Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 18, 2024

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

Re: Reinspection Results
Event ID: PR8U12

Dear Administrator:

On October 3, 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 September 6, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 18, 2024

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

RE: CCN: 245629
Cycle Start Date: August 22, 2024

Dear Administrator:

On September 13, 2024, we notified you a remedy was imposed.

On October 1, 2024, October 3, 2024, and October 16, 2024 (LSC), the Minnesota Departments of Health and Public Safety completed a revisits to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 11, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 22, 2024, did not go into effect. (42 CFR 488.417 (b))

In our letter of September 13, 2024, 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 November 22, 2024, due to denial of payment for new admissions. Since your facility attained substantial compliance on October 11, 2024, 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 Therefore, the NATCEP prohibition is rescinded.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,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 13, 2024

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

RE: CCN: 245629
Cycle Start Date: August 22, 2024

Dear Administrator:

On September 4, 2024, we informed you that we may impose enforcement remedies.

On September 6, 2024, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found 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.

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(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 22, 2024

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 22, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 22, 2024.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

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 $12,924, 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.

If you have not achieved substantial compliance by November 22, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Villas At Osseo Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 22, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

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:

Terri Ament, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 22, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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://forms.web.health.state.mn.us/form/NHDisputeResolution

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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@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 09/06/2024

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 9/6/24, 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 complaint was reviewed: H56297862C (MN00106336) with deficiencies cited at F755 and F880. 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 755 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,	F 755		9/27/24

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

Electronically Signed | 09/19/2024

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 755	Continued From page 1 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 observation, interview and document review, the facility failed to provide medication as ordered by the physician for 3 of 3 residents (R1, R2, R3) reviewed for pharmacy services. Findings include: R1's Physician's Orders dated 8/21/24 directed to hold warfarin (generic name for Coumadin, a blood thinner) 8/21/24 and 8/22/24. Recheck INR (international normalized ratio, a lab test for blood clotting) on Friday 8/23/24. R1's August MAR indicated R1 did not receive Coumadin from 8/23/24 through 8/27/24. On 9/6/24 at 12:25 p.m., case manager (CM)-A stated licensed practical nurse (LPN)-C entered	F 755	F755 -The process for satisfying this requirement has been reviewed and revised as needed, to ensure the facility develops and implements processes and procedures for medication administration in accordance with physician orders. -All residents residing in the facility who receive medications could be affected if this requirement is not met. -R1, R2, and R3s physician orders for medications and care plans have been reviewed and revised as necessary to meet this requirement.	

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F 755	Continued From page 2 the order into the computer system incorrectly, which lead to the omission of the lab being completed as ordered. R1 missed Coumadin dosages 8/23/24 through 8/27/24. On 9/10/24 at 9:04 a.m., LPN-C stated she made an error when entering the lab order into the computer system, for R1's INR, causing it to be missed on 8/23/24. R2's Physician's Orders dated 9/4/24 directed to administer niacin (a form of vitamin B3) 500 milligrams (mg) by mouth daily in the morning. On 9/5/24 at 7:26 a.m., a progress note indicated the niacin was on order from the pharmacy. On 9/6/24 at 11:29 a.m., a progress note indicated the pharmacy was contacted, and the medication was a house stock. The medication was not in the medication room. It would be ordered by the person who orders stock medication. R2's September medication administration record (MAR) indicated R2 did not receive niacin 500mg on 9/5/24 or 9/6/24. On 9/6/24 at 11:24 a.m. LPN-A stated there was no niacin in stock. She was not sure when the medication was expected to arrive. She had not yet informed her supervisor the medication was not in stock. The provider had not been notified R2 had not received the prescribed medication for two days. On 9/6/24 at 1:24 p.m., CM-A stated while the over-the-counter (OTC) medications were typically	F 755	-Facility medication error procedure was followed for R1, R2, and R3. -R2 and R3 medications are in-stock at the facility. -All necessary VAO staff will be educated on the facility policy and procedure for medication administration, including INR & coumadin, over the counter medications, re-ordering medications, and medication errors. -Audits will be complete to ensure compliance. Audits will be done at a frequency of at least 3x per week 2 weeks, 2x per week for 2 weeks, 1x per week for 2 weeks and 1x monthly thereafter. Audit results will be reviewed at QAPI, with any deficient practice corrected at the time of occurrence. - Director of Nursing or designee is the party responsible. - Corrective action will be completed on or before 9/27/24	

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F 755	Continued From page 3	F 755		

obtained through a vendor, they did have a process in place to obtain the OTC medications through their contracted pharmacy. The provider should be informed if a medication was missed.

On 9/6/24 at 3:08 p.m. R2 stated she was not made aware of any missed medications.

On 9/6/24 at 3:26 p.m., nurse practitioner (NP)-A stated R2 was prescribed niacin for hypertension (high blood pressure) and stated R2 needed the niacin.

R3's Physician's Orders dated 8/21/24 directed to administer one nicotine patch 21micrograms (mcg)/hour transdermal (topical to the skin) in the morning.

R3's Physician's Orders dated 9/4/24, directed to administer one nicotine patch 21mcg/hour to skin in the morning.

On 8/22/24 at 11:08 a.m., a progress note indicated the nicotine patch was on order.

On 8/23/24 at 11:06 a.m., a progress note indicated the nicotine patch was on order.

On 9/4/24 at 8:32 a.m., a progress note indicated the nicotine patch was on order.

On 9/5/24 at 9:13 a.m., a progress note indicated the nicotine patch was not given.

R3's August MAR indicated R3 did not receive the nicotine patch on 8/22/24 or 8/23/24.

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F 755	Continued From page 4 R3's September MAR indicated R3 did not receive the nicotine patch on 9/4/24, 9/5/24, or 9/6/24. On 9/6/24 at 11:35 a.m. LPN-A stated R3 did not have her nicotine patch to apply as prescribed. On 9/6/24 at 12:56 p.m., the administrator stated stock medications were typically ordered through a vendor, but if a new resident was admitted with a medication they did not have in stock, they would obtain the medication through their contracted pharmacy or other means. On 9/6/24 at 2:15 p.m., LPN-A stated she was unable to locate a nicotine patch for R3. She had made a progress note in R3's chart. She was not sure how long R3 had been without the medication. LPN-A stated the medication was due to have been administered between 7:00 a.m. to 11:00 a.m. She had not notified the provider or her supervisor, nor had she started a medication error report form. On 9/6/24 at 2:44 p.m., R3 stated she would like to have a nicotine patch on. R3 stated she was not sure why she did not have one on. On 9/6/24 at 4:02 p.m., CM-A stated the pharmacy makes several deliveries each day. CM-A stated he was not made aware of R2 or R3's missing medications by nurses. A facility document Medication Administration dated 4/2018, directed if a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time documentation of the	F 755		

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F 755	Continued From page 5 unadministered dose is done as instructed by the procedures for use of the electronic medication administration record system. Nursing documents the notification and physician response. A facility document Medication Error Procedure, dated 1/2020, directed medication errors should be assessed, documented, and reported according to federal and/or state guidelines as appropriate. An undated facility document Medication Not Available Algorithm directed if medication is not available in med bank (an on site medication source), then call provider to notify medication not available and get order to hold until obtained from pharmacy or temporary orders for alternative medication that is in the med bank. Document notification in computer charting system and what provider orders/directions are. Then call pharmacy to order medication and tell to send on next run. Document that this was done in computer charting system to notify clinical leaders. Document any other reasons why medication may not be able to be sent. Notify family of provider orders in regards to medication not being available.	F 755		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		9/27/24

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F 880	Continued From page 6 program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact	F 880		

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F 880	Continued From page 7 with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain infection control practices while conducting blood glucose checks for 2 of 4 patients (R1, R4) reviewed for medication administration. Findings include: R1's MDS admission Minimum Data Set dated 8/22/24 indicated R1 had a diagnosis of diabetes mellitus. R1's Physician's Order dated 8/31/24, directed to check blood glucose before meals and at bedtime. On 9/6/24 at 11:41 a.m., licensed practical nurse (LPN)-A placed a bin containing blood glucose testing supplies, including a shared glucometer, on the nightstand in R1's room. LPN-A placed the	F 880	F880 - -The process for satisfying this requirement has been reviewed and revised as needed, to ensure the facility develops and implements processes and procedures to maintain infection control practices while conducting blood glucose checks. -All residents residing in the facility who receive blood glucose checks could be affected if this requirement is not met. -R1 and R4 received individual glucometers. -All residents residing in the facility who receive blood glucose checks via manual glucometer will receive an individual	

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	245629	A. BUILDING _____ B. WING _____	C 09/06/2024

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F 880	Continued From page 8 glucometer on the bed linens while she prepared R1's finger, then set the glucometer on the over-the bed table once she had the blood sample applied to the test strip. LPN-A removed the test strip and wiped the glucometer with an alcohol wipe, and immediately placed the glucometer back in the bin. LPN-A stated she was not aware of any other cleaning requirements for the glucometer other than an alcohol wipe. R4's MDS admission MDS dated 8/26/24 indicated R4 had a diagnosis of diabetes mellitus. R4's care plan dated 7/16/24 directed monitor residents blood sugar as ordered. R4's Physician's Order dated 8/20/24 directed to inject sliding scale insulin with meals, based on blood glucose. On 9/6/24 at 12:18 p.m., LPN-B placed a bin containing blood glucose testing supplies on the over-the bed table in R4's room. LPN-B removed the glucometer and placed it directly on the over-the-bed table. Following the procedure, LPN-B placed the glucometer directly into the bin, without disinfecting it. LPN-B brought the bin to the mediation cart, then removed the glucometer, wiped it with an alcohol wipe and set it back into the bin. LPN-B stated she thought she was supposed to wipe the glucometer with an alcohol wipe. On 9/6/24 at 12:25 p.m., clinical manager (CM)-A stated ideally each resident would have their own glucometer. e. CM-A stated the glucometers were	F 880	glucometer. -All necessary VAO staff will be educated on the facility policy and procedure regarding individual glucometer use and disinfecting glucometers. -Audits will be complete to ensure compliance. Audits will be done at a frequency of at least 3x per week 2 weeks, 2x per week for 2 weeks, 1x per week for 2 weeks and 1x monthly thereafter. Audit results will be reviewed at QAPI, with any deficient practice corrected at the time of occurrence. - Director of Nursing or designee is the party responsible. - Corrective action will be completed on or before 9/27/24	

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F 880	Continued From page 9 expected to be cleansed with the designated disinfectant wipes which would remain in contact with the glucometer for a full two minutes. On 9/10/24 at 8:40 a.m., CM-A and the administrator stated there were a total of four residents using the two shared glucometers on 9/6/24 in the transitional care unit (TCU). An undated facility document Cleaning Glucometer Procedure directed after blood sugar is obtained, remove the strip and wipe down the glucometer with a bleach wipe. Take a second bleach wipe and keep the meter wrapped in the wipe for one minute.	F 880		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 13, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: PR8U11

Dear Administrator:

The above facility was surveyed on September 6, 2024 through September 6, 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:

Terri Ament, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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,

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

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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 9/6/24, 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.	2 000		

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2 000	Continued From page 1 Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaint was reviewed: H56297862C (MN00106336) with licensing orders issued at 4658.1325 Subpart 1 and 4658.0800 Subpart 1. 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	2 000		

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2 000	Continued From page 2 corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is 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		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain infection control practices while conducting blood glucose checks for 2 of 4 patients (R1, R4) reviewed for medication administration. Findings include: R1's MDS admission Minimum Data Set dated 8/22/24 indicated R1 had a diagnosis of diabetes mellitus. R1's Physician's Order dated 8/31/24, directed to check blood glucose before meals and at bedtime.	21375	CORRECTED.	9/27/24

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21375	Continued From page 3 On 9/6/24 at 11:41 a.m., licensed practical nurse (LPN)-A placed a bin containing blood glucose testing supplies, including a shared glucometer, on the nightstand in R1's room. LPN-A placed the glucometer on the bed linens while she prepared R1's finger, then set the glucometer on the over-the bed table once she had the blood sample applied to the test strip. LPN-A removed the test strip and wiped the glucometer with an alcohol wipe, and immediately placed the glucometer back in the bin. LPN-A stated she was not aware of any other cleaning requirements for the glucometer other than an alcohol wipe. R4's MDS admission MDS dated 8/26/24 indicated R4 had a diagnosis of diabetes mellitus. R4's care plan dated 7/16/24 directed monitor residents blood sugar as ordered. R4's Physician's Order dated 8/20/24 directed to inject sliding scale insulin with meals, based on blood glucose. On 9/6/24 at 12:18 p.m., LPN-B placed a bin containing blood glucose testing supplies on the over-the bed table in R4's room. LPN-B removed the glucometer and placed it directly on the over-the-bed table. Following the procedure, LPN-B placed the glucometer directly into the bin, without disinfecting it. LPN-B brought the bin to the mediation cart, then removed the glucometer, wiped it with an alcohol wipe and set it back into the bin. LPN-B stated she thought she was supposed to wipe the glucometer with an alcohol wipe.	21375		

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21375	Continued From page 4 On 9/6/24 at 12:25 p.m., clinical manager (CM)-A stated ideally each resident would have their own glucometer. e. CM-A stated the glucometers were expected to be cleansed with the designated disinfectant wipes which would remain in contact with the glucometer for a full two minutes. On 9/10/24 at 8:40 a.m., CM-A and the administrator stated there were a total of four residents using the two shared glucometers on 9/6/24 in the transitional care unit (TCU). An undated facility document Cleaning Glucometer Procedure directed after blood sugar is obtained, remove the strip and wipe down the glucometer with a bleach wipe. Take a second bleach wipe and keep the meter wrapped in the wipe for one minute. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review policies and procedures regarding glucometer cleansing and shared glucometers. The DON or designee could provide education on these policies and procedures to all staff who perform blood glucose checks. The DON or designee could and establish a system to monitor the nurses for infection control practices with the glucometers and report the results of these audits to the Quality Assessment Performance Improvement (QAPI) committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21550	MN Rule 4658.1325 Subp. 1 Adminiatration of Medications; Pharmacy Serv.	21550		9/27/24

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21550	Continued From page 5 Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide medication as ordered by the physician for 3 of 3 residents (R1, R2, R3) reviewed for pharmacy services. Findings include: R1's Physician's Orders dated 8/21/24 directed to hold warfarin (generic name for Coumadin, a blood thinner) 8/21/24 and 8/22/24. Recheck INR (international normalized ratio, a lab test for blood clotting) on Friday 8/23/24. R1's August MAR indicated R1 did not receive Coumadin from 8/23/24 through 8/27/24. On 9/6/24 at 12:25 p.m., case manager (CM)-A stated licensed practical nurse (LPN)-C entered the order into the computer system incorrectly, which lead to the omission of the lab being completed as ordered. R1 missed Coumadin dosages 8/23/24 through 8/27/24. On 9/10/24 at 9:04 a.m., LPN-C stated she made an error when entering the lab order into the computer system, for R1's INR, causing it to be missed on 8/23/24. R2's Physician's Orders dated 9/4/24 directed to administer niacin (a form of vitamin B3) 500	21550	CORRECTED	

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21550	Continued From page 6 milligrams (mg) by mouth daily in the morning. On 9/5/24 at 7:26 a.m., a progress note indicated the niacin was on order from the pharmacy. On 9/6/24 at 11:29 a.m., a progress note indicated the pharmacy was contacted, and the medication was a house stock. The medication was not in the medication room. It would be ordered by the person who orders stock medication. R2's September medication administration record (MAR) indicated R2 did not receive niacin 500mg on 9/5/24 or 9/6/24. On 9/6/24 at 11:24 a.m. LPN-A stated there was no niacin in stock. She was not sure when the medication was expected to arrive. She had not yet informed her supervisor the medication was not in stock. The provider had not been notified R2 had not received the prescribed medication for two days. On 9/6/24 at 1:24 p.m., CM-A stated while the over-the-counter (OTC) medications were typically obtained through a vendor, they did have a process in place to obtain the OTC medications through their contracted pharmacy. The provider should be informed if a medication was missed. On 9/6/24 at 3:08 p.m. R2 stated she was not made aware of any missed medications. On 9/6/24 at 3:26 p.m., nurse practitioner (NP)-A stated R2 was prescribed niacin for hypertension (high blood pressure) and stated R2 needed the niacin.	21550		

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21550	Continued From page 7 R3's Physician's Orders dated 8/21/24 directed to administer one nicotine patch 21micrograms (mcg)/hour transdermal (topical to the skin) in the morning. R3's Physician's Orders dated 9/4/24, directed to administer one nicotine patch 21mcg/hour to skin in the morning. On 8/22/24 at 11:08 a.m., a progress note indicated the nicotine patch was on order. On 8/23/24 at 11:06 a.m., a progress note indicated the nicotine patch was on order. On 9/4/24 at 8:32 a.m., a progress note indicated the nicotine patch was on order. On 9/5/24 at 9:13 a.m., a progress note indicated the nicotine patch was not given. R3's August MAR indicated R3 did not receive the nicotine patch on 8/22/24 or 8/23/24. R3's September MAR indicated R3 did not receive the nicotine patch on 9/4/24, 9/5/24, or 9/6/24. On 9/6/24 at 11:35 a.m. LPN-A stated R3 did not have her nicotine patch to apply as prescribed. On 9/6/24 at 12:56 p.m., the administrator stated stock medications were typically ordered through a vendor, but if a new resident was admitted with a medication they did not have in stock, they would obtain the medication through their contracted pharmacy or other means. On 9/6/24 at 2:15 p.m., LPN-A stated she was	21550		

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21550	Continued From page 8 unable to locate a nicotine patch for R3. She had made a progress note in R3's chart. She was not sure how long R3 had been without the medication. LPN-A stated the medication was due to have been administered between 7:00 a.m. to 11:00 a.m. She had not notified the provider or her supervisor, nor had she started a medication error report form. On 9/6/24 at 2:44 p.m., R3 stated she would like to have a nicotine patch on. R3 stated she was not sure why she did not have one on. On 9/6/24 at 4:02 p.m., CM-A stated the pharmacy makes several deliveries each day. CM-A stated he was not made aware of R2 or R3's missing medications by nurses. A facility document Medication Administration dated 4/2018, directed if a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time documentation of the unadministered dose is done as instructed by the procedures for use of the electronic medication administration record system. Nursing documents the notification and physician response. A facility document Medication Error Procedure, dated 1/2020, directed medication errors should be assessed, documented, and reported according to federal and/or state guidelines as appropriate. An undated facility document Medication Not Available Algorithm directed if medication is not available in med bank (an on site medication source), then call provider to notify medication not available and get order to hold until obtained from	21550		

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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
21550	Continued From page 9 pharmacy or temporary orders for alternative medication that is in the med bank. Document notification in computer charting system and what provider orders/directions are. Then call pharmacy to order medication and tell to send on next run. Document that this was done in computer charting system to notify clinical leaders. Document any other reasons why medication may not be able to be sent. Notify family of provider orders in regards to medication not being available. SUGGESTED METHOD OF CORRECTION: The facility could provide education to the nursing staff on the process of handling missing medications, including notification to physicians and nursing management. The facility could provide a list of over-the-counter (OTC) medications that are to be obtained through the vendor as a reference for the nurses. Nursing leadership could conduct routine audits of medication carts, medication stock, as well as auditing medication administration records. The facility could enhance communication protocols for missing medications as well. The Quality Assessment Performance Improvement (QAPI) committee could provide oversight of the audits. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21550		