Electronically delivered
May 19, 2025

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

RE: CCN: 245629
Cycle Start Date: April 3, 2025

Dear Administrator:

On May 7, 2025, 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 immediate jeopardy (Level J),

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On May 1, 2025, the situation of immediate jeopardy to potential health and safety cited at F760 was removed.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS location.

- Civil money penalty, (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding

of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 7, 2025. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

DEPARTMENT CONTACT

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

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

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May 19, 2025

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

Re: Event ID: WJWO11

Dear Administrator:

The above facility survey was completed on May 7, 2025, 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 no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245629	A. BUILDING _____ B. WING _____	C 05/07/2025

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

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F 000	INITIAL COMMENTS On 5/6/25 through 5/7/25, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was reviewed H56293948C (MN00112757) and a deficiency was issued at (F760) at PAST NON-COMPLIANCE. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.	F 000	Past noncompliance: no plan of correction required.	
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure staff followed five rights of medication administration for 1 of 3 residents (R1) reviewed for significant medication errors. R1 received five times the prescribed dose of Methadone for three days (nine shifts) which impaired her speech, ability to verbalize needs and consume nutrition. This resulted in an immediate jeopardy (IJ) for R1. The IJ began on 4/26/25, when the facility staff	F 760	Past noncompliance: no plan of correction required.	

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

Electronically Signed

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F 760	Continued From page 1 administrating R1's medication failed to compare the written order on the Medication Administration Record (MAR) with the prescription label on the physical bottle of Methadone before administration which resulted in R1 receiving five times the prescribed dose of Methadone nine times over the course of three days. The IJ was identified on 5/7/25, and the administrator was notified of the IJ on 5/7/25 at 1:45 p.m. The immediate jeopardy was removed on 5/1/25, and the deficient practice was corrected prior to the start of the survey and was therefore issued at past noncompliance. Findings include: R1's quarterly Minimum Data Set (MDS) dated 4/8/25, identified moderate cognitive impairment and indicated she received scheduled and as needed pain medication. The MDS indicated R1 had frequent pain that occasionally affected sleep and day to day activities and received opioid (a class of drugs that relieve pain, but can also cause side effects, dependence, and overdose) medications. Diagnosis included Multiple Sclerosis (MS), open wounds, paraplegia, and pain. R1's care plan dated 4/20/25, identified an alteration in comfort related to MS, polyneuropathy and wound cares. The care plan directed staff to assess for pain, document effectiveness of pain medication and administer pain medications as ordered by the physician. R1's prescription medication bottle dated 3/27/25, indicated Methadone SOL (solution) 10 milligrams (mg)/5 milliliters (ml) directed 10 ml (20 mg) by mouth three times daily.	F 760		

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F 760	Continued From page 2 R1's Physician Order details dated 4/11/25, Methadone HCL (hydrochloride) oral solution 10 mg/5 ml. Give 30 mg by mouth three times daily for pain. Give 30 mg = 15 ml. R1's prescription medication bottle dated 4/25/25, indicated Methadone 10 mg/ml. Take three ml by mouth three times daily which equals, 30 mg. R1's MAR April 2025 indicated Methadone HCL oral solution 10 mg/5 ml. Give 30 mg. R1's narcotic record hand written by staff, indicated Methadone 10 mg/ml. Drug dosage indicated 15 mg. Directions: Take 15 ml's three times daily. The record indicated the transcribing staff member failed to identify the change of dosage on the prescription bottle. The record indicated staff gave the following amounts: 4/26/25 at 10:00 a.m., 15 ml, equal to 150 mg. (five times the prescribed dose). 4/26/25 at 12:00 p.m., 15 ml, equal to 150 mg. (five times the prescribed dose). 4/26/25 at (unable to read), 15 ml, equal to 150 mg. (five times the prescribed dose). 4/26/25 at 7:41 a.m., 15 ml, equal to 150 mg. (five times the prescribed dose). 4/27/25 at 12:00 p.m., 15 ml, equal to 150 mg. (five times the prescribed dose). 4/27/25 at 8:00 p.m., 15 ml, equal to 150 mg. (five times the prescribed dose). 4/28/25 at (unable to read), 15 ml, equal to 150 mg. (five times the prescribed dose). 4/28/25 at 12:00 p.m., 15 ml, equal to 150 mg. (five times the prescribed dose). 4/28/25 at 8:00 p.m., 15 ml, equal to 150 mg. (five times the prescribed dose).	F 760		

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F 760	Continued From page 3 A Medication Error Reconciliation Form dated 4/30/25, indicated on 4/26/25 at 10:00 a.m. and 12:00 p.m., agency staff administered Methadone based on supply bottle from hospice which had a different concentration than previous bottle and administered wrong dose from old discontinued medication bottle. Nurse did not follow the five rights of medication administration (right drug, right patient, right dose, right route, right time.) Nurse educated on five rights of medication administration. A Medication Error Reconciliation Form dated 4/30/25, indicated on 4/26/25 at 8:41 p.m. and 4/29/25 at 8:00 a.m. and 12:00 p.m., registered nurse (RN)-A administered Methadone based on supply bottle from hospice which had a different concentration than previous bottle on hand administered wrong dose from old discontinued medication bottle. Nurse did not follow the five rights of medication administration. Nurse educated on five rights of medication administration. A Medication Error Reconciliation Form dated 4/30/25, indicated on 4/27/25 at 7:41 p.m., 12:00 p.m. and 8:00 p.m., licensed practical nurse (LPN)-A administered Methadone based on supply bottle from hospice which had a different concentration than previous bottle on hand administered wrong dose from old discontinued medication bottle. Nurse did not follow the five rights of medication administration. Nurse educated on five rights of medication administration. A Medication Error Reconciliation Form dated 4/30/25, indicated on 4/28/25 at 7:38 a.m., 12:00	F 760		

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F 760	Continued From page 4 p.m. and 8:00 p.m.. registered nurse (RN)-B administered Methadone based on supply bottle from hospice which had a different concentration than previous bottle on hand administered wrong dose from old discontinued medication bottle. Nurse did not follow the five rights of medication administration. Nurse educated on five rights of medication administration. R1's Progress Notes identified the following: 4/30/25, Nurse practitioner and hospice notified of medication concern. 4/30/25, Hospice nurse returned call regarding Methadone dosing, stated to continue to monitor for adverse reactions. R1 had been in active decline with changes in intakes, ability to tolerate meals or activity with therapeutic recreation. 4/30/25, R1 was weak, not much activity occurred. R1 did not eat, just took sips of water. 4/30/25, Hospice routine visit note indicated writer was alerted to change of condition by hospice aide. R1 displayed exertion to respond to yes or no questions. Hospice nurse and aide to start daily visits. 4/30/25, R1 was lethargic at beginning of shift. Awake at supper and requested food. R1 ate 15% of food and drank 40 cubic centimeters (cc) [a teaspoon is typically equal to about 5 cc of fluid] this shift. 5/1/25, R1 unable to take oral medications due to weakness and decline. 5/1/25, Hospice nurse visit: Upon arrival, R1 in	F 760		

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F 760	Continued From page 5 bed sleeping, did not open eyes to verbal or physical stimuli. Respirations even with periods of apnea (the temporary cessation of breathing). All extremities cold to touch. Family member (FM) questioned if medication concern contributed to decline which writer was unable to provide an answer. 5/1/25, R1's verbal communication has declined. 5/2/25, Update to FM given. Notified R1 was unable to tolerate oral medications, not eating or able to tolerate oral intakes due to decline. During observation on 5/6/25 at 2:28 p.m., R1 was laying in bed with staff seated next to her bed. Upon introduction, R1 made a verbalization that sound like "Ahhhh", but no words spoken. During interview on 5/6/25 at 3:45 p.m., R1's significant other (SO) stated the facility had told him the concentration of Methadone came in higher that it was supposed to be and no one had caught it. The SO said R1, "went way down hill real fast" and said prior to the medication error R1 was able to speak and now could not. The SO stated R1 had stopped eating and had trouble swallowing since the medication error occurred. The SO stated he was the person who visited R1 regularly as her family resided in another state. During interview on 5/7/25 at 8:28 a.m., LPN-A stated R1's Methadone order had increased from a previous order. LPN-A said they received a new bottle of Methadone which indicated 30 mg but said the concentration had changed and the staff had not noticed. LPN-A said staff followed the direction on the MAR but not the bottle.	F 760		

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F 760	Continued From page 6 During interview on 5/7/25 at 8:41 a.m., the hospice RN stated they had received an e-mail from the facility about the error but it had gone to a different department than nursing. The hospice RN said she learned about the medication error via text from the hospice physician. The hospice RN stated the facility explained the staff had been giving the wrong dose of the Methadone due to not looking at the bottle. On 5/7/25 at 9:51 a.m., the director of nursing (DON) was interviewed along with the vice president of clinical operations (VPCO) for the Hospice agency. The DON stated the medication error was discovered during the afternoon medication count on 4/30/25. The DON said she was notified of the errors on 5/1/25 and completed the medication error forms along with LPN-A. The DON stated as soon as they learned about the error the nurses involved received immediate education. The DON stated the nurses had not followed the five rights of medication administration. The VPCO said R1 had been placed back on final moments which include daily nurse and aide visits, due to the medication error. The VPCO stated prior to the error it had been many months since R1 had received final moments care. The VPCO said R1 remained on final moments due to decreased appetitive, not eating/drinking as much and decline in verbalizations. During interview on 5/7/25 at 10:35 a.m., when asked about the significance of receiving five times the dose of methadone, the pharmacy consultant (PC) stated with any opioid medication there was a concern for respiratory depression, sedation, confusions or a potential overdose, which was a more life threatening situation. The	F 760		

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F 760	Continued From page 7 CP said Methadone had a longer half life (indicates how long it takes for a drug to be removed from your body) which made it trickier to determine how long it would take for someone to return to their baseline following an over dose. The CP said typically it took from 24 - 36 "ish" hours but fluctuated with patients which was why changes were made slowly. The CP stated she considered the medication error to be significant. During interview on 5/7/25 at 11:33 a.m., nursing assistant (NA)-A and NA-B were interviewed. NA-A stated during the last two weeks, R1 had not been eating very much and would only drink fluids. NA-A said prior to a few weeks ago R1' appetite was normal. NA-B indicated when recently came into work R1's speech was unable to be understood which was a change from previously and said now R1 would not eat. NA-A said the speech had changed in the last week and said R1 was no longer speaking and would just look at him. During interview on 5/7/25 at 11:38 a.m., LPN-A said she had noticed R1 had been sleeping a lot more. LPN-A stated initially she had not realized it was related to the medication errors. LPN-A stated a couple weeks ago was R1's "last good day." LPN-A said since the medication errors occurred R1 was eating less, drinking less and was more lethargic and said R1's speech used to be so clear but now required "so much effort" to get words out. An undated, untitled facility procedure directed staff to review the five rights, three times prior to medication administration. The past noncompliance immediate jeopardy	F 760		

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F 760	Continued From page 8 began on 4/26/25. The immediate jeopardy was removed 5/1/25, and the deficient practice corrected after the facility implemented a systemic plan that included the following actions: - Immediate education was provided to the nurses involved in the medication errors to include: Medication administration and transcription, the five rights of medication administration and ensuring medication labels match physician orders along with contacting pharmacy or physician for clarification. - All nurses received education related to medication types, prevention of errors, high risk medications and compliance with national safety standards. - R1's Pain medication management was reviewed for accuracy along with ensuring the label on the bottle matched the physician ordered in the medical record. - All like residents have had their orders reviewed and liquid medication labels reviewed to ensure labels on bottles match the orders in the medical record. - Compliance audits were initiated.	F 760		