacteria doesn't grow," a being served. 4/13/16, at 1:42 p.m. RD)-A stated foods which are ture danger zone" for uld be discarded because it Unsafe to eat." RD-A stated have consumed the warm be placed at, "Increased ass." paration and Service policy er zone' for food ten 41 degrees and 135 This temperature range bowth of pathogenic ause foodborne illness." everal, "Potentially uding, "seafood, cut jurt and cottage cheese," aintain these foods, "At 41 Further, the policy staff should, "Discard the ermined how long the food e 41 [degrees Fahrenheit]." SANITARY/COMFORTABL le a safe, functional, oble environment for		871 871 85 R72's room has been el urine smell. Resident h med adjustment that w the cause of incontinen Another med adjustme resolved the issue. Car and the odor was elimit	ad been given a vas found to be it episodes. nt was done that pet was cleaned	
		is not met as evidenced		Resident's toileting plar		
	oy:			for staff direction to the		

Event ID: C45Z11

Facility ID: 00733

If continuation sheet Page 17 of 20

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPL	E CONSTRUCTION	OMB NO	
ND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:			COMPL	
		24E117	B. WING		04/4	14/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	14/2010
THE VILL	A AT OSSEO			501 SECOND STREET SOUTHEAST DSSEO, MN 55369		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIC DATE
F 465	Continued From page	17	F 465	care and post-meals.		
	Based on observation	n, interview, and document				
	review the facility faile	ed to ensure the facility was		R64 will be moved to room 242 or	n May	
		2 of 2 residents rooms		20 th 2016. Prior to him moving th		
	(R72, R65) whose roc urine.	om had a strong odor of		will be replace with non-porous		
	unne.			flooring. Room 225 where R64		
	Findings include:			1		
				currently resides will be deep clea	1	
	During observation on	4/11/16, at 11:09 a.m. a		If the urine odor is not resolved w	ith	
	very strong odor of uri	ne was noted when		deep cleaning the carpet will be		
	entering R72's resider	nt room.		replaced with non-porous flooring	g.	
	During observation on	4/12/16, at 6:01 p.m. R72's		Resident has behavior of dumping	his	
	room was again noted	to have a very strong odor		urinal on the floor instead of havir		
	of urine, and the smell	got stronger near the		staff empty for him. His toileting p	-	
	residents bed.	· ·		has been updated with a goal of us		
	0= 4/40/40 -1.40.45					
ł	On 4/13/10, at 12:15 p	.m. R72's door was open open, however, the strong		bathroom during daytime and utili	Izing	
	odor of urine was still j	open, nowever, the strong present.		the urinal only during the night.		
	During observation on	4/11/16, at 11:09 a.m. an		Facility Administrator and Director	of	
	odor of urine was pres	ent in R64's room.		Housekeeping performed an		
	•			environmental walk through of ent	tire	
	On 4/13/16, at 9:00 a.r	n. housekeeping (HK)-B		facility on April 27th 2016. Director	of	
	at the foot of the hed	the carpet in R64's room nowever, during follow up		Housekeeping and her District Mar	nager	
	observation on 4/14/16	b, at 2:26 p.m. the smell of		did an environmental walk through	n of	
	urine still remained ver	y strong.		entire facility May 4 th 2016. Concer		
				addressed as needed.		
	During interview on 4/1	4/16, at 9:24 a.m. HK-B				
	stated the facility had [Deep Cleaning Schedules		R37 was interviewed on May 5 th 20)16 to	
	were checked daily on	ated R64 and R72 rooms d housekeeping used the		see if he noticed a difference in the		
	carpet cleaner to clean	these areas regularly		odors. He stated they haven't noti	1	
	HK-B stated the deep of	cleaning schedule for	1		1	
	R72's room had been i	n place for about 2 weeks.		smell lately. R9 was informed of th	1	
	HK-B stated another re	sidents room [R66] had		plan to reduce odors near her roon	n and 📗	
	also been on a routine	cleaning schedule related		she was agreeable.		

Facility ID: 00733

If continuation sheet Page 18 of 20

DEPARTMENT OF HEA	ARE & ME	DICAID SERVICES		· · · · · · · · · · · · · · · · · · ·		M APPRO\ D. 0938-0
TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY
		24E117	B. WING		04/14/2016	
NAME OF PROVIDER OR SUPP	LIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	14/2010
THE VILLA AT OSSEO				501 SECOND STREET SOUTHEAST DSSEO, MN 55369		
PREFIX (EACH D	FICIENCY MU	IENT OF DEFICIENCIES IST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETI DATE
replaced the c which resolves During intervie stated he coul residents room During intervie stated, "I can s usually in the into to me I can s facility staff us point during th the door to his urine odor. During intervie stated R72's ro chemical odor, HK-A stated pa urine odor was cleaning it. Hk R64 were chec the strong urine During intervie administrator s forward to reme were looking to next few weeks of flooring, cab administrator s in place, and no completion of ta previously beer end of 2015, as	smell, how arpet with I I the urine is w on 4/14/ d smell urin and founce w on 4/14/ mell the urin norning fro mell it reall ually cleans e day, how room close w on 4/14/1 om smelled and maybe rt of the pri- the carpet -A stated the ked and sc e smell. v on 4/14/1 ated the fa odeling the ward finaliz which wou- nets, and Ii ated there o plan for pl isks. The r anticipated stated in the	vever, the facility had hard flooring in that room smell issue. 16, at 10:44 a.m. R37 the over towards another l it offensive. 16, at 10:52 a.m. R9 ine out in the hall m one of the rooms next y bad." R9 stated a the rooms at some ever, R9 needed to keep ad so he didn't smell the 16, at 11:03 a.m. HK-A d, "A little bit of the e a touch of the urine." oblem of the ongoing had not fully dried from he rooms of R72 and rubbed daily related to 6, at 1:08 p.m. the cility was looking existing facility and ting the plans in the ild include replacement ghting. The was no current timeline	F 465		designee vice a week ntinued ty focus list o cleanings. d areas will Audits will	

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OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DAT	O. 0938-0391 E SURVEY
	BENTIFICATION NOWBER.	A. BUILD	ING	COMPLETED	
	24E117	B. WING		04	4/14/2016
ROVIDER OR SUPPLIER					
A AT OSSEO			501 SECOND STREET SOUTHEAS OSSEO, MN 55369	Г	
(EACH DEFICIENC)	MUST BE PRECEDED BY FULL		X (EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
regarding an estimate the facility, the respon time of the project was The facility policy titled Environment dated 10 Policy Interpretation an facility staff and manage the extent possible, the facility that reflect a pe	d start date for remodel on se to an estimated start s "hopefully within 90 days." d Quality of Life-Homelike /09, identified under the nd Implementation, "The gement shall maximize, to e characteristics of the ersonalized, homelike	F			
	Continued From page regarding an estimate the facility policy titled Environment dated 10 Policy Interpretation an facility staff and manage the extent possible, the facility that reflect a pe setting. These charact	F CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 24E117 ROVIDER OR SUPPLIER A AT OSSEO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 19 regarding an estimated start date for remodel on the facility, the response to an estimated start time of the project was "hopefully within 90 days." The facility policy titled Quality of Life-Homelike Environment dated 10/09, identified under the Policy Interpretation and Implementation, "The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include Pleasant,	F CORRECTION IDENTIFICATION NUMBER: A. BUILD 24E117 B. WING ROVIDER OR SUPPLIER A AT OSSEO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 19 regarding an estimated start date for remodel on the facility, the response to an estimated start time of the project was "hopefully within 90 days." The facility policy titled Quality of Life-Homelike Environment dated 10/09, identified under the Policy Interpretation and Implementation, "The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include Pleasant,	F CORRECTION IDENTIFICATION NUMBER: A. BUILDING 24E117 B. WING STREET ADDRESS, CITY, STATE, ZIP A AT OSSEO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING Continued From page 19 ID PROVIDER'S PLAN OF COntinued From page 19 Continued From page 19 F 465 regarding an estimated start date for remodel on the facility, the response to an estimated start time of the project was "hopefully within 90 days." F 465 The facility policy titled Quality of Life-Homelike Environment dated 10/09, identified under the Policy Interpretation and Implementation, "The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include Pleasant,	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DAT P CORRECTION 24E117 B. WING

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

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION 1 - MAIN BUILDING 01		E SURVEY IPLETED
		24E117	B. WING			1143/2045
NAME OF P	ROVIDER OR SUPPLIER	246117		IREET ADDRESS, CITY, STATE, ZIP CODE		4/13/2016
				11 SECOND STREET SOUTHEAST		
THE VILL.	A AT OSSEO		0	SSEO, MN 55369		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	di l	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A		COMPLETION DATE
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K 000	INITIAL COMMENTS		14 000			
					L 1	$ \rangle$
	FIRE SAFETY			PROVED	- hand f	7
				om Linhoff at 1:39 p		. 2016
1		WILL SERVE AS YOUR			, ,	,
		MPLIANCE UPON THE				1
	DEPARTMENT'S ACC					
1		BOTTOM OF THE FIRST				
1	VERIFICATION OF C	2567 WILL BE USED AS				
	UPON RECEIPT OF A	NACCEPTABLE POC, AN				
		YOUR FACILITY MAY BE	4 1			
	CONDUCTED TO VAL SUBSTANTIAL COMP					
	REGULATIONS HAS I					
		YOUR VERIFICATION.				
.	A Life Safety Code Su	vey was conducted by the				
		t of Public Safety, State				
	Fire Marshal Division o	on April 13, 2016. This recertification for the NF				
	portion and an initial ce	ecentrication for the SNE				
		his survey, The Villa at				
0	Osseo was found not ir	n substantial compliance				
1	with the requirements f	or participation in		DEOENT		
L.	Medicare/Medicaid at 4	2 CFR, Subpart		RECEIVE		
		rom Fire, and the 2000 Protection Association				
		Life Safety Code (LSC),				
	Chapter 19 Existing He	alth Care.		MAY - 9 2016		
F	LEASE RETURN THE	E PLAN OF				
	ORRECTION FOR TH			MN DEPT. OF PUBLIC SA	ISION	
	EFICIENCIES (K-TA	GS) TO:		STATE FIRE MARSHAL DIV	131014	
	lealthcare Fire Inspect					
	tate Fire Marshal Divis					
4	45 Minnesota St., Suite	e 145				
ATORY DIR	ECTOR'S OR DROVIDER SOF	PLIER REPRESENTATIVE'S SIGNATURE		TITLE	. ((X6) DATE
1	$\leq 1/$	12/200		Administra	tor !	5-9-16
ficiency sta	tement ending with an aster	isk (*) denotes a deficiency which the is	nstitution may be ex	cused from correcting providing it is dete	ermined that	

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility JD: 00733

If continuation sheet Page 1 of 4

DEPARTME	NT OF H	EALTHA	ND HUMAN	SERVICES
CENTERS F	OR MED	ICARE &	MEDICAID	SERVICES

PRINTED: 04/27/2016 FORM APPROVED OMB NO: 0938-0391

	OF DEFICIENCIES				E SURVEY PLETED	
		24E117	8. WING		04	/13/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST OSSEO, MN 55369		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE
	FOLLOWING INFORM 1. A description of what to correct the deficience 2. The actual, or proper 3. The name and/or tit responsible for correct prevent a reoccurrence This 2-story building is construction Type II (2: wood joist and plywood closets. It has a partial sprinklered. The facility with smoke detection ir and spaces open to the for automatic fire departs September 24, 2015, a of Type V (111) constru- not have a basement a addition has a fire alarred detection in the resider spaces open to the cor- automatic fire department as a capacity of 102 b 76 beds at the time of t	145, OR e.mn.us and estate.mn.us ECTION FOR EACH NCLUDE ALL OF THE MATION: at has been, or will be, done cy. bsed, completion date. le of the person ion and monitoring to e of the deficiency. downgraded from 22) to Type V (111) due to d floors in some of the linen basement and is fully fire y has a fire alarm system in resident rooms, corridors e corridor that is monitored rtment notification. On 1-story addition was build loction. The addition does nd is fully sprinklered. The in system with smoke it rooms, corridors and ridor is monitored for ent notification. The facility eds and had a census of he survey. CFR, Subpart 483.70(a) is	KOC			

FORM CMS-2567(02-99) Previous Versions Obsolate

Event ID: C45Z21

Facility ID: 00733

If continuation sheet Page 2 of 4

		MEDICAID SERVICES		DUK CONSTOLICTION		O. 0938-039 E SURVEY
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLÉ CONSTRUCTION IG 01 - MAIN BUILDING 01		IPLETED
		24E117	B. WING	<u>.</u>	04	1/13/2016
IAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
HE VILL	A AT OSSEO			501 SECOND STREET SOUTHEA OSSEO, MN 55369	AST	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		(X5) COMPLETIO DATE
K 025 SS≂E	Smoke barriers shall least a one half hour constructed in accord barriers shall be perm atrium wall. Windows fire-rated glazing or b steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is r Based on observation facility has failed to m doors in accordance w deficient practice coul Findings include: On facility tour betwee on April 13, 2016, obs was a penetration thro	itted to terminate at an shall be protected by y wired glass panels and	К 02	25 The penetration thr barrier on first floor sealed on April 20 th Johnson, Maintenance smoke barriers are r monthly for 3 month work affecting them	was patched and 2016 by Jack ice Assistant. e will ensure the not compromised ins and after any	
SS=C	This deficient practice Administrator at the tir NFPA 101 LIFE SAFE Generators inspected under load for 30 minu in accordance with NF 3-4.4.1 and 8-4.2 (NFF 110) This STANDARD is no Based on documentat interview, the facility fa emergency generator i	ne of the inspection. TY CODE STANDARD weekly and exercised tes per month and shall be PA 99 and NFPA 110. PA 99), Chapter 6 (NFPA ot met as evidenced by: ion review and staff iled to maintain the n accordance with the 110-1999 edition, Section	K 14	 Facility uses TELS sy monitoring. General documentation prorto system. Facility maintenance April 13th 2016. Maintenance will au period monthly and months to ensure compared to a system. 	ntor cool down mpting was added e was educated on dit cool down report to QA for 3	

Facility ID: 00733

If continuation sheet Page 3 of 4

		AND HUMAN SERVICES				FÖ	ED: 04/27/20 RM APPROVE NO: 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTI ING 01 - MAIN	RUCTION I BUILDING 01		ATE SURVEY
		24E117	B. WING				4/13/2016
NAME OF P	ROVIDER OR SUPPLIER	-d		STREET A	DDRESS, CITY, STATE, ZIP CODE		
THE VILL	A AT OSSEO			501 SECC	OND STREET SOUTHEAST		
				OSSEO,	MN 55369		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
K 144	Continued From pag	ge 3	к	144			
	Findings include:						
	April 13, 2016, reco was not a document Long Term Care ger maintenance runs. These deficient prac	een 9:30 AM and 1:30 PM on rd review revealed that there ted cool down period for the herator during the monthly ctices were verified by the time of the inspection.					
VI CMS-2567(02-99) Previous Versions Ob:	solete Event ID: C45Z	21	Facility ID: 00	0733	If continuation	sheet Page 4

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 02 - THE VILLA OF OSSEO		E SURVEY
		24E117	B. WING			Utained
NAME OF	PROVIDER OR SUPPLIER	24611/		STREET ADDRESS, CITY, STATE ZIP COD		1/13/201
THE VILI	LA AT OSSEO			501 SECOND STREET SOUTHEAST OSSEO, MN 55369		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X) COMPL DA
K 000	INITIAL COMMEN	ſS	K 000	þ		
	FIRE SAFETY					
		DC WILL SERVE AS YOUR	Δ	PPROVED	P M	1
	DEPARTMENT'S A	CCEPTANCE. YOUR E BOTTOM OF THE FIRST		Tom Linhoff at 10:1		r 10. 20
		S-2567 WILL BE USED AS				
	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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on April 13, 2016. This survey will serve as a recertification for the NF portion and an initial certification for the SNF portion. At the time of this survey, The Villa at Osseo was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC),	ent of Public Safety, State n on April 13, 2016. This a recertification for the NF certification for the SNF of this survey, The Villa at t in substantial compliance s for participation in t 42 CFR, Subpart y from Fire, and the 2000 re Protection Association				
	PLEASE RETURN T CORRECTION FOR DEFICIENCIES (K-1	THE FIRE SAFETY				
1	Healthcare Fire Inspe State Fire Marshal D 445 Minnesota St., S	vision				
RATORY DI	RECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURE		A		(X6) DATE
safeguards	s provide sufficient protecti e of survey whether or not	sterisk (*) denotes a deficiency which the ins on to the patients . (See instructions.) Excep a plan of correction is provided. For nursing	ot for nursing ho homes, the abo	mes, the findings stated above are disclo	sable 90 days lisclosable 14	2.9

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

PRINTED 04/27/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG 02 - THE VILLA OF OSSEO	(X3) DAT	E SURVEY
		24E117	B WING_		04	4/13/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST OSSEO, MN 55369		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION (CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	St. Paul, MN 55101-5 By email to: Marian.Whitney@stat Angela.Kappenman@ THE PLAN OF CORR DEFICIENCY MUST I FOLLOWING INFORM 1. A description of whit to correct the deficient 2. The actual, or proper 3. The name and/or tit responsible for correct prevent a reoccurrence This 2-story building is construction Type II (2 wood joist and plywoo closets. It has a partia sprinklered. The facilit with smoke detection i and spaces open to th for automatic fire depa September 24, 2015, a of Type V (111) constru- not have a basement a addition has a fire alar	145, OR e.mn.us and estate.mn.us ECTION FOR EACH NCLUDE ALL OF THE MATION: at has been, or will be, done cy. bsed, completion date. le of the person tion and monitoring to e of the deficiency. completed from 22) to Type V (111) due to d floors in some of the linen basement and is fully fire y has a fire alarm system in resident rooms, corridors e corridor that is monitored rtment notification. On a 1-story addition was build uction. The addition does and is fully sprinklered. The m system with smoke int rooms, corridors and	κo			
	has a capacity of 102 t 76 beds at the time of	CFR, Subpart 483.70(a) is			If continuation	

DEPARTMENT OF HEALTH AND HUMAN SERVIC	ES
OFNELDO COD MEDICADE A MEDICAID DEDVIC	FC

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PRINTED: 04/27/2016 FORM APPROVED PMB NO: 0938-0391

GENTERST	OK MEDICARE &	MEDICAID SERVICES	1		WALDATE	
STATEMENT OF D AND PLAN OF COR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION 12 - THE VILLA OF OSSEO	(X3) DATE SURVEY COMPLETED	
		24E117	B. WING		04/	13/2016
NAME OF PROVI	DER OR SUPPLIER		5	TREET ADDRESS, CITY, STATE, ZIP CODE 01 SECOND STREET SOUTHEAST DSSEO, MN 55369		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
SS=C Get und in a 3-4 110 Thi Ba inte em req 6-4 res Fin On Apr was TC run The	enerators inspected der load for 30 minu accordance with NF 1.4.1 and 8-4.2 (NF 0) is STANDARD is n ased on documenta erview, the facility fa iergency generator juirements of NFPA b. This deficient pra- idents. dings include: facility tour betwee ril 13, 2016, record is not a documented U generator during s.	TY CODE STANDARD weekly and exercised utes per month and shall be PA 99 and NFPA 110. PA 99), Chapter 6 (NFPA ot met as evidenced by: tion review and staff ailed to maintain the in accordance with the 110-1999 edition, Section ctice could affect all 76 on 9:30 AM and 1:30 PM on review revealed that there d cool down period for the the monthly maintenance wes were verified by the ne of the inspection.	K 144	Facility uses TELS system for gene monitoring. Generator cool dow documentation prompting was at to system. Facility maintenance was educate April 13 th 2016. Maintenance will audit cool down period monthly and report to QA months to ensure compliance.	n dded ed on n	

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00733

If continuation sheet Page 3 of 3

CENTERS FOR MEDICARE & MEDICAID SERVICES

					AND TRANSMITTAL TE SURVEY AGENCY	ID: SLSD Facility ID: 00733
1. MEDICARE/MEDICAID PROVIDER N (L1) 24E117 2.STATE VENDOR OR MEDICAID NO. (L2) 836420100	0.	 NAME AND ADI (L3) THE VILLA (L4) 501 SECONE (L5) OSSEO, MN 	AT OSSEO		(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
5. EFFECTIVE DATE CHANGE OF OWN (L9)	NERSHIP	7. PROVIDER/SUF 01 Hospital	7. PROVIDER/SUPPLIER CATEGORY 10 (L7) 01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA			7. On-Sife Visit 9. Other 8. Full Survey After Complaint
 6. DATE OF SURVEY 04/09 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other 	2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31
 11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 	 115 (L18) 115 (L17) 19 SNF 115 	B. Not in Com	ce With quirements	Vaivers:	And/Or Approved Waivers Of The2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SNF)5. Life Safety Code * Code: A* 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	6. Scope of Services Limit 7. Medical Director
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY AP	PROVAL Date:
Jessica Sellner, U	*		04/09/2015	(L19)	Kate JohnsTon, Enfo	(L20)
 19. DETERMINATION OF ELIGIBILITY <u>X</u> 1. Facility is Eligible to Part <u>2</u>. Facility is not Eligible 		20. COM	PLIANCE WITH CI		21. 1. Statement of Financi	
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEME	NT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 01/01/1975	BEGINNING	DATE	ENDING DATE		VOLUNTARY 00 01-Merger, Closure 00	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbursemen 03-Risk of Involuntary Termination	nt 06-Fail to Meet Agreement
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIV A. Suspension B. Rescind Sus	of Admissions:	(L44)		04-Other Reason for Withdrawal	<u>OTHER</u> 07-Provider Status Change 00-Active
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS	
	(L28)			(L31)	_	
31. RO RECEIPT OF CMS-1539	32	DETERMINATION C	OF APPROVAL DAT	Е	Posted 04/22/2015 Co).
	(L32)	04/02/2015		(L33)	DETERMINATION APPRO	VAL



Protecting, Maintaining and Improving the Health of Minnesotans CMS Certification Number (CCN): 24E117 April 10, 2015

Mr. Michael Marchant, Administrator The Villa At Osseo 501 Second Street Southeast Osseo, Minnesota 55369

Dear Mr. Marchant:

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 April 7, 2015 the above facility is certified for or recommended for:

115 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 115 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,

Kate Johnston, Program Specialist Licensing and Certification Program Health Regulations Division Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

April 10, 2015

Mr. Michael Marchant, Administrator The Villa At Osseo 501 Second Street Southeast Osseo, Minnesota 55369

RE: Project Number SE117024

Dear Mr. Marchant:

On March 11, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 26, 2015. 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 April 9, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 26, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 7, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 26, 2015, effective April 7, 2015 and therefore remedies outlined in our letter to you dated March 11, 2015, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist Licensing and Certification Program Health Regulations Division Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 24E117	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 4/9/2015
Name	of Facility		Street Address, City, State, Zip Code	·
TH	E VILLA AT OSSEO		501 SECOND STREET SOUTHEAS OSSEO. MN 55369	ST

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item		(Y5)	Date	(Y4) I	tem		(Y5)	Date	(Y4)	ltem		(Y5)	Date
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0221		04/07/2015) Prefix	F0282		04/07/2015		ID Prefix	F0323		04/07/2015
0	483.13(a)				-	483.20(k)(3)(ii)				-	483.25(h)		
LSC					LSC					LSC			
			Correction					Correction					Correction
ID Prefix	E0220		Completed 04/07/2015		Drofiv	F0356		Completed 04/07/2015		ID Prefix	E0274		Completed 04/07/2015
			04/07/2015					04/07/2015					04/07/2015
0	483.25(I)				0	483.30(e)				-	483.35(i)		
LSC				<u> </u>	LSC					LSC			
			o "					o "					0 "
			Correction					Correction					Correction
ID Prefix	F0428		Completed 04/07/2015	10) Prefix	F0492		Completed 04/07/2015		ID Prefix			Completed
Reg #	483.60(c)		-		Rea #	483.75(b)				Reg. #			
LSC	400.00(0)				LSC	483.75(b)							
			Correction					Correction					Correction
			Completed					Completed					Completed
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Reviewed By	·	Reviewed I	Зу	Date:		Signature of	f Surve	yor:				Date:	
State Agenc	/		JS/KJ	4/1	0/20	15		292	49				4/9/2015
Reviewed By	/ <u> </u>	Reviewed I	Зу	Date:		Signature of	f Surve	yor:				Date:	
CMS RO													
Followup to	Survey Compl	eted on:				Check f	or any	Uncorrected I	Defic	encies. Was	a Summary of	1	
	2/26/	2015					-				to the Facility?	YES	NO
				1									

CENTERS FOR MEDICARE & MEDICAID SERVICES

					ND TRANSMITTAL E SURVEY AGENCY		C45Z lity ID: 00733
I. MEDICARE/MEDICAID PROVIDER N (L1) 24E117 2.STATE VENDOR OR MEDICAID NO. (L2) 836420100	0.	(L3) THE VILLA	D STREET SOUT		(L6) 55369	 Termination Validation 	<u>2 (</u> L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9)		01 Hospital	PPLIER CATEGORY 05 HHA	09 ESRD	<u>10</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After Comple	9. Other aint
6. DATE OF SURVEY 04/14/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DAT 12/31	TE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b):		10.THE FACILITY A. In Complia Program Re Compliance	nce With quirements		And/Or Approved Waivers Of Th 2. Technical Personnel 3. 24 Hour RN	e Following Requirements: 6. Scope of Services 7. Medical Director	
12.Total Facility Beds 13.Total Certified Beds	102 (L18)20 (L17)	X B. Not in Com	Acceptable POC pliance with Program and/or Applied Waive		4. 7-Day RN (Rural SNF 5. Life Safety Code * Code: B *) 8. Patient Room Size 9. Beds/Room (L12)	
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF	19 SNF 20	ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38) 16. STATE SURVEY AGENCY REMARK This revis		(L42) SHOW LTC CANCELI ted 5/11/2016.	*				
17. SURVEYOR SIGNATURE	HFE NE II	Date :	05/10/2016	(L19)	18. STATE SURVEY AGENCY AI		Date: 05/11/2016 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RE	GIONAL	OFFICE OR SINGLE STAT	FE AGENCY	
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Part 2. Facility is not Eligible			IPLIANCE WITH CI TTS ACT:	WIL	 Statement of Finance Ownership/Control Both of the Above : 	Interest Disclosure Stmt (HCFA-15	13)
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	24. LTC AGREEME	NT	26. TERMINATION ACTION:	(L30))
OF PARTICIPATION 01/01/1975	BEGINNING	DATE	ENDING DATE		<u>VOLUNTARY</u> <u>0</u> 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme	05-Fail to Meet F	Health/Safety
(L24) 25. LTC EXTENSION DATE: (L27)	(L41) 27. ALTERNATIVI A. Suspension o B. Rescind Sus	of Admissions:	(L25) (L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	ent 06-Fail to Meet A <u>OTHER</u> 07-Provider Stat 00-Active	-
28. TERMINATION DATE:	20	. INTERMEDIARY/C	(L45)		30. REMARKS		
2. TEMINUTORDALE.	(L28)		. addin 100.	(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (OF APPROVAL DAT	Е	Posted 05/20/2016 Co.		
	(L32)			(L33)	DETERMINATION APPRO	OVAL	

CENTERS FOR MEDICARE & MEDICAID SERVICES

		ICARE/MEDICA I - TO BE COM						ID: SLSD Facility ID: 00733
1. MEDICARE/MEDICAID PROVIDER N (L1) 24E117 2.STATE VENDOR OR MEDICAID NO. (L2) 836420100	чЮ.	3. NAME AND ADI (L3) THE VILLA. (L4) 501 SECOND (L5) OSSEO, MN	AT OSSEO		(L6)	55369	 TYPE OF ACTION Initial Termination Validation 	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OW (L9)	NERSHIP	7. PROVIDER/SUP 01 Hospital	PPLIER CATEGORY 05 HHA	09 ESRD	<u>10</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit 8. Full Survey After (9. Other Complaint
6. DATE OF SURVEY 02/26 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	5/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDIN	G DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF	19 SNF	B. Not in Com	ce With quirements	'aivers:	2. Techn 3. 24 Hi 4. 7-Da 5. Life s	nical Personnel our RN y RN (Rural SNF) Safety Code A1* EETS	Following Requirements: 6. Scope of Ser 7. Medical Diro 8. Patient Room 9. Beds/Room (L12) (L15)	ector
(L37) (L38)	115 (L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARI	KS (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURV	YEY AGENCY APP	PROVAL	Date:
Christine Bodick-No			03/26/2015	(L19)			Forcement Spec	cialist 03/30/2015 (L20)
 DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Par 2. Facility is not Eligible 	Y		D BY HCFA RE		21. 1. S 2. O	tatement of Financia	al Solvency (HCFA-2572) nterest Disclosure Stmt (HC	FA-1513)
22. ORIGINAL DATE OF PARTICIPATION 01/01/1975	23. LTC AGREEM BEGINNING		4. LTC AGREEMEN ENDING DATE	ΝT	26. TERMINAT VOLUNTARY 01-Merger, Closur	00		(L30) <u>NTARY</u> Meet Health/Safety
(L24) 25. LTC EXTENSION DATE:	(L41) 27. ALTERNATIV	E SANCTIONS	(L25)		-	W/ Reimbursemen		Meet Agreement
(L27)	A. Suspension		(L44)		04-Other Reason fi	or Withdrawal		er Status Change
	B. Rescind Sus		(1.45)					
28. TERMINATION DATE:		. INTERMEDIARY/C	(L45) ARRIER NO.		30. REMARKS			
28. TERMINATION DATE:		. INTERMEDIARY/C.		(L31)	30. REMARKS			
28. TERMINATION DATE: 31. RO RECEIPT OF CMS-1539	29 (L28)	. INTERMEDIARY/C.	ARRIER NO.		30. REMARKS			

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDIC	ARE/M	EDICAID	CERTIF	ICATION	AND	FRANS	AITTAL
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ID: SLSD

					ND TRANSMITTAL E SURVEY AGENCY	Facility ID: 00733
1. MEDICARE/MEDICAID PROVIDER (L1) 24E117 2.STATE VENDOR OR MEDICAID NO (L2) 836420100		3. NAME AND AD (L3) THE VILLA (L4) 501 SECONE (L5) OSSEO, MN	AT OSSEO) STREET SOUT		(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
5. EFFECTIVE DATE CHANGE OF OV (L9)	VNERSHIP	7. PROVIDER/SUB 01 Hospital	PLIER CATEGOR	9 ESRD	<u>10</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 02/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 ΛΟΛ 3 Other 3 Other	. (L34)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	05 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (1.35) 12/31
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14. LTC CERTIFIED BED BREAKDOW					15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF 115	ICF	ID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
17. SURVEYOR SIGNATURE			03/26/2015 D BY HCFA RI	(L19) EGIONAL	18. STATE SURVEY AGENCY AP Kate Johns Ton, En OFFICE OR SINGLE STAT	forcement Specialist 03/30/2015
DETERMINATION OF ELIGIBILIT 1. Facility is Eligible to Pa 2. Facility is not Eligible			PLIANCE WITH C FIS ACT:	IVIL		al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA-1513)
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OF PARTICIPATION 01/01/1975	BEGINNING	DATE	ENDING DATI	E .	VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursemen	05-Fail to Meet Health/Safety
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	D. Roberta dad		(L45)			
28. TERMINATION DATE:	29	INTERMEDIARY/C	ARRIER NO.		30. REMARKS	
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31. RO RECEIPT OF CMS-1539	,	DETERMINATION				1 20
	(L32)	7-6-0		(L33)	DETERMINATION APPRO	VAL VIJQ



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 0470 0000 5262 1345 March 11, 2015

Mr. Michael Marchant, Administrator The Villa At Osseo 501 Second Street Southeast Osseo, Minnesota 55369

RE: Project Number SE117024

Dear Mr. Marchant:

On February 26, 2015, 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 attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - 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;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - 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 a "F" tag), i.e., the plan of correction should be directed to:

Jessica Sellner, Unit Supervisor Minnesota Department of Health 3333 West Division, #212 St. Cloud, Minnesota 56301 Telephone: (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 April 7, 2015, 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 April 7, 2015 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,
- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved

The Villa At Osseo March 11, 2015 Page 4 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 May 26, 2015 (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 August 26, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is

The Villa At Osseo March 11, 2015 Page 5

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 a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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,

ate Comston

Kate Johnston, Program Specialist Licensing and Certification Program Health Regulations Division Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File

STATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION RECEIVED	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		24E117	B. WING	MAR 2 3 2015	00/00/0045
NAME OF F	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	02/26/2015
	A AT OSSEO		50	1 SECOND STREET SOUTHEAST SSEO, MN 55369 MN Dept of Health St.Cloud	
(X4) ID PREFIX TAG	EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 221 SS=D	as your allegation of Department's accept bottom of the first pa be used as verification Upon receipt of an ac revisit of your facility that substantial comp has been attained in verification. 483.13(a) RIGHT TO PHYSICAL RESTRA The resident has the physical restraints im	correction (POC) will serve compliance upon the tance. Your signature at the ge of the CMS-2567 form will on of compliance. cceptable POC an on-site will be conducted to validate bliance with the regulations accordance with your BE FREE FROM	F 000	The Villa at Osseo objects to and disagrees with both the findings noncompliance and the level of th deficiency cited. Submission of the Credible Allegation of Compliance is not a Legal admission that the deficiency exists or that the Statements of Deficiency were correctly cited. It is also not to be construed as an admission against the interests of the Facility, its Administrator or any employees, agents or other individuals who may be discussed in the Credible Allegation of Compliance .	/
t I I I I I I I I I I I I I I I I I I I	reat the resident's me This REQUIREMENT by: Based on observation eview, the facility faile estraints were adequa the least restrictive de estidents medial symp (81) reviewed who w indings include: 81's History and Physi entified R81 had diag late stage Alzheimer 81's quarterly Minimu 15/15, identified R81 pairment, required estimation	edical symptoms. is not met as evidenced n, interview, and document ed to ensure physical ately assessed to ensure vice was used to treat the toms for 1 of 1 residents as using restraints.		The facility does attempt to keep residents free of any physical restraints. Restraints are not imposed for the purposes of discipline or convenience. The restraints are used only as an intervention to treat the residents medical symptoms.	ioved 3) John Shan

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.

IDENTIFICATION NUMBER: A. BUILDING COMPLETED 24E117 B. WING 02/26/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE THE VILLA AT OSSEO 501 SECOND STREET SOUTHEAST (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE DEFICIENCIES PROVIDER'S PLAN OF CORRECTION	CENTE	RS FOR MEDICARE &	ND HUMAN SERVICES					0RM APPROV NO. 0938-03
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CALL OSSED, NN 55369 CALL SUMARY STREMENT OF DEFICIENCIES EACH DEFICIENCY AND TE OF DEFICIENCIES ACH DEFICIENCY AND TE OF DEFICIENCY ACH DEFICIENC ACH DEFICIENCY ACH DEFICIENCY A	NAME OF F	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	1	02/20/2015
OSECO, NN 55369 OVAID PREFX TAG SUMMARY STATEMENT OF DEFIDENCIES (EACH DERIDENCY MUST BE PRECEDED BY INLL PRECULTORY OR LSD IDENTIFYING INFORMATION) DD PREFX (EACH DERIDENCY MUST BE PRECEDED BY INLL PRECULTORY OR LSD IDENTIFYING INFORMATION) DD PREFX (EACH DERIDENCY (EACH DERIDENCY MUST REPRECEDED BY INLL PRECULTORY OR LSD IDENTIFYING INFORMATION) DD PREFX (EACH DERIDENCY (EACH DERIDENCY MUST REPRECEDED BY INLL PRECULTORY OR LSD IDENTIFYING INFORMATION) DD PREFX (EACH DERIDENCY (EACH DERIDENCY MUST REPRECEDED BY INLL PRECULTORY OR LSD IDENTIFYING INFORMATION) DD PREFX (EACH DERIDENCY (EACH DERIDENCY MUST REPRECEDED BY INLL PRECULTORY OR LSD IDENTIFYING INFORMATION) DD PREFX (EACH DERIDENCY (EACH DERIDENCY MUST REPRECEDED BY INLL PRECULTORY OR LSD IDENTIFYING INFORMATION) DD PREFX (EACH DERIDENCY (EACH DERIDENCY MUST AND PRICED BY INLL PRECULTORY OR LSD IDENTIFYING INFORMATION) DD PREFX (EACH DERIDENCY INLL PRECULTORY OR LSD IDENTIFYING INFORMATION) DD PREFX (EACH DERIDENCY INTEGED BY (EACH DERIDENCY INTEGED AND INFORMATION) DD PREFX (EACH DERIDENCY INFORMATION) DD PREFX (EACH DERIDENCY INFORMATION) DD PREFX (EACH DERIDENCY INFORMATION) DD PREFX (EACH DERIDENCY INFORMATION (EACH DERIDENCY INFORMATION) DD PREFX (EACH DERIDENCY INFORMATION) DD PREFX (EACH DERIDENCY INFORMATION) DD PREFX (EACH DERIDENCY INFORMATION) DD PREFX (EACH DERIDENCY INFORMATION INFORMATION) DD PREFX (EACH DERIDENCY INFORMATION INFORMATION INFORMATION INFORMATION INFORM	THE VILL	A AT OSSEO			501	SECOND STREET SOUTHEAST		
PHEERX CACH CORPORTING AND SHOULD BE CROSS AREPROCED TO X ATOM SHOULD BE ADDED TO X ATOM SHOULD BE ADDED AT					oss	EO, MN 55369		
 which was used to prevent rising. R81's care plan dated 8/21/14, identified risk of fails related to dementia, balance/transfer implement. lack of understanding instructions, and poor judgment. The care plan identified when the resident was up and not in direct supervision of staff, R81 should be using a lap buddy (a seatbelt like strap to hold a resident in the wheelchair) and anti-tip bars and anti-roliback bars on the wheelchair. The care plan also indicated R81 was required to wear two lap buddy son as well as because she liked to rook back and forth while having the two lap buddy for as well as because she could remove just one lap buddy and would try to stand up on her own. R81's current physician orders dated 2/15, indicated R81 was able to use two lap buddies to prevent the resident from removing the restraint, as well as to prevent ther form standing up and taking the wheelchair, however, within a week of being admitted, R81 was given a wheelchair. A Consent For Physical Restraints Form dated 6/20/14, indicated the restraints (fite 2 lap buddy dides) were needed for safety related to a lack of safety awareness, poor judgment, gait mobalance, inpulsiveness, and inability to follow directions to stay seated. R81's quarterly Physical Restraint Assessment R81's quarterly Physical Restraint Assessment 	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	×	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	BE	COMPLETIO
of safety awareness, poor judgment, gait F221. (Completed by the imbalance, impulsiveness, and inability to follow DON/Designee 03/30/2015). directions to stay seated. R81's quarterly Physical Restraint Assessment	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	which was used to pre- R81's care plan dated falls related to dement impairment, lack of un and poor judgment. The the resident was up ar of staff, R81 should be seatbelt like strap to he wheelchair) and anti-tij bars on the wheelchair indicated R81 was req buddies while in the wh to rock back and forth buddy's on, as well as just one lap buddy and her own. R81's current physiciar indicated R81 was able prevent the resident fro as well as to prevent he taking the wheelchair w During interview on 2/2. (F)-A stated when R81 was walking on her own wheelchair, however, w admitted, R81 was give A Consent For Physical 5/20/14, indicated the re- ouddies) were needed for	8/21/14, identified risk of ia, balance/transfer derstanding instructions, he care plan identified when hd not in direct supervision e using a lap buddy (a bld a resident in the b bars and anti-rollback . The care plan also uired to wear two lap heelchair because she liked while having the two lap because she could remove would try to stand up on a orders dated 2/15, to use two lap buddies to m removing the restraint, er from standing up and ith her. 4/15, at 10:24 a.m. family entered the facility she a and did not use a ithin a week of being in a wheelchair. Restraints Form dated estraints (the 2 lap or safety related to a lack	F2	221	 the use of the lap buddy and a reduction attempt has been implemented. MD, Family and therapy have been consulted and Plan of Care for the resident has been updated and reviewed. The resident #81 has suffered no adverse effects as a result of the use of the lap buddy. (Completed by the Director of Nursing, DON 03/23/2015). All Residents in the facility with restraint type devices have been re assessed to ensure that the device is the least restrictive intervention. The MD, Family and the Plan of Care for the identified residents has been reviewed and updated. (Completed by the DON and the Interdisciplinary Team 03/23/2015). The risk and benefit of the devices utilized will be reviewed with the Family, resident or Guardian of the identified residents. (Completed by the DON 03/23/2015). Staff educated on the Policy and 		
R81's quarterly Physical Restraint Assessment	o ir	if safety awareness, po nbalance, impulsivenes	or judgment, gait ss, and inability to follow			F221. (Completed by the		
	R	81's quarterly Physical	Restraint Assessment	DERMISTANE PERSONNEL UND A 2017				

Facility ID: 00733

If continuation sheet Page 2 of 40

PRINTED: 03/11/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 24E117 B. WING 02/26/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **501 SECOND STREET SOUTHEAST** THE VILLA AT OSSEO **OSSEO, MN 55369** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 221 Continued From page 2 F 221 5.) Random Audits of the residents behavior such as being impulsive, lack of safety utilizing restraint type devices to be awareness in the surroundings, walking and done to ensure appropriateness of standing independently, and trying to stand in the use, application, and release. (wheelchair. The assessment noted R81 liked to Completed by the DON or rock herself back and forth with the two lap Designee, 03/30/2015). buddies on, and when using the two lap buddies they prevented her from trying to stand up in the 6.) QAA (Quality Assurance) to wheelchair. review the audits of the restraint type devices. QAA will identify During observation on 2/23/14, at 5:18 p.m. R81 trends, make recommendations was in the hallway walking and wandering into and ensure ongoing compliance other residents' rooms. NA-B directed R81 to her with F221. (To be completed by wheelchair and applied the two lap buddies to the QAA Committee and the R81. NA-B stated R81 often tried to get up and Nursing home Administrator, NHA run when she was in her wheelchair. R81 03/30/2015). continued to try to stand up at 5:21 p.m., 5:22 p.m., and 5:23 p.m. The two lap buddies kept R81 restrained in the wheelchair, and when R81 was trying to stand up she was able to lift the wheelchair off the ground with her. At approximately 5:25 p.m., the director of nursing (DON) approached R81 and attempted to redirect the resident and took her for a ride in her wheelchair. During observation on 2/25/15, at 7:47 a.m. nursing assistant (NA)-D and NA-E were getting R81 out of bed and dressed for the day. After washing R81 in bed they placed the resident in her wheelchair. NA-D and NA-E needed to apply force to R81's shoulders to get her to sit down into the wheelchair. After the first lap buddy was applied, R81 attempted to stand up from the wheelchair and got to nearly a full standing position before she was redirected to sit back down. NA-D and NA-E then quickly applied the second lap buddy to R81 to restrain her in the wheelchair.

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00733

If continuation sheet Page 3 of 40

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	ED: 03/11/2015 MAPPROVED O. 0938-0391
TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		ECONSTRUCTION	(X3) DAT	E SURVEY PLETED
		24E117	B. WING			02	/26/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 221	wheelchair into the dir breakfast by the DON. in her wheelchair by th	m. R81 was pushed in her ning room to a table for . R81 remained restrained	F 2	221			
	stated R81 had two lap otherwise she would w didn't know what she v walking. NA-D stated F would frequently get up and start walking her a stated when R81 was	valk around on her own and was doing when she was R81 was very strong and p out of bed on her own around her room. NA-D observed trying to get out the staff would try to take			-		
	lap buddies were used resident was first admit around and bump into t	e (LPN)-C stated the two for R81 because when the					
	R81 had not had any fa not exhibited agitated b oss of balance while st	t dated 5/14/14, indicated alls since admission, had behavior but did have a anding, and required move from place to place.					
F a t	R81 was in and out of h about her room. R81 wa	as assisted to the movement, was directed					
F	Incident Progress No	ote date 6/1/14, indicated			nagen noon oan turnen er de tot terren au opertoisken oan aan aan aan de seren seren beken seren kan de seren u		

Facility ID: 00733

If continuation sheet Page 4 of 40

PRINTED: 03/11/2015

DB_PLANDE CORRECTION DEMINFICATION NUMBER: A. BUILDING COMPLETED 24E117 8. WING 01/20/20/2016 IMME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STARE, ZP CODE STREET ADDRESS, CITY, STARE, ZP CODE STREET ADDRESS, CITY, STARE, ZP CODE VALUE VILLA AT OSSED STREET ADDRESS, CITY, STARE, ZP CODE STREET ADDRESS, CITY, STARE, ZP CODE STREET ADDRESS, CITY, STARE, ZP CODE VALUE VILLA AT OSSED STREET ADDRESS, CITY, STARE, ZP CODE TAX REGULATORY OR LSC IDENTIFIES BY FULL PREFX, TXG REGULATORY OR LSC IDENTIFIES BY FULL TXG PREFX, REGULATORY OR LSC IDENTIFIES BY FULL TXG PREFX, TXG F 221 Continued From page 4 R81 Had missed the wheelchair in the dining room while trying to STREAM TO THE form after eating. The note identified R81 appeared confused but was not injured. F 221 A Care Conference Note dated 6/20/14, identified R81 had been waking in her room when she lost her balance, when Fetch. No lightes were noted. The Progress Note dated 6/20/14, identified R81 had been waking in her room when she lost her balance, she ad adgross of demendied ther was unable to follow directions A Behavior Progress Note dated 7/6/14, indicated R81 was in the wheelchair because R81 lacked safety awareness, had a dignosis of demendied, and was unable to follow directions A Behavior Progress Note dated 7/20/14, idmetified R81 had neen waking out into the nail and times each evening and R81 sensed to being and tup while in wreachair. An antidepressent medication was given to the resident, and R81 was noted to	NAME OF PROVIDER OR SUPPLER Image: the image: t								<u>IO. 0938-0391</u>
MAKE OF PROVIDER OR SUPPLIER STREET ADDRESS, GITV, STATE, ZP CODE THE VILLA AT OSSEO SIRVET ADDRESS, GITV, STATE, ZP CODE PREFX SIRVET ADDRESS, GITV, STATE, ZP CODE PREFX BANMARY STATEMENT OF DEFRICICUES TAG SUMMARY STATEMENT OF DEFRICICUES PREFX BACH EXERCISION WIGHT BE RECEIPED BY FULL RECOLLATORY OR LSC IDENTIFYING INFORMATION TAG PROVIDERS PLAN OF CORRECTION RECOLLATORY OR LSC IDENTIFYING INFORMATION F 221 Confinued From page 4 RS1 had missed the wheelchair in the dining room while trying to sit down, and sato in the floor after eating. The note identified RS1 appeared confised but was not injured. A Care Conference Note dated 6/20/14, identified RS1 had been walking in her room when she lost her balance, tired to correct herself, but stumbled over her fets. No injuries were noted. The Progress Note dated 7/6/14, indicated RS1 had been walking in her room when she lost her balance, tired to correct herself, but stumbled where for a lap buddy when RS1 was in the wheelchair because RS1 lacked safety awareness, had a diagnosis of domentia, and was unable to follow directions A Behavior Progress Note dated 7/6/14, indicated RS1 had been wandering into ther resident's rooms, and staff had taken her or walks several times each evening and RS1 seemed to enjoy the activity and interaction. On 71/9/14, a Behavior Progress Note indicated RS1 was in the wheelchair with a lap buddy in place and was trying to take it off and stand up while in wheelchair an antindepressant medication was given to the resident RS	MAKE OF PROVIDER OR SUPPLIER STREET ADDRESS. GITY, STATE, ZP COOE 91 SECOND STREET SOUTHEAST THE VILLA AT OSSEO SUMMARY STATEMENT OF DEPOINTERS DSSEO, MM SSS9 DSSEO, MM SSS9 TAG SUMMARY STATEMENT OF DEPOINTERS PROVIDERS, CITY, STATE, ZP COOE SSEO, MM SSS9 DSSEO, MM SSSS9 DSSEO, MM SSS9 DSSEO			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					
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R81 had missed the wheelchair in the dining room while trying to sit down, and sat on the floor after eating. The note identified R81 appeared confused but was not injured. A Care Conference Note dated 6/4/14, indicated R81 was at moderate risk for falls and walked with supervision. An Incident Progress Note dated 6/20/14, identified R81 had been walking in her room when she lost there balance, tried to correct herself, but stumbled over her feet. No injuries were noted. The Progress note identified the facility received orders for a lap buddy when R81 was unable to follow directions A Behavior Progress Note dated 7/6/14, indicated R81 had been wandering into other resident's rooms, and staff had taken her for walks several times each evening and R81 secmed to enjoy the activity and interaction. On 7/19/14, a Behavior Progress Note indicated R81 was in the wheelchair with a lap buddy in place and was trying to take it off and stand up while in wheelchair. An antidepressant medication was given to the resident, and R81 was noted to be calmer afterward and was assisted to bed. A Behavior Progress Note dated 7/20/14, identified R81 was walking out into the hall and she was assisted to the wheelchair but was noted to be calmer afterward and was assisted to bed.	R81 had missed the wheelchair in the dining room while trying to sit down, and sat on the floor after eating. The note identified R81 appeared confused but was not injured. A Care Conference Note dated 6/4/14, indicated R81 was at moderate risk for falls and walked with supervision. An Incident Progress Note dated 6/20/14, identified R81 had been walking in her room when she lost there balance, tried to correct herself, but stumbled over her feet. No injuries were noted. The Progress note identified the facility received orders for a lap buddy when R81 was unable to follow directions A Behavior Progress Note dated 7/6/14, indicated R81 had been wandering into other resident's rooms, and staff had taken her for walks several times each evening and R81 secmed to enjoy the activity and interaction. On 7/19/14, a Behavior Progress Note indicated R81 was in the wheelchair with a lap buddy in place and was trying to take it off and stand up while in wheelchair. An antidepressant medication was given to the resident, and R81 was noted to be calmer afterward and was assisted to bed. A Behavior Progress Note dated 7/20/14, identified R81 was walking out into the hall and she was assisted to the wheelchair but was noted to be calmer afterward and was assisted to bed.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF	D BE	COMPLETION
given with, "Some relief."			R81 had missed the w room while trying to si after eating. The note confused but was not A Care Conference No R81 was at moderate with supervision. An Incident Progress N identified R81 had bee when she lost her bala herself, but stumbled of were noted. The Progr facility received orders was in the wheelchair I awareness, had a diag was unable to follow di A Behavior Progress N R81 had been wanderi rooms, and staff had ta times each evening and activity and interaction. On 7/19/14, a Behavior R81 was in the wheelch place and was trying to while in wheelchair. An was given to the reside the calmer afterward and A Behavior Progress No dentified R81 was walk she was assisted to the stand up, so an antidep	Wheelchair in the dining t down, and sat on the floor identified R81 appeared injured. Dete dated 6/4/14, indicated risk for falls and walked Note dated 6/20/14, en walking in her room nace, tried to correct over her feet. No injuries ess note identified the for a lap buddy when R81 because R81 lacked safety nosis of dementia, and rections ote dated 7/6/14, indicated ng into other resident's iken her for walks several d R81 seemed to enjoy the Progress Note indicated hair with a lap buddy in take it off and stand up antidepressant medication int, and R81 was noted to d was assisted to bed. Dete dated 7/20/14, ing out into the hall and wheelchair but tried to ressant medication was	F	221			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: SLSD11

Facility ID: 00733

If continuation sheet Page 5 of 40

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA	NO. 0938-0391 ATE SURVEY MPLETED
		24E117	B. WING			
NAME OF F	ROVIDER OR SUPPLIER		T	STREET ADDRESS, CITY, STATE, ZIP (2/26/2015
THE VILL	A AT OSSEO			501 SECOND STREET SOUTHEAST OSSEO, MN 55369		
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F 221	started walking down redirected and escort followed by assistanc placed into her wheel	e 5 rself up out of bed and the hall and she was quickly ed by a NA for exercise e to the toilet. R81 was then chair, the lap buddies were wed no further signs of	F 2:	21		
	had demonstrated son taken off the single lap had also been standir wheelchair attached to of the shift. A Progress Note dated	d 11/19/14, indicated R81 me increased agitation, had b buddy and thrown it, and ig and walking with the b her by the lap buddy most d 12/8/14, identified the ck lap buddy on R81's				
	wheelchair and in its p thinner lap buddies on maintain R81's safety	lace, the nurse applied two the wheelchair to help while in the wheelchair.				
1	and wanted to stand u forward and lifting the l the ground while walkin	te restless during the day p, and had been leaning back of the wheelchair off ng the chair along. The n alternative chair to make				
i c	A Physician progress n ndicated R81 had bee	ote dated 1/27/15, n constantly trying to get s lifting the entire chair				
[During interview on 2/2 DON stated R81 was n he needed to be restra	5/15, at 1:05 p.m. the ot steady on her feet so ained in a wheelchair. The				

If continuation sheet Page 6 of 40

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TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	(X3) DA	NO. 0938-039 ITE SURVEY MPLETED
	24E117	B. WING			2/26/2015
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		2/20/2015
THE VILLA AT OSSEO			501 SECOND STREET SOUTHEAST OSSEO, MN 55369		
PREFIX (EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
therapy had tried a wheelchair) and of R81 still wanted to and walk. The DO buddy was therape to rock back and fo verified R81 was s with the two lap bud During interview or therapy assistant (completed a scree could walk and felt benefited from som however, the family therapy services so During observation was observed to ha able to stand and w attached to her. LP second lap buddy to still attempting to ge wheelchair attached During interview on and NA-C stated R8 grabbing at people a around when not res They stated the lap R81 if she was unsu to attempt to stand w buddies, however, it	sit everywhere. Additionally, a Geri chair (a reclining her thicker lap buddies, but get up out of the wheelchair N believed adding a second lap putic to R81 because she liked rth with it, however, the DON ill trying to get up and walk ddies in place. 2/25/15, at 1:53 p.m. physical PTA)-A stated she had hing of R81. PTA-A stated R81 the resident would have e physical conditioning, did not want to pay for nothing further was done. on 2/26/15, at 8:42 a.m. R81 ve one lap buddy on and was alk with the wheelchair N-A and NA-C applied the b R81, and the resident was it up and walk with the to her. 2/26/15, at 8:42 a.m. LPN-A 1 had behaviors such as and things, and wandering trained in her wheelchair. buddies were not safe for pervised, and R81 continued vith the use of the lap was less than before when ed with two of the lap	F 22			

Facility ID: 00733

If continuation sheet Page 7 of 40

		MEDICAID SERVICES				OMB	<u>IO. 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI				TE SURVEY MPLETED
		24E117	B. WING			0	2/26/2015
	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST OSSEO, MN 55369		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
	environment was over when R81 was down working one on one a quiet, she was calm. (made the decision to a time, and nursing had not restrained in the w to get up and walk on needed heavy staff su balance and safety aw was not aware of any reduce or remove the used. During interview on 2/2 medication assistant (ability to walk, but nee wheelchair because sh on her own. During interview on 2/2 stated R81 was able to own, and she had see wheelchair while attern lap buddies on restrain TMA-B stated R81 was believed R81 got agita	to get up and walk when the r stimulating. OT-A stated in the therapy department nd the environment was DT-A identified nursing had apply two lap buddies at a stated R81 was unsafe if wheelchair because she tried her own. OT-A stated R81 pervision, and R81's vareness was poor. OT-A plans to try and attempt to current restraints being 26/15, at 9:33 a.m. trained TMA)-A stated R81 had the ded to be restrained in her ne would get up and walk 26/15, at 9:44 a.m. TMA-B o get up and walk on her n R81 carrying her pting to walk with the two ing her in the wheelchair.	F	22-	1		
i \ t t	a.m. DON stated she fe were the least restrictiv for R81. The DON state medical symptom the th reating, however, they R81 from falling. The D	e restraint option available ed there wasn't a particular					

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Facility ID: 00733

If continuation sheet Page 8 of 40

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SUI COMPLET	
		24E117	B. WING _		02/26/	2015
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		2013
	A AT OSSEO			501 SECOND STREET SOUTHEAST OSSEO, MN 55369		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	I	PROVIDER'S PLAN OF CORF	PECTION	0.00
PRÉFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		HOULD BE CO	(X5) DMPLETION DATE
F 221	Continued From page	8	F 2:	21		
	they needed to leave		F 2.			
	resident or R81 would	be up and walking around				
	the dining room. The I	DON stated there was no				
		pt to reduce or remove the				
	restraints, and the DON was aware R81 still tried to stand with the two lap buddies in place, but not					
	as often as before when there was only one lap					
	buddy restraining R81	in the wheelchair.				
	During interview on 2/	26/15 of 11:00 a m tha				
	During interview on 2/26/15, at 11:08 a.m. the medical director stated he was aware R81 could					
	stand up even with the two lap buddies in place					
	and try to walk, however, he felt she tried less to					
	stand up less with two one.	lap buddies applied vs				
	The facility policy titled	Safety Devices dated				
	3/2/06, indicated the sa	afety of all residents should				
	be maintained using th	e least restrictive devices.				,
F 282	483.20(k)(3)(ii) SERVI	CES BY QUALIFIED	F 28	2 F282	Ш	7/1-
SS=D	PERSONS/PER CARE	E PLAN			171	ן ציוו
	The services provided	or arranged by the facility				
	must be provided by qu	ualified persons in		The facility does attempt to fo	ollow	
		resident's written plan of		the individual Plan of Care. T		
1	care.			facility also provides services	by	
				qualified persons in accordan		
		is not met as evidenced		with each resident written Pla Care.	in of	
	by: Based on choon ation	Interview				
l r	eview, the facility failed	interview, and document d to follow the individual		1.) The Plan of Care for	or the	
ļ	plan of care related to r	emoving a restraint while		Resident #81 has been review		
1	under direct staff obser	vation for 1 of 1 residents		and updated. The resident han no adverse effects as a result	1	
1	(R81) reviewed with res	straints.				
(Lap Buddy and the observatio	יח ו	1
(Findings include:			Lap Buddy and the observatio identified in the Statement of		

Facility ID: 00733

If continuation sheet Page 9 of 40

STATEMENT	AS FOR MEDICARE & MEDICAID SERVICES		(X2) MULTI	PLE CONSTRUCTION		NO. 0938-03 ATE SURVEY
IND FLAN O	FURRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	COMPLETED	
		24E117	B. WING			2/26/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		2.20.2013
THE VILL	A AT OSSEO			501 SECOND STREET SOUTHEAST OSSEO, MN 55369		
(X4) ID PREFIX TAG	EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC	OULD BE	(X5) COMPLETIC DATE
t t t t t t t t t t t t t t t t t t t	R81 had diagnoses and depression. The quarterly Minim 1/15/15, identified R impaired, required e eating, and was usir used to prevent risin R81's care plan date falls related to deme impairment, lack of u and poor judgment. The resident was up i direct supervision of lap buddy (a seatbelf in the wheelchair) an anti-rollback bars on plan also indicated R lap buddies while in t liked to rock back and lap buddy's on, as we remove just one lap b up on her own. On 2/25/15 at 8:26 a. the dining room in her buddies on, one around around the lower torse wheelchair. R81 was and NA-E sat down an a.m. Although R81 w upervision while bein emained restrained ir During interview on 2/	including Alzheimer's disease um Data Set (MDS) dated 81 was severely cognitively xtensive assistance with g a chair restraint which was g. d 8/21/14, identified risk of ntia, balance/transfer understanding instructions, The care plan identified when n the wheelchair and not in staff, R81 should be using a like strap to hold a resident d anti-tip bars and the wheelchair. The care 81 was required to wear two he wheelchair because she d forth while having the two ell as because she could buddy and would try to stand m., R81 was brought into r wheelchair and had two lap nd her upper torso, and one p, restraining her into the brought to the dining table, nd fed R81 her meal at 8:47 as under constant staff ig fed by NA-E, R81 n the wheelchair.	F 28	 Deficiency. (Completed by the I 03/30/2015). 2.) The Plans of Care for other resident that may utilize a restraint type device has been reviewed and updated. The Residents have all been re-asses for a reduction. (Completed by the DON and Designee 03/30/2015). 3.) Resident Plans of Carr for the identified residents will b reviewed on a quarterly basis an as needed. (Completed by the DON, and the MDS Coordinator 03/30/2015). 4.) The staff will be educated on the policy and the regulations associated with F282 (Completed by the DON 03/30/2015). 5.) Random Audits of the Care Plans for Residents using Restraint type devices will be dor The implementation of the interventions identified in the Plan of Care to be validated includes t release of restraint type devices. (Completed by the DON or designee 03/30/2015). 	any sed e e d	
s b	tated R81 had two la ecause she would wa	25/15 at 12:35 p.m., NA-D p buddies on to restrain her alk around on her own and ned for her safety. NA-D				

Facility ID: 00733

If continuation sheet Page 10 of 40

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED
		24E117	B. WING			2/26/2015
NAME OF F	ROVIDER OR SUPPLIER					2/20/2013
THE VILL	A AT OSSEO			501 SECOND STREET SOUTHEAST		
				OSSEO, MN 55369		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 282 [.]	Continued From page	10	F 28	32		
	attempt to get out of h if staff noted the reside to get out of the wheel for a walk to calm her helpful. During interview on 2/2 director of nursing (DC in direct staff supervisi will leave the restraints up walking around the the care plan instructed restraints when R81 w supervision.	er wheelchair. NA-D stated ent was restless and trying Ichair, staff would take her down, which was usually 26/15, at 10:29 a.m. 20/15,		6.) Care Plan Aud reviewed by the QAA co identify trends, make recommendations and t ongoing compliance with (Completed by the QAA and the NHA 03/30/201	mmittee to o ensure n F 282. Committee	
F 323	483.25(h) FREE OF AC HAZARDS/SUPERVIS	er, none was provided. CCIDENT	F 32	3		4/7/15
	as is possible; and eac adequate supervision a prevent accidents.	s free of accident hazards h resident receives and assistance devices to		F323 The facility does attemp that the resident enviror remains as free of accide as is possible and each re receives adequate super assistance devices to pre- accidents.	nment ent Hazards esident vision and	
	review the facility failed	interview, and document to ensure a wheelchair was adequately assessed 1 resident (R81) who				

Facility ID: 00733

If continuation sheet Page 11 of 40

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

ND PLAN C	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		<u>3 NO. 0938-03</u> DATE SURVEY COMPLETED
		24E117	B. WING			02/26/2045
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	02/26/2015
THE VILL	A AT OSSEO			501 SECOND STREET SOUTHE		
				OSSEO, MN 55369		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	iD PREFI; TAG	K (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETIO DATE
F 323	Continued From page	a 11				
	e en andea i ronn page		F 3	323		
	stare Alzhoimor's dia	ncluding moderate to late		1.) Reside	nt # R81 has been	
:	R81's quarterly Minim	ease and depression. Jum Data set (MDS) dated		re- assessed for th		
	1/15/15, identified PR	1 had severe cognitive		Buddy. The resid		
	impairment required	extensive assistance with		Plan of care review		
	activities of daily living	and had a chair restraint		The resident has b		
	activities of daily living, and had a chair restraint which was used to prevent rising.			therapy (OT). All	· · ·	
		e e e e e e e e e e e e e e e e e e e		interventions have		
	R81's care plan dated	8/21/14, identified risk of		The resident has n		
	falls related to demen	tia, balance/transfer		as a result of the i		
	impairment, lack of un	derstanding instructions.		the Lap Buddy.		
	and poor judgment. Th	ne care plan identified when		the DON 03/30/20		
	the resident was up ar	nd not in direct supervision			dents in the	
	of staff, R81 should be	e using a lap buddy (a		facility utilizing res		
	seatbelt like strap to h	old a resident in the		devices have been		
	wheelchair) and anti-ti	p bars and anti-rollback		the Plan of Care ha	as been reviewed	
	bars on the wheelchair	 The care plan also 		and updated. Red	luction attempts	
	indicated R81 was req	uired to wear two lap		have been trialed f		
	buddles while in the wi	neelchair because she liked		appropriately iden	tified residents. (
	buddy's on as well as	while having the two lap		Completed by the	DON	
	iust one lan huddu and	because she could remove		03/30/2015).		
1	her own.	would try to stand up on			members/	
'				Guardians of identi	ified residents	
F	R81's current physiciar	Orders dated 2/2015		who are utilizing a	<i>n</i> -	
i	ndicated R81 was able	e to use two lap buddies to		device will have the		
r	prevent the resident fro	m removing the restraint,		benefits of the devi		
a	as well as to prevent he	er from standing up and		(Completed by the		
t	aking the wheelchair w	vith her.		Designee 03/30/20		
					be educated on	
C	Ouring interview on 2/2	4/15, at 10:24 a.m. family		the resident safety		
(1	F)-A stated when R81	entered the facility she		implementation of		
W	/as walking on her owr	and did not use a		devices. (Complete	ed by the DON	
W	/heelchair, however, w	ithin a week of being		03/30/2015).	A	
a	dmitted, R81 was give	n a wheelchair.		5.) Random Residents utilizing r	Audits of estraint type	
A	Consent For Physical /20/14, indicated the re	Restraints Form dated				
	uddies) were needed f	Straints (the 2 idp				

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Facility ID: 00733

If continuation sheet Page 12 of 40

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 24E117 B. WING 02/26/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **501 SECOND STREET SOUTHEAST** THE VILLA AT OSSEO **OSSEO, MN 55369** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 323 Continued From page 12 F 323 of safety awareness, poor judgment, gait devices will be completed. (imbalance, impulsiveness, and inability to follow Completed by the DON or Designee directions to stay seated. 03/30/2015). 6.) QAA committee will During observation on 2/23/14, at 5:18 p.m. R81 review the Random Audits of the was in the hallway walking and wandering into Restraint type devices to identify other residents' rooms. NA-B directed R81 to her trends, make recommendations wheelchair and applied the two lap buddies to and ensure ongoing compliance R81. NA-B stated R81 often tried to get up and with F323. (Completed by the QAA run when she was in her wheelchair. R81 Committee and the NHA). continued to try to stand up at 5:21 p.m., 5:22 p.m., and 5:23 p.m. The two lap buddles kept R81 restrained in the wheelchair, and when R81 was trying to stand up she was able to lift the wheelchair off the ground with her. At approximately 5:25 p.m., the director of nursing (DON) approached R81 and attempted to redirect the resident and took her for a ride in her wheelchair. During observation on 2/25/15, at 7:47 a.m. nursing assistant (NA)-D and NA-E were getting R81 out of bed and dressed for the day. After washing R81 in bed they placed the resident in her wheelchair. NA-D and NA-E needed to apply force to R81's shoulders to get her to sit down into the wheelchair. After the first lap buddy was applied, R81 attempted to stand up from the wheelchair and got to nearly a full standing position before she was redirected to sit back down. NA-D and NA-E then quickly applied the second lap buddy to R81. On 2/25/15, at 8:26 a.m. R81 was pushed in her wheelchair into the dining room to a table for breakfast by the DON. R81 remained restrained in her wheelchair by the two lap buddies throughout the entire meal while being fed by NA-E.

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00733

If continuation sheet Page 13 of 40

PRINTED: 03/11/2015

	F DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION CORRECTION IDENTIFICATION NUMBER: A. BUILDING (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
		24E117	B. WING		02	/26/2015
NAME OF P	ROVIDER OR SUPPLIER	02/20/2013				
	A AT OSSEO			501 SECOND STREET SOUTHEAST OSSEO, MN 55369	г	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	. PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 323	Continued From pag	e 13	F 32	23		
	stated R81 had two I	2/25/15, at 12:35 p.m. NA-D ap buddies on because				
	she didn't know what was walking. NA-D s	walk around on her own and she was doing when she tated R81 was very strong get up out of bed on her				
	own and start walking NA-D stated when Ra get out of her chair fr	g her around her room. 81 was observed trying to equently, the staff would try				
	to take her on a walk During interview on 2 licensed practical nur					
	lap buddies were use resident was first adn	d for R81 because when the nitted, she used to walk o things, and the restraints				
	dated 2/16/15, identif	cal Restraint Assessment ied the resident had unsafe ng impulsive, lacking of				
	and standing indepen the wheelchair. The a	he surroundings, walking dently, and trying to stand in ssessment noted R81 liked				
	buddies on, and wher they prevented her fro wheelchair. The asse	nd forth with the two lap n using the two lap buddies om trying to stand up in the essment did not include any				
	information the facility the restraint in use, al	assessed R81's safety with though they were aware d up with the wheelchair still				
		prehensive Fall Risk 4/14, indicated R81 had not mission, had not exhibited				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TPLE CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
ND PLAN OF	FCORRECTION	IDENTIFICATION NUMBER:		A. BUILDING		PLETED
		24E117	B. WING _		02/	26/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
THE VILL	A AT OSSEO			501 SECOND STREET SOUTHEAST		
				OSSEO, MN 55369		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 323	Continued From page	14	F 3	22		
	to move from place to			23		
	R81 was in and out of about her room. R81	el movement, and was				
	R81 had missed the w room while trying to sit	Note date 6/1/14, indicated /heelchair in the dining t down, and sat on the floor identified R81 appeared injured.				
	A Care Conference No R81 was at moderate supervision.	ote dated 6/4/14, indicated risk for falls but walked with				
	were noted. The Prog facility received orders was in the wheelchair I	n walking in her room ince, tried to correct over her feet. No injuries ress note identified the for a lap buddy when R81 because R81 lacked safety nosis of dementia, and				
	identified R81 had tippe the lap buddy in place.	on report dated 6/21/14 ed over the wheelchair with Anti-tip and anti-rollback wheelchair. R81 did not				
i r	A Behavior Progress N indicated R81 had beer resident's rooms, and s	n wandering into other staff had taken her for				
	walks several times each seemed to enjoy the ac	ch evening and R81				

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00733

If continuation sheet Page 15 of 40

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DPLAN OF CORRECTION UMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DA	NO. 0938-0391 TE SURVEY MPLETED	
		24E117	B. WING		0	2/26/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
	A AT OSSEO			501 SECOND STREET SOUTHEAST			
				OSSEO, MN 55369			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 323	Continued From pag	ge 15	F 3:	23			
	R81 was in the whee place and was trying while in wheelchair. was given to the resise be calmer afterward A Behavior Progress identified R81 was with she was assisted to stand up, so an antio given with, "Some residentified R81 was for knees in her room an had happened. No in On 11/14/14, a Beha R81 got herself up of down the hall and she escorted by a NA for assistance to the toil her wheelchair, the la R81 showed no furth A behavior note date had demonstrated so taken off the single la had also been standi wheelchair attached of the shift.	ation report dated 7/15/14, bund getting up from her nd was unable to say what njuries were noted. wor Progress Note identified ut of bed and started walking e was quickly redirected and exercise followed by et. R81 was then placed into ap buddies were applied, and er signs of agitation. d 11/19/14, indicated R81 ome increased agitation, had ap buddy and thrown it, and ng and walking with the to her by the lap buddy most ed 12/8/14, identified the					
	nurse removed the th wheelchair, and in its	ick lap buddy on R81's place the nurse applied two n the wheelchair to help					

Event ID: SLSD11

Facility ID: 00733

If continuation sheet Page 16 of 40

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 24E117 B. WING 02/26/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **501 SECOND STREET SOUTHEAST** THE VILLA AT OSSEO **OSSEO, MN 55369** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRFFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 323 Continued From page 16 F 323 indicated R81 was quite restless during the day and wanted to stand up, and had been leaning forward and lifting the back of the wheelchair off the ground while walking the chair along. The plan noted was to try an alternative chair to make it less likely she could tip the chair over and cause injury. Another physician progress note dated 1/27/15, indicated R81 had been constantly trying to get out of her chair and was lifting the entire chair with her. During interview on 2/25/15, at 1:05 p.m. the DON stated R81 was not steady on her feet so she needed to be in a wheelchair. The DON stated R81 would get up and take off walking and try to sit everywhere. Additionally, therapy had tried a Geri chair (a reclining wheelchair) and other thicker lap buddies, but R81 still wanted to get up out of the wheelchair and walk. The DON believed adding a second lap buddy was therapeutic to R81 because she liked to rock back and forth with it, however, the DON verified R81 was still trying to get up and walk with the two lap buddies in place. DON verified R81 was able to walk when first admitted to the facility, but was placed in a wheelchair shortly after admission and restrained because the resident would sit on the floor, and had poor safety awareness. DON verified R81 had no injury's from any falls. During interview on 2/25/15, at 1:53 p.m. physical therapy assistant (PTA)-A stated she had completed a screening of R81. PTA-A stated R81 could walk and felt the resident would have benefited from some physical conditioning, however, the family did not want to pay for therapy services so nothing further was done During observation on 2/26/15 at 8:42 a.m., R81

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MUL	TIPL	LE CONSTRUCTION		<u>D. 0938-0391</u> E SURVEY	
ND PLAN OI	CORRECTION	IDENTIFICATION NUMBER:					PLETED	
		24E117	B. WING			02	/26/2015	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
	A AT OSSEO				501 SECOND STREET SOUTHEAST OSSEO, MN 55369			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE		
F 323	Continued From page	e 17	F	323	3			
	was observed to have	e one lap buddy on and was			-			
	able to stand and wal	k with the wheelchair						
	attached to her. LPN-A and NA-C applied the second lap buddy and R81 still was attempting to get up and walk with the wheelchair attached to							
	her.	the wheelchair attached to						
	During interview on 2	/26/14, at 8:42 a.m. LPN-A						
		had behaviors such as						
	grabbing at people an	nd things and wandering						
		rained. They stated they						
		to walk R81 or give her a						
		ned to be having a lot of ated the lap buddies were						
	not very safe if R81 w							
		npted to stand from the						
	wheelchair, and the w							
	attached to her.							
	During interview on 2/	26/15, at 9:10 a.m.						
	made more attempts t	t (OT)-A stated she felt R81 to get up and walk when the						
	environment was over	stimulating. OT-A stated						
		in the therapy department						
		nd the environment was						
	quiet, she was calm. C	DT-A identified nursing had						
	made the decision to a	apply two lap buddies at a						
	time, and nursing had	stated R81 needed to be						
		he tried to get up and walk						
	supervision, and R81's	ted R81 needed heavy staff						
		OT-A was not aware of any						
	plans to try and attemn	ot to reduce or remove the						
	current restraints being	g used.						
	During interview on 2/2	26/15, at 9:33 a.m. trained						
	medication assistant (TMA)-A stated R81 had the						
	ability to walk, but nee	ded to be restrained						
	pecause she would ge	t up and walk on her own.						
	During interview on 2/2	26/15 at 9:44 a.m., TMA-B						

Facility ID: 00733

If continuation sheet Page 18 of 40

PRINTED: 03/11/2015

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		(X3) DATE SURVEY COMPLETED		
		24E117	B. WING		02/26/2015		
NAME OF P	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CODE			
	A AT OSSEO		501 SECOND STREET SOUTHEAST OSSEO, MN 55369				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION		
F 329 SS=D	stated R81 was able to own, and she had see wheelchair while atter buddies on. TMA-B s and she believed that wanted to be active au to be a very active per During a follow up inte a.m. DON stated she were the least restrictif for R81. The DON sta medical symptom the treating, however, the R81 from falling. The during meal times R87 staff needed to leave to resident or R81 would the dining room. The D plan in place to attemp restraints, and the DO to stand with the two la as often as before whe in place restraining R8 During interview on 2/2 medical director stated stand up even with the and try to walk, howev stand up less with two one. 483.25(I) DRUG REGI UNNECESSARY DRU	o get up and walk on her an R81 carrying her appling to walk with the lap tated R81 was confused R81 got agitated when she ad walk because she used rson. erview on 2/26/15, at 10:29 felt the two lap buddies ve restraint option available ted there wasn't a particular two lap buddies were y were needed to prevent DON stated even though I was directly supervised, he restraints on the be up and walking around DON stated there was no ot to reduce or remove the N was aware R81 still tried ap buddies in place, but not en only one lap buddy was 1 in the wheelchair. 26/15, at 11:08 a.m. the I he was aware R81 could two lap buddies in place er, he felt she tried less to lap buddies applied vs MEN IS FREE FROM GS	F 323		4/17/15		
		or excessive duration; or toring; or without adequate or in the presence of					

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Facility ID: 00733

If continuation sheet Page 19 of 40

TATEMENT ND PLAN O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		STRUCTION	(X3) DATE	<mark>D. 0938-039</mark> E SURVEY PLETED	
		245447						
NAME OF F	ROVIDER OR SUPPLIER	24E117	B. WING			02/	/26/2015	
	NO NOEN ON SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE			
THE VILL	A AT OSSEO				COND STREET SOUTHEAST D, MN 55369			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	. ID	1	PROVIDER'S PLAN OF CORRECTION	ROVIDER'S PLAN OF CORRECTION (X5)		
PREFIX TAG	(EACH DEFICIENC REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E JTE	(X5) COMPLETION DATE	
F 329			F 32	29	F 329			
	adverse consequence	es which indicate the dose			The facility does attempt to ensure			
	should be reduced or	discontinued; or any			that each resident's drug regime is			
	combinations of the re	asons above.			free from unnecessary drugs. The			
					, .			
	Based on a comprehe	nsive assessment of a			facility also attempts to ensure that the resident's drug regime is			
	resident, the facility m	ust ensure that residents			monitored for excessive doses,			
	who have not used an							
	given these drugs unle			duplication of therapy, and that				
	therapy is necessary to	o treat a specific condition			adequate monitoring is in place.			
	as diagnosed and doc	umented in the clinical			1.) Resident #R81 was			
	record; and residents v	who use antipsychotic			reviewed for both the use of			
	drugs receive gradual							
	behavioral intervention	s, unless clinically			laxatives and for the Diagnosis for			
	contraindicated, in an e	effort to discontinue these			Depakote. The MD and the			
	drugs.				Pharmacist have both provided			
					additional information for the			
					resident chart. The resident has			
					not had any adverse effects as a			
					result of the use of the			
					medications. (Completed by the			
-	This REQUIREMENT	is not met as evidenced			DON 03/30/2015).			
ł	by:				2.) The Pharmacist has			
	Based on observation,	interview, and document			completed a whole house audit of			
ļr	eview the facility failed	to ensure laxatives were			the medication regime for all			
r	not given in an excessiv	ve dose, and mood			residents in the facility.			
S	stabilizing agents had a	ppropriate indications for			(Completed by the Pharmacist			
. L	use and ongoing monito	oring for effectiveness for			03/30/2015).			
1	of 5 residents (R81) r	eviewed for unnecessary			3.) Care plans for residents			
n	nedications.	· · ·			with the identified medications of			
_					Mood Stabilizers and or laxatives			
F	indings include:				has been reviewed, updated and			
_					revised as necessary. (Completed			
	81 was admitted to the	facility on 5/14/14.			by the DON, MDS Coordinator and			
	81's most current phys	sician's orders dated			or Designee 03/30/2015).			
1	/2//15, indicated diagn	osis including Alzheimer's			4.) Staff to be educated on			
ty	pe dementia. Addition	ally, the physician's			the Guidelines associated with			
0	rders identified R81 cu	rrently received depakote (t) 125 milligrams (mg) by			medications and F329 and F 428. (

Facility ID: 00733

If continuation sheet Page 20 of 40

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		24E117	B. WING		02/26/2015
	PROVIDER OR SUPPLIER		50	TREET ADDRESS, CITY, STATE, ZIP CODE 01 SECOND STREET SOUTHEAST ISSEO, MN 55369	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
	mg/50 mg (a stimulan tablets by mouth twice constipation. R81's quarterly minim indicated R81 had sev exhibited inattention a a continuous basis, ha frequently incontinent program, and had no p R81's care plan dated used psychoactive me Alzheimer's disease w issues, and possible d care plan identified R8 and received medicatin goal listed of having a every third day. The c should be monitored for constipation, but lacke non-pharmacological in attempted for any spect Review of R81's bowel reviewed and indicated medium incontinent bo basis. R81's physician progree indicated R81 was star depakote to reduce day reduce mumbling and r herself.	t laxative) tablet three e daily (6 tablets total) for um data set (MDS) vere cognitive impairment, nd disorganized thinking on ad no behaviors, was of bowel, not on a toileting problems with constipation. 2/26/15, indicated R81 edications for insomnia, ith related mood/behavioral epression. In addition, the thad bowel incontinence on for constipation with a soft, formed stool at least are plan indicated R81 or pain relief and d direction to staff for any neterventions that could be prific behaviors.	F 329	Completed by DON or designee 03/30/2015). 5.) Random Audits to be done of resident medication profiles to ensure proper diagno doses, duplication of therapy is addressed and proper monitorir in place. (Completed by the DO or designee 03/30/2015). 6.) Audits of the medica profiles to be reviewed by the C committee to identify trends, m recommendations and to ensur ongoing compliance with F329 s F428. (Completed by QAA Committee and the NHA 03/30/2015).	isis, ng is N tion QAA nake e

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Event ID: SLSD11

Facility ID: 00733

If continuation sheet Page 21 of 40

	OF DEFICIENCIES	MEDICAID SERVICES	<u> </u>				IO. 0938-039 ⁻		
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY IPLETED		
		24E117	B. WING			0	2/26/2015		
NAME OF P	ROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE	-			
THE VILL	A AT OSSEO			501 SECOND STREET SOUTHEAST OSSEO, MN 55369					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 329	Continued From page	e 21	F	329	9				
	physician to decrease two tablets twice daily six tablets daily was g recommended maxim physician's response	recommendation to the R81's Senexon-S tablets to a s the current total dose of greater than the usual um of four tablets. The listed at the bottom of the							
	Pharmacist Consultation Report indicated to "continue same" and lacked a clear risk versus benefit statement from the physician indicating why R81 was to continue taking more then the daily recommended maximum dosage. The consultant pharmacy recommendations did not identify a need for behavior monitoring related to the depakote usage.	n the physician indicating nue taking more then the naximum dosage. The recommendations did not			1				
	During interview on 2/. Family-A stated they for and expressed concer may be unnecessary a	elt R81 was "Drugged up," n some of her medications							
	During observation on 2/25/15, at 8:41 a.m. R81 was observed in her wheelchair eating breakfast and was sitting quietly in the wheelchair, no behaviors were exhibited. During observation on 2/25/15, at 12:05 p.m. R81 was observed lying down in her bed, no behaviors were exhibited.								
	assistant (NA)-C were cares. R81 was obser when she assisted R8 ²	e (LPN)-A and nursing assisting R81 with morning ved grabbing at NA-C							
	especially grabbing at	other people. When this							
	appened they would a	attempt to walk R81 or offer							

Facility ID: 00733

If continuation sheet Page 22 of 40

	OF DEFICIENCIES		()(0) 111			NO. 0938-0391
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		24E117	B. WING		0	2/26/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
THE VILL	A AT OSSEO			501 SECOND STREET SOUTHEAST OSSEO, MN 55369		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		
	R81. LPN-A and NA incontinent of bowel stated R81's bowel n over the place," and tracked in the electro During interview on 2 director of nursing (D behaviors and was re with two lap buddies During interview on 2 indicated R81's beha documented on the n stated R81 had beha grabbing at other peo medication sheets for were no behaviors do insomnia monitoring. Should be more beha stated she would only dose reduction from t had constant loose st loose stools per day. any issues with R81's During another intervi a.m. the DON stated hold laxatives if a resi loose stools per day of The DON stated the of	vas usually useful in calming -C stated R81 was frequently on a daily basis. NA-C novements would get "All bowel movements were onic health record. 2/26/15, at 8:59 a.m. the PON) state R81 had frequent estrained in the wheelchair to help her "Stand up less." 2/26/15, at 10:22 a.m. LPN-A vior symptom frequency was nedication sheets, and viors including agitation and ople. LPN-A pulled out R81's r 2/15, and verified there bocumented for R81, only LPN-A stated, There aviors on there." LPN-A v hold laxatives or request a he physician if a resident ools or more than three LPN-A was not aware of b bowel movements. New on 2/26/15, at 10:23 she would expect staff to dent had three or more or "Constant" loose stools. lepakote had helped with	F 3	329	· · · · · · · · · · · · · · · · · · ·	
	R81's "Overall dementia." The DON could not state which symptoms the divalproex (depakote) was specifically to treat, but she felt the medical director (MD) knew what the indication for use of the medication was. DON stated staff would try					
	to walk R81 or give he behaviors,	a suar in tennice	and a lot and a lot and a lot a l			<u> </u>

Event ID: SLSD11

Facility ID: 00733

If continuation sheet Page 23 of 40

PRINTED: 03/11/2015

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				RM APPROVED 10. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '	IPLE CONSTRUCTION		TE SURVEY MPLETED
		24E117	B. WING_		0	2/26/2015
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		
	A AT OSSEO			501 SECOND STREET SOUTHEAST		
				OSSEO, MN 55369		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOL		(X5) COMPLETION DATE
F 329	Continued From page 23		F3	29		
	During interview on 2	10011E at 11:00 a m the MD				
		/26/15, at 11:08 a.m. the MD e depakote for physical				
		as hoping to decrease the				
		of grabbing at staff and other				
		not being used to treat				
		ated he was unaware R81				
		uent bowel movements, and bowel documentation on				
	rounds. The MD also					
	reviewed any data rel	ated to frequency of R81's				
		the effectiveness of the				
		ment was based on a verbal				
	report from the DON a	and/or the facility nurses.				
	During interview on 2/	/26/15, at 11:34 a.m. the				
		t (CP) stated one bowel				
	movement every one	to two days should be				
		pattern and R81's Sennexon				
		for a dose reduction. The				
		a was not an appropriate e and there should have				
		rs being monitored for R81				
	to evaluate the depake					
		of psychoactive drugs and				
	bowel management w provided.	ere requested, but not				
1	483.30(e) POSTED N	LIRSE STAFFING	F 3	56		
	INFORMATION		F3			Alie
00-0				F356		CIUIS
	The facility must post	the following information on		The facility does attempt	to post	
	a daily basis:			Nurse Staff information.	The	
	o Facility name.			Facility also maintains the		
	o The current date.			Data in accordance State	law.	
1	A Ind total number	d the estual here we dead				
	by the following categoria	d the actual hours worked				

Event ID: SLSD11

Facility ID: 00733

If continuation sheet Page 24 of 40

TATEMENT	OF DEFICIENCIES				OMB	ORM APPROV <u>NO. 0938-03</u>
ND PLAN O	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) D	OATE SURVEY OMPLETED
		24E117	B. WING			02/26/2045
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE	02/26/2015
THE VILL	A AT OSSEO			501 SECOND STREET SOUT OSSEO, MN 55369	HEAST	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES				
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page	24	F 3	56		
	resident care per shift				facility has	
	- Registered nurse	es.		developed a poli	cy to correctly post	
	- Licensed practica	al nurses or licensed		the Nurse Staffin		
	Vocational nurses (as	defined under State law).		(Completed by th		
	- Certified nurse ai o Resident census.	des.		Coordinator and	the NHA	
	o resident census.			03/23/2015).		
S C	The facility must post t	he nurse staffing data			Staff Posting form	
	specified above on a d	aily basis at the beginning		was created. (Co Staffing Coordina		
	of each shift. Data mu	st be posted as follows:			And the second second second second second second	
	o Clear and readable f	ormat.			ducation provided	
	o In a prominent place readily accessible to residents and visitors.			to the Staffing Coo		
				Nurse staff regard		
.		facility must, upon oral or written request,		policies. (Complet and the Staffing Co		
	The facility must, upon			03/23/2015).	oorumator	
	make nurse staffing da	ta available to the public			g Postings will be	
	standard.	to exceed the community		audited weekly for		
	stanuaru.			information. (Com		
- 1	The facility must mainta	ain the posted daily nurse		NHA 03/30/2015).		
s	staffing data for a minin	num of 18 months, or as		5.) Staff Po	ostings and audits	
r	equired by State law, v	vhichever is greater		will be reviewed by		
		sinche ver le greater.		Committee to iden	tify trends, make	
				recommendations		
T	This REQUIREMENT is	s not met as evidenced		ongoing complianc		
D	ey:			(Completed by the		
	pased on observation,	interview, and document		and the NHA 03/30	/2015.)	
	eview, the facility failed	to ensure the posted				
Ŵ	orked for unlicensed a	n included the actual time irect care staff, nursing				
a	ssistants (NA's) and tra	need medication				
a	ssistants (TMA's). This	had the potential to				
a	ffect all 81 residents cu	rrently residing in the				
ta	icility, as well as family	members or the general				:
pi	JDIIC Who may wish to r	eview this information.			:	
+	ndings include:					
	uring the initial tour obs	servation on 2/23/15, at				
12	2:51 p.m. the facility's E	aily Staffing Poporting				

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Event ID: SLSD11

Facility ID: 00733

If continuation sheet Page 25 of 40

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 24E117 B. WING 02/26/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **501 SECOND STREET SOUTHEAST** THE VILLA AT OSSEO OSSEO, MN 55369 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 356 Continued From page 25 F 356 plastic sleeve mounted on the wall. The posting lacked identification of the day and evening shift times for the NA's and the TMA's. During interview on 2/23/15, at 1:00 p.m. licensed practical nurse (LPN)-B verified the posting did not include shift times and stated the NA's and the TMA's work staggered shifts. During interview on 2/25/15, at 3:07 p.m. director of nursing (DON) stated the staffing coordinator was responsible for filling out and posting the Daily Staffing Reporting Form. DON verified the shift times for the NA's and TMA's were not included on the form, and it was difficult to determine when staff directly responsible for providing resident care were working by looking at the form because they worked staggered shifts. DON stated she was unaware the specific times of the shifts were not included on the Postina. During interview on 2/25/15, at 3:31 p.m. the staffing coordinator stated she recently started in her role and wasn't aware of specific rules or policy for filling out the Daily Staffing Reporting Form. She stated she was just using the form that the previous person in this position used, and verified the specific hours were not listed on the Daily Staffing Form she was using. A policy was requested for completing the Daily Staffing Reporting Form, but was not provided. F 371 483.35(i) FOOD PROCURE. F 371 STORE/PREPARE/SERVE - SANITARY SS=F The facility must -(1) Procure food from sources approved or.

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00733

If continuation sheet Page 26 of 40

PRINTED: 03/11/2015

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	OF DEFICIENCIES OF CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	<u>D. 0938-03</u> E SURVEY PLETED
		24E117	B. WING			
NAME OF F	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	02	/26/2015
	A AT OSSEO			1 SECOND STREET SOUTHEAST SSEO, MN 55369		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	Continued From page	26	E 074			
	considered satisfactor	ry by Federal, State or local	F 371	F371		
	authorities; and (2) Store prepare dis	stribute and serve food		13/1		
	under sanitary conditi	ons		The facility does attempt to ensur	e	
				that dishes and utensils used in		
				resident food preparation are		
				stored in a clean and sanitary		
				manner. The facility also attempt to ensure that food is served at a	S	
		is not met as evidenced		safe temperature to prevent food		
	by:	is not met as evidenced		borne illness.		
		n, interview, and document				
	review the facility faile	d to ensure dishes and				
	utensils used in reside	ent food preparation were				
	stored in a clean and s	sanitary manner. In		1.) There was no s/s of		
	addition, the facility fai	led to ensure foods were at		resident illness associated with the		
	a safe serving tempera	ature prior to serving to		food service on the identified dates. Food Temperature Policy		
	prevent the potential o	al to affect all 81 residents		posted in the serving areas. New		
	who resided in the faci	lity		Calibrated Thermometers		
				implemented. (Completed by the	2	
	Findings include:			DON and RDCS Regional Director o		
				Clinical Services, 03/03/2015)		
	During kitchen tour on	2/23/15, at 12:42 p.m.		2.) Food Service Staff was		
	eight shelves were obs	erved covered with were covered with dust and		re- educated on the cleaning		
	debris. Items stored on	the shelves included		procedures and the cleaning lists. Cleaning schedules have been		
1	baking pans, steam tab	ble pans, storage		revised to include assigned person		
0	containers, drinking pite	chers, equipment utensils.		to the cleaning tasks. Food Service		
ä	and cutlery. The Food \$	Service Director (FSD)		Staff educated on proper food		
	was present at the time shelves.	and verified the dirty		temperatures, and the calibration		
0	Cook-A was interviewed	d on 2/23/15, at 1:27 p.m.				
a	and stated no one was	assigned the actual task				
C	of cleaning the shelves,	but staff was expected if				
t	hey were dusty or cove	ered with debris, they				
V	hings stored on the sto	s off. Cook-A stated the				Martin Containing and Annual State

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00733

If continuation sheet Page 27 of 40

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/11/2015 FORM APPROVED

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION		TE SURVEY MPLETED
		24E117	B. WING		0:	2/26/2015
NAME OF F	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
THE VILL	A AT OSSEO			SECOND STREET SOUTHEAST SEO, MN 55369		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIOI DATE
F 371	Continued From pag prepare and serve re	sident food.	F 371	of the thermometers. Food temperatures to be recorded o	n all	
	and included duties t as wiping down all si machine, and sweep	Cleaning List was reviewed o be completed by staff such nks, cleaning the dish ing the floor. There was no cleaning the shelves.		of the food leaving the kitchen prior to the meal service. If the food is not at proper temperatu will be re-heated or cooled as necessary prior to leaving the	ure it	
	a.m. FSD stated he v not regularly cleaning	view on 2/25/15, at 11:32 vasn't aware the staff were the shelves and stated that regular kitchen cleaning		kitchen. (Completed by the Die Manager 03/15/2015). 3.) The cleaning lists wil audited by the Dietary Manager ensure that all procedures are completed and the staff assigne	ll be r to	
	During interview on 2 Resident (97) stated meals was often cold an egg roll that was c	the food served during , and today at lunch he had		held accountable for the identification tasks. Food temperatures will be taken upon arrival in the Dining Room. (Completed 03/15/2015) 4.) The Dietary Manager	e 5).	
	stated the food at the including the coffee th	hat is served.		will audit all areas of sanitation 3 times a week for one month the times a week for the next three months. The Dietary Manager w audit all food temp logs 3 times	e 2	
	stated the food served	23/15, at 5:46 p.m. R68 I at the facility is cold. 24/15, at 8:35 a.m. R76		week for one month then 2 time week for the next 3 months. (Completed by the Dietary	s a	
	reported hot food is of During observation of	ten not hot enough.		Manager 03/30/2015). 5.) The Dietary Manager Designee will complete resident	or	
	2/23/15, at 5:11 p.m. o thermometer to check	cook-A used a food the temperatures of the e she was preparing to		food service satisfaction surveys every week for the next 3 month (Completed by the Dietary Manager 03/30/2015).	1	
	checked the temperation was 130 degrees Fahr	ure of the sauerkraut which enheit (F), the tomato soup s F, the pureed vegetables				

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00733

If continuation sheet Page 28 of 40

					OMB NO. 0938-0391 (X3) DATE SURVEY		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SI COMPLE		
		24E117	B. WING		02/26	5/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
HE VILL	A AT OSSEO			501 SECOND STREET SOUTHEAST OSSEO, MN 55369			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE	
	of the food was hot e used a phone to call (FSD), and reported back to the kitchen to metal containers of th directed a dietary aid kitchen to be heated. temperature of the pot next to the steam tab placed inside of a lar layer of ice in the bot temperature of the pot F and stated that was she would not be able 5:39 p.m., a dietary a was reheated back to used the thermomete of all of the food and were now acceptable between 150-180 deg brought to the dining the potato salad, and During observation on cook-A was preparing residents in the first fi meal, and checked th that remained in the s meat was 100 degrees 110 degrees F, mash sauerkraut was 125 d was 110 degrees F. (asked him to come to the concern again the	e 28 rees F. Cook-A stated none enough to serve. Cook-A the food service director she was sending all the food o be heated. Cook-A put the he food items onto a cart and le to bring them back to the . Cook-A checked the otato salad that was on a cart ole in a large bowl which was rge steel pan with a one inch tom. Cook-A stated the otato salad was 70 degrees is too warm to be served and e to serve that either. At aide brought the food that o the dining room and cook-A er to check the temperatures stated all the temperatures stated all the temperatures e with the hot items being grees F. Coleslaw was room to be used in place of was at 40 degrees F. In 2/23/15, at 6:06 p.m. g to serve the second shift of loor dining room the supper he temperature of the food steam table. The ground es F, the pureed meat was ed potatoes 130 degrees F, legrees F, and the bratwurst Cook-A called the FSD and o the dining room because of e food was not hot enough to m., FSD came to the dining	F 3	6.) The audits of sanitati and food service satisfaction surveys, will be reviewed by the QAA Committee to identify tren make recommendations and to ensure ongoing compliance with F371. (Completed by the QAA Committee and the NHA 03/30/2015.)	ds,		
		the food was not holding at					

Facility ID: 00733

If continuation sheet Page 29 of 40

	MENT OF HEALTH AN						ED: 03/11/2018 MAPPROVED
STATEMENT	AS FOR MEDICARE & OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DAT	<u>O. 0938-0391</u> E SURVEY IPLETED
		24E117	B. WING			02/26/2015	
NAME OF F	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	1 02	
					1 SECOND STREET SOUTHEAST		
THE VILL	A AT OSSEO				SSEO, MN 55369		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 371	submerged in the wat the containers needed food hot. FSD and co containers of food from them back to the kitch On 2/23/15, at 6:41 p. the kitchen with conta	er on the steam table and I to be covered to keep the ok-A removed the n the steam table and sent en to be reheated. m. cook-A returned from iners of precooked pureed	FS	371			
	she had remade the for again, and proceeded The pureed polish sau degrees F, and the me was 135 F. The FSD e	a sausage. Cook-A stated bod rather than reheating it to check the temperatures. Isage only registered at 140 echanical polish sausage entered the dining room to tures of the food, and told bod at the current					
	the kitchen prior to the arrived to the dining ro trained to check food to and she was not aware until now. RD-A stated 140 degrees F when so	D)-A stated food pposed to be checked in meal, and again when it om. RD stated staff were emperatures in the kitchen, e staff were not doing that I hot food should be above					
	FSD stated he had just cook-A was using to ch resident food, and it wa colder than his thermon was actually 20 degree originally thought. Whe salad that registered 70	neter, so he felt the meat is hotter than they had n asked about the potato 0 degree F FSD verified					
	me temperature would	have been 90 degrees F					
	with the more accurate	thermometer. FSD stated					

Facility ID: 00733

If continuation sheet Page 30 of 40

ND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		E SURVEY PLETED
		24E117	B. WING		02	/26/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	A AT OSSEO			501 SECOND STREET SOUTHEAST OSSEO, MN 55369		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	potatoes well enough salad. When asked at served to the resident FSD stated the tempe probably closer to 60 of accurate thermometer have been too warm to have been thrown awa food bourne illness. During a follow up inte p.m. cook-A stated she temperature of the foo dining room, however, on Monday evening. Of the food was not stayir not wrapping the conta cellophane and tin foil, enough water in the sta were sitting in the wate not turning on the steal bringing the food upsta The facility policy titled 2010, included, "All hot cooked to appropriate i and served at a temper [degrees] FHot food i	ehind and didn't cool the before making the potato yout the coleslaw that was as at 6:32 p.m. on 2/23/15, rature was actually degrees F with the more , and stated this would be served and it should ay to preventable potential rview on 2/26/15, at 1:30 e usually checks the d before taking it to the she did not complete that Cook-A stated she believed ag warm because she was iners of food with not ensuring there was eam table so the pans or to remain hot, and was m wells one hour prior to irs to serve. Food Temperatures dated food items must be nternal temperatures, held ature of at least 135 tems may not fall below	F 37	71		
 	must be maintained and of 41 [degrees] F or bel be taken periodically to above 135 [degrees] F	vingAll cold food items d served at a temperature owTemperatures should ensure hot foods stay and cold foods stay below portioning, transporting,				

Facility ID: 00733

If continuation sheet Page 31 of 40

PRINTED: 03/11/2015

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		24E117	B. WING			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	0	2/26/2015
THE VILL	A AT OSSEO			501 SECOND STREET SOUTHEAST OSSEO, MN 55369		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 371	Tray line policy dated service salads and oth service are to be place 3-4 hours before servi	d Handling Cold Foods for 2010, instructed prior to ner cold food items for meal ed in the refrigerator at least ing and Food should be	F 37	1		
F 428 SS=D	chilled to equal to or le 483.60(c) DRUG REG IRREGULAR, ACT O	ess then 41 degrees F. BIMEN REVIEW, REPORT N	F 42			4/7/15
	pharmacist.	a month by a licensed		The facility does ensure that the drug regime of each resident is reviewed by a Licensed Pharmac monthly. The Pharmacist report on irregularities and they are	ict	
	the attending physiciar	eport any irregularities to n, and the director of orts must be acted upon.		followed up on. 1.) Resident #81 had the drug regime and profile of the resident reviewed by the pharmacist on a monthly basis.		
r c	by: Based on observation, review the facility failed consultant recommend	ations regarding laxatives		Irregularities were addressed. Th Facility had the Pharmacist re- review all of the information in th recommendations was brought to the attention of the DON, and the Primary MD for the resident. New Orders were received. The	e	
r a tu u n	esidents reviewed, (R& addition, the facility cor o identify irregularities use and ongoing monite	by the physician for 1 of 4 31) for laxative use. In isultant pharmacist failed related to indications for pring for effectiveness of ations for 1 of 5 residents accessary medications.		diagnosis for the medication and the tracking of behaviors are in place. (Completed by the DON an the RDCS on 03/15/2015). 2.) The medication profiles for all of the residents in the facility were reviewed by the pharmacist		
	indings include: 81 was admitted to the			with a specific review of Laxatives and Mood altering medications. (Completed by the Pharmacist		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00733

If continuation sheet Page 32 of 40

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING	DNSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
	24E117	B. WING		02/26/2015
JAME OF PROVIDER OR SUPPLIER		501 S	EET ADDRESS, CITY, STATE, ZIP CODE SECOND STREET SOUTHEAST EO, MN 55369	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
type dementia. Additi orders identified R81 (a mood stabilizing ag mouth every morning, mg/50 mg (a stimulan tablets by mouth twice constipation. R81's quarterly minimi indicated R81 had sev exhibited inattention a a continuous basis, ha frequently incontinent program, and had no p R81's care plan dated used psychoactive me Alzheimer's disease w issues, and possible di care plan identified R8 and received medication goal listed of having a every third day. The ca should be monitored for constipation, but lacked non-pharmacological ir attempted for any spect Review of R81's bowel reviewed and indicated medium bowel moveme R81's physician progres indicated R81 was start	gnosis including Alzheimer's onally, the physician's currently received depakote ent) 125 milligrams (mg) by as well as Senexon-S 8.6 t laxative) tablet three e daily (6 tablets total) for um data set (MDS) rere cognitive impairment, nd disorganized thinking on id no behaviors, was of bowel, not on a toileting problems with constipation. 2/26/15, indicated R81 dications for insomnia, ith related mood/behavioral epression. In addition, the 1 had bowel incontinence on for constipation with a soft, formed stool at least are plan indicated R81 r pain relief and d direction to staff for any iterventions that could be ific behaviors. records for 2/15 were R81 had 1-3 large to ents on a daily basis. ss notes dated 11/05/14, ted on low dose of time restlessness and to naking statements to	F 428	 3.) Staff and Pharmacist were educated on the guidelines of F428 along with the follow up and review of recommendations issue (Completed by the RDCS 03/15/2015). 4.) Recommendations and outstanding recommendations issued by the pharmacist will be reviewed by the DON on a monthl basis via the Summary Format. (Completed by the DON o3/30/2015). 5.) Audits of the Summary and recommendations to be done on a quarterly basis. (Completed by the DON aid Pharmacist 03/30/2015). 6.) QAA Committee will review the audits of Pharmacy Recommendations, identify trends make recommendations and to ensure ongoing compliance with F429. (Completed by the QAA Committee and the NHA 03/30/2015). 	d Iv

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00733

If continuation sheet Page 33 of 40

DEPARTMENT OF HEALTH AN	D HUMAN SERVICES	
CENTERS FOR MEDICARE & I	MEDICAID SERVICES	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		24E117	B. WING		02/26/2015
	ROVIDER OR SUPPLIER	· ·		STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST	
				OSSEO, MN 55369	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
	R81's consultant pha 12/10/14, indicated a physician to decrease two tablets twice daily six tablets twice daily six tablets daily was g recommended maxim physician's response Pharmacist Consultan "continue same" and benefit statement fror why R81 was to conti daily recommended r consultant pharmacy identify a need for be the depakote usage. During interview on 2 Family-A stated they and expressed conce may be unnecessary During observation or was observed in her and was sitting quietly behaviors were exhib During observation or licensed practical nur- assistant (NA)-C were cares. R81 was obser when she assisted R8 LPN-A and NA-C indic	rmacist notes dated recommendation to the e R81's Senexon-S tablets to y, as the current total dose of greater than the usual num of four tablets. The listed at the bottom of the tion Report indicated to lacked a clear risk versus in the physician indicating nue taking more then the naximum dosage. The recommendations did not havior monitoring related to /24/15, at 10:24 a.m. felt R81 was "Drugged up," rn some of her medications and excessive. n 2/25/15, at 8:41 a.m. R81 wheelchair eating breakfast y in the wheelchair, no ited. n 2/26/15; at 8:42 a.m. se (LPN)-A and nursing assisting R81 with morning rved grabbing at NA-C 11 into her wheelchair. cated R81 had behaviors,	F 42	18	
	happened they would her a snack, which wa R81. LPN-A and NA- incontinent of bowel o	other people. When this attempt to walk R81 or offer as usually useful in calming C stated R81 was frequently n a daily basis. NA-C ovements would get "All			
	over the place," and b	•			

	(X3) DATE COMP	CONSTRUCTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	OF DEFICIENCIES CORRECTION	STATEMENT (AND PLAN OF
6/2015	02/		NG	24E117		
0/2015		STREET ADDRESS, CITY, STATE, ZIP CODE		· · · · · · · · · · · · · · · · · · ·	ROVIDER OR SUPPLIER	NAME OF PR
	501 SECOND STREET SOUTHEAST			47.000-0		
		SSEO, MN 55369			A AT OSSEO	
	DEGTION	PROVIDER'S PLAN OF CORREC		ATEMENT OF DEFICIENCIES	SUMMARY STA	(X4) ID
(X5) COMPLETION DATE	SHOULD BE	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	REFIX TAG	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	(EACH DEFICIENCY	PRÉFIX TAG
			F 428	34	Continued From page	F 428
			1 720		tracked in the electron	1
					During interview on 2/2	
				DN) state R81 had frequent	director of nursing (DC	
				strained in the wheelchair	behaviors and was res	
				o help her "Stand up less."	with two lap buddies to	
				26/15, at 10:22 a.m. LPN-A	During interview on 2/2	
				ior symptom frequency was	indicated R81's behavi	
					documented on the me	
				iors including agitation and	stated R81 had behavi	
				ble. LPN-A pulled out R81's	grabbing at other peop	
				2/15, and verified there	medication sheets for 2 were no behaviors doc	
				PN-A stated There	insomnia monitoring. L	
				viors on there " $I PN_A$	Should be more behav	
				hold laxatives or request a		
	-			e physician if a resident	dose reduction from the	
				ols or more than three	had constant loose stor	
				_PN-A was not aware of	loose stools per day. L	
				bowel movements.	any issues with R81's b	á
				w on 2/26/15, at 10:23	During another interview	[
				he would expect staff to	a.m. the DON stated sh	á
				ent had three or more	hold laxatives if a reside	ľ
				"Constant" loose stools.	The DON stated the de	יי יי ר
				pakote had helped with a." The DON could not	R81's "Overall demention	F
				the divalproex (depakote)	state which symptoms t	s
				t, but she felt the medical	vas specifically to treat	v v
				at the indication for use of	lirector (MD) knew wha	d
				ON stated staff would try	he medication was. Do	t
		,		a snack to reduce	o walk R81 or give her	te
					ehaviors.	b
				6/15, at 11:08 a.m. the MD	During interview on 2/26	
				depakote for physical	tated R81 was on the c	S
				hoping to decrease the	ggression and he was	a
				grapping at staff and other	acidente and it was	
				or being used to treat	esidents, and it was not	in line
				ed rie was unaware R81	ad been having frogues	II b
				woldoonwooted	ad not reviewed hor hor	
				grabbing at staff and other it being used to treat ed he was unaware R81 int bowel movements, and	umber of incidents of g esidents, and it was not isomnia. The MD state	n re in h:

Event ID: SLSD11

Facility ID: 00733

If continuation sheet Page 35 of 40

PRINTED: 03/11/2015

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · ·	TE SURVEY MPLETED
		24E117	B. WING		0	2/26/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE VILL	A AT OSSEO			501 SECOND STREET SOUTHEAST OSSEO, MN 55369		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 428	rounds. The MD also reviewed any data rel behaviors to evaluate depakote, his assess report from the DON During interview on 2 consultant pharmacis movement every one considered a normal should be considered CP indicated insomnia indication for depakot been specific behavio to evaluate the depak Policies regarding use bowel management w provided.	a indicated he had not lated to frequency of R81's the effectiveness of the ment was based on a verbal and/or the facility nurses. /26/15, at 11:34 a.m. the t (CP) stated one bowel to two days should be battern and R81's Sennexon for a dose reduction. The a was not an appropriate e and there should have rs being monitored for R81 ote's effectiveness. e of psychoactive drugs and vere requested, but not	F 42		-	
SS=E	FEDERAL/STATE/LO The facility must opera compliance with all ap local laws, regulations accepted professional that apply to profession such a facility. This REQUIREMENT by: Based on interview ar facility failed to ensure service agency (SNSA with the Minnesota con required was not used	CAL LAWS/PROF STD ate and provide services in plicable Federal, State, and a, and codes, and with standards and principles nals providing services in is not met as evidenced and document review, the the supplemental nursing b) which was not registered mmissioner of health as by the facility to provide This had the potential to	F 49	F492 The facility does attempt t services in compliance wit applicable Federal, State, a laws, regulations and code with accepted professiona standards and principals p 'services in this facility.	h all and local es, and l	4/7/15

Event ID: SLSD11

Facility ID: 00733

PRINTED: 03/11/2015

If continuation sheet Page 36 of 40

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION	(X3) DATE SURVE COMPLETED	
		24E117	B. WING	·	02/26/20	15
AME OF P	ROVIDER OR SUPPLIER		STR	REET ADDRESS, CITY, STATE, ZIP CODE		
HE VILL	A AT OSSEO			SECOND STREET SOUTHEAST SEO, MN 55369		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	ВЕ СОМІ	(X5) PLETION DATE
F 492	Continued From page	9 36	F 492			
	approximately 2:30 p. the facility had previou nursing staff agency of which was previously however, the agency of The administrator was was currently not regis state of Minnesota, and the SNSA. During interview on 2/2 staffing coordinator state be using All Heart Sen registered with the stath had contacted All Heart nursing assistant (NA) facility on 2/15/15, for and provided care to re 2nd floor of the facility. During interview on 2/2 facility nurse consultant had gone out of busine bought and renamed A nurse consultant stated Heart Service did not h Minnesota as an SNSA knowledge of All Heart registered as an SNSA	was sold and renamed. a ware All Heart Service stered as an SNSA with the id the facility was not to use 24/15, at 2:52 p.m. the ated the facility was not to vice because it was not te, however, a facility nurse rt Service and was provided -F, who worked in the n 4:30 p.m. to 10:30 p.m., esidents on unit 3 on the 24/15, at 4:15 p.m. the it stated Soul Care SNSA ess last fall, and was all Heart Service. The d the facility was aware All wave current registration in A, however, despite facility		 The identified agency has been contacted by the facility. The agency has been removed fror the lists or resources utilized at the facility. (Completed by the NHA and the Staffing Coordinator 03/15/2015). The facility has currentl not used any agency staff since 02/19/2015. The facility has filed a complaint with the Minnesota Department of Health, Lisc. Commission regarding the Staffing Agency All Heart. (Completed by the RDCS 02/24/2015). The facility has filed a complaint with the Better Business Bureau regarding the Staffing Agency All Heart. (Completed by the NHA 02/24/2015). The Facility has filed a complaint with CEP and OHFC regarding the staffing Agency All Heart. (Completed by the RDCS 02/24/2015). The facility has reviewed the contracts with service providers to ensure compliance with F492. (Completed by the NHA 02/24/2015). 	n Y	
	Jpon review, it was de					

Facility ID: 00733

If continuation sheet Page 37 of 40

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DAT	IO. 0938-0391 TE SURVEY APLETED
		24E117	B. WING			0	2/26/2015
NAME OF P	ROVIDER OR SUPPLIER		l	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
THE VILL	A AT OSSEO				ECOND STREET SOUTHEAST EO, MN 55369		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	SNSA, refer to SNSA 144A.71 Subdivision 1.Duty to A person who operate services agency shall commissioner. Each s business of a supplem agency shall register to commissioner. Each s business of a supplem agency shall have a s Subd. 2.Application in The commissioner sha procedures for proces nursing services agen An application for a su services agency regist the following: (1) the names and add owners of the supplem agency; (2) if the owner is a co articles of incorporation together with the name officers and directors; (3) satisfactory proof o 144A.72, subdivision 1 clauses (5) to (7); (4) any other relevant if commissioner determing properly evaluate an a and	statute 144A.71. register. Is a supplemental nursing register the agency with the separate location of the nental nursing services he agency with the separate location of the nental nursing services eparate registration. formation and fee. all establish forms and sing each supplemental cy registration application. Ipplemental nursing tration must include at least dresses of the owner or nental nursing services rporation, copies of its n and current bylaws, es and addresses of its f compliance with section , information that the nes is necessary to pplication for registration; ion fee for a supplemental cy, which is \$891. ot transferable.	F	492	 7.) The Facility staff was educated on the regulatory guidelines associated with 492. (Completed by the RDCS 02/24/2015). 8.) The Contract binder will be reviewed on a quarterly basis and with the change in any providers PRN. (Completed by the NHA 03/30/2015). 9.) QAA Committee will review Contract Binder Audits quarterly to identify trends, make recommendations and to ensure ongoing compliance with F 492. (Completed by NHA and QA Committee 03/30/2015). 		
	A registration issued by according to this section						

Facility ID: 00733

If continuation sheet Page 38 of 40

STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(Y2) MIL		CONSTRUCTION		<u>10. 0938-039</u>	
	CORRECTION	IDENTIFICATION NUMBER:					TE SURVEY MPLETED	
		24E117	B. WING	·		0	02/26/2015	
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE			
THE VILL	A AT OSSEO			501	SECOND STREET SOUTHEAST			
				os	SEO, MN 55369			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 492	Continued From page	38	F	492				
	the registration is revo section 144A.72, sub supplemental nursing	oked or suspended under division 2 ′2>, or unless the services agency is sold or		102				
	supplemental nursing ownership or manage	ment is transferred. When a services agency is sold or ment is transferred, the ncy must be voided and the r may apply for a new						
	p.m. the administrator approached by All Hea and was told the alleg Soul Care prior clients the facility refused to s current registration wa Service, and the staff Heart Service was not facility until further noti stated All Heart Servic registration with the sta	art Service in October 2014, ed SNSA was taking over . The administrator stated ign the contract until a s provided by All Heart were educated to ensure All used to provide staff to the ce. The administrator e did not provide a copy of ate of Minnesota, and Heart Service had worked						
	educated in October 20 Service for staffing nee registered as an SNSA an oversight by one of Service was called to p acility on 2/15/15. DO All Heart Service, the p	N) stated the nurses were 014, not to use All Heart ds because it was not in Minnesota, and it was the nurses when All Heart						

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Facility ID: 00733

If continuation sheet Page 39 of 40

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED		
		24E117	B. WING			02/26/2015		
	PROVIDER OR SUPPLIER			501	REET ADDRESS, CITY, STATE, ZIP CODE SECOND STREET SOUTHEAST SEO, MN 55369	02/20/2015		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETIO TE DATE		
	Heart Service and Vil dated October 2, 2014 indicated, "All Heart p insurance coverage's law on its employees, compensation and lial malpractice insurance The Staffing Agreeme Service was, "A provid professional on a temp number 612-617-7777	la Health Care at Osseo 4, was provide and rovides all required that are mandated by state including workers bility insurance, medical a, and employee bonding" nt identified All Heart der of health care porary basis phone "." The Staffing Agreement eart was registered as an ces in the state of	F-4	192				

F 7(02-99) Previous Versions Obsolete

If continuation sheet Page 40 of 40

	MENT OF HEALTH			FEII	7023	FORM	02/27/2015 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		1 · · ·	PLE CONSTRUCTION 3 01 - Main Building 01	(X3) DATE SU COMPLE	
	24E117			B. WING		02/2	5/2015
	ROVIDER OR SUPPLIER				STATE, ZIP CODE REET SOUTHEAST		
), MN 553			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL F NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS		K 000			
	FIRE SAFETY						
	Minnesota Departm time of this survey, in substantial comp for participation in M Subpart 483.70(a). 2000 edition of Nati	Survey was conduct ent of Public Safety. The Villa of Osseo w liance with the requir Aedicare/Medicaid at Life Safety from Fire onal Fire Protection Safety Code (LSC) C e.	At the vas found rements t 42 CFR and the (NFPA)		,		
	construction Type II wood joist and plyw closets. It has a par sprinklered. The fac with smoke detection and spaces open to for automatic fire de facility has a capaci	g is downgraded from (222) to Type V (11 ood floors in some of tial basement and is cility has a fire alarm on in resident rooms, the corridor that is re epartment notification ty of 115 beds and h at the time of the sur	1) due to of the linen system corridors monitored n. The ad a				
	The requirement at met.	42 CFR, Subpart 48	3.70(a) is				
y.							æ
LABORATO	RY DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESE	ENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

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.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 0470 0000 5262 1345 March 11, 2015

Mr. Michael Marchant, Administrator The Villa At Osseo 501 Second Street Southeast Osseo, Minnesota 55369

Re: Enclosed State Boarding Care Home Licensing Orders - Project Number SE117024

Dear Mr. Marchant:

The above facility survey was completed on February 26, 2015 for the purpose of assessing compliance with Minnesota Department of Health Boarding Care Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 of the Minnesota Department of Health.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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 Boarding Care 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 after the statement, "This Rule is not met as evidenced by." Following the surveyors findings is 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.

The Villa At Osseo March 11, 2015 Page 2

When all orders are corrected, the order form should be signed and returned to Jessica Sellner, Unit Supervisor at Minnesota Department of Health, 3333 W Division #212, St Cloud MN, 56301.

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 me.

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 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 with any questions related to this letter.

Sincerely,

ate Comston

Kate Johnston, Program Specialist Licensing and Certification Program Health Regulations Division Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File

STATEMENT	a Department of Hea	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE S COMPL	
				· · · · · · · · · · · · · · · · · · ·		
		00733	0. WING		02/2	6/2015
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CHY, STATE			
THE VILL/	A AT OSSEO		OND STREET SOL MN 65369	JIHEAST		
(X4) ID PRFFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (FACH CORRECTIVE ACTION SI CROSS-REFERENCED 10 THE AP DEFICIENCY)	HOULD DE	(X5) COMPLETE DATE
3 00 0	INITIAL COMMENT	s	3 000			Weeks and a star of a second second second
	*****ATTENTIC)N******				
	BOARDING CAR LICENSING CORRE					
	In accordance with M 144A.10, this correct	Alinnesota Statute, section to order has been issued				
	pursuant to a survey	 If, upon reinspection, it is ency or deficiencies cited 				
	herein are not correct	sted, a fine for each violation				
		e assessed in accordance nes promulgated by rule of				
tt 0	the Minnesota Depa				н. Н	
		ether a violation has been				
	corrected requires or requirements of the r	ompliance with all rule provided at the tag				
	number and MN Rul	e number indicated below.				
		s several items, failure to re items will be considered				
	lack of compliance.	Lack of compliance upon				
	re-inspection with an result in the assessment	y item of multi-part rule will tent of a fine even if the item				
	that was violated dur	ing the initial inspection was		λ		
	corrected.			·NR		
		earing on any assessments			$\langle \rangle \rangle$	
	orders provided that	non-compliance with these a written request is made to		$\langle x' \rangle \langle y \rangle$		
	the Department withi	n 15 days of receipt of a		2/ 2/0 / 2	M	
	notice of assessmen	t for non-compliance.		in the	Mr I	
1	INITIAL COMMENTS				2	
		26, 2015 surveyors of this sited the above provider and		All a		
	the following licensing	g orders were issued. When				
		leted, please sign and date,		\sim		
	original/lo/the Minnes	e orders and return the sota Department of Health,				
esola Depa	intnienVdFillgallh IREGTOR Star IROVIDAR	N			Managen Color Holder Color	
JRATORY D		SUPPLIER HEPRESENTATIVE'S SIGNALURE	As	MILLI CTD Dorop	3/0	
E FORM	- Construct Inder	× · · · · · · · · · · · · · · · · · · ·	MAN PLO	DAA	If continuatio	2/10

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00733	B. WING		02/26/2015	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
	A AT OSSEO		OND STREET SOL MN 55369	ITHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
3 000	INITIAL COMMENTS		3 000			
	*****ATTENTION*****					
	BOARDING CARE HOME LICENSING CORRECTION ORDER					
	144A.10, this correction pursuant to a survey. found that the deficience herein are not correction ot corrected shall be with a schedule of finithe Minnesota Depart Determination of when corrected requires correquirements of the minnes when a rule contains comply with any of the lack of compliance. If re-inspection with any result in the assessmit	ther a violation has been				
	that may result from r orders provided that	earing on any assessments non-compliance with these a written request is made to n 15 days of receipt of a t for non-compliance.				
	Department's staff vis the following licensing corrections are comp	26, 2015 surveyors of this sited the above provider and g orders were issued. When leted, please sign and date, e orders and return the				

SLSD11

6899

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00733	B. WING	B. WING		02/26/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
	A AT OSSEO		OND STREET SOU MN 55369	ITHEAST			
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3 000	Continued From page	e 1	3 000				
		ce Monitoring, Licensing and ; 3333West Division Street, MN 56301.					
3 310	MN Rule 4655.1200 S Licensee;Appointmer	Subp. 2B ntof Admin/person in charge	3 310				
	develop written bylaw be available to all me and shall assume full matters under its con rendered and for com and rules of legally au responsibilities of the B. Appointment of administrator or a per responsible for the op	duties. The licensee shall vs and/or policies which shall embers of the governing body legal responsibility for trol, for the quality of care apliance with applicable laws uthorized agencies. The licensee shall include: T a licensed nursing home rson in charge who shall be peration of the home in and established policies.					
	by: Based on interview a facility failed to ensur service agency (SNS facility was registered commissioner of heat	at is not met as evidenced nd document review, the re the supplemental nursing A) which was used by the d with the Minnesota lth as required. This had the 81 residents who resided in					
	-	ice conference on 2/23/15, at					
	the facility had previo	.m. the administrator stated ously utilized a supplemental called All Heart Service,					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMP	SURVEY LETED
		00733	B. WING	B. WING		26/2015
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE		02/	20/2015
	A AT OSSEO		OND STREET SOU	ITHEAST		
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PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN) THE APPROPRIATE	COMPLET DATE
3 310	Continued From page	e 2	3 310			
	 which was previously known as Soul Care, however, the agency was sold and renamed. The administrator was aware All Heart Service was currently not registered as an SNSA with the state of Minnesota, and the facility was not to use the SNSA. During interview on 2/24/15, at 2:52 p.m. the staffing coordinator stated the facility was not to be using All Heart Service because it was not registered with the state, however, a facility nurse had contacted All Heart Service and was provided nursing assistant (NA)-F, who worked in the facility on 2/15/15, from 4:30 p.m. to 10:30 p.m. 					
	facility nurse consulta had gone out of busin bought and renamed nurse consultant stat Heart Service did not Minnesota as an SNS knowledge of All Hea registered as an SNS State of MN, a nurse	SA to provide services in the at the facility had contacted provided NA-F to work at				
		determined All Heart Service the state of Minnesota as an statute 144A.71.				
	services agency shal commissioner. Each business of a supplet agency shall register	es a supplemental nursing I register the agency with the separate location of the mental nursing services				

STATE FORM

6899

STATEMENT	a Department of Healt FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
			P. 14940			
	ROVIDER OR SUPPLIER	00733	DDRESS, CITY, STATE		02	2/26/2015
NAIVIE OF PI	ROVIDER OR SUPPLIER					
THE VILL	A AT OSSEO		MN 55369	III LAOT		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE	(X5) COMPLET DATE
				DEFICIEN	ICY)	_
3 310	Continued From page	e 3	3 310			
	agency shall have a Subd. 2.Application i The commissioner sh procedures for proce nursing services age An application for a s services agency regit the following: (1) the names and ac owners of the supple agency; (2) if the owner is a c articles of incorporati together with the nam officers and directors (3) satisfactory proof 144A.72, subdivision clauses (5) to (7); (4) any other relevan commissioner determ properly evaluate an and (5) the annual registr nursing services age Subd. 3.Registration A registration issued according to this sec of one year from the the registration is rev section 144A.72, sub	hall establish forms and sising each supplemental ncy registration application. supplemental nursing stration must include at least ddresses of the owner or mental nursing services corporation, copies of its on and current bylaws, nes and addresses of its of compliance with section 1 , t information that the nines is necessary to application for registration; ration fee for a supplemental ncy, which is \$891. not transferable. by the commissioner tion is effective for a period date of its issuance unless roked or suspended under odivision 2 72>, or unless the g services agency is sold or ement is transferred. When a g services agency is sold or				
	of one year from the the registration is rev section 144A.72, sub supplemental nursing ownership or manage supplemental nursing ownership or manage registration of the ag	date of its issuance unless roked or suspended under odivision 2 72>, or unless the g services agency is sold or ement is transferred. When a				

STATEMENT	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. BUILDING:			
	ROVIDER OR SUPPLIER	00733	B. WING		02	2/26/2015
THE VILL/	A AT OSSEO		MN 55369			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETI DATE
3 310		e 4 erview on 3/9/15, at 4:30	3 310			
	p.m. the administrato approached by All He and was told the alleg Soul Care prior client the facility refused to current registration w Service, and the staff Heart Service was no facility until further no stated All Heart Servi registration with the s verified NA-F from All at the facility on 2/15// During interview on 3 director of nursing (D educated in October Service for staffing ne registered as an SNS an oversight by one of Service was called to facility on 2/15/15. D All Heart Service, the	r stated the facility was eart Service in October 2014, ged SNSA was taking over s. The administrator stated sign the contract until a ras provided by All Heart f were educated to ensure All ot used to provide staff to the otice. The administrator ce did not provide a copy of state of Minnesota, and I Heart Service had worked				
	Heart Service and VII dated October 2, 201 indicated, "All Heart p insurance coverage's law on its employees compensation and lia malpractice insurance	provides all required that are mandated by state				
	number 612-617-777	ider of health care nporary basis phone 7." The Staffing Agreement Heart was registered as an				

Minnesota Department of Health STATE FORM

6899

STATEMENT	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00733	B. WING		02/26/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
HE VILL	A AT OSSEO		OND STREET SOL MN 55369	ITHEAST		
		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O		(X5)
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3 310	Continued From page	9 5	3 310			
	SNSA to provide serv Minnesota in accorda 144A.71.	ices in the state of nce with SNSA statute				
	not utilize outside age	ain and ensure staff does ency for staffing purposes to es that are not registered				
	TIME PERIOD FOR (CORRECTION: One (1) day.				
31240	MN Rule 4655.8520 E Dietary Staff Requirements;Sanitary condition		31240			
	Dietary staff:					
		edures and conditions shall operation of the dietary es.				
	by: Based on observation review the facility faile utensils used in reside stored in a clean and addition, the facility fa a safe serving temper prevent the potential of	alled to ensure foods were at rature prior to serving to of food bourne illness. ial to affect all 81 residents				
	Findings include:					
	eight shelves were ob	n 2/23/15, at 12:42 p.m. oserved covered with I were covered with dust and				

Minnesota Department of Health STATE FORM

6899

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00733	B. WING		02	2/26/2015
IAME OF PF	ROVIDER OR SUPPLIER	L	DDRESS, CITY, STATE	, ZIP CODE		
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TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO DEFICIEN		DATE
31240	Continued From page	e 6	31240			
	 debris. Items stored on the shelves included baking pans, steam table pans, storage containers, drinking pitchers, equipment utensils, and cutlery. The Food Service Director (FSD) was present at the time and verified the dirty shelves. Cook-A was interviewed on 2/23/15, at 1:27 p.m. and stated no one was assigned the actual task of cleaning the shelves, but staff was expected if they were dusty or covered with debris, they would clean the shelves off. Cook-A stated the things stored on the storage shelf were all used to prepare and serve resident food. 					
	and included duties to as wiping down all sir	ng the floor. There was no				
	a.m. FSD stated he w not regularly cleaning	view on 2/25/15, at 11:32 vasn't aware the staff were the shelves and stated that regular kitchen cleaning				
		the food served during , and today at lunch he had				
	During interview on 2 stated the food at the including the coffee th					
	-	/23/15, at 5:46 p.m. R68 d at the facility is cold.				
	During interview on 2 partment of Health	/24/15, at 8:35 a.m. R76				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00733	B. WING		02	2/26/2015	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE				
	A AT OSSEO		OND STREET SOU MN 55369	THEAST			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
31240	Continued From page	27	31240				
	reported hot food is often not hot enough.						
	food in the steam tabl serve in the first floor checked the temperat was 130 degrees Fah which was 130 degree which was 120 degree of the food was hot en used a phone to call the (FSD), and reported as back to the kitchen to metal containers of the directed a dietary aided kitchen to be heated. temperature of the por next to the steam table placed inside of a lan layer of ice in the bott temperature of the por F and stated that was she would not be able 5:39 p.m., a dietary a was reheated back to used the thermomete of all of the food and a were now acceptable between 150-180 deg brought to the dining	cook-A used a food a the temperatures of the le she was preparing to dining room. Cook-A ture of the sauerkraut which menheit (F), the tomato soup es F, the pureed vegetables ees F, the pureed meat es F, the pureed meat es F, the mashed potatoes ees F. Cook-A stated none hough to serve. Cook-A the food service director she was sending all the food be heated. Cook-A put the e food items onto a cart and e to bring them back to the					
	cook-A was preparing	n 2/23/15, at 6:06 p.m. I to serve the second shift of oor dining room the supper					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00733	B. WING		02	/26/2015
NAME OF PROVIDER	OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
THE VILLA AT OSS	EO		OND STREET SOU MN 55369	THEAST		
	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETE DATE
that ref meat w 110 de sauerk was 11 asked the corr be serv room a a warm contair subme the cor food he contair them b On 2/2 the kite and me she ha again, The pu degree was 13 check o cook-A temper	vas 100 degree grees F, mash raut was 125 o 0 degrees F. him to come to cern again the ved. At 6:15 p. nd told cook-A n temperature ters the food v rged in the wa tainers needed of. FSD and c ters of food fro ack to the kito 3/15, at 6:41 p then with cont echanical polis d remade the and proceede reed polish sa s F, and the n 5 F. The FSD on the tempera- to serve the f atures.	steam table. The ground es F, the pureed meat was hed potatoes 130 degrees F, degrees F, and the bratwurst Cook-A called the FSD and o the dining room because of e food was not hot enough to m., FSD came to the dining A the food was not holding at because the metal was in needed to be iter on the steam table and ed to be covered to keep the ook-A removed the om the steam table and sent hen to be reheated. 0.m. cook-A returned from ainers of precooked pureed sh sausage. Cook-A stated food rather than reheating it d to check the temperatures. ausage only registered at 140 hechanical polish sausage entered the dining room to atures of the food, and told ood at the current	31240	DEFICIEN	ICY)	
The pu degree was 13 check cook-A temper During registe temper the kito arrived trained and sh	reed polish sa s F, and the n 5 F. The FSD on the temper to serve the f atures. interview on 2 red dietician (l atures were s then prior to th to the dining to check food	Ausage only registered at 140 nechanical polish sausage entered the dining room to atures of the food, and told ood at the current 2/23/15, at 6:49 p.m. RD)-A stated food upposed to be checked in ne meal, and again when it room. RD stated staff were I temperatures in the kitchen, are staff were not doing that				

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00733	B. WING		02/26/2015	
NAME OF P	ROVIDER OR SUPPLIER		I DDRESS, CITY, STATE	, ZIP CODE	02	
	A AT OSSEO	501 SEC	OND STREET SOU	THEAST		
	AAI 033E0	OSSEO,	MN 55369			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE
31240	Continued From page	e 9	31240			
	 Continued From page 9 During another interview on 2/23/15, at 7:10 p.m. FSD stated he had just tested the thermometer cook-A was using to check the temperature of the resident food, and it was reading 20 degrees colder than his thermometer, so he felt the meat was actually 20 degrees hotter than they had originally thought. When asked about the potato salad that registered 70 degree F FSD verified the temperature would have been 90 degrees F with the more accurate thermometer. FSD stated cook-A was running behind and didn't cool the potatoes well enough before making the potato salad. When asked about the coleslaw that was served to the residents at 6:32 p.m. on 2/23/15, FSD stated the temperature was actually probably closer to 60 degrees F with the more accurate thermometer, and stated this would have been too warm to be served and it should have been thrown away to preventable potential 					
	p.m. cook-A stated sl temperature of the fo dining room, howeve on Monday evening. the food was not stay not wrapping the con cellophane and tin fo enough water in the s were sitting in the wa not turning on the ste bringing the food ups	il, not ensuring there was steam table so the pans tter to remain hot, and was eam wells one hour prior to tairs to serve.				
	2010, included, "All h cooked to appropriate and served at a temp [degrees] FHot food	ed Food Temperatures dated not food items must be e internal temperatures, held perature of at least 135 d items may not fall below r cookingat least 165				

STATEMENT	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00733	B. WING		02	/26/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
	A AT OSSEO		OND STREET SOU MN 55369	THEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
31240	must be maintained a of 41 [degrees] F or b be taken periodically above 135 [degrees] 41 [degrees] during th and delivery process individual recipient" The facility policy title Tray line policy dated service salads and ot service are to be place 3-4 hours before service	ervingAll cold food items and served at a temperature belowTemperatures should to ensure hot foods stay F and cold foods stay below ne portioning, transporting, until received by the	31240			
31915	Service Director (FSE all staff is trained on o appropriate food temp audit food temperatur food at appropriate te potential food bourne TIME PERIOD FOR 0 (21) days.	f Correction: The Food D) or designee could ensure cleaning procedures and peratures. The FSD could res to ensure staff is serving emperatures to prevent illness. CORRECTION: Twenty One bd. 27 Patients & Residents	31915			
5 15 15	of HCF Bill of Rights Subd. 27. Advisory their families shall ha maintain, and particip family councils. Each assistance and space meetings shall be affer visitors attending only	councils. Residents and ve the right to organize, pate in resident advisory and facility shall provide for meetings. Council prded privacy, with staff or				

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING			(X3) DATE SURVEY COMPLETED	
		00733			02/26/2015		
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE				
THE VILL	A AT OSSEO		OND STREET SOU MN 55369	THEAST			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE	CTION SHOULD BE COMPLE O THE APPROPRIATE DATE		
31915	Continued From page 11		31915				
	responsibility of providing this assistance and responding to written requests which result from council meetings. Resident and family councils shall be encouraged to make recommendations regarding facility policies.						
	This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to attempt to organize a family council on at least an annual basis. This had the potential to affect all 81 residents' residing in the facility who had families who would potentially attend family council. Findings include:						
	activities director state family council and wa	/25/15, at 2:30 p.m. the ed the facility did not have a is not aware of any attempts cil in the nine years she had acility.					
	facility which stated, " like to offer the opport concerned persons to receive responses fro Family Council can be be posted in the news first meeting would be	ument was provided by the As 2014 begins, we would tunity for our families or o start a family council. If we om people interested, the e established and notice will sletter to announce when the e." The document directed contact the facility social					
	provided had been m sometime at the start when. RN-A stated th)-A stated the document					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 02/26/2015	
		00733				
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE	•	
HE VILL	A AT OSSEO		OND STREET SOU MN 55369	THEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLE D THE APPROPRIATE DATE	
31915	unavailable for interv had been no family r further attempts to or been completed since The facility was unab tracking of who the u or if there was any for responses to the lett Suggested Method or worker or designee or contacted at least an family council group. designee could ensu follow up with familie	riew, but she believed there esponses to the letter and no rganize a family council had ee. ble to provide a date or any undated letter was sent out to, blow up needed or any er. of Correction: The Social could ensure all family is unually to attempt to set up a The administrator or ure the letter is sent and	31915			