DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 11, 2024

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

RE: CCN: 245629
Cycle Start Date: February 29, 2024

Dear Administrator:

On April 1, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 11, 2024

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

Re: Reinspection Results
Event ID: KWGS12

Dear Administrator:

On April 1, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 29, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 14, 2024

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

RE: CCN: 245629
Cycle Start Date: February 29, 2024

Dear Administrator:

On February 29, 2024, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by May 29, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 29, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the

Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

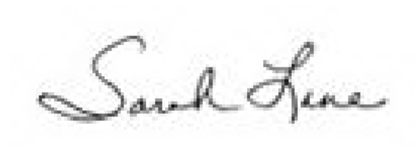
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245629	A. BUILDING _____ B. WING _____	C 02/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 2/28/24 through 2/29/24 , a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H56291244C (MN00101077), HE1171205C (MN00098764), and HE1171280C (MN00098375) with a deficiencies issued at F656, F689, and F726. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must	F 656		3/29/24

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

Electronically Signed | 03/19/2024

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

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F 656	Continued From page 1 describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to implement comprehensive care plans for 1 of 1 residents	F 656	F656 Develop/Implement Comprehensive Care Plan	

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F 656	Continued From page 2 (R1) reviewed for toileting and falls. Findings include: Vulnerable adult maltreatment report dated 2/22/24, indicated R1 was not provided with timely toileting. R1 face sheet identified R1 had diagnoses that included anoxic brain damage, muscle weakness, difficulty in walking, fall from bed, and unspecified fall. R1's admission Minimum Data Set (MDS) dated 2/5/24, identified R1 was cognitive and did not have behaviors. R1 required partial/moderate assistance to transfer on and off the toilet and was dependent for toileting hygiene. R1 was not on a toileting program and frequently incontinent of urine and bowel. R1's bladder evaluation dated 1/31/24, reviewed on 2/1/24. Identified R1 was not content of bladder and potential causes include weakness and limited mobility. R1 had functional incontinence (impaired mobility, manual dexterity impairment, lack of toilet or toilet substitute, use of restraints, medications). Individualized treatment plan was not completed. Summery and plan identify R1 had baseline incontinence on admission. R1 had some sensation to void, not consistently. Staff were to toilet upon rising, after meals and bedtime as well as requested. R1 had physical limitations which required her to need assistance. Wears pad to keep skin dry. Staff to manage toileting needs. R1's nursing assistant care guide that was not dated, identified R1 directed staff to offer R1 to	F 656	-The process for satisfying this requirement has been reviewed and revised as needed, to ensure the facility implements processes and procedures to develop comprehensive care plans for residents who are at risk for falls and require assistance with toileting. -All residents residing in the facility who require assistance with toileting and are at risk of falling could be affected if this requirement is not met. -R1 comprehensive care plan was reviewed and revised as necessary to meet this requirement. -All necessary VAO staff have received appropriate education on developing and implementing comprehensive care plans, specifically for those who are at risk of falling and require assistance with toileting. -Audits will be completed to ensure compliance. Audit results will be reviewed at QAPI, with any deficient practice corrected at the time of occurrence. - Director of Nursing or designee is the responsible party. - Corrective action will be completed on or before 3/29/2024	

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F 656	Continued From page 3 lay down after meals. Further, R1 required assist of one staff to turn and reposition every 2-3 hours and as needed and required assist of one to toilet and check and change every 2-3 hours. Follow up question report reviewed for toileting on 2/27/24 through 2/29/24 identified the following: -On 2/27/24, R1 was toileted at 2:19 a.m., 2:59 p.m., and 8:05 p.m. with no refusals documented. -On 2/28/24, R1 was toileted at 12:49 a.m. and 9:05 a.m. with no refusals documented -On 2/29/24, R1 was toileted at 3:33 a.m. and 2:17 p.m. with no refusals documented. During continuous observation on 2/28/24 at 8:56 a.m., R1 was noted to be sleeping in bed with lights off and door closed. At 9:19 a.m. nursing assistant (NA)-B entered the room and offered to get up for the day. R1 reported she did not sleep well and refused breakfast at this time and wanted to sleep longer. NA-B did not offer a check and change or toileting. NA-B reported planning on coming back at 11:00 a.m. to complete cares. At 10:59 a.m. R1's call light was on and at 11:04 a.m. licensed practical nurse (LPN)-A answered the light. R1 reported to LPN-A she wanted to get up. R1's room had a significant urine odor present. At 11:09 a.m. NA-B entered room and pulled down R1's blankets. R1 reported to NA-B her bed was wet; R1's brief was fully saturated with urine and bed linen was observed to be wet underneath her. NA-B completed cares, transferred R1 into her wheelchair, and left the room. NA-B returned with abolish (odor eliminator) and super sani-cloths (disinfectant wipes). NA-B continued to strip the wet bed linen from the bed and wetness noted on top of the surface of the mattress. NA-B sprayed the	F 656		

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F 656	Continued From page 4 abolish spray and wiped the bed with super sani-cloths. During interview on 11:30 a.m., NA-B reported R1 was last toileted at 7:30 a.m. and when she had just changed her R1 had a significant amount of urine in the brief and the room smelt of urine. NA-B reported R1 was a "heavy wetter" and urinates frequently. R1 would not use the call light to use the bathroom but would call after already soiled. R1 was on a repositioning and toileting schedule of every 2 hours, staff should follow the care plan, and document completion and/or refusals. During interview on 2/28/24 at 12:40 p.m., R1 expressed some concerns with timeliness and reported having to wait to be changed after incontinence accidents due to facility staff being busy. During interview on 2/28/24 at 1:41 p.m., nurse manager NM-(A) stated R1 was incontinent at baseline and required assist for toileting. R1 was supposed to be repositioned and toileted every 2 to 3 hours. Staff should be asking and offering check and changes if not toileted; staff should then document in the record when this was completed. NM-A reviewed R1's toileting documentation; NM-A indicated according to the documentation R1 had last been changed was at 9:00 a.m. however NA's may not be done documenting until the end of their shift. During interview on 2/28/24 at 3:55 p.m., R1 was seated in wheelchair following an activity. R1 stated she had not been offered toileting or repositioning since getting out of bed before lunch.	F 656		

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F 656	Continued From page 5 During interview on 2/28/24 at 3:57 p.m., nursing assistant NA-C reported her shift on R1's unit started at 2:30 p.m. and had not provided any cares including toileting for R1. NA-C stated R1 should be changed every two hours. NA-C was unaware of when R1 had last been toileted. NA-C looked at R1's toileting record and reported it was completed by previous nursing assistant at 9:05 a.m. on 2/28/24. During interview on 2/28/24 at 4:08 p.m., nursing assistant NA-D reported the shift started at 2:30 p.m. and had not provided any cares. NA-D had brought R1 to her room following the activity but had not toileted or changed R1. NA-D reported R1 would put on the call light when she was wet or needed to use the bathroom. NA-D was unaware the last time R1 had been toileted. During interview on 2/28/24 at 4:15 p.m., NM-A reviewed R1's toileting documentation and indicated according to the documentation R1 was last toileted at 9:00 a.m. NM-A was not aware R1 had not been toileted and the evening shift NA's were not aware of when R1 was last offered toileting. NM-A indicated NA's should toilet R1 according to the care plan. NM-A then directed NA's to toilet R1. During interview on 2/29/24 at 12:24 p.m., director of nursing (DON) indicated R1 should be toileted or offered every two to three hours and was important for all residents in the facility. Going more than three hours would be inappropriate and could lead to larger health issues or falls. Toileting should be offered frequently and refusals should be documented and reported as well as a resident being dry. Staff	F 656		

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F 656	Continued From page 6 were supposed to communicate at shift change when residents were last toileted and if that did not occur, oncoming staff should look at the record. All facility staff should be following the care plan and identifying the residents needs. During interview on 2/28/24 at 4:37 p.m., administrator reported the nurse manager was to update care plans and care guides and facility staff should follow the care plans and the care guides to provide safe and appropriate care. Facility policy titled Care Planning dated 1/6/22 identified the purpose is to be in accordance with state and federal regulations, each resident will have a person-centered care plan developed by the interdisciplinary team for the purpose of meeting the resident's individual medical, physical, psychosocial, and functional needs. The interdisciplinary team (IDT), in conjunction with the resident and the resident representative, will develop and implement a comprehensive individualized care plan no later than the 21st day of admission of the resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive person-centered care plan will be consistent with the resident's rights to participate in the development and implementation of his or her care plan. The goal of the person centered, individualized care plan is to identify problem areas and their causes, and develop interventions that are targeted and meaningful to the resident. The resident has the right and is encouraged to participate in the development of his or her care plan. The care plan shall be used in developing the resident's daily care routines and will be utilized by staff personnel for the purposes of	F 656		

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F 656	Continued From page 7 providing care or services to the resident. The plan of care will be utilized to provide care to the resident. The care plan is to be modified and updated as the condition and care needs of the resident changes.	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure safe transfers to prevent or mitigate the risk of falls and/or injury for 2 of 4 residents (R4, R1) reviewed for falls. Findings include: R4's face sheet identified R4 had diagnoses that included abnormalities of gait and mobility, dementia, muscle weakness, unsteadiness on feet and repeated falls. R4's quarterly Minimum Data Set (MDS) dated 2/8/24, identified R4 was to walk with a walker. R4 required partial/moderate assistance to go from sit to stand. R4's care plan dated 8/31/23, identified R4 required assist with transfers with the use of sit-to-stand mechanical lift.	F 689	F689 Accidents/Supervision - The process for satisfying this requirement has been reviewed and revised as needed, to ensure the facility develops and implements processes and procedures for safe transfers to prevent or mitigate the risk of falls and/or injury for residents. -All residents residing in the facility that need assistance with transfers have the potential to be affected if this requirement is not met. - R1 and R4□s care plan, care guide, and assessments were reviewed and revised as necessary to meet this requirement. - All necessary VAO staff have received	3/29/24

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F 689	Continued From page 8 R4's therapy note dated 2/6/24 identified R4 required several standing rest breaks throughout ambulation. R4 ambulates with shuffling festinating gait, was occasionally able to achieve foot clearance but not consistently. R4 required moderate assist to stand from wheelchair. R4's nursing assistant care guide undated provided on 2/29/24 by administrator identified R4 was at high risk for falls. Staff were to remind R4 to walk with walker at all times and required assist of one staff for transfers, mobility and ambulation. Medline Guardian Basic steal rollator with 8" wheels rolling walker [Reference number MDS86860ERS8] manufactures recommendations dated 07/21/22, identified the purpose is to ensure safety in using the Medline rollator, and the safety information and all instructions must be followed. The rollator is NOT intended to be used to move around while seated. Rollators are intended for individual use only and are NOT TO BE USED AS A WHEELCHAIR. Serious injury to the user and/or damage to the rollator's frame or wheels may result from improper use. DO NOT use the rollator to walk backwards, down gradients or to clime stairs, curbs, or to go over obstacles. Serious risk of fall or injury may occur. The backrest is intended to provide back support while seated. The backrest is not intended to support full body weight. Avoid leaning while seating as this may result in a fall. The breaks MUST be in the locked position BEFORE sitting on the seat. When rising from a lower position, DO NOT use the rollator to provide assistance to the user. If the rollator is used to pull the user up	F 689	appropriate education using the Monarch Healthcare Management policy and procedure on Safe Resident Handling; which includes but is not limited to the use of gait belts. -Audits will be completed to ensure compliance. Audit results will be reviewed at QAPI, with any deficient practice corrected at the time of occurrence. - Director of Nursing or designee is the responsible party. - Corrective action will be completed on or before 3/29/2024.	

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	245629	A. BUILDING _____ B. WING _____	C 02/29/2024

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F 689	Continued From page 9 to a standing position, the rollator may move even if the brakes are in the locked position, and this could result in a fall. During observation on 2/29/24 at 9:02 a.m., R4 was walking out of the dining room with a Medline Guardian Basic rolling four wheeled walker. R4 stated to therapeutic recreation department director (TRD)-A "My legs aren't working". TRD-A instructed R4 to sit on the seat of the four wheeled walker, TRD-A held onto the walker, and did not lock the brakes. TRD-A pushed R4 who was seated on the walker down the hallway. As TRD-A passed physical therapy assistant (PTA)-B in the hallway, PTA-B stated to TRD-A "you should not push him on the walker". TRD-A continued to push R4 down the hallway. Once to R4's room, TRD-A pivoted the walker from a pushing to a pulling position and pulled R4 into the room while R4 continued in seated position on the walker. R4 reported pain from shoes and requested help to take off the shoes in which TRD-A assisted in the removal. R4 requested to get into bed and attempted to stand from four-wheel walker. TRD-A locked the walker breaks. R4 stated, "I do not have confidence in this little chair". R4 was unable to stand up from the walker independently, TRD-A grabbed onto the back of R4's pants and under his arm to assist R4 in a standing position. Once to a standing position R4 walked over to his bed in stocking feet without the use of the walker. R4 laid down on his bed and TRD-A exited the room. During interview on 9:10 a.m., TRD-A reported it was not typical for her to assist with transfers and only able to help in emergency situations. TRD-A felt it was an emergency situation as R4 could not move his legs. TRD-A had not been trained to	F 689		

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F 689	Continued From page 10 transfer residents in the facility. TRD-A reported to hearing PTA-B state R4 should not be pushed in the walker, but continued because R4 needed to get back to his room. TRD-A had planned on notifying R4's nurse he was having difficulty when the task was completed. During observation on 2/29/24 at 9:20 a.m., TRD-A reported to licensed practical nurse (LPN)-A R4 could not move his legs and explained how she assisted R4. LPN-A explained to TRD-A residents were not supposed to be pushed on four-wheeled walkers due to safety concerns, staff should not lift residents by their clothing or body parts, gait belts were required for tranfers/ambulating, and R4 should have had his shoes on while ambulating. During interview on 2/29/24 at 9:49 a.m., PTA-B reported observing TRD-A pushing R4 on the four-wheeled walker platform and had attempted to intervene by informing TRD-A it was not appropriate. PTA-B explained she did not stop TRD-A from proceeding because R4's room was close by and was busy with another resident. Staff were not supposed to push residents on four-wheeled walkers as the platform was not designed to push people on and could cause a fall or injury. PTA-B stated the walkers have a warning label on them to notify people not to use the walker in this manner. During interview on 2/29/24 at 12:04 p.m., NA-B indicated staff were not to push residents on four-wheeled walkers with platforms as it was not safe and could cause harm. The platform was for small things to be transported, it was not meant to be used as a chair to ride on. NA-B explained if staff witnessed unsafe practices the expectation	F 689		

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F 689	Continued From page 11 was to intervene and stop the action. During interview on 2/29/24 at 11:59 a.m., LPN -A reported facility staff should not push residents on four-wheel walker platforms as the platform was not meant for transportation and would be unsafe for the resident. Pushing a resident in a walker could cause a fall or injury. Staff were trained to not push four wheeled walkers with resident on the platform. During interview on 2/29/24 at 9:41 a.m., walker manufacturer representative (MR)-A stated the walker which was observed in the transfer was not to be used to transport residents on the platform and should not be pushed or pulled with weight on it and definitely not the weight of a human body. If someone was sitting on the walker during transport the wheels could jam and a person could tip over. The caster could turn and could shift the center of gravity causing the person and the whole unit to fall or thrown/ejected from it. Additionally, if someone accidentally pushed the break in transport it could cause a sudden stopping force also ejecting a person. The wheels designed on the model of walker were not meant to be used while moving weight and could break. Additionally pivoting the wheels with weight on it or pulling over thresholds increases the chance of a wheel breaking and a person being ejected. By using this model walker not in accordance to manufactures recommendation a person could fall and could cause serious injury or death. R1's face sheet identified R1 had diagnoses that included anoxic brain damage, muscle weakness, difficulty in walking, fall from bed, and unspecified fall.	F 689		

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F 689	Continued From page 12 R1's admission assessment Minimum Data Set (MDS) dated 2/5/24, identified R1 required partial/moderate assistance to go from sit to standing position and partial to moderate assistance for chair to bed transfer. R1 had a fall in the last month prior to admission and a fall with fracture in the last six months prior to admission. R1's fall review evaluation dated 2/1/24 identified R1 has had multiple falls in the last 6 months. R1's gait analysis identified R1 was unable to independently come to a standing position. R1's care plan dated 2/14/24, identified R1 had an alteration in mobility related to weakness, failure to thrive and pain and R1 required assist of 1 to 2 with transfers. R1's care paln did not address transfer aides/devices and/or the usage of a gait belt for safety in order to assist R1 to stand and stabalize. R1's nursing assistant care guide that was not dated provided on 2/28/24 by facility staff identified R1 required assist of 1 to 2 staff for transfers and used a wheelchair for mobility and ambulation. During observation on 2/28/24 at 9:22 a.m., R1 observed for morning cares with NA-B. R1 was seated at edge of bed. A transfer belt was observed approximately 5 feet away from the bed. NA-B assisted R1 to a standing position with the use of a walker and by lifting R1 under the left arm to come to a standing position. NA-B stopped supporting R1 by letting go of R1's arm, then NA-B bent down to complete peri-cares. While NA-B was providing cares R1 became unbalanced and started leaning to the left. NA-B	F 689		

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F 689	Continued From page 13 who was providing cares, did not notice R1 had become unbalanced and instructed R1 to take a step forward away from the bed to pull up the new brief. Surveyor stopped the transfer due to the risk of R1 falling. NA-B then grabbed and applied the transfer gait belt to assist R1 to a balanced standing position and assisted R1 away from the bed to complete pulling up R1's pants. During interview on 2/28/24 at 11:30 a.m., NA-B reported she should have used the gait belt for R1's safety. R1 did not like to use it which was why NA-B did not use it initially. NA-B indicated R1 was stiff and could not do two things at once safely which was the reason R1 started to lean. NA-B preferred to transfer R1 with two people due to R1's stiffness, however NA-B wanted to "be quick" because R1 had a tendency to become resitive to cares with too many people in the room. During interview on 2/28/24 at 1:19 p.m. Nurse manager NM-A indicated care plans should be updated an appropriate for residents for transfer status and should be updated with any change of condition. Further indicated NA's should communicate to nursing if transfers were difficult or unsafe so further evaluation of transfer status should be completed to reduce the risk for falls or injury. All trained facility staff should know the transfer status of everyone as it was updated on the care plan and the care guides and staff were to follow them. During interview on 2/29/24 12:24 p.m., director of nursing (DON) reported all staff have been trained and signed off for through the facilities training program and have credentialing to reflect it was safe for staff to transfer residents and have	F 689		

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F 689	Continued From page 14 completed safe patient handling training. All staff have been trained in safe patient handling including the use of gait belts. Facility policy titled Safe Resident Handling Program dated 3/2020, identified the purpose of the policy is to protect the health and comfort of residents and staff when residents require assistance in moving through the consistent use of mechanical aids/devices, and to meet regulatory requirements. Safe patient handling (SPH) is a key component to reducing hazards of injury to our employees and our residents. Therefore, it is the policy of Monarch Healthcare Management that when residents receiving care require assistance from facility employee to move (e.g. transferring, lifting, repositioning), that assistance is provided in a manner that is safe to both the resident and employee. Gait belts must be used for ambulatory residents when indicated in the patient care plan to allow employees to hold onto the belt to provide support and stabilize the resident when walking. A gait belt must also be used during a stand pivot transfer and during a slide board or seated transfer to provide guidance to the resident, when indicated in the care plan. Gait belts are not designed to be used for manual lifting of residents. Physical plant/environmental barriers to the use of safe patient handling equipment will be evaluated and minimized to the extent possible. Each resident will be assessed for safe patient handling needs during the admission process to our facility using the MHM Lift/Mobility Status Form and for each relevant activity in the care delivery process. The information from this assessment will be contained in the care plan for each resident and the care plan will identify the safe patient handling requirements for that individual. Training of	F 689		

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F 689	Continued From page 15 nurses and other direct care employees will be provided to demonstrate proper application and use of available SPH equipment: 1. The training will be conducted initially and then periodically thereafter, based on observed need, individual requests for training, or as needed to correct improper use or understanding of safe patient handling. 2. Training will demonstrate how equipment can be used; proper methods for use and application relative to the care activity being provided.	F 689		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.	F 726		3/29/24

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F 726	Continued From page 16 §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the therapeutic recreational director TRD-(A) was trained or had demonstrated competency prior to assisting residents with transfers, locomotion on/off unit, dressing, and ambulation for 1 of 1 residents (R4) reviewed for falls. Findings include: R4's face sheet identified R4 had diagnoses that included abnormalities of gait and mobility, dementia, muscle weakness, unsteadiness on feet and repeated falls. R4's quarterly Minimum Data Set (MDS) dated 2/8/24, identified R4 was to walk with a walker. R4 required partial/moderate assistance to go from sit to stand. R4's care plan dated 8/31/23, identified R4 required assist with transfers with the use of mechanical sit to stand lift. During observation on 2/29/24 at 9:02 a.m., R4 was walking out of the dining room with a four wheeled walker that had a seat. R4 stated to therapeutic recreation department director (TRD)-A "My legs aren't working". TRD-A instructed R4 to sit on the seat of the four	F 726	F726 Competent Nursing Staff -The process for satisfying this requirement has been reviewed and revised as needed, to ensure the facility develops and implements processes and procedures for training and competency completion prior to staff assisting residents with transfers and ADLs. - TRD-A received education, including corrective action, regarding Safe Resident Handling. -All residents residing in the facility that need assistance with transfers and ADLs have the potential to be affected if this requirement is not met. -All necessary VAO staff have received appropriate education using Monarch Healthcare Management policy and procedure on Safe Resident Handling, including positions who can and cannot assist with resident transfers and ADLs. -Audits will be completed to ensure compliance. Audit results will be reviewed at QAPI, with any deficient practice corrected at the time of occurrence.	

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F 726	Continued From page 17 wheeled walker, TRD-A held onto the walker, and did not lock the brakes. TRD-A pushed R4 who was seated on the walker down the hallway. As TRD-A passed physical therapy assistant (PTA)-B in the hallway, PTA-B stated to TRD-A "you should not push him on the walker". TRD-A continued to push R4 down the hallway. Once to R4's room, TRD-A pivoted the walker from a pushing to a pulling position and pulled R4 into the room while R4 continued in seated position on the walker. R4 reported pain from shoes and requested help to take off the shoes in which TRD-A assisted in the removal. R4 requested to get into bed and attempted to stand from four-wheel walker. TRD-A locked the walker breaks. R4 stated, "I do not have confidence in this little chair". R4 was unable to stand up from the walker independently, TRD-A grabbed onto the back of R4's pants and under his arm to assist R4 in a standing position. Once to a standing position R4 walked over to his bed in stocking feet without the use of the walker. R4 laid down on his bed and TRD-A exited the room. During interview on 9:10 a.m., TRD-A stated she was not a certified nursing assistant and had not been trained or found competent to complete activities of daily living tasks for residents. TRD-A's training file identified no training and skills testing for completing activities of daily living including but not limited to safe transfers, locomotion on/off unit, and ambulation. During interview on 2/29/24 at 12:24 p.m., director of nursing (DON) reported the facility had a training system for safe patient handling and staff were required to complete the training prior to providing cares or assisting with transfers. Staff	F 726	- Director of Nursing or designee is the responsible party. - Corrective action will be completed on or before 3/29/2024	

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F 726	Continued From page 18 who were not trained should not assist with resident cares. If staff were to observe a non-trained employee completing transfers or care, trained staff should intervene immediately. Trained staff were educated four wheel walkers were not safe to be pushed while resident sat on them. During interview on 2/29/24 at 12:52 p.m., administrator stated TRD-A was not trained to complete transfers or direct patient care. Any skilled staff who observed should have intervened. Training policy titled Quality of Care undated, identifies all staff must be instructed in the requirements of the law and the rules pertaining to their respective duties; these instructions must be documented. Similarly, all staff must be informed of the policies of our facilities.	F 726		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 14, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: KWGS11

Dear Administrator:

The above facility was surveyed on February 28, 2024 through February 29, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

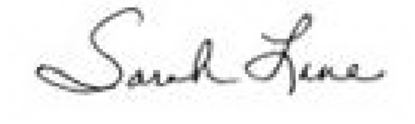
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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	00733	A. BUILDING: _____ B. WING _____	02/29/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/28/24 through 2/29/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed. H56291244C (MN00101077) HE1171205C (MN00098764) HE1171280C (MN00098375) with a licensing orders issued at (300, 565, 830). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is	2 000		

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2 000	Continued From page 2 not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 300	MN Rule 4658.0105 Competency A nursing home must ensure that direct care staff are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through the comprehensive resident assessments and described in the comprehensive plan of care, and are able to perform their assigned duties. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the therapeutic recreational director TRD-(A) was trained or had demonstrated competency prior to assisting residents with transfers, locomotion on/off unit, dressing, and ambulation for 1 of 1 residents (R4) reviewed for falls. Findings include: R4's face sheet identified R4 had diagnoses that included abnormalities of gait and mobility, dementia, muscle weakness, unsteadiness on feet and repeated falls. R4's quarterly Minimum Data Set (MDS) dated 2/8/24, identified R4 was to walk with a walker. R4 required partial/moderate assistance to go	2 300	CORRECTED.	3/29/24

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2 300	Continued From page 3 from sit to stand. R4's care plan dated 8/31/23, identified R4 required assist with transfers with the use of mechanical sit to stand lift. During observation on 2/29/24 at 9:02 a.m., R4 was walking out of the dining room with a four wheeled walker that had a seat. R4 stated to therapeutic recreation department director (TRD)-A "My legs aren't working". TRD-A instructed R4 to sit on the seat of the four wheeled walker, TRD-A held onto the walker, and did not lock the brakes. TRD-A pushed R4 who was seated on the walker down the hallway. As TRD-A passed physical therapy assistant (PTA)-B in the hallway, PTA-B stated to TRD-A "you should not push him on the walker". TRD-A continued to push R4 down the hallway. Once to R4's room, TRD-A pivoted the walker from a pushing to a pulling position and pulled R4 into the room while R4 continued in seated position on the walker. R4 reported pain from shoes and requested help to take off the shoes in which TRD-A assisted in the removal. R4 requested to get into bed and attempted to stand from four-wheel walker. TRD-A locked the walker breaks. R4 stated, "I do not have confidence in this little chair". R4 was unable to stand up from the walker independently, TRD-A grabbed onto the back of R4's pants and under his arm to assist R4 in a standing position. Once to a standing position R4 walked over to his bed in stocking feet without the use of the walker. R4 laid down on his bed and TRD-A exited the room. During interview on 9:10 a.m., TRD-A stated she was not a certified nursing assistant and had not been trained or found competent to complete activities of daily living tasks for residents.	2 300		

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2 300	Continued From page 4 TRD-A's training file identified no training and skills testing for completing activities of daily living including but not limited to safe transfers, locomotion on/off unit, and ambulation. During interview on 2/29/24 at 12:24 p.m., director of nursing (DON) reported the facility had a training system for safe patient handling and staff were required to complete the training prior to providing cares or assisting with transfers. Staff who were not trained should not assist with resident cares. If staff were to observe a non-trained employee completing transfers or care, trained staff should intervene immediately. Trained staff were educated four wheel walkers were not safe to be pushed while resident sat on them. During interview on 2/29/24 at 12:52 p.m., administrator stated TRD-A was not trained to complete transfers or direct patient care. Any skilled staff who observed should have intervened. Training policy titled Quality of Care undated, identifies all staff must be instructed in the requirements of the law and the rules pertaining to their respective duties; these instructions must be documented. Similarly, all staff must be informed of the policies of our facilities. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review/revise policies and procedures on training/quality of care. The administrator or designee could educate all staff on these policies and procedures. The administrator or designee could audit to ensure all staff are aware of resident safety and scope of practice, and report these	2 300		

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2 300	Continued From page 5 findings to their QAPI committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 300		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to implement comprehensive care plans for 1 of 1 residents (R1) reviewed for toileting and falls. Findings include: Vulnerable adult maltreatment report dated 2/22/24, indicated R1 was not provided with timely toileting. R1 face sheet identified R1 had diagnoses that included anoxic brain damage, muscle weakness, difficulty in walking, fall from bed, and unspecified fall. R1's admission Minimum Data Set (MDS) dated 2/5/24, identified R1 was cognitive and did not have behaviors. R1 required partial/moderate assistance to transfer on and off the toilet and was dependent for toileting hygiene. R1 was not on a toileting program and frequently incontinent	2 565	CORRECTED.	3/29/24

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2 565	Continued From page 6 of urine and bowel. R1's bladder evaluation dated 1/31/24, reviewed on 2/1/24. Identified R1 was not content of bladder and potential causes include weakness and limited mobility. R1 had functional incontinence (impaired mobility, manual dexterity impairment, lack of toilet or toilet substitute, use of restraints, medications). Individualized treatment plan was not completed. Summery and plan identify R1 had baseline incontinence on admission. R1 had some sensation to void, not consistently. Staff were to toilet upon rising, after meals and bedtime as well as requested. R1 had physical limitations which required her to need assistance. Wears pad to keep skin dry. Staff to manage toileting needs. R1's nursing assistant care guide that was not dated, identified R1 directed staff to offer R1 to lay down after meals. Further, R1 required assist of one staff to turn and reposition every 2-3 hours and as needed and required assist of one to toilet and check and change every 2-3 hours. Follow up question report reviewed for toileting on 2/27/24 through 2/29/24 identified the following: -On 2/27/24, R1 was toileted at 2:19 a.m., 2:59 p.m., and 8:05 p.m. with no refusals documented. -On 2/28/24, R1 was toileted at 12:49 a.m. and 9:05 a.m. with no refusals documented -On 2/29/24, R1 was toileted at 3:33 a.m. and 2:17 p.m. with no refusals documented. During continuous observation on 2/28/24 at 8:56 a.m., R1 was noted to be sleeping in bed with lights off and door closed. At 9:19 a.m. nursing assistant (NA)-B entered the room and offered to get up for the day. R1 reported she did not sleep	2 565		

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2 565	Continued From page 7 well and refused breakfast at this time and wanted to sleep longer. NA-B did not offer a check and change or toileting. NA-B reported planning on coming back at 11:00 a.m. to complete cares. At 10:59 a.m. R1's call light was on and at 11:04 a.m. licensed practical nurse (LPN)-A answered the light. R1 reported to LPN-A she wanted to get up. R1's room had a significant urine odor present. At 11:09 a.m. NA-B entered room and pulled down R1's blankets. R1 reported to NA-B her bed was wet; R1's brief was fully saturated with urine and bed linen was observed to be wet underneath her. NA-B completed cares, transferred R1 into her wheelchair, and left the room. NA-B returned with abolish (odor eliminator) and super sani-cloths (disinfectant wipes). NA-B continued to strip the wet bed linen from the bed and wetness noted on top of the surface of the mattress. NA-B sprayed the abolish spray and wiped the bed with super sani-cloths. During interview on 11:30 a.m., NA-B reported R1 was last toileted at 7:30 a.m. and when she had just changed her R1 had a significant amount of urine in the brief and the room smelt of urine. NA-B reported R1 was a "heavy wetter" and urinates frequently. R1 would not use the call light to use the bathroom but would call after already soiled. R1 was on a repositioning and toileting schedule of every 2 hours, staff should follow the care plan, and document completion and/or refusals. During interview on 2/28/24 at 12:40 p.m., R1 expressed some concerns with timeliness and reported having to wait to be changed after incontinence accidents due to facility staff being busy.	2 565		

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2 565	Continued From page 8 During interview on 2/28/24 at 1:41 p.m., nurse manager NM-(A) stated R1 was incontinent at baseline and required assist for toileting. R1 was supposed to be repositioned and toileted every 2 to 3 hours. Staff should be asking and offering check and changes if not toileted; staff should then document in the record when this was completed. NM-A reviewed R1's toileting documentation; NM-A indicated according to the documentation R1 had last been changed was at 9:00 a.m. however NA's may not be done documenting until the end of their shift. During interview on 2/28/24 at 3:55 p.m., R1 was seated in wheelchair following an activity. R1 stated she had not been offered toileting or repositioning since getting out of bed before lunch. During interview on 2/28/24 at 3:57 p.m., nursing assistant NA-C reported her shift on R1's unit started at 2:30 p.m. and had not provided any cares including toileting for R1. NA-C stated R1 should be changed every two hours. NA-C was unaware of when R1 had last been toileted. NA-C looked at R1's toileting record and reported it was completed by previous nursing assistant at 9:05 a.m. on 2/28/24. During interview on 2/28/24 at 4:08 p.m., nursing assistant NA-D reported the shift started at 2:30 p.m. and had not provided any cares. NA-D had brought R1 to her room following the activity but had not toileted or changed R1. NA-D reported R1 would put on the call light when she was wet or needed to use the bathroom. NA-D was unaware the last time R1 had been toileted. During interview on 2/28/24 at 4:15 p.m., NM-A reviewed R1's toileting documentation and	2 565		

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2 565	Continued From page 9 indicated according to the documentation R1 was last toileted at 9:00 a.m. NM-A was not aware R1 had not been toileted and the evening shift NA's were not aware of when R1 was last offered toileting. NM-A indicated NA's should toilet R1 according to the care plan. NM-A then directed NA's to toilet R1. During interview on 2/29/24 at 12:24 p.m., director of nursing (DON) indicated R1 should be toileted or offered every two to three hours and was important for all residents in the facility. Going more than three hours would be inappropriate and could lead to larger health issues or falls. Toileting should be offered frequently and refusals should be documented and reported as well as a resident being dry. Staff were supposed to communicate at shift change when residents were last toileted and if that did not occur, oncoming staff should look at the record. All facility staff should be following the care plan and identifying the residents needs. During interview on 2/28/24 at 4:37 p.m., administrator reported the nurse manager was to update care plans and care guides and facility staff should follow the care plans and the care guides to provide safe and appropriate care. Facility policy titled Care Planning dated 1/6/22 identified the purpose is to be in accordance with state and federal regulations, each resident will have a person-centered care plan developed by the interdisciplinary team for the purpose of meeting the resident's individual medical, physical, psychosocial, and functional needs. The interdisciplinary team (IDT), in conjunction with the resident and the resident representative, will develop and implement a comprehensive individualized care plan no later than the 21st day	2 565		

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2 565	Continued From page 10 of admission of the resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive person-centered care plan will be consistent with the resident's rights to participate in the development and implementation of his or her care plan. The goal of the person centered, individualized care plan is to identify problem areas and their causes, and develop interventions that are targeted and meaningful to the resident. The resident has the right and is encouraged to participate in the development of his or her care plan. The care plan shall be used in developing the resident's daily care routines and will be utilized by staff personnel for the purposes of providing care or services to the resident. The plan of care will be utilized to provide care to the resident. The care plan is to be modified and updated as the condition and care needs of the resident changes. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review/revise policies and procedures on implementing comprehensive care plans. The administrator or designee could educate all staff on these policies and procedures. The administrator or designee could audit to ensure all residents are care plans are being followed, and report these findings to their QAPI committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must	2 830		3/29/24

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2 830	Continued From page 11 receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure safe transfers to prevent or mitigate the risk of falls and/or injury for 2 of 4 residents (R4, R1) reviewed for falls. Findings include: R4's face sheet identified R4 had diagnoses that included abnormalities of gait and mobility, dementia, muscle weakness, unsteadiness on feet and repeated falls. R4's quarterly Minimum Data Set (MDS) dated 2/8/24, identified R4 was to walk with a walker. R4 required partial/moderate assistance to go from sit to stand. R4's care plan dated 8/31/23, identified R4 required assist with transfers with the use of sit-to-stand mechanical lift. R4's therapy note dated 2/6/24 identified R4 required several standing rest breaks throughout ambulation. R4 ambulates with shuffling	2 830	CORRECTED	

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2 830	Continued From page 12 festinating gait, was occasionally able to achieve foot clearance but not consistently. R4 required moderate assist to stand from wheelchair. R4's nursing assistant care guide undated provided on 2/29/24 by administrator identified R4 was at high risk for falls. Staff were to remind R4 to walk with walker at all times and required assist of one staff for transfers, mobility and ambulation. Medline Guardian Basic steal rollator with 8" wheels rolling walker [Reference number MDS86860ERS8] manufactures recommendations dated 07/21/22, identified the purpose is to ensure safety in using the Medline rollator, and the safety information and all instructions must be followed. The rollator is NOT intended to be used to move around while seated. Rollators are intended for individual use only and are NOT TO BE USED AS A WHEELCHAIR. Serious injury to the user and/or damage to the rollator's frame or wheels may result from improper use. DO NOT use the rollator to walk backwards, down gradients or to clime stairs, curbs, or to go over obstacles. Serious risk of fall or injury may occur. The backrest is intended to provide back support while seated. The backrest is not intended to support full body weight. Avoid leaning while seating as this may result in a fall. The breaks MUST be in the locked position BEFORE sitting on the seat. When rising from a lower position, DO NOT use the rollator to provide assistance to the user. If the rollator is used to pull the user up to a standing position, the rollator may move even if the brakes are in the locked position, and this could result in a fall. During observation on 2/29/24 at 9:02 a.m., R4	2 830		

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2 830	Continued From page 13 was walking out of the dining room with a Medline Guardian Basic rolling four wheeled walker. R4 stated to therapeutic recreation department director (TRD)-A "My legs aren't working". TRD-A instructed R4 to sit on the seat of the four wheeled walker, TRD-A held onto the walker, and did not lock the brakes. TRD-A pushed R4 who was seated on the walker down the hallway. As TRD-A passed physical therapy assistant (PTA)-B in the hallway, PTA-B stated to TRD-A "you should not push him on the walker". TRD-A continued to push R4 down the hallway. Once to R4's room, TRD-A pivoted the walker from a pushing to a pulling position and pulled R4 into the room while R4 continued in seated position on the walker. R4 reported pain from shoes and requested help to take off the shoes in which TRD-A assisted in the removal. R4 requested to get into bed and attempted to stand from four-wheel walker. TRD-A locked the walker breaks. R4 stated, "I do not have confidence in this little chair". R4 was unable to stand up from the walker independently, TRD-A grabbed onto the back of R4's pants and under his arm to assist R4 in a standing position. Once to a standing position R4 walked over to his bed in stocking feet without the use of the walker. R4 laid down on his bed and TRD-A exited the room. During interview on 9:10 a.m., TRD-A reported it was not typical for her to assist with transfers and only able to help in emergency situations. TRD-A felt it was an emergency situation as R4 could not move his legs. TRD-A had not been trained to transfer residents in the facility. TRD-A reported to hearing PTA-B state R4 should not be pushed in the walker, but continued because R4 needed to get back to his room. TRD-A had planned on notifying R4's nurse he was having difficulty when the task was completed.	2 830		

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	00733	A. BUILDING: _____ B. WING _____	02/29/2024

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2 830	Continued From page 14 During observation on 2/29/24 at 9:20 a.m., TRD-A reported to licensed practical nurse (LPN)-A R4 could not move his legs and explained how she assisted R4. LPN-A explained to TRD-A residents were not supposed to be pushed on four-wheeled walkers due to safety concerns, staff should not lift residents by their clothing or body parts, gait belts were required for tranfers/ambulating, and R4 should have had his shoes on while ambulating. During interview on 2/29/24 at 9:49 a.m., PTA-B reported observing TRD-A pushing R4 on the four-wheeled walker platform and had attempted to intervene by informing TRD-A it was not appropriate. PTA-B explained she did not stop TRD-A from proceeding because R4's room was close by and was busy with another resident. Staff were not supposed to push residents on four-wheeled walkers as the platform was not designed to push people on and could cause a fall or injury. PTA-B stated the walkers have a warning label on them to notify people not to use the walker in this manner. During interview on 2/29/24 at 12:04 p.m., NA-B indicated staff were not to push residents on four-wheeled walkers with platforms as it was not safe and could cause harm. The platform was for small things to be transported, it was not meant to be used as a chair to ride on. NA-B explained if staff witnessed unsafe practices the expectation was to intervene and stop the action. During interview on 2/29/24 at 11:59 a.m., LPN -A reported facility staff should not push residents on four-wheel walker platforms as the platform was not meant for transportation and would be unsafe for the resident. Pushing a resident in a walker	2 830		

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2 830	Continued From page 15 could cause a fall or injury. Staff were trained to not push four wheeled walkers with resident on the platform. During interview on 2/29/24 at 9:41 a.m., walker manufacturer representative (MR)-A stated the walker which was observed in the transfer was not to be used to transport residents on the platform and should not be pushed or pulled with weight on it and definitely not the weight of a human body. If someone was sitting on the walker during transport the wheels could jam and a person could tip over. The caster could turn and could shift the center of gravity causing the person and the whole unit to fall or thrown/ejected from it. Additionally, if someone accidentally pushed the break in transport it could cause a sudden stopping force also ejecting a person. The wheels designed on the model of walker were not meant to be used while moving weight and could break. Additionally pivoting the wheels with weight on it or pulling over thresholds increases the chance of a wheel breaking and a person being ejected. By using this model walker not in accordance to manufactures recommendation a person could fall and could cause serious injury or death. R1's face sheet identified R1 had diagnoses that included anoxic brain damage, muscle weakness, difficulty in walking, fall from bed, and unspecified fall. R1's admission assessment Minimum Data Set (MDS) dated 2/5/24, identified R1 required partial/moderate assistance to go from sit to standing position and partial to moderate assistance for chair to bed transfer. R1 had a fall in the last month prior to admission and a fall with fracture in the last six months prior to admission.	2 830		

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2 830	Continued From page 16 R1's fall review evaluation dated 2/1/24 identified R1 has had multiple falls in the last 6 months. R1's gait analysis identified R1 was unable to independently come to a standing position. R1's care plan dated 2/14/24, identified R1 had an alteration in mobility related to weakness, failure to thrive and pain and R1 required assist of 1 to 2 with transfers. R1's care paln did not address transfer aides/devices and/or the usage of a gait belt for safety in order to assist R1 to stand and stabalize. R1's nursing assistant care guide that was not dated provided on 2/28/24 by facility staff identified R1 required assist of 1 to 2 staff for transfers and used a wheelchair for mobility and ambulation. During observation on 2/28/24 at 9:22 a.m., R1 observed for morning cares with NA-B. R1 was seated at edge of bed. A transfer belt was observed approximately 5 feet away from the bed. NA-B assisted R1 to a standing position with the use of a walker and by lifting R1 under the left arm to come to a standing position. NA-B stopped supporting R1 by letting go of R1's arm, then NA-B bent down to complete peri-cares. While NA-B was providing cares R1 became unbalanced and started leaning to the left. NA-B who was providing cares, did not notice R1 had become unbalanced and instructed R1 to take a step forward away from the bed to pull up the new brief. Surveyor stopped the transfer due to the risk of R1 falling. NA-B then grabbed and applied the transfer gait belt to assist R1 to a balanced standing position and assisted R1 away from the bed to complete pulling up R1's pants.	2 830		

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2 830	Continued From page 17 During interview on 2/28/24 at 11:30 a.m., NA-B reported she should have used the gait belt for R1's safety. R1 did not like to use it which was why NA-B did not use it initially. NA-B indicated R1 was stiff and could not do two things at once safely which was the reason R1 started to lean. NA-B preferred to transfer R1 with two people due to R1's stiffness, however NA-B wanted to "be quick" because R1 had a tendency to become resitive to cares with too many people in the room. During interview on 2/28/24 at 1:19 p.m. Nurse manager NM-A indicated care plans should be updated an appropriate for residents for transfer status and should be updated with any change of condition. Further indicated NA's should communicate to nursing if transfers were difficult or unsafe so further evaluation of transfer status should be completed to reduce the risk for falls or injury. All trained facility staff should know the transfer status of everyone as it was updated on the care plan and the care guides and staff were to follow them. During interview on 2/29/24 12:24 p.m., director of nursing (DON) reported all staff have been trained and signed off for through the facilities training program and have credentialing to reflect it was safe for staff to transfer residents and have completed safe patient handling training. All staff have been trained in safe patient handling including the use of gait belts. Facility policy titled Safe Resident Handling Program dated 3/2020, identified the purpose of the policy is to protect the health and comfort of residents and staff when residents require assistance in moving through the consistent use of mechanical aids/devices, and to meet	2 830		

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2 830	Continued From page 18 regulatory requirements. Safe patient handling (SPH) is a key component to reducing hazards of injury to our employees and our residents. Therefore, it is the policy of Monarch Healthcare Management that when residents receiving care require assistance from facility employee to move (e.g. transferring, lifting, repositioning), that assistance is provided in a manner that is safe to both the resident and employee. Gait belts must be used for ambulatory residents when indicated in the patient care plan to allow employees to hold onto the belt to provide support and stabilize the resident when walking. A gait belt must also be used during a stand pivot transfer and during a slide board or seated transfer to provide guidance to the resident, when indicated in the care plan. Gait belts are not designed to be used for manual lifting of residents. Physical plant/environmental barriers to the use of safe patient handling equipment will be evaluated and minimized to the extent possible. Each resident will be assessed for safe patient handling needs during the admission process to our facility using the MHM Lift/Mobility Status Form and for each relevant activity in the care delivery process. The information from this assessment will be contained in the care plan for each resident and the care plan will identify the safe patient handling requirements for that individual. Training of nurses and other direct care employees will be provided to demonstrate proper application and use of available SPH equipment: 1. The training will be conducted initially and then periodically thereafter, based on observed need, individual requests for training, or as needed to correct improper use or understanding of safe patient handling. 2. Training will demonstrate how equipment can be used; proper methods for use and application relative to the	2 830		

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2 830	Continued From page 19 care activity being provided. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review/revise policies and procedures on resident safety and falls. The administrator or designee could educate all staff on these policies and procedures. The administrator or designee could audit to ensure all residents are comprehensively assessed and report these findings to their QAPI committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 830		