



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 2, 2026

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

RE: CCN: 245629
Cycle Start Date: June 4, 2026

Dear Administrator:

On June 23, 2026, we notified you a remedy was imposed.

On August 4, 2026, the Minnesota Departments of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 8, 2026.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 8, 2026, did not go into effect. (42 CFR 488.417 (b))

In our letter of June 23, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 8, 2026, due to denial of payment for new admissions. Since your facility attained substantial compliance on July 8, 2026, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'H. Zahler'.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us



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September 2, 2026

Administrator

The Villas at Osseo Llc

501 Second Street Southeast

Osseo, MN 55369

Re: Reinspection Results

Event ID: 234332-H2

Dear Administrator:

On July 9, 2026, 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 June 4, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink that reads 'H. Zahler'.

Holly Zahler, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

Office: 651-201-4384

Email: holly.zahler@state.mn.us

An equal opportunity employer.



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June 23, 2026

Administrator

THE VILLAS AT OSSEO LLC

501 SECOND STREET SOUTHEAST

OSSEO, MN 55369

RE: CCN:245629

Cycle Start Date: June 4, 2026

Dear Administrator:

On June 4, 2026, 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, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by September 4, 2026 (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 December 4, 2026 (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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



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Electronically delivered
June 23, 2026

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

Re: State Nursing Home Licensing Orders
Event ID: 234332-H1

Dear Administrator:

The above facility survey was completed on June 4, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/04/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 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
F0000	INITIAL COMMENTS On 6/2/26 through 6/4/26, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H56292691C (3026942), H56292683C (3026696) and H56291724C (2998916) with citation issued at F755, F697 and F580. 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.			F0000			07/02/2026
F0580 SS = D	Notify of Changes (Injury/Delirium/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or			F0580	Notifications of changes -The Notification of Changes policy was reviewed with no revisions necessary. -Residents with a change of condition have potential to be affected if this requirement is not met. -R1 and R4 have been discharged from the facility. -Residents who had a recent change of condition were reviewed to ensure the physician and resident representative were notified in a timely manner. -All necessary Villas at Osseo (VAO) staff have received appropriate education on the facility policy and procedures regarding Notification of Changes. -DON or Designee will utilize the 24-hour summary to audit resident change in condition and if notifications were made in a timely manner to the Provider and/or Resident Representative. - Audits will be completed three (3) times per week for two (2) weeks; two (2) times per week for two (2) weeks; one (1) time per week for one (1) week; and		07/02/2026

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 reverse for further 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.

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

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F0580 SS = D	Continued from page 1 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to notify the physician and or the resident representative timely for 2 of 3 residents (R1,R4) reviewed for change in condition. Findings include: R1's hospital discharge summary dated 5/12/26, identified R1's primary diagnoses included type two diabetes mellitus, acquired absence of right leg below knee (BKA), acute on chronic left lower extremity (LLE), rheumatoid arthritis with rheumatoid factor, and peripheral vascular disease. R1's admission Minimum Data Set (MDS) dated 5/12/26, indicated R1 had no cognitive impairment			F0580	Continued from page 1 monthly thereafter for one (1) month. 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 7/2/26.		07/02/2026

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F0580 SS = D	Continued from page 2 and was receiving a pain medication. R1's care plan dated 5/8/26 identified a focus of alteration in comfort related to left lower extremity pain with staff interventions included providing non-medicinal forms of pain relief such as positioning, rest, massage, etc; administering pain medication as ordered by the provider, and documenting the effectiveness of the pain medication. On 5/21/26 at 6:55 a.m., R1's progress note indicated the resident complained of pain and was administered oxycodone 10 mg as needed (PRN) along with acetaminophen (Tylenol). The documentation further indicated R1 was transferred to the hospital per family request for pain control. However, review of the clinical record did not evidence whether the administered pain interventions were effective or whether R1's response to the medications was assessed and communicated to the provider timely prior to transfer. Review of the provider call logs dated 5/20/26 through 5/21/26 showed no evidence the provider was notified regarding R1's missed doses of ordered hydromorphone, reports of unmanaged pain, and transfer to the hospital for pain control. R4's hospital discharge summary dated 10/2/25, identified R4's primary diagnoses included confusion, frequent falls, dementia, chronic low back pain, and generalized weakness. R4's admission Minimum Data Set (MDS) dated 10/6/25, indicated R4 had severe cognitive impairment and required partial/moderate assistance for toileting and transfers. R4's care plan dated 10/6/25 identified a focus of alteration in mood and behavior, resident expresses agitation during cares. Staff interventions included monitor and document mood state/behaviors upon occurrence, if resident becomes anxious, remove from crowd area, reorientation, and supervision as needed. Keep MD or PA informed of changes. R4's x-ray results right wrist, two views dated 10/19/25 at 7:14 p.m., identified R4 had a distal ulnar fracture. R4's incident review and analysis, dated 10/20/25, indicated that on 5/18/25 at approximately 12:00 p.m., R4 attempted to stand and ambulate without assistance. Staff instructed the resident to sit down for safety; however, R4 became agitated and			F0580			07/02/2026

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F0580 SS = D	Continued from page 3 forcefully slammed her right hand/arm onto a chair in the lunchroom, resulting in a major injury. The injury was characterized by redness and swelling of the right hand. Although the incident resulted in a major injury, the record did not indicate whether the resident's representative was notified at the time of the incident. On 10/18/2025 at 10:39 p.m., a progress note documented that R4 was observed to have swelling and redness in the right wrist area. The note indicated the provider was notified. However, a review of R4's medical record did not contain documentation demonstrating that the resident's representative was notified of the change in condition or the incident. During an interview on 6/3/26 at 10:39 a.m., Nurse Practitioner (NP-A) stated R1 was experiencing severe pain in the left lower extremity (LLE). NP-A explained, on 5/20/26, the treatment plan was revised to transition R1 from oxycodone 10 mg to hydromorphone 4 mg every four hours in an effort to achieve better pain control. NP-A further stated she faxed the new medication order to the pharmacy and confirmed the facility had been notified of the change. NP-A indicated she was unable to locate documentation in R1's medical record verifying hydromorphone 4 mg had been administered as ordered. Additionally, NP-A stated she could not confirm whether the on-call provider had been notified when R1 experienced a change in condition. During an interview on 6/2/26 at 2:25 p.m., Family Member (FM)-A stated she had never received a phone call or any update from the facility regarding R1's change in condition. During an interview on 6/2/26 at 2:43 p.m., FM-B stated R1 called him at approximately 4:00 a.m. on 5/21/26. According to FM-B, R1 was crying in pain, appeared to be in poor condition, and begged him to come get her and take her to the hospital. During an interview conducted on June 2, 2026, at 4:04 p.m., FM-C stated she arrived at the facility at approximately 5:00 a.m. on May 21, 2026, and found R1 lying in a fetal position in bed, crying and complaining of pain. FM-C reported she requested staff send R1 to the hospital for evaluation. FM-C stated, after waiting approximately 45 minutes without any action being taken, she called 911 to have R1 transported to the hospital. During an interview conducted on 6/4/26 at 11:01			F0580			07/02/2026

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F0580 SS = D	Continued from page 4 a.m., FM-D stated he did not recall receiving a call from the facility regarding R4's 5/18/25 incident involving a right wrist injury. FM-D further stated he was not informed of R4's increased agitation or resistance to care on 5/18/25. During an interview on 06/03/26 at 11:19 a.m., Registered Nurse (RN-A) stated she was not aware of R1's hydromorphone 4 mg one-time order. RN-A confirmed R1 was experiencing ongoing pain related to her wound and expressed frustration. RN-A stated she was unclear whether the existing oxycodone 10 mg order should have been discontinued and whether the hydromorphone 4 mg every 4 hours was intended to replace the oxycodone order. RN-A explained she did not notify the provider regarding R1's ongoing pain or whether oxycodone 10 mg was not effective and to request further directions. During an interview on 6/4/26 at 4:04 p.m., the Director of Nursing (DON) stated staff were expected to immediately report any change in condition or resident concern to the provider. The DON stated that he could not locate documentation indicating whether R4's representative had been notified. The DON further explained that when the incident occurred, the nurse should have timely assessed R4, administered pain medication, notified the provider, and contacted the resident's family. The DON confirmed also the provider was not notified when R1 experienced a change in condition. Notification of Changes Policy dated 3/2024 directed the facility staff to make appropriate and timely notification to the physician and delegated non-physician practitioner and notification to the resident representative when there is a change in the resident's condition that may require physician intervention.			F0580			07/02/2026
F0697 SS = D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility			F0697	-The process for satisfying this requirement has been reviewed and revised as needed, to ensure the facility develops and implements processes and procedures to ensure staff provide pain management in accordance with the resident's new physician's orders. -R1 has been discharged from the facility. -Residents with new physician orders for pain management have potential to be affected if this requirement is not met.		07/08/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/04/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
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F0697 SS = D	Continued from page 5 failed to provide pain management in accordance with the resident's new physician's orders to a resident experiencing pain for 1 of 3 residents (R1) reviewed for medication administration. Findings include: R1's hospital discharge summary dated 5/12/26, identified R1's primary diagnoses included type two diabetes mellitus, acquired absence of right leg below knee (BKA), acute on chronic left lower extremity (LLE), rheumatoid arthritis with rheumatoid factor, and peripheral vascular disease. R1's admission Minimum Data Set (MDS) dated 5/12/26, indicated R1 had no cognitive impairment and was receiving pain medications. R1's care plan dated 5/8/26 identified a focus of alteration in comfort related to left lower extremity pain with staff interventions included providing non-medicinal forms of pain relief such as positioning, rest, massage, etc; administering pain medication as ordered by the provider, and documenting the effectiveness of the pain medication. R1's physician order dated 5/20/26 instructed: - to discontinue oxycodone 10 mg. - to administer hydromorphone (use to manage moderate to severe pain) 4mg per mouth (po) one time only for left foot pain. -to start hydromorphone 4 mg po every 4 hours as needed for left foot pain. Review of May 2026 medication administration record (MAR) showed R1 did not receive any doses of hydromorphone 4 mg from 5/20/26 through 5/21/26. R1's medication incident report dated 5/21/26 at 11:45 a.m., indicated the facility failed to timely transcribe the hydromorphone 4 mg every four hours as needed order and failed to transcribe the hydromorphone 4 mg one-time order as per physician's order on 5/20/26. R1's progress note dated 5/21/26 at 6:55 a.m., indicated R1 had complained of pain and was administered oxycodone 10 mg as needed (PRN) along with acetaminophen (Tylenol). The note further indicated R1 was transferred to the hospital per family request for pain control. However, review of			F0697	Continued from page 5 -DON spoke with the rounding pain management provider regarding the current process for written order transcription. The process was revised to ensure timely transcription of pain medication orders by requiring the rounding pain management provider to hand all written orders directly to a clinical leader immediately following resident rounds. The clinical leader is responsible for promptly reviewing and transcribing the orders. In addition, the Pain Management Provider Scribe now provides a list of Residents seen during each rounding visit. -Residents seen by the rounding pain management provider had their medication orders reviewed to verify that all orders were current and accurately transcribed. -Residents receiving pain management services had their pain assessments, monitoring, and treatment regimens audited to ensure ongoing evaluation of pain control and the effectiveness of prescribed interventions. When pain management was determined to be ineffective, the provider was notified for evaluation and potential modification of the treatment plan. -All applicable VAO staff received education on the Monarch Healthcare Pain Management Protocol policy and procedure. Education included the assessment and recognition of pain, identification of potential causes, implementation of appropriate treatment and management interventions, ongoing monitoring of pain, documentation requirements, and timely reporting to the provider. -DON or Designee will audit residents receiving pain medications to ensure Monarch Healthcare Pain Management Protocol was followed appropriately. - Audits will be completed three (3) times per week for two (2) weeks; two (2) times per week for two (2) weeks; one (1) time per week for one (1) week; and monthly thereafter for one (1) month. 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.		07/08/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/04/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
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F0697 SS = D	Continued from page 6 R1's clinical record did not evidence whether the administered pain interventions were effective or whether R1's response to the medications was assessed and documented prior to transfer. During an interview on 06/03/26 at 11:19 a.m., Registered Nurse (RN-A) stated she was not aware of R1's hydromorphone 4 mg one-time order. RN-A reported R1 was frustrated regarding her wound and was consistently experiencing pain. RN-A further stated she was uncertain whether the previously ordered oxycodone 10 mg should have been discontinued and whether hydromorphone 4 mg every four hours was intended to replace it. During an interview conducted on 6/3/26 at 1:49 p.m., RN-C stated when a resident reports pain, nursing staff should assess the location of the pain and determine the severity using a 0 (no pain) to 10 (severe pain) scale. RN-C further stated non-pharmacological interventions should be offered prior to administering pain medication. She added the nurse should reassess the resident at a later time to evaluate the effectiveness of the intervention. RN-C explained she was unable to locate documentation indicating why hydromorphone 4 mg was not administered to R1 as ordered. RN-C confirmed failure to administer hydromorphone 4 mg to R1 as prescribed constituted a medication error. During an interview on 6/3/26 at 10:39 a.m., Nurse Practitioner (NP-A) stated she expected the nurse to administer the one-time dose order immediately as prescribed. NP-A explained R1 was experiencing severe pain in the left lower extremity (LLE) and the treatment plan was to transition from oxycodone 10 mg to hydromorphone 4 mg every four hours to achieve improved pain control. NP-A further stated she faxed the new order to the pharmacy and confirmed the facility was aware of the change. However, NP-A indicated she was unable to locate documentation in R1's medical record confirming hydromorphone 4 mg had been administered as ordered. During an interview on 6/4/26 at 4:04 p.m., the Director of Nursing (DON) stated he expected nurses to follow physician orders. The DON confirmed the hydromorphone 4 mg one-time dose, as well as the hydromorphone 4 mg every four hours, were not administered as ordered on 5/20/26. The DON further stated RN-A did not return his call for interview. The Pain Management Protocol dated 3/23/2025 directed the provider to order appropriate medication			F0697	Continued from page 6 - Corrective action will be completed on or before 7/8/26.		07/08/2026

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F0697 SS = D	Continued from page 7 interventions to address individuals' pain and for the staff to evaluate and report how much and how often the resident utilizes PRN pain medication. It also directed staff to notify the provider if the prescribed medications are not available or there is a delay in obtaining the medication.			F0697			07/08/2026
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to timely transcribe the physician's new orders to initiate a pain management therapy for 1 of 3 residents (R1) reviewed for medication administration. Findings include:			F0755	-The process for satisfying this requirement has been reviewed and revised as needed, to ensure the facility develops and implements processes and procedures to ensure staff transcribe physician orders to initiate a pain management therapy timely. -Residents with new physician orders for pain management have potential to be affected if this requirement is not met. -R1 has been discharged from the facility. -All residents seen by the rounding pain provider were audited to ensure their new pain management therapy physician orders were transcribed in a timely manner. -All necessary Villas at Osseo (VAO) staff have received appropriate education on the facility policy and procedures regarding physician order transcription for pain medications. - Audits will be completed three (3) times per week for two (2) weeks; two (2) times per week for two (2) weeks; one (1) time per week for one (1) week; and monthly thereafter for one (1) month. 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 07/02/2026.		07/02/2026

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F0755 SS = D	Continued from page 8 R1's hospital discharge summary dated 5/12/26, identified R1's primary diagnoses included type two diabetes mellitus, right leg below knee amputation (BKA), acute on chronic left lower extremity (LLE), rheumatoid arthritis with rheumatoid factor, and peripheral vascular disease. R1's admission Minimum Data Set (MDS) dated 5/12/26, indicated R1 had no cognitive impairment and was receiving a pain medication. R1's physician order dated 5/20/26 instructed: - to discontinue oxycodone 10 mg. - to administer hydromorphone (use to manage moderate to severe pain) 4mg per mouth (po) one time only for left foot pain. -to start hydromorphone 4 mg po every 4 hours as needed for left foot pain. R1's facility physician orders that were transcribed into electronic health record (EHR) did not include orders for hydromorphone 4 mg one time only or hydromorphone 4 mg every 4 hours as needed per physician order dated 5/20/26. Review of R1's physician orders dated 5/20/26 revealed that orders for hydromorphone 4 mg one-time dose and hydromorphone 4 mg every 4 hours as needed (PRN) were not transcribed into the facility's EHR, resulting in the EHR not accurately reflecting the physician's prescribed medication orders. Review of May 2026 medication administration record (MAR) showed R1 did not receive any doses of hydromorphone 4 mg as prescribed from 5/20/26 through 5/21/26. Review of R1's medication incident report dated on 5/21/26 at 11:45 a.m. revealed the facility failed to accurately and timely transcribe physician orders for hydromorphone. Specifically, a physician order dated 5/20/26 for hydromorphone 4 mg every four hours as needed (PRN) was not transcribed in a timely manner, and a separate one-time order for hydromorphone 4 mg was not transcribed as ordered. As a result, the facility failed to ensure physician medication orders were implemented according to prescribed directions. R1's progress note dated 5/21/26 at 6:55 a.m., indicated R1 had complained of pain, she was			F0755			07/02/2026

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F0755 SS = D	Continued from page 9 administered oxycodone as needed, Tylenol, and was transferred to the hospital per family request for pain control. During an interview on 6/3/26 at 9:31 a.m., pharmacy technician (pharm tech)-A stated R1's hydromorphone 4 mg was delivered to the facility on 5/20/26 at 6:00 p.m. Pharm Tech-A explained a registered nurse (RN)-A signed for receipt of the medication at the time of delivery. During an interview on 6/3/26 at 11:19 a.m., RN-A stated medications were administered per physician orders. RN-A recalled receiving R1's hydromorphone 4 mg delivery on 5/20/26 and securing it in the narcotic book. However, she did not recall receiving the one-time physician order for the medication. RN-A explained she did not transcribe the hydromorphone 4 mg order into the EHR and did not co-sign the order for R1 on 5/20/26. During an interview on 6/3/26 at 4:44 p.m., RN-B explained new physician orders must be transcribed into the EHR and cosigned by a second nurse before becoming available in the MAR for administration. RN-B further stated medications will populate in the MAR for administration based on the documented start date entered during transcription. During an interview on 6/3/26 at 9:08 a.m., a nurse practitioner (NP)-A stated one-time dose medications are expected to begin on the day they are ordered. NP-A reported she was at the facility on 5/20/26 when she found R1 crying in pain. After assessing R1, NP-A issued new orders for a one-time dose of hydromorphone 4 mg, discontinued oxycodone 10 mg, and initiated hydromorphone 4 mg every four hours for left leg pain. NP-A further stated on 5/21/26, the director of nursing (DON) informed her that the 5/20/26 orders had not been transcribed into the EHR, and R1 had been sent to the hospital at the family's request for pain management. During an interview conducted on 6/4/26 at 4:04 p.m., the DON confirmed R1's new physician orders dated 5/20/26 were not entered into the EHR until 5/21/26. This delay occurred after R1 had already been transferred to the hospital for pain management. The order for hydromorphone, which was scheduled to begin on 5/20/26 at 6:00 p.m., was not initiated as ordered. As a result, R1 experienced a delay in receiving the prescribed medication, resulting in missed doses.			F0755			07/02/2026

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F0755 SS = D	Continued from page 10 The Medication and Treatment Orders policy dated 2/2024 instructed orders for medications and treatment will be transcribed accurately and in a timely manner. Orders must include: Name and strength of the drug. Number of doses, start and stop date, and/or specific duration of therapy. Dosage and frequency of administration. Route of administration. Clinical condition or symptoms for which the medication is prescribed; and Any interim follow-up requirements.			F0755			07/02/2026

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20000	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 6/2/26 through 6/4/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. The following complaints were reviewed: H56292691C (3026942), H56292683C (3026696), and H56291724C (2998916) with licensing orders issued at 20265 and 21550. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal			20000			07/02/2026

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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20000	Continued from page 1 software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.		20000			07/02/2026	
20265	Notification of Chg in Resident Health Status CFR(s): MN Rule 4658.0085 A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to notify the physician and or the resident representative timely for 2 of 3 residents (R1,R4) reviewed for change in condition.		20265	corrected.		07/02/2026	

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20265	Continued from page 2 Findings include: R1's hospital discharge summary dated 5/12/26, identified R1's primary diagnoses included type two diabetes mellitus, right, below the knee amputation (BKA), acute on chronic left lower extremity (LLE), rheumatoid arthritis with rheumatoid factor, and peripheral vascular disease. R1's admission Minimum Data Set (MDS) assessment, dated 5/12/26, indicated R1 had no cognitive impairment and was receiving pain medication. R1's care plan dated 5/8/26 identified a focus of alteration in comfort related to left lower extremity pain with staff interventions included providing non-medicinal forms of pain relief such as positioning, rest, massage, etc; administering pain medication as ordered by the provider, and documenting the effectiveness of the pain medication. On 5/21/26 at 6:55 a.m., R1's progress note indicated the resident complained of pain and was administered oxycodone 10 mg as needed (PRN) along with acetaminophen (Tylenol). The documentation further indicated R1 was transferred to the hospital per family request for pain control. However, review of the clinical record lacked whether the administered pain interventions were effective or whether R1's response to the medications was assessed and communicated to the provider timely prior to transfer. R1's record review dated 5/20/26 through 5/21/26 lacked evidence the provider was notified regarding R1's missed doses of ordered hydromorphone, reports of unmanaged pain, and transfer to the hospital for pain control. R4 R4's hospital discharge summary dated 10/2/25, identified R4's primary diagnoses included confusion, frequent falls, dementia, chronic low back pain, and generalized weakness. R4's admission Minimum Data Set (MDS) assessment, dated 10/6/25, indicated R4 had severe cognitive impairment and required partial/moderate assistance for toileting and transfers. R4's care plan dated 10/6/25 identified a focus of alteration in mood and behavior, resident expresses agitation during cares. Staff interventions included			20265			07/02/2026

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20265	Continued from page 3 monitor and document mood state/behaviors upon occurrence, if resident becomes anxious, remove from crowed area, reorientation, and supervision as needed. Keep MD (medical doctor) or PA (physician assistant) informed of changes. R4's incident review, indicated on 10/18/25 at approximately 12:00 p.m., R4 attempted to stand and ambulate without assistance. Staff instructed the resident to sit down for safety; however, R4 became agitated and forcefully slammed her right hand/arm onto a chair in the lunchroom, resulting in a major injury. The injury was characterized by redness and swelling of the right hand. Although the incident resulted in a major injury, the record did not indicate whether the resident's representative was notified at the time of the incident. R4's progress note dated on 10/18/2025 at 10:39 p.m., R4 was observed to have swelling and redness in the right wrist area. The note indicated the provider was notified. However, a review of R4's medical record did not contain documentation demonstrating that the resident's representative was notified of the change in condition or the incident. R4's x-ray results right wrist, two views dated 10/19/25 at 7:14 p.m., identified R4 had a distal ulnar fracture. During an interview on 6/3/26 at 10:39 a.m., Nurse Practitioner (NP-A) stated R1 was experiencing severe pain in the left lower extremity (LLE). NP-A explained, on 5/20/26, the treatment plan was revised to transition R1 from oxycodone 10 mg to hydromorphone 4 mg every four hours in an effort to achieve better pain control. NP-A further stated she faxed the new medication order to the pharmacy and confirmed the facility had been notified of the change. NP-A indicated she was unable to locate documentation in R1's medical record verifying hydromorphone 4 mg had been administered as ordered. Additionally, NP-A stated she could not confirm whether the on-call provider had been notified when R1 experienced a change in condition. During an interview on 6/2/26 at 2:25 p.m., Family Member (FM)-A stated she had never received a phone call or any update from the facility regarding R1's change in condition. During an interview on 6/2/26 at 2:43 p.m., FM-B stated R1 called him at approximately 4:00 a.m. on 5/21/26. According to FM-B, R1 was crying in pain,			20265			07/02/2026

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20265	Continued from page 4 appeared to be in poor condition, and begged him to come get her and take her to the hospital. During an interview conducted on 6/2/26, at 4:04 p.m., FM-C stated she arrived at the facility at approximately 5:00 a.m. on May 21, 2026, and found R1 lying in a fetal position in bed, crying and complaining of pain. FM-C reported she requested staff send R1 to the hospital for evaluation. FM-C stated, after waiting approximately 45 minutes without any action being taken, she called 911 to have R1 transported to the hospital. During an interview conducted on 6/4/26 at 11:01 a.m., FM-D stated he did not recall receiving a call from the facility regarding R4's 5/18/25 incident involving a right wrist injury. FM-D further stated he was not informed of R4's increased agitation or resistance to care on 5/18/25. During an interview on 06/03/26 at 11:19 a.m., Registered Nurse (RN-A) stated she was not aware of R1's hydromorphone 4 mg one-time order. RN-A confirmed R1 was experiencing ongoing pain related to her wound and expressed frustration. RN-A stated she was unclear whether the existing oxycodone 10 mg order should have been discontinued and whether the hydromorphone 4 mg every 4 hours was intended to replace the oxycodone order. RN-A explained she did not notify the provider regarding R1's ongoing pain or whether oxycodone 10 mg was not effective and to request further directions. During an interview on 6/4/26 at 4:04 p.m., the director of nursing (DON) stated staff were expected to immediately report any change in condition or resident concern to the provider. The DON stated that he could not locate documentation indicating whether R4's representative had been notified. The DON further explained that when the incident occurred, the nurse should have timely assessed R4, administered pain medication, notified the provider, and contacted the resident's family. The DON confirmed also the provider was not notified when R1 experienced a change in condition. Notification of Changes Policy dated 3/2024 directed the facility staff to make appropriate and timely notification to the physician and delegated non-physician practitioner and notification to the resident representative when there is a change in the resident's condition that may require physician intervention. SUGGESTED METHOD OF CORRECTION: The			20265			07/02/2026

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20265	Continued from page 5 director of nursing (DON) or designee could review notification of changes policies and procedures to make appropriate and timely notification to the physician and resident's representative. Staff could be educated on the need to make appropriate and timely notification to the physician and resident's representative with supporting assessments. The DON or designee could review all current resident orders to ensure timely notification to the physician/resident's representative of any changes in condition and audit periodically per recommendation from the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time. Those results could be taken back to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20265			07/02/2026	
21550	Adminiatration of Medications; Pharmacy Serv. CFR(s): MN Rule 4658.1325 Subp. 1 Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to provide pain management in accordance with the resident's new physician's orders to a resident experiencing pain for 1 of 3 residents (R1) reviewed for medication administration. Findings include: R1's hospital discharge summary dated 5/12/26, identified R1's primary diagnoses included type two diabetes mellitus, right leg below knee amputation (BKA), acute on chronic left lower extremity (LLE), rheumatoid arthritis with rheumatoid factor, and peripheral vascular disease. R1's admission Minimum Data Set (MDS) dated 5/12/26, indicated R1 had no cognitive impairment and was receiving pain medications. R1's care plan dated 5/8/26 identified a focus of alteration in comfort related to left lower extremity pain with staff interventions included providing non-medicinal forms of pain relief such as positioning, rest, massage, etc; administering pain medication as ordered by the provider, and		21550	corrected.		07/02/2026	

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21550	Continued from page 6 documenting the effectiveness of the pain medication. R1's physician order dated 5/20/26 instructed: - to discontinue oxycodone 10 mg. - to administer hydromorphone (use to manage moderate to severe pain) 4mg per mouth (po) one time only for left foot pain. -to start hydromorphone 4 mg po every 4 hours as needed for left foot pain. Review of May 2026 medication administration record (MAR) showed R1 did not receive any doses of hydromorphone 4 mg from 5/20/26 through 5/21/26. R1's medication incident report dated 5/21/26 at 11:45 a.m., indicated the facility failed to timely transcribe the hydromorphone 4 mg every four hours as needed order and failed to transcribe the hydromorphone 4 mg one-time order as per physician's order on 5/20/26. R1's progress note dated 5/21/26 at 6:55 a.m., indicated R1 had complained of pain and was administered oxycodone 10 mg as needed (PRN) along with acetaminophen (Tylenol). The note further indicated R1 was transferred to the hospital per family request for pain control. However, review of R1's clinical record did not evidence whether the administered pain interventions were effective or whether R1's response to the medications was assessed and documented prior to transfer. During an interview on 06/03/26 at 11:19 a.m., Registered Nurse (RN-A) stated she was not aware of R1's hydromorphone 4 mg one-time order. RN-A reported R1 was frustrated regarding her wound and was consistently experiencing pain. RN-A further stated she was uncertain whether the previously ordered oxycodone 10 mg should have been discontinued and whether hydromorphone 4 mg every four hours was intended to replace it. During an interview conducted on 6/3/26 at 1:49 p.m., RN-C stated when a resident reports pain, nursing staff should assess the location of the pain and determine the severity using a 0 (no pain) to 10 (severe pain) scale. RN-C further stated non-pharmacological interventions should be offered prior to administering pain medication. She added the nurse should reassess the resident at a later time to evaluate the effectiveness of the intervention.			21550			07/02/2026

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21550	Continued from page 7 RN-C explained she was unable to locate documentation indicating why hydromorphone 4 mg was not administered to R1 as ordered. RN-C confirmed failure to administer hydromorphone 4 mg to R1 as prescribed constituted a medication error. During an interview on 6/3/26 at 10:39 a.m., Nurse Practitioner (NP-A) stated she expected the nurse to administer the one-time dose order immediately as prescribed. NP-A explained R1 was experiencing severe pain in the left lower extremity (LLE) and the treatment plan was to transition from oxycodone 10 mg to hydromorphone 4 mg every four hours to achieve improved pain control. NP-A further stated she faxed the new order to the pharmacy and confirmed the facility was aware of the change. However, NP-A indicated she was unable to locate documentation in R1's medical record confirming hydromorphone 4 mg had been administered as ordered. During an interview on 6/4/26 at 4:04 p.m., the Director of Nursing (DON) stated he expected nurses to follow physician orders. The DON confirmed the hydromorphone 4 mg one-time dose, as well as the hydromorphone 4 mg every four hours, were not administered as ordered on 5/20/26. The DON further stated RN-A did not return his call for interview. The Pain Management Protocol dated 3/23/2025 directed the provider to order appropriate medication interventions to address individuals' pain and for the staff to evaluate and report how much and how often the resident utilizes PRN pain medication. It also directed staff to notify the provider if the prescribed medications are not available or there is a delay in obtaining the medication. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review policies and procedures for medication administration to include processes related to how medication is ordered and transcribed into the electronic medical record. Staff could be educated on the need to clarify discrepancies in medication orders. The DON or designee could review all current resident medication orders to ensure accuracy and audit new medication orders per recommendation from the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time. Those results could be taken back to the QAPI committee to determine compliance or the need for further monitoring.			21550			07/02/2026

Minnesota Department of Health

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21550	Continued from page 8 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21550			07/02/2026