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.

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.

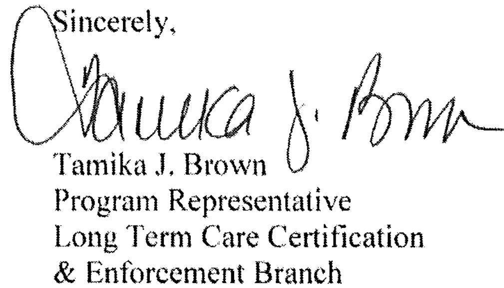
If you are dissatisfied with the effective date of Medicare participation indicated above, you may request that the determination of the effective date be reconsidered. The request must be submitted in writing to this office within 60 days of the date you receive this notice. The request

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,



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

00733

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 2Q1O

Facility ID: 00733

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

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

4. TYPE OF ACTION: 1 (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY 03/10/16 (L34)

8. ACCREDITATION STATUS: ___ (L10)

0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 3 (L7)

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

FISCAL YEAR ENDING DATE: (L35) 12/31

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

12. Total Facility Beds 102
13. Total Certified Beds 102

10. THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:

___ 1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:

___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: A* (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	20	82		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

Page #1 of this CMS 1539 is being forwarded to CMS and will serve to correct and replace the first page of the CMS 1539 completed 3/14/16.

17. SURVEYOR SIGNATURE Date:

Timothy Rhonemus - HFE II 3/10/16 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:

Colleen B. Leach, Certification Specialist 11/15/2016 (L20)

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

19. DETERMINATION OF ELIGIBILITY

X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible

(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY 00
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. (L31)

30. REMARKS

Sent to CMS/RO___________
As an Email notification.
Attached in ACO.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE 05/20/2016 (L33)

DETERMINATION APPROVAL

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: WWW3
Facility ID: 00733

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **Initial**

2. STATE VENDOR OR MEDICAID NO.
(L2 **836420100**

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

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

5. EFFECTIVE DATE CHANGE OF
(L9

6. DATE OF **03/10/2016** (L34)

8. ACCREDITATION __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02	06 PRTF	10 NF	14 CORF	
03	07 X-Ray	11	15 ASC	
04 SNF	08	12 RHC	16	

FISCAL YEAR ENDING (L35)
12/31

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

12. Total Facility Beds **20** (L18)

13. Total Certified Beds 20 (L17)

10. THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

* Code: A (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Timothy Rhonemus – HFE II 03/10/16
(L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Certification Specialist 03/14/2016
(L20)

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

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

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3. Both of the Above :

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01/01/1975
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY 00
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS

Sent to CMS / (RO)
As an Email notification.
Attached in ACO.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

IDM-Find

FORM CMS-1539 (7-84) (Destroy Prior Editions)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED
			03/10/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On March 10, 2016, surveyors from this department performed an Initial Certification survey using the Traditional Survey process, at The Villa at Osseo to federally certify a newly added 20 bed TCU. No beds were added. The facility has been found to be in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E117	A. BUILDING **02 - THE VILLA OF OSSEO** B. WING	**09/24/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS An Initial Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on September 24, 2015. At the time of this survey, The Villa of Osseo, Southwest Wing addition was found to be 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), Chapter 18 New Health Care. The Villa of Osseo, Southwest Wing is a 1-story building with no basement the construction Type II(000) construction. The facility has a 2-hr separation from existing 2-story nursing home. This facility will be surveyed as 2 buildings because of the existing and new building. The facility is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 20 beds and had a census of 0 beds at the time of the survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | 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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: C45Z
Facility ID: 00733

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **24E117**

2.STATE VENDOR OR MEDICAID NO.
(L2) **836420100**

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

4. TYPE OF ACTION: **2** (L8)

1. Initial
2. Recertification
3. Termination
4. CHOW
5. Validation
6. Complaint
7. On-Site Visit
9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/14/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 10 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

13.Total Certified Beds **20** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With
Program Requirements
Compliance Based On:
____1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:

___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

This revises the 1539 dated 5/11/2016.

17. SURVEYOR SIGNATURE Date :
Jennifer Bahr, HFE NE II 05/10/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 05/11/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1975
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS

Posted 05/20/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: C45Z
Facility ID: 00733

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **24E117**

2.STATE VENDOR OR MEDICAID NO.
(L2) **836420100**

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

4. TYPE OF ACTION: **2** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/14/2016** (L34)

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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From (a) :
To (b) :

12.Total Facility Beds **20** (L18)

13.Total Certified Beds **20** (L17)

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A. In Compliance With
Program Requirements
Compliance Based On:
____1. Acceptable POC

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And/Or Approved Waivers Of The Following Requirements:

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___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Jennifer Bahr, HFE NE II 05/10/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 05/11/2016 (L20)

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A. Suspension of Admissions:
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B. Rescind Suspension Date:
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26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
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INVOLUNTARY
05-Fail to Meet Health/Safety
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OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

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(L31)

30. REMARKS

Posted 05/20/2016 Co.

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32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: C45Z
Facility ID: 00733

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)
6. DATE OF SURVEY **04/14/2016** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 10 (L7)
01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA
02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF
03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC
04 SNF 08 OPT/SP 12 RHC 16 HOSPICE

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12. Total Facility Beds 20 (L18)
13. Total Certified Beds 20 (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With
Program Requirements
Compliance Based On:
___ 1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: B* (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date:
Jennifer Bahr, HFE NE II 05/10/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 05/11/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1975
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

26. TERMINATION ACTION: (L30)
VOLUNTARY 00
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

25. LTC EXTENSION DATE:
(L27)

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
5-20-2016 (L33)

DETERMINATION APPROVAL [signature]

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:

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

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by 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 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.

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

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

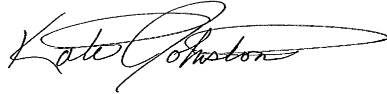
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E117	A. BUILDING ______ B. WING ______	04/14/2016

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

RECEIVED MAY 10 2016 MN Dept of Health St. Cloud

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	approved 5/10/16 [signature]	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess and implement meaningful activities for 1 of 4 residents (R50) reviewed for activities. In addition, the facility failed to provide sufficient activity opportunities during weekend hours for 2 of 4 residents (R75, R37) reviewed who indicated there were not enough activities provided on the weekends. Findings include: R50's annual Minimum Data Set (MDS) dated 3/15/16, identified R50 had severe cognitive	F 248	R50 is completely dependent and not able to communicate needs or wishes. An activity assessment was completed with resident's family on April 27th 2016 and care plan was updated. Resident will be brought to attend activities that meet his interest if he is awake. One-on-one visits with R50 have increased from once a week to twice per week. Residents who are dependent and not able to communicate needs or wishes were reviewed for proper activity programming. Sensory activities have been added to the activity calendar for May for residents who may benefit from them. R75 was interviewed on April 26th 2016 for activity interest and care plan was updated. Activity staff working the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 5-5-16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 248	Continued From page 1 impairment and had diagnosis including Alzheimer's disease. R50's care area assessment (CAA) for activities dated 3/22/16, indicated R50 had little interest or pleasure in doing things, had chronic heath issues which resulted in reduced activity participation, and had functional mobility deficits. The CAA indicated R50, "Is not able to participate in structured activities or communicate. Resident is laid down in between meals and is on a weekly one on one visit from activities staff members." R50's care plan for activities dated 4/13/16, identified R50 was dependent for meeting "emotional, intellectual, physical and social needs," and listed interventions including, "All staff to converse with resident while providing cares; provide with activities calendar, notify resident of any changes to the calendar of activities; thank resident for attendance at activity function; the res [resident] needs 1:1 bedside/ in-room visit and activities is unable to attend out of room events; the resident needs assistance/escort to activity functions; and the resident's preferred activities are: resident enjoys music, observed by tapping of feet and hands, provided with cd player/radio in room for stimulation." During observation on 4/11/16, between 11:40 a.m. and 3:30 p.m., R50 was either in his wheel chair, being assisted in the dining room with eating, or observed lying in his bed in his room. At 1:37 p.m. while lying in bed, music was heard from a CD player in R50's room. R50 was not observed being offered any activities.	F 248	weekends will inform resident of what is going on that day and offer to attend. F37 was interviewed on April 22nd 2016 for activity interest and care plan was updated. Activity staff working the weekends will inform resident of what is going on that day and offer to attend. Residents were interviewed in regards to activity enjoyment and to give ideas on what can be offered. At resident council May 4th 2016, residents were asked about what activities they enjoyed, which they didn't care for and what else they would like to see offered. 2 hours were added to activity staff on Saturdays starting May 1st 2016 to ensure more group activities could be offered. Staff education will be completed by May 24th. All residents will have an activity assessment completed quarterly. Resident attendance at activities will continue to be tracked. Residents with decreased activity attendance will be reported to QA monthly.	

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F 248	Continued From page 2 During observation on 4/12/16, at 12:47 p.m., R50 was observed in the 1st floor dining room. Following the noon meal, R50 was observed sleeping in his room at 2:12 p.m. The same evening, at 7:38 p.m., nursing assistants (NA)-J and NA-K began R50's evening routine, providing with cares, and assisting him into bed. During interview on 4/12/16, at 7:47 p.m. NA-H stated she talks with R50 when getting him ready for bed or taking him to meals, however, she stated this was something she did with all residents; there was nothing special she did with R50 pertaining to activities. During interview on 4/13/16, at 9:33 a.m. NA-B stated R50 did not go to activities, and after meals staff just put him back to bed. NA-B thought R50 slept most of the time, and the resident rarely responded and could not make his needs known. A review of the facility's activity calendar for March 2016, listed activities including: Susie's sewing, coffee shop, bingo, visits & mail, dice game, Rosary, fitness club, book club, Catholic and protestant religious services and communion, fitness club, manicures, and art. A review of activities from January 2016, to April 2016, also indicated music offerings on various dates, including hymn sings, "music with Gary," "music with Vern," "Triniti Singers," and "classical music with Ernest." A review of the facility's recreation participation records for R50 from January through April 2016, indicated a daily, one-to-one visit recorded for R50, however, there were no other structured activities documented for R50 on any of the	F 248	Facility will be in compliance May 24th 2016.	

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F 248	Continued From page 3 participation records. Even though R50 liked music, as identified in the care plan, the participation records indicated R50 had no outside music activity offered. A review of nursing progress notes from 12/31/2015, to 4/14/2016, indicated R50 had a weekly, one-to-one visit 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. During interview on 4/13/16, at 11:44 a.m. the activities director (AD) stated the focus for R50 was 1:1 visits which were completed by her or volunteer staff on a weekly basis. The AD stated she had known R50 for about three years, and R50's condition had remained about the same, however, R50 used to be brought out to activities. AD stated R50 no longer went to activities because it upset his spouse (who also lived at the facility), when she saw R50 at an activity and R50 no longer recognized his spouse. In addition to 1:1 visits, the AD stated R50 enjoyed music, however, if R50 was laying down as he often did, staff would not awaken him. The AD also stated in the past she would bring R50 out to hear the player piano, and also when entertainers came out, but acknowledged it was hard, "especially at a change of shift" to get him out. The AD stated now he has a music CD player for his room, but said she did not know the last time R50 was out at a music event. The AD further stated R50's routine "includes a lot of sleep" and "we stop and see him, and all the residents" and give a greeting. The AD acknowledged R50's initial activity assessment was completed 2/2/10; subsequent activity assessments for the MDS were completed in the computer. The AD said an annual MDS assessment was completed "last	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E117	A. BUILDING ____ B. WING ____	04/14/2016

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F 248	Continued From page 4 month", but was not aware of a more comprehensive assessment that evaluated and addressed R50's present activity needs. In a follow up interview on 4/14/16, at 1:06 p.m., the AD stated "we would continue with R50's one-to-one visits," but certainly could increase the frequency of those visits. The AD also stated staff would be completing a more comprehensive individualized activity assessment to see if R50 could benefit more from activity stimulation, and "how that could be a part of his plan." R75's annual MDS dated 8/25/16, indicated it was very important to R75 to participate in her favorite activities. R75's quarterly MDS dated 2/4/16, indicated R75 had moderate cognitive impairments and included a diagnosis of depression. R75's last comprehensive activity assessment was dated 3/24/14, indicated R75 needed encouragement to come to activities, and the residents interests included spiritual, gardening, library cart, music, walking, art, baseball, jewelry making, outdoor games, indoor games, reading, cards, poetry, nails, cooking, baking, scrap booking, outings, word find books, and puzzles. R75's care plan dated 11/16/15, indicated R75 was dependent on staff for meeting emotional and social needs, and directed staff R75 preferred activities that did not involve overly demanding cognitive tasks, and to engage her in simple structured activities, such as writing cards to family. When interviewed on 4/12/16, at 12:41 p.m. R75 stated there were no activities on Saturday's and	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 248	Continued From page 5	F 248		

there was nothing to do for her at the facility.

During a follow up interview on 4/14/16, at 8:47 a.m. R75 stated she doesn't do anything on Saturday's and that it was not by her choice, she stated there were no activities provided.

R75's February, March, and April 2016 Recreation Participation Record reviewed for weekends indicated R75 did not participate in any weekend activities for February, attended a music activity on 3/12/16, and attended church on 4/3/16. In the 3 months reviewed, R75 did not participate in any other activities.

R37's annual MDS dated 3/29/16, indicated R37 was cognitively intact, had a diagnosis of depression, and indicated it was very important to R37 to do his favorite activities.

The facility did not have a individualized comprehensive activity assessment which included past interests, current activity preferences, and how the activity department was going to meet R37's social needs.

R37's care plan dated 6/13/14, directed the staff to assist the resident with a program of activities that was meaningful and of interest to R75, however, there was no specific direction to staff regarding R37's interests.

When interviewed on 4/11/16, at 11:20 a.m. R37 stated the facility didn't have anything for activities on the weekends and it was "very boring" on Saturday and Sunday's. R37 further stated " They [the facility] act like they lock the place down [on weekends]."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E117	A. BUILDING ______ B. WING ______	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 6 R37's February and March 2016 Recreation Participation Record for weekends indicated R37 did not participate in any activities on the weekends. The facility was unable to provide a April 2016, Recreation Participation Record for R37. Review of the activity calendar for February 2016, indicated on each Saturday there were only two activities offered to the residents which included visits and mail every Saturday and then one other alternating activity of a movie, manicures, bingo, and/ or dictionary. The activities were scheduled at 1:00 p.m. or 1:30 p.m. and 2:00 p.m. or 2:30 p.m. with no activities scheduled for the rest of the day. Sunday's there were only three activities scheduled with the exception of 2/14/16 which included four activities. Activities included were Sunday Service or Hymn Sing, visits with Jada and then alternating another activity of crafts, coffee and treats, dice game, manicures or card game. The activities were scheduled at 10:00 a.m. 11:00 a.m. and 3:00 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 March 2016, indicated that on each Saturday there were only two activities offered to the residents which included visits and mail every Saturday and then one other alternating activity of Easter craft, triniti singers, yahtzee and arts and crafts. The activities were scheduled at 1:00 p.m. and 2:00 p.m. or 2:15 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 then alternating activities of visits with Jada, dice, cover that number, coffee and	F 248		

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F 248	Continued From page 7 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	F 248		

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F 248	Continued From page 8 for a few hours each day on the weekends and had requested more hours on the weekends but had been told there isn't enough hours to be scheduled longer shifts. When interviewed on 4/14/16, at 9:48 a.m. AD stated she was only allotted a few hours on each day of the weekend for activity staff and staffing for activities was based on the current resident census. The AD stated she had residents complain of the lack of activities on the weekends but had made available DVD's for residents to watch if they are bored. AD stated the activities on the weekends are to be more self directed. The facility policy Quality of Life- Self Determination and Participation dated 10/09, indicated residents shall be provided assistance to engage in their preferred activities on a routine basis.	F 248		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess the safe use of a perimeter mattress with a fixed grab bar which did not meet FDA (Federal	F 323	R28 has had no negative outcomes from the assist rail placed on bed. Her bed was reassessed for safety. Her perimeter mattress was replaced with a regular flat mattress and a second rail was place to secure mattress from sliding – the maximum gap is now 1.25" An audit of all beds with an assist rail was performed by Administrator to ensure no others exceeded the FDA recommendation of 4.75". Facility Administrator updated policy regarding use of side rails to ensure	

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F 323	Continued From page 9 Drug Administration) guidelines to prevent entrapment for 1 of 1 residents (R28) reviewed for accidents and hazards related to a large gap between the mattress and grab bar. Findings include: R28's significant change Minimum Data Set (MDS) dated 2/6/16, identified R28 had moderate cognitive impairment, required extensive assistance from staff for bed mobility, had hemiparesis (paralysis of one side of the body), and had a seizure disorder. During observation on 4/11/16, at 1:27 p.m. R28's bed had a perimeter mattress and metal grab rail (used to help with bed mobility) which was fixed to the bed frame. R28's mattress moved easily when slight pressure was applied to it, which created a large gap (approximately 5-6 inches) between the grab bar and mattress. R28's Evaluation for Use of Side Rails dated 1/11/16, identified R28 had a recent increase in falls and demonstrated a loss of balance at times. The evaluation identified R28 used the mobility (grab) bar, "To assist with transfers and bed mobility." However, the evaluation did not identify if R28 had been assessed for the safe use of the easily moveable perimeter mattress that resulted in a large gap between the mobility rail and mattress which could cause entrapment if R28 attempted to exit the bed by herself and was unable too. R28's care plan dated 2/12/16, identified R28 had an activities of daily living (ADL) self performance deficit and was, "Able to make positional changes in bed independently. Occasionally able to get in	F 323	there is no gap larger than 4.75" when rails are placed on bed and mattress is secured. Staff will be educated on bed safety and assist rail guidelines by May 24th. All beds will be audited by maintenance for safety on a month basis for 3 months. Results of audit and policy will be reviewed at QA. Facility will be in compliance May 24th 2016.	

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F 323	Continued From page 10 and out of bed, but generally needs staff to assist ... Is able to self-transfer out of bed and walk to the bathroom per self at times." R28's progress note dated 3/21/16, identified, "NAR reported that @ 4:15 pm she found R28 sitting on her buttocks near her bed ... No apparent injuries noted, denies pain." Further, the note identified staff, "Reminded [R28] to call for assistance with all transfers. Call light in place. Will continue monitoring." The U.S. Department of Health and Human Services Food and Drug Administration (FDA) guidance for Bed System Dimensional Assessment and Guidance to Reduce Entrapment, issues 3/10/06, included information for facilities to reduce entrapment risk of patients with side/assist rails, which may result in death or serious injury. The guidance identified vulnerable patients as those who have problems with memory, sleeping, incontinence, pain or uncontrolled body movements, or those who get out of bed unsafely without assistance. Zone 3 included, the gap, "between the rail and mattress." The FDA recommended this space be less than 4 3/4" (inches), a space where a head could become entrapped. During an interview on 4/16/16, at 7:50 a.m. nursing assistant (NA)-C observed R28's mattress and applied pressure to it causing it to move over on the frame exposing a large gap between the fixed grab rail and perimeter mattress. NA-C pushed on R28's perimeter mattress and stated it, "Slides easily" and was, "Not a good thing." Further, NA-C stated maintenance should secure the mattress to the bed frame so it doesn't slide.	F 323		

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F 323	Continued From page 11 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 323		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP	F 364		

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F 364	Continued From page 12 Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure refrigerated foods were served cold and palatable for 1 of 1 residents (R41) observed who received warm cottage cheese. Findings include: 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 waiting to be served her meal. 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 steam table which contained pooled water and partially melted crushed ice, and sitting inside the pool of ice/water was a clear container of mandarin oranges, and a 5 lbs (pound) white container of cottage cheese which appeared to have a watery texture. At 12:25 p.m. cook (CK)-A walked behind the steam table to begin serving meals. She removed a thermometer from a plastic container behind the steam table and checked the temperature of the stroganoff, and vegetables, however did not check any of the temperatures of the cold items, including the	F 364	The cottage cheese found at improper temperature was immediately thrown away. R41 was monitored and had no negative outcome from receiving the cottage cheese. No other residents were observed to have GI issues or negative outcomes from cottage cheese. Staff will be educated on proper procedures for temping food and setting up the serving area to ensure food stays at proper temperatures. At Resident Council on May 4th 2016, residents were made aware of audit process. Residents were also reminded there are always alternate options available if they do not like the meal they received, they are able to ask for something else. Audits of food palatability will be conducted 3x week per meal. Food temps will be taken at each meal to ensure safe zone – any food found in the danger zone will be immediately thrown away. Audits will be review by QA monthly.	

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F 364	Continued From page 13 cottage cheese. CK-A picked up a plate, scooping servings of the cottage cheese and mandarin oranges on it before setting it on the serving bar. Dietary manager (DM)-A picked up the plate with the cottage cheese and mandarin oranges and served it to R41 who was seated at a table. The surveyor requested CK-A check the temperature of the cottage cheese which remained uncovered on the steam table. CK-A checked the temperature of the cottage cheese, stated it was 60.9 degrees Fahrenheit, and she would obtain a new container of cottage cheese to serve the residents. During interview on 4/12/16, at 12:36 p.m. R41 stated she didn't like the cottage cheese served that day because it didn't, "Taste right." R41 stated it had a, "Kind of sour taste to it," and stated nobody offered to get her a new plate of food since it had been served. When interviewed on 4/12/16, at 1:13 p.m. DM-A stated cottage cheese should be served at, "40 or below [degrees]," in order to, "Guarantee freshness." Further, DM-A stated the staff offered R41 a new plate of cottage cheese, but only after they observed the surveyor speaking to the resident about her meal palatability. During interview on 4/13/16, at 1:42 p.m. the registered dietician (RD)-A stated cottage cheese should be served, "Nice and cold." If cottage cheese was served warm it could have, "A little bit of a sour taste" which was, "Not optimal by any means." A facility policy on food palatability was requested, but none was provided.	F 364	Facility will be in compliance May 24th 2016.	

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F 371	Continued From page 14	F 371		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure refrigerated foods were held and served at or below 41 degrees to reduce the risk of potential food borne illness for 1 of 1 residents (R41) observed to receive warm cottage cheese. This had potential to affect 8 of 8 residents observed during the same meal service who were served cottage cheese. Findings include: 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	F 371	The cottage cheese found at improper temperature was immediately thrown away. R41 was monitored and had no negative outcome from receiving the cottage cheese. No other residents were observed to have GI issues or negative outcomes from cottage cheese. Staff will be educated on proper procedures for temping food and setting up the serving area to ensure food stays at proper temperatures. Food temps will be taken at each meal to ensure safe zone – any food found in the danger zone will be immediately thrown away. Audits will be review by QA monthly. Facility will be in compliance May 24th 2016.	

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F 371	Continued From page 15 steam table which contained pooled water and partially melted crushed ice, and sitting inside the ice was a clear container of mandarin oranges, and a 5 lbs (pound) white container of cottage cheese which was approximately half full and appeared to have a watery texture. At 12:25 p.m. cook (CK)-A walked behind the steam table to begin serving meals. She removed a thermometer from a plastic container behind the steam table and checked the temperature of the stroganoff, and vegetables, however did not check any of the temperatures of the cold items, including the cottage cheese. CK-A picked up a plate, scooping servings of the cottage cheese and mandarin oranges on it before setting it on the serving bar. Dietary manager (DM)-A picked up the plate with the cottage cheese and mandarin oranges and served it to R41 who was seated at a table. The surveyor requested CK-A check the temperature of the cottage cheese which remained uncovered on the steam table. CK-A checked the temperature of the cottage cheese, and stated it was 60.9 degrees Fahrenheit. When interviewed on 4/12/16, at 12:31 p.m. CK-A stated the opened container of cottage cheese had been sitting out un-covered for, "About 45 minutes" since the prior meal service started. CK-A stated there had been ice in the bin but it had melted, and the cottage cheese should have been kept cold to ensure it was safe to eat. During interview on 4/12/16, at 1:13 p.m. DM-A stated she immediately discarded the warm cottage cheese after it was identified the temperature was 60.9 degrees Fahrenheit. DM-A stated she didn't feel there had been enough ice placed in the container to ensure the cottage	F 371		

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F 371	Continued From page 16 cheese remained at, "40 [degrees] or below," which would help ensure, "Bacteria doesn't grow," in the products before being served. When interviewed on 4/13/16, at 1:42 p.m. registered dietician (RD)-A stated foods which are kept in the, "Temperature danger zone" for extended periods should be discarded because it could potentially be, "Unsafe to eat." RD-A stated residents who might have consumed the warm cottage cheese would be placed at, "Increased risk for foodborne illness." An undated Food Preparation and Service policy identified, "The 'danger zone' for food temperatures is between 41 degrees and 135 degrees Fahrenheit. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness." The policy identified several, "Potentially hazardous foods," including, "...seafood, cut melon, eggs, milk, yogurt and cottage cheese," and directed staff to maintain these foods, "At 41 [degrees] or below ..." Further, the policy identified food service staff should, "Discard the food if it cannot be determined how long the food temperature was above 41 [degrees Fahrenheit]."	F 371		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by:	F 465	R72's room has been eliminated from urine smell. Resident had been given a med adjustment that was found to be the cause of incontinent episodes. Another med adjustment was done that resolved the issue. Carpet was cleaned and the odor was eliminated. Resident's toileting plan was updated for staff direction to the bathroom with	

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F 465	Continued From page 17 Based on observation, interview, and document review the facility failed to ensure the facility was free of urine odors for 2 of 2 residents rooms (R72, R65) whose room had a strong odor of urine. Findings include: During observation on 4/11/16, at 11:09 a.m. a very strong odor of urine was noted when entering R72's resident room. During observation on 4/12/16, at 6:01 p.m. R72's room was again noted to have a very strong odor of urine, and the smell got stronger near the residents bed. On 4/13/16, at 12:15 p.m. R72's door was open and the windows were open, however, the strong odor of urine was still present. During observation on 4/11/16, at 11:09 a.m. an odor of urine was present in R64's room. On 4/13/16, at 9:00 a.m. housekeeping (HK)-B was observed cleaning the carpet in R64's room at the foot of the bed, however, during follow up observation on 4/14/16, at 2:26 p.m. the smell of urine still remained very strong. During interview on 4/14/16, at 9:24 a.m. HK-B stated the facility had Deep Cleaning Schedules they complete, and stated R64 and R72 rooms were checked daily, and housekeeping used the carpet cleaner to clean these areas regularly. HK-B stated the deep cleaning schedule for R72's room had been in place for about 2 weeks. HK-B stated another residents room [R66] had also been on a routine cleaning schedule related	F 465	care and post-meals. R64 will be moved to room 242 on May 20th 2016. Prior to him moving the floor will be replace with non-porous flooring. Room 225 where R64 currently resides will be deep cleaned. If the urine odor is not resolved with deep cleaning the carpet will be replaced with non-porous flooring. Resident has behavior of dumping his urinal on the floor instead of having staff empty for him. His toileting plan has been updated with a goal of using bathroom during daytime and utilizing the urinal only during the night. Facility Administrator and Director of Housekeeping performed an environmental walk through of entire facility on April 27th 2016. Director of Housekeeping and her District Manager did an environmental walk through of entire facility May 4th 2016. Concerns addressed as needed. R37 was interviewed on May 5th 2016 to see if he noticed a difference in the odors. He stated they haven't noticed a smell lately. R9 was informed of the plan to reduce odors near her room and she was agreeable.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 18 to strong urine smell, however, the facility had replaced the carpet with hard flooring in that room which resolved the urine smell issue. During interview on 4/14/16, at 10:44 a.m. R37 stated he could smell urine over towards another residents room and found it offensive. During interview on 4/14/16, at 10:52 a.m. R9 stated, "I can smell the urine out in the hall... usually in the morning from one of the rooms next to me... I can smell it really bad." R9 stated facility staff usually cleans the rooms at some point during the day, however, R9 needed to keep the door to his room closed so he didn't smell the urine odor. During interview on 4/14/16, at 11:03 a.m. HK-A stated R72's room smelled, "A little bit of the chemical odor, and maybe a touch of the urine." HK-A stated part of the problem of the ongoing urine odor was the carpet had not fully dried from cleaning it. HK-A stated the rooms of R72 and R64 were checked and scrubbed daily related to the strong urine smell. During interview on 4/14/16, at 1:08 p.m. the administrator stated the facility was looking forward to remodeling the existing facility and were looking toward finalizing the plans in the next few weeks which would include replacement of flooring, cabinets, and lighting. The administrator stated there was no current timeline in place, and no plan for prioritization of completion of tasks. The remodeling project had previously been anticipated to start prior to the end of 2015, as stated in the letter to residents and families dated 10/27/15, and, in an email dated 4/14/16 provided by the administration	F 465	Staff education will be completed by May 24th 2016. Director of Housekeeping or designee will audit facility for odors twice a week for 3 months. Areas with continued odors will be placed on facility focus list to include more routine deep cleanings. If odors cannot be eliminated areas will be schedule for renovation. Audits will be reviewed by QA. Facility will be in compliance May 24th 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E117	A. BUILDING ______ B. WING ______	04/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	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, neutral scents."	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E117	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/13/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. 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), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	APPROVED By Tom Linhoff at 1:39 pm, May 09, 2016 RECEIVED MAY - 9 2016 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	5-9-16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E117	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/13/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 St. Paul, MN 55101-5145, OR By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This 2-story building is downgraded from construction Type II (222) to Type V (111) due to wood joist and plywood floors in some of the linen closets. It has a partial basement and is fully fire sprinklered. The facility has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridor that is monitored for automatic fire department notification. On September 24, 2015, a 1-story addition was build of Type V (111) construction. The addition does not have a basement and is fully sprinklered. The addition has a fire alarm system with smoke detection in the resident rooms, corridors and spaces open to the corridor is monitored for automatic fire department notification. The facility has a capacity of 102 beds and had a census of 76 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E117	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/13/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to maintain smoke/fire barrier doors in accordance with LSC 19.3.7.5. This deficient practice could affect on 58 residents. Findings include: On facility tour between 09:30 AM and 01:30 PM on April 13, 2016, observation revealed that there was a penetration through the smoke barrier wall, above the doors, on the first floor, in the existing building. This deficient practice was verified by the Administrator at the time of the inspection.	K 025	The penetration through the smoke barrier on first floor was patched and sealed on April 20th 2016 by Jack Johnson, Maintenance Assistant. Facility maintenance will ensure the smoke barriers are not compromised monthly for 3 months and after any work affecting them is completed.	
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to maintain the emergency generator in accordance with the requirements of NFPA 110-1999 edition, Section 6-4. This deficient practice could affect all 76 residents.	K 144	Facility uses TELS system for generator monitoring. Generator cool down documentation prompting was added to system. Facility maintenance was educated on April 13th 2016. Maintenance will audit cool down period monthly and report to QA for 3 months to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E117	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**04/13/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 3 Findings include: On facility tour between 9:30 AM and 1:30 PM on April 13, 2016, record review revealed that there was not a documented cool down period for the Long Term Care generator during the monthly maintenance runs. These deficient practices were verified by the Administrator at the time of the inspection.	K 144		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E117	A. BUILDING 02 - THE VILLA OF OSSEO B. WING	04/13/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 5-9-16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E117	A. BUILDING 02 - THE VILLA OF OSSEO B. WING ______	04/13/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 St. Paul, MN 55101-5145, OR By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This 2-story building is downgraded from construction Type II (222) to Type V (111) due to wood joist and plywood floors in some of the linen closets. It has a partial basement and is fully fire sprinklered. The facility has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridor that is monitored for automatic fire department notification. On September 24, 2015, a 1-story addition was build of Type V (111) construction. The addition does not have a basement and is fully sprinklered. The addition has a fire alarm system with smoke detection in the resident rooms, corridors and spaces open to the corridor is monitored for automatic fire department notification. The facility has a capacity of 102 beds and had a census of 76 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E117	A. BUILDING 02 - THE VILLA OF OSSEO B. WING ______	04/13/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to maintain the emergency generator in accordance with the requirements of NFPA 110-1999 edition, Section 6-4. This deficient practice could affect all 76 residents. Findings include: On facility tour between 9:30 AM and 1:30 PM on April 13, 2016, record review revealed that there was not a documented cool down period for the TCU generator during the monthly maintenance runs. These deficient practices were verified by the Administrator at the time of the inspection.	K 144	Facility uses TELS system for generator monitoring. Generator cool down documentation prompting was added to system. Facility maintenance was educated on April 13th 2016. Maintenance will audit cool down period monthly and report to QA for 3 months to ensure compliance.	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: SLSD
Facility ID: 00733

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **24E117**

2. STATE VENDOR OR MEDICAID NO. (L2) **836420100**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **04/092015** (L34)

7. PROVIDER/SUPPLIER CATEGORY 10 (L7)
01 Hospital, 05 HHA, 09 ESRD, 13 PTIP, 22 CLIA, 02 SNF/NF/Dual, 06 PRTF, 10 NF, 14 CORF, 03 SNF/NF/Distinct, 07 X-Ray, 11 ICF/IID, 15 ASC, 04 SNF, 08 OPT/SP, 12 RHC, 16 HOSPICE

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

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

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

12.Total Facility Beds **115** (L18)

13.Total Certified Beds **115** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
		115		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Jessica Sellner, Unit Supervisor 04/09/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 04/10/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **01/01/1975** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. (L31)

30. REMARKS
Posted 04/22/2015 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **04/02/2015** (L33)

DETERMINATION APPROVAL

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

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

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

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	(Y2) Multiple Construction	(Y3) Date of Revisit
24E117	A. Building B. Wing	4/9/2015

Name of Facility	Street Address, City, State, Zip Code
THE VILLA AT OSSEO	501 SECOND STREET SOUTHEAST OSSEO, MN 55369

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 ID Prefix	Reg. #	LSC	(Y5) Date Correction Completed
F0221	483.13(a)		04/07/2015
F0282	483.20(k)(3)(ii)		04/07/2015
F0323	483.25(h)		04/07/2015
F0329	483.25(l)		04/07/2015
F0356	483.30(e)		04/07/2015
F0371	483.35(i)		04/07/2015
F0428	483.60(c)		04/07/2015
F0492	483.75(b)		04/07/2015

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	JS/KJ	4/10/2015	29249	4/9/2015
CMS RO				

Followup to Survey Completed on: 2/26/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: C45Z
Facility ID: 00733

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **24E117**

2.STATE VENDOR OR MEDICAID NO.
(L2) **836420100**

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

4. TYPE OF ACTION: **2** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/14/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 10 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

13.Total Certified Beds **20** (L17)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

This revises the 1539 dated 5/11/2016.

17. SURVEYOR SIGNATURE Date :
Jennifer Bahr, HFE NE II 05/10/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 05/11/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1975
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS

Posted 05/20/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: SLSD

Facility ID: 00733

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **24E117**

2.STATE VENDOR OR MEDICAID NO.
(L2) **836420100**

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

4. TYPE OF ACTION: **2** (L8)

1. Initial
2. Recertification
3. Termination
4. CHOW
5. Validation
6. Complaint
7. On-Site Visit
9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/26/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)

0 Unaccredited | 1 TJC
2 AOA | 3 Other

7. PROVIDER/SUPPLIER CATEGORY 10 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **115** (L18)

13.Total Certified Beds **115** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
X 1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:

___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
		115		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Christine Bodick-Nord, HFE NE II 03/26/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 03/30/2015 (L20)

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

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

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

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01/01/1975
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: SLSD
Facility ID: 00733

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **24E117**

2. STATE VENDOR OR MEDICAID NO.
(L2) **836420100**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY 02/26/2015 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 10 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12. Total Facility Beds 115 (L18)

13. Total Certified Beds 115 (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
X 1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: A1* (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
		115		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date:
Christine Bodick-Nord, HFE NE II 03/26/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 03/30/2015 (L20)

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

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

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3. Both of the Above:

22. ORIGINAL DATE OF PARTICIPATION
01/01/1975
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

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

25. LTC EXTENSION DATE:
(L27)

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
4-2-2015 (L33)

DETERMINATION APPROVAL

FORM CMS-1539 (7-84) (Destroy Prior Editions)

020499

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:

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

<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

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

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

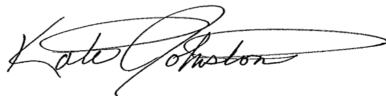
This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E117	A. BUILDING ______ B. WING ______	02/26/2015

RECEIVED MAR 2 3 2015 MN Dept of Health St.Cloud

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	The Villa at Osseo objects to and disagrees with both the findings noncompliance and the level of the 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.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure physical restraints were adequately assessed to ensure the least restrictive device was used to treat the residents medial symptoms for 1 of 1 residents (R81) reviewed who was using restraints. Findings include: R81's History and Physical dated 5/9/14, identified R81 had diagnoses including moderate to late stage Alzheimer's disease and depression. R81's quarterly Minimum Data set (MDS) dated 1/15/15, identified R81 had severe cognitive impairment, required extensive assistance with activities of daily living, and had a chair restraint	F 221	F221 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. approved 3/26/15	4/7/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: ADMINISTRATOR

(X6) DATE: 3/20/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E117	A. BUILDING ______ B. WING ______	02/26/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 1 which was used to prevent rising. R81's care plan dated 8/21/14, identified risk of falls related to dementia, balance/transfer impairment, 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-rollback bars on the wheelchair. The care plan also indicated R81 was required to wear two lap buddies while in the wheelchair because she liked to rock back and forth while having the two lap buddy's on, 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 her from standing up and taking the wheelchair with her. During interview on 2/24/15, at 10:24 a.m. family (F)-A stated when R81 entered the facility she was walking on her own and did not use a 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 (the 2 lap buddies) were needed for safety related to a lack of safety awareness, poor judgment, gait imbalance, impulsiveness, and inability to follow directions to stay seated. R81's quarterly Physical Restraint Assessment dated 2/16/15, identified the resident had unsafe	F 221	1. R #81 has been re- assessed for 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). 2. 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). 3.) 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). 4.) Staff educated on the Policy and the regulations associated with F221. (Completed by the DON/Designee 03/30/2015).	

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	24E117	A. BUILDING ______ B. WING ______	02/26/2015

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F 221	Continued From page 2 behavior such as being impulsive, lack of safety awareness in the surroundings, walking and standing independently, and trying to stand in the wheelchair. The assessment noted R81 liked to rock herself back and forth with the two lap buddies on, and when using the two lap buddies they prevented her from trying to stand up in the wheelchair. During observation on 2/23/14, at 5:18 p.m. R81 was in the hallway walking and wandering into other residents' rooms. NA-B directed R81 to her wheelchair and applied the two lap buddies to R81. NA-B stated R81 often tried to get up and run when she was in her wheelchair. R81 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.	F 221	5.) Random Audits of the residents utilizing restraint type devices to be done to ensure appropriateness of use, application, and release. (Completed by the DON or Designee, 03/30/2015). 6.) QAA (Quality Assurance) to review the audits of the restraint type devices. QAA will identify trends, make recommendations and ensure ongoing compliance with F221. (To be completed by the QAA Committee and the Nursing home Administrator, NHA 03/30/2015).	

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F 221	Continued From page 3 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. During interview on 2/25/15, at 12:35 p.m. NA-D stated R81 had two lap buddies on because otherwise she would walk around on her own and didn't know what she was doing when she was walking. NA-D stated R81 was very strong and would frequently get up out of bed on her own and start walking her around her room. NA-D stated when R81 was observed trying to get out of her chair frequently, the staff would try to take her on a walk to calm her down. During interview on 2/25/15, at 12:48 p.m. licensed practical nurse (LPN)-C stated the two lap buddies were used for R81 because when the resident was first admitted, she used to walk around and bump into things, and the restraints prevented her from being impulsive and walking around the facility. A Fall Risk Assessment dated 5/14/14, indicated R81 had not had any falls since admission, had not exhibited agitated behavior but did have a loss of balance while standing, and required hands-on assistance to move from place to place. A Nursing Progress Note dated 5/29/14, indicated R81 was in and out of her bed and wandering about her room. R81 was assisted to the bathroom, had a bowel movement, was directed back to bed, and soon fell asleep. An Incident Progress Note date 6/1/14, indicated	F 221		

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F 221	Continued From page 4 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 her 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 in the wheelchair because R81 lacked safety awareness, had a diagnosis of dementia, and 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 seemed 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 tried to stand up, so an antidepressant medication was given with, "Some relief."	F 221		
	A Behavior Progress Note dated 11/14/14,			

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F 221	Continued From page 5 identified R81 got herself up out of bed and started walking down the hall and she was quickly redirected and escorted by a NA for exercise followed by assistance to the toilet. R81 was then placed into her wheelchair, the lap buddies were applied, and R81 showed no further signs of agitation. A Behavior Note dated 11/19/14, indicated R81 had demonstrated some increased agitation, had taken off the single lap buddy and thrown it, and had also been standing and walking with the wheelchair attached to her by the lap buddy most of the shift. A Progress Note dated 12/8/14, identified the nurse removed the thick lap buddy on R81's wheelchair and in its place, the nurse applied two thinner lap buddies on the wheelchair to help maintain R81's safety while in the wheelchair. A Physician Progress Note dated 11/5/14, 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. A 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 restrained in a wheelchair. The DON stated R81 would get up and take off	F 221		

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F 221	Continued From page 6 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. 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 was observed to have one lap buddy on and was able to stand and walk with the wheelchair attached to her. LPN-A and NA-C applied the second lap buddy to R81, and the resident was still attempting to get up and walk with the wheelchair attached to her. During interview on 2/26/15, at 8:42 a.m. LPN-A and NA-C stated R81 had behaviors such as grabbing at people and things, and wandering around when not restrained in her wheelchair. They stated the lap buddies were not safe for R81 if she was unsupervised, and R81 continued to attempt to stand with the use of the lap buddies, however, it was less than before when she was not restrained with two of the lap buddies. During interview on 2/26/15, at 9:10 a.m. occupational therapist (OT)-A stated she felt R81	F 221		

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F 221	Continued From page 7 made more attempts to get up and walk when the environment was over stimulating. OT-A stated when R81 was down in the therapy department working one on one and the environment was quiet, she was calm. OT-A identified nursing had made the decision to apply two lap buddies at a time, and nursing had stated R81 was unsafe if not restrained in the wheelchair because she tried to get up and walk on her own. OT-A stated R81 needed heavy staff supervision, and R81's balance and safety awareness was poor. OT-A was not aware of any plans to try and attempt to reduce or remove the current restraints being used. During interview on 2/26/15, at 9:33 a.m. trained medication assistant (TMA)-A stated R81 had the ability to walk, but needed to be restrained in her wheelchair because she would get up and walk on her own. During interview on 2/26/15, at 9:44 a.m. TMA-B stated R81 was able to get up and walk on her own, and she had seen R81 carrying her wheelchair while attempting to walk with the two lap buddies on restraining her in the wheelchair. TMA-B stated R81 was confused and she believed R81 got agitated when she wanted to be active and walk because she used to be a very active person. During a follow up interview on 2/26/15, at 10:29 a.m. DON stated she felt the two lap buddies were the least restrictive restraint option available for R81. The DON stated there wasn't a particular medical symptom the two lap buddies were treating, however, they were needed to prevent R81 from falling. The DON stated even though during meal times R81 was directly supervised,	F 221		

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F 221	Continued From page 8 they needed to leave the restraints on the resident or R81 would be up and walking around the dining room. The DON stated there was no plan in place to attempt 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, 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 lap buddies applied vs one. The facility policy titled Safety Devices dated 3/2/06, indicated the safety of all residents should be maintained using the least restrictive devices.	F 221		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the individual plan of care related to removing a restraint while under direct staff observation for 1 of 1 residents (R81) reviewed with restraints. Findings include: R81's history and physical dated 5/9/14, identified	F 282	F282 The facility does attempt to follow the individual Plan of Care. The facility also provides services by qualified persons in accordance with each resident written Plan of Care. 1.) The Plan of Care for the Resident #81 has been reviewed and updated. The resident has had no adverse effects as a result of the Lap Buddy and the observation identified in the Statement of	4/7/15

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F 282	Continued From page 9 R81 had diagnoses including Alzheimer's disease and depression. The quarterly Minimum Data Set (MDS) dated 1/15/15, identified R81 was severely cognitively impaired, required extensive assistance with eating, and was using a chair restraint which was used to prevent rising. R81's care plan dated 8/21/14, identified risk of falls related to dementia, balance/transfer impairment, lack of understanding instructions, and poor judgment. The care plan identified when the resident was up in the wheelchair 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-rollback bars on the wheelchair. The care plan also indicated R81 was required to wear two lap buddies while in the wheelchair because she liked to rock back and forth while having the two lap buddy's on, as well as because she could remove just one lap buddy and would try to stand up on her own. On 2/25/15 at 8:26 a.m., R81 was brought into the dining room in her wheelchair and had two lap buddies on, one around her upper torso, and one around the lower torso, restraining her into the wheelchair. R81 was brought to the dining table, and NA-E sat down and fed R81 her meal at 8:47 a.m. Although R81 was under constant staff supervision while being fed by NA-E, R81 remained restrained in the wheelchair. During interview on 2/25/15 at 12:35 p.m., NA-D stated R81 had two lap buddies on to restrain her because she would walk around on her own and the facility was concerned for her safety. NA-D stated R81 was very strong and would frequently	F 282	Deficiency. (Completed by the DON 03/30/2015). 2.) The Plans of Care for any other resident that may utilize a restraint type device has been reviewed and updated. The Residents have all been re-assessed for a reduction. (Completed by the DON and Designee 03/30/2015). 3.) Resident Plans of Care for the identified residents will be reviewed on a quarterly basis and 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 done. The implementation of the interventions identified in the Plan of Care to be validated includes the release of restraint type devices. (Completed by the DON or designee 03/30/2015).	

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F 282	Continued From page 10 attempt to get out of her wheelchair. NA-D stated if staff noted the resident was restless and trying to get out of the wheelchair, staff would take her for a walk to calm her down, which was usually helpful. During interview on 2/26/15, at 10:29 a.m. director of nursing (DON) stated although R81 is in direct staff supervision during meal times, staff will leave the restraints in place or R81 would be up walking around the dining room. DON verified the care plan instructed staff to only use the restraints when R81 was not in direct staff supervision. A policy related to following a resident's care plan was requested, however, none was provided.	F 282	6.) Care Plan Audits to be reviewed by the QAA committee to identify trends, make recommendations and to ensure ongoing compliance with F 282. (Completed by the QAA Committee and the NHA 03/30/2015).	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a wheelchair with a lap buddy device was adequately assessed to ensure safety for 1 of 1 resident (R81) who was using a restraint in the wheelchair. Findings include: R81's history and physical dated 5/9/14, identified	F 323	F323 The facility does attempt to ensure that the resident environment remains as free of accident Hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents.	4/7/15

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F 323	Continued From page 11 R81 had diagnoses including moderate to late stage Alzheimer's disease and depression. R81's quarterly Minimum Data set (MDS) dated 1/15/15, identified R81 had severe cognitive impairment, required extensive assistance with activities of daily living, and had a chair restraint which was used to prevent rising. R81's care plan dated 8/21/14, identified risk of falls related to dementia, balance/transfer impairment, 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-rollback bars on the wheelchair. The care plan also indicated R81 was required to wear two lap buddies while in the wheelchair because she liked to rock back and forth while having the two lap buddy's on, 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 2/2015, indicated R81 was able to use two lap buddies to prevent the resident from removing the restraint, as well as to prevent her from standing up and taking the wheelchair with her. During interview on 2/24/15, at 10:24 a.m. family (F)-A stated when R81 entered the facility she was walking on her own and did not use a 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 (the 2 lap buddies) were needed for safety related to a lack	F 323	1.) Resident # R81 has been re- assessed for the use of the Lap Buddy. The resident has had the Plan of care reviewed and updated. The resident has been seen by therapy (OT). All resident care interventions have been updated. The resident has no adverse effects as a result of the implementation of the Lap Buddy. (Completed by the DON 03/30/2015). 2.) All Residents in the facility utilizing restraint type devices have been re-assessed and the Plan of Care has been reviewed and updated. Reduction attempts have been trialed for the appropriately identified residents. (Completed by the DON 03/30/2015). 3.) Family members/ Guardians of identified residents who are utilizing a restraint type device will have the Risk and benefits of the device reviewed. (Completed by the DON or Designee 03/30/2015). 4.) Staff to be educated on the resident safety and the safe implementation of restraint type devices. (Completed by the DON 03/30/2015). 5.) Random Audits of Residents utilizing restraint type	

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F 323	Continued From page 12 of safety awareness, poor judgment, gait imbalance, impulsiveness, and inability to follow directions to stay seated. During observation on 2/23/14, at 5:18 p.m. R81 was in the hallway walking and wandering into other residents' rooms. NA-B directed R81 to her wheelchair and applied the two lap buddies to R81. NA-B stated R81 often tried to get up and run when she was in her wheelchair. R81 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. 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.	F 323	devices will be completed. (Completed by the DON or Designee 03/30/2015). 6.) QAA committee will review the Random Audits of the Restraint type devices to identify trends, make recommendations and ensure ongoing compliance with F323. (Completed by the QAA Committee and the NHA).	

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F 323	Continued From page 13	F 323		

During interview on 2/25/15, at 12:35 p.m. NA-D stated R81 had two lap buddies on because otherwise she would walk around on her own and she didn't know what she was doing when she was walking. NA-D stated R81 was very strong and would frequently get up out of bed on her own and start walking her around her room. NA-D stated when R81 was observed trying to get out of her chair frequently, the staff would try to take her on a walk to calm her down.

During interview on 2/25/15, at 12:48 p.m. licensed practical nurse (LPN)-C stated the two lap buddies were used for R81 because when the resident was first admitted, she used to walk around and bump into things, and the restraints prevented her from being impulsive.

R81's quarterly Physical Restraint Assessment dated 2/16/15, identified the resident had unsafe behavior such as being impulsive, lacking of safety awareness in the surroundings, walking and standing independently, and trying to stand in the wheelchair. The assessment noted R81 liked to rock herself back and forth with the two lap buddies on, and when using the two lap buddies they prevented her from trying to stand up in the wheelchair. The assessment did not include any information the facility assessed R81's safety with the restraint in use, although they were aware R81 was able to stand up with the wheelchair still attached to her.

The most recent comprehensive Fall Risk assessment dated 5/14/14, indicated R81 had not had any falls since admission, had not exhibited agitated behavior but did have a loss of balance while standing, and required hands-on assistance

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F 323	Continued From page 14 to move from place to place. A Nursing Progress Note dated 5/29/14, indicated R81 was in and out of her bed and wandering about her room. R81 was assisted to the bathroom, had a bowel movement, and was directed back to bed and soon fell asleep. An Incident Progress Note date 6/1/14, indicated 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 but walked with supervision. An Incident Progress Note dated 6/20/14, identified R81 had been walking in her room when she lost her 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 in the wheelchair because R81 lacked safety awareness, had a diagnosis of dementia, and was unable to follow directions. An incident Investigation report dated 6/21/14 identified R81 had tipped over the wheelchair with the lap buddy in place. Anti-tip and anti-rollback bars were added to the wheelchair. R81 did not sustain any injuries. 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 seemed to enjoy the activity and interaction.	F 323		

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F 323	Continued From page 15 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 tried to stand up, so an antidepressant medication was given with, "Some relief." An incident investigation report dated 7/15/14, identified R81 was found getting up from her knees in her room and was unable to say what had happened. No injuries were noted. On 11/14/14, a Behavior Progress Note identified R81 got herself up out of bed and started walking down the hall and she was quickly redirected and escorted by a NA for exercise followed by assistance to the toilet. R81 was then placed into her wheelchair, the lap buddies were applied, and R81 showed no further signs of agitation. A behavior note dated 11/19/14, indicated R81 had demonstrated some increased agitation, had taken off the single lap buddy and thrown it, and had also been standing and walking with the wheelchair attached to her by the lap buddy most of the shift. A Progress Note dated 12/8/14, identified the nurse removed the thick lap buddy on R81's wheelchair, and in its place the nurse applied two thinner lap buddies on the wheelchair to help maintain R81's safety while in the wheelchair. A Physician Progress Note dated 11/5/14,	F 323		

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F 323	Continued From page 16 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	F 323		

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F 323	Continued From page 17 was observed to have one lap buddy on and was able to stand and walk 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. During interview on 2/26/14, at 8:42 a.m. LPN-A and NA-C stated R81 had behaviors such as grabbing at people and things and wandering around when not restrained. They stated they would sometimes try to walk R81 or give her a snack when she seemed to be having a lot of behaviors. They indicated the lap buddies were not very safe if R81 was left unsupervised because she still attempted to stand from the wheelchair, and the wheelchair remained attached to her. During interview on 2/26/15, at 9:10 a.m. occupational therapist (OT)-A stated she felt R81 made more attempts to get up and walk when the environment was over stimulating. OT-A stated when R81 was down in the therapy department working one on one and the environment was quiet, she was calm. OT-A identified nursing had made the decision to apply two lap buddies at a time, and nursing had stated R81 needed to be restrained because she tried to get up and walk on her own. OT-A stated R81 needed heavy staff supervision, and R81's balance and safety awareness was poor. OT-A was not aware of any plans to try and attempt to reduce or remove the current restraints being used. During interview on 2/26/15, at 9:33 a.m. trained medication assistant (TMA)-A stated R81 had the ability to walk, but needed to be restrained because she would get up and walk on her own. During interview on 2/26/15 at 9:44 a.m., TMA-B	F 323		

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F 323	Continued From page 18 stated R81 was able to get up and walk on her own, and she had seen R81 carrying her wheelchair while attempting to walk with the lap buddies on. TMA-B stated R81 was confused and she believed that R81 got agitated when she wanted to be active and walk because she used to be a very active person. During a follow up interview on 2/26/15, at 10:29 a.m. DON stated she felt the two lap buddies were the least restrictive restraint option available for R81. The DON stated there wasn't a particular medical symptom the two lap buddies were treating, however, they were needed to prevent R81 from falling. The DON stated even though during meal times R81 was directly supervised, staff needed to leave the restraints on the resident or R81 would be up and walking around the dining room. The DON stated there was no plan in place to attempt 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 only one lap buddy was in place restraining R81 in the wheelchair. 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 lap buddies applied vs one.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of	F 329		4/7/15

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F 329	Continued From page 19 adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure laxatives were not given in an excessive dose, and mood stabilizing agents had appropriate indications for use and ongoing monitoring for effectiveness for 1 of 5 residents (R81) reviewed for unnecessary medications. Findings include: R81 was admitted to the facility on 5/14/14. R81's most current physician's orders dated 1/27/15, indicated diagnosis including Alzheimer's type dementia. Additionally, the physician's orders identified R81 currently received depakote (a mood stabilizing agent) 125 milligrams (mg) by mouth every morning, as well as Senexon-S 8.6	F 329	F 329 The facility does attempt to ensure that each resident's drug regime is free from unnecessary drugs. The facility also attempts to ensure that the resident's drug regime is monitored for excessive doses, duplication of therapy, and that adequate monitoring is in place. 1.) Resident #R81 was reviewed for both the use of laxatives and for the Diagnosis for Depakote. The MD and the 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 DON 03/30/2015). 2.) The Pharmacist has completed a whole house audit of the medication regime for all residents in the facility. (Completed by the Pharmacist 03/30/2015). 3.) Care plans for residents with the identified medications of Mood Stabilizers and or laxatives has been reviewed, updated and revised as necessary. (Completed by the DON, MDS Coordinator and or Designee 03/30/2015). 4.) Staff to be educated on the Guidelines associated with medications and F329 and F 428. (	

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F 329	Continued From page 20 mg/50 mg (a stimulant laxative) tablet three tablets by mouth twice daily (6 tablets total) for constipation. R81's quarterly minimum data set (MDS) indicated R81 had severe cognitive impairment, exhibited inattention and disorganized thinking on a continuous basis, had no behaviors, was frequently incontinent of bowel, not on a toileting program, and had no problems with constipation. R81's care plan dated 2/26/15, indicated R81 used psychoactive medications for insomnia, Alzheimer's disease with related mood/behavioral issues, and possible depression. In addition, the care plan identified R81 had bowel incontinence and received medication for constipation with a goal listed of having a soft, formed stool at least every third day. The care plan indicated R81 should be monitored for pain relief and constipation, but lacked direction to staff for any non-pharmacological interventions that could be attempted for any specific behaviors. Review of R81's bowel records for 2/15 were reviewed and indicated R81 had 1-3 large to medium incontinent bowel movements on a daily basis. R81's physician progress notes dated 11/05/14, indicated R81 was started on low dose of depakote to reduce daytime restlessness and to reduce mumbling and making statements to herself. A physician's progress note dated 1/27/14, indicated R81 had improved behavioral outbursts, however, there was no specific information as to which behaviors had improved.	F 329	Completed by DON or designee 03/30/2015). 5.) Random Audits to be done of resident medication profiles to ensure proper diagnosis, doses, duplication of therapy is addressed and proper monitoring is in place. (Completed by the DON or designee 03/30/2015). 6.) Audits of the medication profiles to be reviewed by the QAA committee to identify trends, make recommendations and to ensure ongoing compliance with F329 and F428. (Completed by QAA Committee and the NHA 03/30/2015).	

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F 329	Continued From page 21	F 329		

R81's consultant pharmacist notes dated 12/10/14, indicated a recommendation to the physician to decrease R81's Senexon-S tablets to two tablets twice daily, as the current total dose of six tablets daily was greater than the usual recommended maximum of four tablets. The physician's response 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.

During interview on 2/24/15, at 10:24 a.m. Family-A stated they felt R81 was "Drugged up," and expressed concern some of her medications may be unnecessary and excessive.

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.

During observation on 2/26/15, at 8:42 a.m. licensed practical nurse (LPN)-A and nursing assistant (NA)-C were assisting R81 with morning cares. R81 was observed grabbing at NA-C when she assisted R81 into her wheelchair. LPN-A and NA-C indicated R81 had behaviors, especially grabbing at other people. When this happened they would attempt to walk R81 or offer

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F 329	Continued From page 22 her a snack, which was usually useful in calming R81. LPN-A and NA-C stated R81 was frequently incontinent of bowel on a daily basis. NA-C stated R81's bowel movements would get "All over the place," and bowel movements were tracked in the electronic health record. During interview on 2/26/15, at 8:59 a.m. the director of nursing (DON) state R81 had frequent behaviors and was restrained in the wheelchair with two lap buddies to help her "Stand up less." During interview on 2/26/15, at 10:22 a.m. LPN-A indicated R81's behavior symptom frequency was documented on the medication sheets, and stated R81 had behaviors including agitation and grabbing at other people. LPN-A pulled out R81's medication sheets for 2/15, and verified there were no behaviors documented for R81, only insomnia monitoring. LPN-A stated, There Should be more behaviors on there." LPN-A stated she would only hold laxatives or request a dose reduction from the physician if a resident had constant loose stools or more than three loose stools per day. LPN-A was not aware of any issues with R81's bowel movements. During another interview on 2/26/15, at 10:23 a.m. the DON stated she would expect staff to hold laxatives if a resident had three or more loose stools per day or "Constant" loose stools. The DON stated the depakote had helped with 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 her a snack to reduce behaviors.	F 329		

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F 329	Continued From page 23 During interview on 2/26/15, at 11:08 a.m. the MD stated R81 was on the depakote for physical aggression and he was hoping to decrease the number of incidents of grabbing at staff and other residents, and it was not being used to treat insomnia. The MD stated he was unaware R81 had been having frequent bowel movements, and had not reviewed her bowel documentation on rounds. The MD also indicated he had not reviewed any data related to frequency of R81's behaviors to evaluate the effectiveness of the depakote, his assessment was based on a verbal report from the DON and/or the facility nurses. During interview on 2/26/15, at 11:34 a.m. the consultant pharmacist (CP) stated one bowel movement every one to two days should be considered a normal pattern and R81's Sennexon should be considered for a dose reduction. The CP indicated insomnia was not an appropriate indication for depakote and there should have been specific behaviors being monitored for R81 to evaluate the depakote's effectiveness. Policies regarding use of psychoactive drugs and bowel management were requested, but not provided.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for	F 356	F356 The facility does attempt to post Nurse Staff information. The Facility also maintains the Staffing Data in accordance State law.	4/7/15

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F 356	Continued From page 24 resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the posted nurse staffing information included the actual time worked for unlicensed direct care staff, nursing assistants (NA's) and trained medication assistants (TMA's). This had the potential to affect all 81 residents currently residing in the facility, as well as family members or the general public who may wish to review this information. Findings include: During the initial tour observation on 2/23/15, at 12:51 p.m. the facility's Daily Staffing Reporting Form was noted near the front entrance, in a	F 356	1.) The facility has developed a policy to correctly post the Nurse Staffing information. (Completed by the Nurse Staffing Coordinator and the NHA 03/23/2015). 2.) New Staff Posting form was created. (Completed by the Staffing Coordinator 03/23/2015). 3.) Staff education provided to the Staffing Coordinator and the Nurse staff regarding the staff policies. (Completed by the NHA and the Staffing Coordinator 03/23/2015). 4.) Staffing Postings will be audited weekly for the correct information. (Completed by the NHA 03/30/2015). 5.) Staff Postings and audits will be reviewed by QAA Committee to identify trends, make recommendations and to ensure ongoing compliance with F 356. (Completed by the QAA Committee and the NHA 03/30/2015.)	

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	24E117	A. BUILDING ______ B. WING ______	02/26/2015

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F 356	Continued From page 25 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 Posting. 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 356		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or	F 371		4/7/15

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F 371	Continued From page 26 considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure dishes and utensils used in resident food preparation were stored in a clean and sanitary manner. In addition, the facility failed to ensure foods were at a safe serving temperature prior to serving to prevent the potential of food bourne illness. These had the potential to affect all 81 residents who resided in the facility. Findings include: During kitchen tour on 2/23/15, at 12:42 p.m. eight shelves were observed covered with textured linoleum and were covered with dust and 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	F 371	F371 The facility does attempt to ensure that dishes and utensils used in resident food preparation are stored in a clean and sanitary manner. The facility also attempts to ensure that food is served at a safe temperature to prevent food borne illness. 1.) There was no s/s of resident illness associated with the food service on the identified dates. Food Temperature Policy posted in the serving areas. New Calibrated Thermometers implemented. (Completed by the DON and RDCS Regional Director of Clinical Services, 03/03/2015) 2.) Food Service Staff was re- educated on the cleaning procedures and the cleaning lists. Cleaning schedules have been revised to include assigned person to the cleaning tasks. Food Service Staff educated on proper food temperatures, and the calibration	

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F 371	Continued From page 27 prepare and serve resident food. The Employee Daily Cleaning List was reviewed and included duties to be completed by staff such as wiping down all sinks, cleaning the dish machine, and sweeping the floor. There was no duty which identified cleaning the shelves. During follow up interview on 2/25/15, at 11:32 a.m. FSD stated he wasn't aware the staff were not regularly cleaning the shelves and stated that should be part of the regular kitchen cleaning task. During interview on 2/23/15, at 4:19 p.m. Resident (97) stated the food served during meals was often cold, and today at lunch he had an egg roll that was cold. During interview on 2/23/15, at 4:39 p.m. R63 stated the food at the facility is often cold, including the coffee that is served. During interview on 2/23/15, at 5:46 p.m. R68 stated the food served at the facility is cold. During interview on 2/24/15, at 8:35 a.m. R76 reported hot food is often not hot enough. During observation of the supper meal on 2/23/15, at 5:11 p.m. cook-A used a food thermometer to check the temperatures of the food in the steam table she was preparing to serve in the first floor dining room. Cook-A checked the temperature of the sauerkraut which was 130 degrees Fahrenheit (F), the tomato soup which was 130 degrees F, the pureed vegetables which were 120 degrees F, the pureed meat which was 120 degrees F, the mashed potatoes	F 371	of the thermometers. Food temperatures to be recorded on all of the food leaving the kitchen prior to the meal service. If the food is not at proper temperature it will be re-heated or cooled as necessary prior to leaving the kitchen. (Completed by the Dietary Manager 03/15/2015). 3.) The cleaning lists will be audited by the Dietary Manager to ensure that all procedures are completed and the staff assigned is held accountable for the identified tasks. Food temperatures will be taken upon arrival in the Dining Room. (Completed 03/15/2015). 4.) The Dietary Manager will audit all areas of sanitation 3 times a week for one month the 2 times a week for the next three months. The Dietary Manager will audit all food temp logs 3 times week for one month then 2 times a week for the next 3 months. (Completed by the Dietary Manager 03/30/2015). 5.) The Dietary Manager or Designee will complete resident food service satisfaction surveys every week for the next 3 months. (Completed by the Dietary Manager 03/30/2015).	

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F 371	Continued From page 28 which were 110 degrees F. Cook-A stated none of the food was hot enough to serve. Cook-A used a phone to call the food service director (FSD), and reported she was sending all the food back to the kitchen to be heated. Cook-A put the metal containers of the food items onto a cart and directed a dietary aide to bring them back to the kitchen to be heated. Cook-A checked the temperature of the potato salad that was on a cart next to the steam table in a large bowl which was placed inside of a large steel pan with a one inch layer of ice in the bottom. Cook-A stated the temperature of the potato salad was 70 degrees F and stated that was too warm to be served and she would not be able to serve that either. At 5:39 p.m., a dietary aide brought the food that was reheated back to the dining room and cook-A used the thermometer to check the temperatures of all of the food and stated all the temperatures were now acceptable with the hot items being between 150-180 degrees F. Coleslaw was brought to the dining room to be used in place of the potato salad, and was at 40 degrees F. During observation on 2/23/15, at 6:06 p.m. cook-A was preparing to serve the second shift of residents in the first floor dining room the supper meal, and checked the temperature of the food that remained in the steam table. The ground meat was 100 degrees F, the pureed meat was 110 degrees F, mashed potatoes 130 degrees F, sauerkraut was 125 degrees F, and the bratwurst was 110 degrees F. Cook-A called the FSD and asked him to come to the dining room because of the concern again the food was not hot enough to be served. At 6:15 p.m., FSD came to the dining room and told cook-A the food was not holding at ~~a warm temperature because the metal~~ containers the food was in needed to be	F 371	6.) The audits of sanitation, and food service satisfaction surveys, will be reviewed by the QAA Committee to identify trends, make recommendations and to ensure ongoing compliance with F371. (Completed by the QAA Committee and the NHA 03/30/2015.)	

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F 371	Continued From page 29 submerged in the water on the steam table and the containers needed to be covered to keep the food hot. FSD and cook-A removed the containers of food from the steam table and sent them back to the kitchen to be reheated. On 2/23/15, at 6:41 p.m. cook-A returned from the kitchen with containers of precooked pureed and mechanical polish sausage. Cook-A stated she had remade the food rather than reheating it again, and proceeded to check the temperatures. The pureed polish sausage only registered at 140 degrees F, and the mechanical polish sausage was 135 F. The FSD entered the dining room to check on the temperatures of the food, and told cook-A to serve the food at the current temperatures. During interview on 2/23/15, at 6:49 p.m. registered dietician (RD)-A stated food temperatures were supposed to be checked in the kitchen prior to the meal, and again when it arrived to the dining room. RD stated staff were trained to check food temperatures in the kitchen, and she was not aware staff were not doing that until now. RD-A stated hot food should be above 140 degrees F when served, and cold food should not be served if it is below 40 degrees F. 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	F 371		

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F 371	Continued From page 30 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 food bourne illness. During a follow up interview on 2/26/15, at 1:30 p.m. cook-A stated she usually checks the temperature of the food before taking it to the dining room, however, she did not complete that on Monday evening. Cook-A stated she believed the food was not staying warm because she was not wrapping the containers of food with cellophane and tin foil, not ensuring there was enough water in the steam table so the pans were sitting in the water to remain hot, and was not turning on the steam wells one hour prior to bringing the food upstairs to serve. The facility policy titled Food Temperatures dated 2010, included, "All hot food items must be cooked to appropriate internal temperatures, held and served at a temperature of at least 135 [degrees] F...Hot food items may not fall below 135 [degrees] F after cooking...at least 165 [degrees] F prior to serving...All cold food items must be maintained and served at a temperature of 41 [degrees] F or below...Temperatures should be taken periodically to ensure hot foods stay above 135 [degrees] F and cold foods stay below 41 [degrees] during the portioning, transporting, and delivery process until received by the individual recipient..."	F 371		

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F 371	Continued From page 31 The facility policy titled Handling Cold Foods for Tray line policy dated 2010, instructed prior to service salads and other cold food items for meal service are to be placed in the refrigerator at least 3-4 hours before serving and Food should be chilled to equal to or less then 41 degrees F.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure pharmacy consultant recommendations regarding laxatives use were implemented by the physician for 1 of 4 residents reviewed, (R81) for laxative use. In addition, the facility consultant pharmacist failed to identify irregularities related to indications for use and ongoing monitoring for effectiveness of mood stabilizing medications for 1 of 5 residents (R81) reviewed for unnecessary medications. Findings include: R81 was admitted to the facility on 5/14/14. R81's most current physician's orders dated	F 428	F428 The facility does ensure that the drug regime of each resident is reviewed by a Licensed Pharmacist monthly. The Pharmacist reports on irregularities and they are followed up on. 1.) Resident #81 had the drug regime and profile of the resident reviewed by the pharmacist on a monthly basis. Irregularities were addressed. The Facility had the Pharmacist re-review all of the information in the recommendations was brought to the attention of the DON, and the Primary MD for the resident. New Orders were received. The diagnosis for the medication and the tracking of behaviors are in place. (Completed by the DON and the RDCS on 03/15/2015). 2.) The medication profiles for all of the residents in the facility were reviewed by the pharmacist with a specific review of Laxatives and Mood altering medications. (Completed by the Pharmacist 03/30/2015).	4/7/15

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F 428	Continued From page 32 1/27/15, indicated diagnosis including Alzheimer's type dementia. Additionally, the physician's orders identified R81 currently received depakote (a mood stabilizing agent) 125 milligrams (mg) by mouth every morning, as well as Senexon-S 8.6 mg/50 mg (a stimulant laxative) tablet three tablets by mouth twice daily (6 tablets total) for constipation. R81's quarterly minimum data set (MDS) indicated R81 had severe cognitive impairment, exhibited inattention and disorganized thinking on a continuous basis, had no behaviors, was frequently incontinent of bowel, not on a toileting program, and had no problems with constipation. R81's care plan dated 2/26/15, indicated R81 used psychoactive medications for insomnia, Alzheimer's disease with related mood/behavioral issues, and possible depression. In addition, the care plan identified R81 had bowel incontinence and received medication for constipation with a goal listed of having a soft, formed stool at least every third day. The care plan indicated R81 should be monitored for pain relief and constipation, but lacked direction to staff for any non-pharmacological interventions that could be attempted for any specific behaviors. Review of R81's bowel records for 2/15 were reviewed and indicated R81 had 1-3 large to medium bowel movements on a daily basis. R81's physician progress notes dated 11/05/14, indicated R81 was started on low dose of depakote to reduce daytime restlessness and to reduce mumbling and making statements to herself. A physician's progress note dated 1/27/14, indicated R81 had improved behavioral outbursts, however, there was no specific information as to which behaviors had improved.	F 428	3.) Staff and Pharmacist were educated on the guidelines of F428 along with the follow up and review of recommendations issued. (Completed by the RDCS 03/15/2015). 4.) Recommendations and outstanding recommendations issued by the pharmacist will be reviewed by the DON on a monthly basis via the Summary Format. (Completed by the DON 03/30/2015). 5.) Audits of the Summary and recommendations to be done on a quarterly basis. (Completed by the DON and 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).	

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F 428	Continued From page 33 R81's consultant pharmacist notes dated 12/10/14, indicated a recommendation to the physician to decrease R81's Senexon-S tablets to two tablets twice daily, as the current total dose of six tablets daily was greater than the usual recommended maximum of four tablets. The physician's response 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. During interview on 2/24/15, at 10:24 a.m. Family-A stated they felt R81 was "Drugged up," and expressed concern some of her medications may be unnecessary and excessive. 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. During observation on 2/26/15, at 8:42 a.m. licensed practical nurse (LPN)-A and nursing assistant (NA)-C were assisting R81 with morning cares. R81 was observed grabbing at NA-C when she assisted R81 into her wheelchair. LPN-A and NA-C indicated R81 had behaviors, especially grabbing at other people. When this happened they would attempt to walk R81 or offer her a snack, which was usually useful in calming R81. LPN-A and NA-C stated R81 was frequently incontinent of bowel on a daily basis. NA-C stated R81's bowel movements would get "All over the place," and bowel movements were	F 428		

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F 428	Continued From page 34 tracked in the electronic health record. During interview on 2/26/15, at 8:59 a.m. the director of nursing (DON) state R81 had frequent behaviors and was restrained in the wheelchair with two lap buddies to help her "Stand up less." During interview on 2/26/15, at 10:22 a.m. LPN-A indicated R81's behavior symptom frequency was documented on the medication sheets, and stated R81 had behaviors including agitation and grabbing at other people. LPN-A pulled out R81's medication sheets for 2/15, and verified there were no behaviors documented for R81, only insomnia monitoring. LPN-A stated, There Should be more behaviors on there." LPN-A stated she would only hold laxatives or request a dose reduction from the physician if a resident had constant loose stools or more than three loose stools per day. LPN-A was not aware of any issues with R81's bowel movements. During another interview on 2/26/15, at 10:23 a.m. the DON stated she would expect staff to hold laxatives if a resident had three or more loose stools per day or "Constant" loose stools. The DON stated the depakote had helped with 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 her a snack to reduce behaviors. During interview on 2/26/15, at 11:08 a.m. the MD stated R81 was on the depakote for physical aggression and he was hoping to decrease the number of incidents of grabbing at staff and other residents, and it was not being used to treat insomnia. The MD stated he was unaware R81 had been having frequent bowel movements, and had not reviewed her bowel documentation on	F 428		

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F 428	Continued From page 35 rounds. The MD also indicated he had not reviewed any data related to frequency of R81's behaviors to evaluate the effectiveness of the depakote, his assessment was based on a verbal report from the DON and/or the facility nurses. During interview on 2/26/15, at 11:34 a.m. the consultant pharmacist (CP) stated one bowel movement every one to two days should be considered a normal pattern and R81's Sennexon should be considered for a dose reduction. The CP indicated insomnia was not an appropriate indication for depakote and there should have been specific behaviors being monitored for R81 to evaluate the depakote's effectiveness. Policies regarding use of psychoactive drugs and bowel management were requested, but not provided.	F 428		
F 492 SS=E	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the supplemental nursing service agency (SNSA) which was not registered with the Minnesota commissioner of health as required was not used by the facility to provide care to the residents. This had the potential to affect all residents residing on unit 3, on the second floor.	F 492	F492 The facility does attempt to provide services in compliance with all applicable Federal, State, and local laws, regulations and codes, and with accepted professional standards and principals providing 'services in this facility.	4/7/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E117	A. BUILDING ______ B. WING ______	02/26/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 492 Continued From page 36

Findings include:

During the the entrance conference on 2/23/15, at approximately 2:30 p.m. the administrator stated the facility had previously utilized a supplemental nursing staff agency called All Heart Service, 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., and provided care to residents on unit 3 on the 2nd floor of the facility.

During interview on 2/24/15, at 4:15 p.m. the facility nurse consultant stated Soul Care SNSA had gone out of business last fall, and was bought and renamed All Heart Service. The nurse consultant stated the facility was aware All Heart Service did not have current registration in Minnesota as an SNSA, however, despite facility knowledge of All Heart Service not being registered as an SNSA to provide services in the State of MN, a nurse at the facility had contacted All Heart Service and provided NA-F to work at the facility on 2/15/15.

Upon review, it was determined All Heart Service was not registered in the state of Minnesota as an

F 492

1.) The identified agency has been contacted by the facility. The agency has been removed from the lists or resources utilized at the facility. (Completed by the NHA and the Staffing Coordinator 03/15/2015).
2.) The facility has currently not used any agency staff since 02/19/2015.
3.) 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).
4.) The facility has filed a complaint with the Better Business Bureau regarding the Staffing Agency All Heart. (Completed by the NHA 02/24/2015).
5.) The Facility has filed a complaint with CEP and OHFC regarding the staffing Agency All Heart. (Completed by the RDCS 02/24/2015).
6.) The facility has reviewed the contracts with service providers to ensure compliance with F492. (Completed by the NHA 02/24/2015).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E117	A. BUILDING ______ B. WING ______	02/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 492	Continued From page 37 SNSA, refer to SNSA statute 144A.71. 144A.71 Subdivision 1.Duty to register. A person who operates a supplemental nursing services agency shall register the agency with the commissioner. Each separate location of the business of a supplemental nursing services agency shall register the agency with the commissioner. Each separate location of the business of a supplemental nursing services agency shall have a separate registration. Subd. 2.Application information and fee. The commissioner shall establish forms and procedures for processing each supplemental nursing services agency registration application. An application for a supplemental nursing services agency registration must include at least the following: (1) the names and addresses of the owner or owners of the supplemental nursing services agency; (2) if the owner is a corporation, copies of its articles of incorporation and current bylaws, together with the names and addresses of its officers and directors; (3) satisfactory proof of compliance with section 144A.72, subdivision 1 </statutes/?id=144A.72>, clauses (5) to (7); (4) any other relevant information that the commissioner determines is necessary to properly evaluate an application for registration; and (5) the annual registration fee for a supplemental nursing services agency, which is $891. Subd. 3.Registration not transferable. A registration issued by the commissioner according to this section is effective for a period of one year from the date of its issuance unless	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).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E117	A. BUILDING ______ B. WING ______	02/26/2015

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

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F 492	Continued From page 38 the registration is revoked or suspended under section 144A.72, subdivision 2 </statutes/?id=144A.72>, or unless the supplemental nursing services agency is sold or ownership or management is transferred. When a supplemental nursing services agency is sold or ownership or management is transferred, the registration of the agency must be voided and the new owner or operator may apply for a new registration. During a follow up interview on 3/9/15, at 4:30 p.m. the administrator stated the facility was approached by All Heart Service in October 2014, and was told the alleged SNSA was taking over Soul Care prior clients. The administrator stated the facility refused to sign the contract until a current registration was provided by All Heart Service, and the staff were educated to ensure All Heart Service was not used to provide staff to the facility until further notice. The administrator stated All Heart Service did not provide a copy of registration with the state of Minnesota, and verified NA-F from All Heart Service had worked at the facility on 2/15/15. During interview on 3/9/15, at 4:30 p.m. the director of nursing (DON) stated the nurses were educated in October 2014, not to use All Heart Service for staffing needs because it was not registered as an SNSA in Minnesota, and it was an oversight by one of the nurses when All Heart Service was called to provide staffing to the facility on 2/15/15. DON stated when contacting All Heart Service, the phone number and contact person remained the same as previous owners under Soul Care.	F 492		
	An unsigned Staffing Agreement between All			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E117	A. BUILDING ____ B. WING ____	02/26/2015

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

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F 492	Continued From page 39 Heart Service and Villa Health Care at Osseo dated October 2, 2014, was provide and indicated, "All Heart provides all required insurance coverage's that are mandated by state law on its employees, including workers compensation and liability insurance, medical malpractice insurance, and employee bonding..." The Staffing Agreement identified All Heart Service was, "A provider of health care professional on a temporary basis... phone number 612-617-7777." The Staffing Agreement did not indicate if All Heart was registered as an SNSA to provide services in the state of Minnesota in accordance with SNSA statute 144A.71.	F 492		

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

FE117023

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24E117	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	(X3) DATE SURVEY COMPLETED 02/25/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, The Villa of Osseo was found 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 (NFPA) Standard 101, Life Safety Code (LSC) Chapter 19 Existing Health Care. This 2-story building is downgraded from construction Type II (222) to Type V (111) due to wood joist and plywood floors in some of the linen closets. It has a partial basement and is fully fire sprinklered. The facility has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 115 beds and had a census of 81 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is met.	K 000		

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

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.

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.

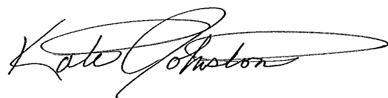
We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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,



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

PRINTED: 03/11/2015
FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00733	A. BUILDING: ______ B. WING ______	02/26/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
3 000	INITIAL COMMENTS *****ATTENTION****** BOARDING CARE HOME LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/23, 24, 25, and 26, 2015 surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health,	3 000	Approved 3/26/15	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 3/26/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00733	A. BUILDING: ______ B. WING ______	02/26/2015

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

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3 000	INITIAL COMMENTS	3 000		

INITIAL COMMENTS

*****ATTENTION******

BOARDING CARE HOME
LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
On 2/23, 24, 25, and 26, 2015 surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health,

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3 000	Continued From page 1 Division of Compliance Monitoring, Licensing and Certification Program; 3333West Division Street, Suite 212, St. Cloud, MN 56301.	3 000		
3 310	MN Rule 4655.1200 Subp. 2B Licensee;Appointmentof Admin/person in charge Subp. 2. Specific duties. The licensee shall develop written bylaws and/or policies which shall be available to all members of the governing body and shall assume full legal responsibility for matters under its control, for the quality of care rendered and for compliance with applicable laws and rules of legally authorized agencies. The responsibilities of the licensee shall include: B. Appointment of a licensed nursing home administrator or a person in charge who shall be responsible for the operation of the home in accordance with law and established policies. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the supplemental nursing service agency (SNSA) which was used by the facility was registered with the Minnesota commissioner of health as required. This had the potential to affect all 81 residents who resided in the facility. Findings include: During the the entrance conference on 2/23/15, at approximately 2:30 p.m. the administrator stated the facility had previously utilized a supplemental nursing staff agency called All Heart Service,	3 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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3 310	Continued From page 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.

During interview on 2/24/15, at 4:15 p.m. the facility nurse consultant stated Soul Care SNSA had gone out of business last fall, and was bought and renamed All Heart Service. The nurse consultant stated the facility was aware All Heart Service did not have current registration in Minnesota as an SNSA, however, despite facility knowledge of All Heart Service not being registered as an SNSA to provide services in the State of MN, a nurse at the facility had contacted All Heart Service and provided NA-F to work at the facility on 2/15/15.

Upon review, it was determined All Heart Service was not registered in the state of Minnesota as an SNSA, refer to SNSA statute 144A.71.

144A.71
Subdivision 1.Duty to register.
A person who operates a supplemental nursing services agency shall register the agency with the commissioner. Each separate location of the business of a supplemental nursing services agency shall register the agency with the commissioner. Each separate location of the

Minnesota Department of Health

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3 310	Continued From page 3 business of a supplemental nursing services agency shall have a separate registration. Subd. 2.Application information and fee. The commissioner shall establish forms and procedures for processing each supplemental nursing services agency registration application. An application for a supplemental nursing services agency registration must include at least the following: (1) the names and addresses of the owner or owners of the supplemental nursing services agency; (2) if the owner is a corporation, copies of its articles of incorporation and current bylaws, together with the names and addresses of its officers and directors; (3) satisfactory proof of compliance with section 144A.72, subdivision 1 </statutes/?id=144A.72>, clauses (5) to (7); (4) any other relevant information that the commissioner determines is necessary to properly evaluate an application for registration; and (5) the annual registration fee for a supplemental nursing services agency, which is $891. Subd. 3.Registration not transferable. A registration issued by the commissioner according to this section is effective for a period of one year from the date of its issuance unless the registration is revoked or suspended under section 144A.72, subdivision 2 </statutes/?id=144A.72>, or unless the supplemental nursing services agency is sold or ownership or management is transferred. When a supplemental nursing services agency is sold or ownership or management is transferred, the registration of the agency must be voided and the new owner or operator may apply for a new registration.	3 310		

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3 310	Continued From page 4	3 310		

During a follow up interview on 3/9/15, at 4:30 p.m. the administrator stated the facility was approached by All Heart Service in October 2014, and was told the alleged SNSA was taking over Soul Care prior clients. The administrator stated the facility refused to sign the contract until a current registration was provided by All Heart Service, and the staff were educated to ensure All Heart Service was not used to provide staff to the facility until further notice. The administrator stated All Heart Service did not provide a copy of registration with the state of Minnesota, and verified NA-F from All Heart Service had worked at the facility on 2/15/15.

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An unsigned Staffing Agreement between All Heart Service and Villa Health Care at Osseo dated October 2, 2014, was provide and indicated, "All Heart provides all required insurance coverage's that are mandated by state law on its employees, including workers compensation and liability insurance, medical malpractice insurance, and employee bonding..." The Staffing Agreement identified All Heart Service was, "A provider of health care professional on a temporary basis... phone number 612-617-7777." The Staffing Agreement did not indicate if All Heart was registered as an

Minnesota Department of Health

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
3 310	Continued From page 5 SNSA to provide services in the state of Minnesota in accordance with SNSA statute 144A.71. Suggested Method of Correction: The Administrator could train and ensure staff does not utilize outside agency for staffing purposes to prevent using agencies that are not registered with the state of Minnesota. TIME PERIOD FOR CORRECTION: One (1) day.	3 310		
31240	MN Rule 4655.8520 E Dietary Staff Requirements;Sanitary condition Dietary staff: E. Sanitary procedures and conditions shall be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure dishes and utensils used in resident food preparation were stored in a clean and sanitary manner. In addition, the facility failed to ensure foods were at a safe serving temperature prior to serving to prevent the potential of food bourne illness. These had the potential to affect all 81 residents who resided in the facility. Findings include: During kitchen tour on 2/23/15, at 12:42 p.m. eight shelves were observed covered with textured linoleum and were covered with dust and	31240		

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	00733	A. BUILDING: ____ B. WING ____	02/26/2015

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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.

The Employee Daily Cleaning List was reviewed and included duties to be completed by staff such as wiping down all sinks, cleaning the dish machine, and sweeping the floor. There was no duty which identified cleaning the shelves.

During follow up interview on 2/25/15, at 11:32 a.m. FSD stated he wasn't aware the staff were not regularly cleaning the shelves and stated that should be part of the regular kitchen cleaning task.

During interview on 2/23/15, at 4:19 p.m. Resident (97) stated the food served during meals was often cold, and today at lunch he had an egg roll that was cold.

During interview on 2/23/15, at 4:39 p.m. R63 stated the food at the facility is often cold, including the coffee that is served.

During interview on 2/23/15, at 5:46 p.m. R68 stated the food served at the facility is cold.

During interview on 2/24/15, at 8:35 a.m. R76

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reported hot food is often not hot enough.

During observation of the supper meal on 2/23/15, at 5:11 p.m. cook-A used a food thermometer to check the temperatures of the food in the steam table she was preparing to serve in the first floor dining room. Cook-A checked the temperature of the sauerkraut which was 130 degrees Fahrenheit (F), the tomato soup which was 130 degrees F, the pureed vegetables which were 120 degrees F, the pureed meat which was 120 degrees F, the mashed potatoes which were 110 degrees F. Cook-A stated none of the food was hot enough to serve. Cook-A used a phone to call the food service director (FSD), and reported she was sending all the food back to the kitchen to be heated. Cook-A put the metal containers of the food items onto a cart and directed a dietary aide to bring them back to the kitchen to be heated. Cook-A checked the temperature of the potato salad that was on a cart next to the steam table in a large bowl which was placed inside of a large steel pan with a one inch layer of ice in the bottom. Cook-A stated the temperature of the potato salad was 70 degrees F and stated that was too warm to be served and she would not be able to serve that either. At 5:39 p.m., a dietary aide brought the food that was reheated back to the dining room and cook-A used the thermometer to check the temperatures of all of the food and stated all the temperatures were now acceptable with the hot items being between 150-180 degrees F. Coleslaw was brought to the dining room to be used in place of the potato salad, and was at 40 degrees F.

During observation on 2/23/15, at 6:06 p.m. cook-A was preparing to serve the second shift of residents in the first floor dining room the supper meal, and checked the temperature of the food

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that remained in the steam table. The ground meat was 100 degrees F, the pureed meat was 110 degrees F, mashed potatoes 130 degrees F, sauerkraut was 125 degrees F, and the bratwurst was 110 degrees F. Cook-A called the FSD and asked him to come to the dining room because of the concern again the food was not hot enough to be served. At 6:15 p.m., FSD came to the dining room and told cook-A the food was not holding at a warm temperature because the metal containers the food was in needed to be submerged in the water on the steam table and the containers needed to be covered to keep the food hot. FSD and cook-A removed the containers of food from the steam table and sent them back to the kitchen to be reheated.

On 2/23/15, at 6:41 p.m. cook-A returned from the kitchen with containers of precooked pureed and mechanical polish sausage. Cook-A stated she had remade the food rather than reheating it again, and proceeded to check the temperatures. The pureed polish sausage only registered at 140 degrees F, and the mechanical polish sausage was 135 F. The FSD entered the dining room to check on the temperatures of the food, and told cook-A to serve the food at the current temperatures.

During interview on 2/23/15, at 6:49 p.m. registered dietician (RD)-A stated food temperatures were supposed to be checked in the kitchen prior to the meal, and again when it arrived to the dining room. RD stated staff were trained to check food temperatures in the kitchen, and she was not aware staff were not doing that until now. RD-A stated hot food should be above 140 degrees F when served, and cold food should not be served if it is below 40 degrees F.

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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 food bourne illness.

During a follow up interview on 2/26/15, at 1:30 p.m. cook-A stated she usually checks the temperature of the food before taking it to the dining room, however, she did not complete that on Monday evening. Cook-A stated she believed the food was not staying warm because she was not wrapping the containers of food with cellophane and tin foil, not ensuring there was enough water in the steam table so the pans were sitting in the water to remain hot, and was not turning on the steam wells one hour prior to bringing the food upstairs to serve.

The facility policy titled Food Temperatures dated 2010, included, "All hot food items must be cooked to appropriate internal temperatures, held and served at a temperature of at least 135 [degrees] F...Hot food items may not fall below 135 [degrees] F after cooking...at least 165

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31240	Continued From page 10 [degrees] F prior to serving...All cold food items must be maintained and served at a temperature of 41 [degrees] F or below...Temperatures should be taken periodically to ensure hot foods stay above 135 [degrees] F and cold foods stay below 41 [degrees] during the portioning, transporting, and delivery process until received by the individual recipient..." The facility policy titled Handling Cold Foods for Tray line policy dated 2010, instructed prior to service salads and other cold food items for meal service are to be placed in the refrigerator at least 3-4 hours before serving and Food should be chilled to equal to or less then 41 degrees F. Suggested Method of Correction: The Food Service Director (FSD) or designee could ensure all staff is trained on cleaning procedures and appropriate food temperatures. The FSD could audit food temperatures to ensure staff is serving food at appropriate temperatures to prevent potential food bourne illness. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	31240		
31915	MN Rule 144.651 Subd. 27 Patients & Residents of HCF Bill of Rights Subd. 27. Advisory councils. Residents and their families shall have the right to organize, maintain, and participate in resident advisory and family councils. Each facility shall provide assistance and space for meetings. Council meetings shall be afforded privacy, with staff or visitors attending only upon the council's invitation. A staff person shall be designated the	31915		

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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:

During interview on 2/25/15, at 2:30 p.m. the activities director stated the facility did not have a family council and was not aware of any attempts to form a family council in the nine years she had been working at the facility.

A typed, undated document was provided by the facility which stated, "As 2014 begins, we would like to offer the opportunity for our families or concerned persons to start a family council. If we receive responses from people interested, the Family Council can be established and notice will be posted in the newsletter to announce when the first meeting would be." The document directed interested people to contact the facility social worker.

During interview on 2/26/15, at 12:00 p.m. registered nurse (RN)-A stated the document provided had been mailed out to families sometime at the start of 2014 but was unsure when. RN-A stated the social worker at the time was no longer employed at the facility and was

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unavailable for interview, but she believed there had been no family responses to the letter and no further attempts to organize a family council had been completed since.

The facility was unable to provide a date or any tracking of who the undated letter was sent out to, or if there was any follow up needed or any responses to the letter.

Suggested Method of Correction: The Social worker or designee could ensure all family is contacted at least annually to attempt to set up a family council group. The administrator or designee could ensure the letter is sent and follow up with families is complete.

TIME PERIOD FOR CORRECTION: Twenty One (21) days.