Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 6, 2024

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

RE: CCN: 245629
Cycle Start Date: April 3, 2024

Dear Administrator:

On May 8, 2024, we notified you a remedy was imposed. On May 29, 2024 the Minnesota Department 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 May 22, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 3, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of , 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 3, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on May 22, 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 Therefore, the NATCEP prohibition is rescinded.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,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 6, 2024

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

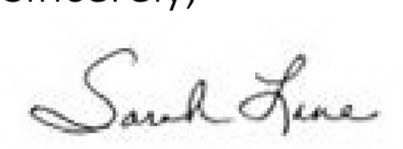
Re: Reinspection Results
Event ID: 9B2R12

Dear Administrator:

On May 29, 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 April 25, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,



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Protecting, Maintaining and Improving the Health of All Minnesotans

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May 8, 2024

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

RE: CCN: 245629
Cycle Start Date: April 3, 2024

Dear Administrator:

On April 17, 2024, we informed you that we may impose enforcement remedies.

On April 25, 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 Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 3, 2024

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 3, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 3, 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 $11,995, 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 July 3, 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 July 3, 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:

Susie Haben, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 October 3, 2024 (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
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 04/25/2024

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 4/24/24 and 4/25/24, 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: HE1173353C (MN102684) with a deficiency cited at F552. As a result of the investigation a deficiency was also issued at F609. 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 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in	F 552		5/22/24

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

Electronically Signed | 05/13/2024

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 552	Continued From page 1 advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to allow a resident/resident's legal representative to participate in treatment decisions for 1 of 1 resident (R1) who was on hospice, had a seizure and was initially denied access to medical treatment at a hospital. Findings include: R1's minimum data status (MDS) undated, was not completed due to admit date of 3/06/2024 and discharge date of 3/09/2024. R1's Care Plan dated 3/07/24, indicated R1 had malignant carcinoid tumor of the sigmoid colon, restless leg syndrome, chronic obstructive pulmonary disease, anxiety disorder, malignant neoplasm of the rectum stage IV (The earliest stage of colorectal cancers is called stage 0 (a very early cancer), and then range from stages I (1) through IV (4)). In addition, R1's care plan indicated a coccyx wound on buttock staff were directed to turn and reposition every two hours with weekly skin inspections by a nurse. R1's care plan also indicated she had alteration in cognition and was forgetful, on hospice care related to diagnosis of stage IV metastatic rectal cancer, and resident and family will receive	F 552	F552 s/s D - The process for satisfying this requirement has been reviewed and revised as needed, to ensure residents/residents legal representatives have the right to participate in treatment decisions. - All residents in the facility receiving hospice services could be affected if this requirement is not met. - R1 discharged from the facility on 03/09/2024. - Like-Residents were interviewed to ensure they have been allowed to participate in their treatment decisions. -All necessary VAO staff will receive education on Resident Rights, with emphasis on the Right to Participate in Treatment, along with education on Seizure Activity and Hospice Care. -Audits will be completed to ensure compliance. Audit results will be reviewed	

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F 552	Continued From page 2 comfort cares as desired and verbalize satisfaction with cares received. Staff were directed to maintain communication with hospice and keep them informed of residents condition, keep hospice informed of any changes in condition, involve hospice care workers in care conferences. R1's care plan indicated the current Code Status of do not resuscitate (DNR) and directed staff advanced directive in place and will be honored during the review period and to review residents advanced directive as needed per resident and/or family request and staff to follow POLST guidelines. R1's Interdisciplinary Progress Notes (IPN) indicated the following: -On 3/09/24 at approximately 1545 (3:45 p.m.) family called and stated that R1 was having a seizure. Registered Nurse (RN)-A) and RN-B went to R1's room and observed R1's lying on her back with arms straight out and eyes open. When RN-A touched R1 and asked if she was ok, R1 started flaring her arms up and yelling. Writer informed family that hospice will be notified. Family member (FM-A) called hospice from personal cell phone. RN-A then talked to hospice nurse on FM-A phone who stated to administer Ativan (anti-anxiety medication) and monitor. RN-A got the medication and went into R1's room and family notified but insisted to call 911. RN-A attempted to administer as needed Ativan sublingually, but family refused. Family called 911 and R1 was transported to the hospital at 1615 (4:15 p.m.). -On 3/11/24 at 13:17 (1:17 p.m.), note written by director of nursing (DON)-A , (previous DON who no longer works at the facility) indicated, called	F 552	at QAPI, with any deficient practice corrected at the time of occurrence. - The Administrator or Designee is the Responsible Party - Corrective action will be completed on or before 5/22/2024	

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F 552	Continued From page 3 hospital for update on R1 and spoke to nurse who indicated R1 was admitted and diagnosed with seizures, and skin was emaciated (extreme thinness), and very fragile, coccyx wound present, and had very dry mouth and sores in mouth and not letting staff do oral cares. Hospital nurse reported that R1 will motion and point to area for needs. The IPN note further indicated the DON-A called FM-A and she had reported that resident had been telling FM-A of concerns every day and stated R1 had more bruising, stated concerns with length of time for call light answering and coming to shut off call light asking question and not coming back, and on Saturday noted R1 jerking movements and put on call light and nurse came and stated R1 was not having a seizure, that it was a panic attack. FM-A mentioned concerns that R1's leg had not moved in a while and now was jerking. FM-A reported wanting to call 911 and was told staff could not call 911, that hospice needed to be called. FM-A called hospice, nurse spoke with hospice on her phone and RN-A was overheard telling hospice R1 was not having a seizure and it was a panic attack, FM-A reported calling 911. FM-A stated R1 did not have mouth sores prior to this past weekend and bruising on face and arms were new. DON-A thanked FM-A for talking with writer. During interview on 4/24/24 at 1:08 p.m., with R1's family (FM)-A stated R1 passed away in the hospital on 3/13/24. FM-A stated she had arrived at the Nursing Home on 3/09/24, at around 2:30 p.m. to 3:00 p.m. and found R1 was having seizures. FM-A stated the RN at the facility denied R1 was having a seizure and was insistent she was having a panic attack. FM-A indicated she contacted the hospice nurse and told them she wanted R1 sent to the hospital and the	F 552		

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F 552	Continued From page 4 hospice nurse told her that was okay. FM-A stated it was then that the RN insisted on speaking to the hospice nurse on FM-A's cell phone and after she spoke to the hospice nurse told FM-A she was going to administer Ativan (anti-anxiety medication first). FM-A stated the nurse came back and attempted to give R1 the oral medication (pill form) and she told the RN to stop and then called called 911 herself to have R1 sent into the emergency room. FM-A stated once she was in the emergency room she continued to have several more seizures and then passed away at the hospital on 3/13/24. In addition, FM-A stated R1 on 3/09/24, R1 had visible blood on her mouth and when she asked what happened staff could not tell her what happened. Additionally, R1 kept telling FM-A the staff were hitting her on the back of the head and and pushing her against the wall over and over. FM-A indicated R1 also told her that again at the hospital that same day. FM-A stated she had received a call from a male staff at the facility (unknown date and time) who asked what concerns she had and FM-A stated she told him about the bruises, blood on face and staff not wanting to send R1 to the hospital. She also received another call on Monday 3/11/24, where she explained the same concerns but never heard back from the facility. During interview on 4/25/24 at 10:13 a.m., facility consultant director of nursing (DON), stated he was not informed about the family's concerns until the next day on 3/10/24 at 3:18 a.m., in communication from the administrator and at the time he was the unit manager for the transitional care unit (TCU)(not the unit R1 was on). The DON further indicated once they did receive the complaint RN-A was suspended pending there	F 552		

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F 552	Continued From page 5 investigation and she was assigned to receive education in change of condition, seizure activity, answering call lights timely and assessments per Human Resources (HR). Facility lacked evidence in their investigation which identified a failure to allow R1's family timely access to treatment decisions and any follow up communication with the family or correction/training with staff. During interview on 4/25/24 at 1:58 p.m., hospice clinical manager (CM)-A stated the triage nurse who spoke to the facility nurse on 3/09/24. CM-A stated according to the emergency room documentation (ED) on 3/09/24, R1 had no history of seizures but was witnessed to have seizures in the ED. During interview on 4/25/24 at 3:00 p.m. RN-A stated she was the nurse working with R1 on 3/06/24, and the family was in the room and called stating R1 was having a seizure and she called LPN-A to come into the room with her. RN-A stated she was trying to get the vital signs of R1 and noticed she was raising her arms but was not certain she was having a seizure. During that time the family picked up her cell phone and called hospice and spoke to the triage nurse and handed me the phone telling me hospice was already on the phone with her. RN-A indicated she spoke to the hospice nurse and communicated R1's vital signs were with in normal range and was not certain it was a seizure and was instructed to give Ativan. RN-A stated she then informed the family and left to get the medication and when she returned to the room, the family was already on the phone with the paramedics. I never even gave the medication or	F 552		

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F 552	Continued From page 6 attempted to give the medication to R1. RN-A's interview was inconsistent with IPN note documented for [3/09/24 at approximately 1545 (3:45 p.m.)] where it was stated she attempted to administered the medication but family refused. During interview on 4/26/24 at 2:15 p.m., from a return call made on 4/25/24, the hospice supervisor (HS)-A (for hospice triage nurse which was working on 3/09/24), stated a family always had the choice to call 911, in this case, if the seizure had lasted more than five minutes we automatically would say to send them to the hospital, but from the call the seizure did not last five minutes but since the beginning the family was adamant they wanted R1 sent in so the facility nurse should have just stopped and called 911. The family said it was a seizure, and our hospice nurse said yes to call 911 to the family, prior to saying to give Ativan and I could hear it in her voice on the recording and feel our nurse said the right thing. The facility nurse felt it was a panic attack and wanted to give the Ativan first. The HS-A further stated she felt the staff might need some training on patient/family wishes when they are on hospice and still being able to go to the hospital. Facility Policy dated 1/2024, indicated it is the practice of this facility to uphold the rights of all residents. The facility and its staff will follow the below requirements as it relates to resident rights. 1. Residents will be provided with a copy of the Combined Federal and State Bill of Rights in writing via the electronic admissions process. 2. Residents will acknowledge in the electronic admissions packet that they have been given the Combined Federal and State Bill of Rights in	F 552		

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 04/25/2024

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F 552	Continued From page 7 writing via the electronic admissions packet. 3. Residents can request a physical copy of the Combined Federal and State Bill of Rights upon admission via the option in the electronic admissions packet or at any time by requesting a copy from social services. 4. The Combined Federal and State Bill of Rights will be posted in the facility in a location accessible to all residents. 5. Current copies of the Combined Federal and State Bill of Rights, in multiple languages, can be found at the following website: Patient, Resident and Home Care Bill of Rights - MN Dept. of Health (state.mn.us)	F 552		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		5/22/24

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F 609	Continued From page 8 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a potential allegation of neglect was recognized and reported to the State agency (SA) in a timely manner for 1 of 1 resident (R1) reviewed. Findings include: R1's minimum data status (MDS) undated, was not completed due to admit date of 3/06/2024 and discharge date of 3/09/2024. R1's Care Plan dated 3/07/24, indicated R1 had malignant carcinoid tumor of the sigmoid colon and malignant neoplasm of the rectum stage IV (The earliest stage of colorectal cancers is called stage 0 (a very early cancer), and then range from stages I (1) through IV (4). Review of an email received by the Monarch Group on 3/10/24 at 1:42 a.m. indicated concerns related to the care of R1 for services provided during the date of 3/7/24-3/9/24. The email indicated a summary of the following: -Unsanitary room conditions -Unsafe room conditions (exposed electrical wiring) -bruising and bleeding in mouth related to forceful medication administration -wait times to use bathroom/delayed patient care	F 609	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance. F609 s/s D	

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F 609	Continued From page 9 times -patient rights concerns related to Nurse refusing to contact 911 at family's request. R1's Interdisciplinary Progress Notes (IPN) indicated the following: -On 3/11/24 at 13:17 (1:17 p.m.), note written by director of nursing (DON)-A , (previous DON who no longer works at the facility) indicated, called hospital for update on R1 and spoke to nurse who indicated R1 was admitted and diagnosed with seizures, and skin was emaciated (extreme thinness), and very fragile, coccyx wound present, and had very dry mouth and sores in mouth and not letting staff do oral cares. Hospital nurse reported that R1 will motion and point to area for needs. The IPN note further indicated the DON-A called FM-A and she had reported that resident had been telling FM-A of concerns every day and stated R1 had more bruising, stated concerns with length of time for call light answering and coming to shut off call light asking question and not coming back, and on Saturday noted R1 jerking movements and put on call light and nurse came and stated R1 was not having a seizure, that it was a panic attack. FM-A mentioned concerns that R1's leg had not moved in a while and now was jerking. FM-A reported wanting to call 911 and was told staff could not call 911, that hospice needed to be called. FM-A called hospice, nurse spoke with hospice on her phone and RN-A was overheard telling hospice R1 was not having a seizure and it was a panic attack, FM-A reported calling 911. FM-A stated R1 did not have mouth sores prior to this past weekend and bruising on face and arms were new. DON-A thanked FM-A for talking with writer. The facility lacked evidence a report was filed	F 609	-The process for satisfying this requirement has been reviewed and revised as needed, to ensure allegations of abuse are reported to the State agency no later than 2 hours. - All residents in the facility could be affected if this requirement is not met. - R1 discharged from the facility on 03/09/2024. - Like residents were interviewed and review of their medical record was completed to ensure there was no harm. - All necessary staff have received training utilizing Monarch Healthcare Management□s Abuse Prohibition and Vulnerable Adult Policy, with emphasis on reporting requirements related to allegations of abuse or neglect. - Audits will be completed to ensure compliance. Audit results will be reviewed at QAPI, with any deficient practice corrected at the time of occurrence. - The Administrator or Designee is the Responsible Party. - Corrective action will be completed on or before 5/22/2024	

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F 609	Continued From page 10 with the State Agency on 3/9/24 related to suspected abuse after R1's family reported unknown bruising and blood on R1's face to staff at the facility and on 3/10/24 upon receiving an email from the family regarding concerns of neglect and abuse and/or after speaking directly to FM-A on 3/11/24. During interview on 4/24/24 at 1:08 p.m., with R1's family (FM)-A stated R1 passed away in the hospital on 3/13/24. FM-A stated she had arrived at the Nursing Home on 3/09/24, at around 2:30 p.m. to 3:00 p.m. and found R1 was having seizures. FM-A stated the RN at the facility denied R1 was having a seizure and was insistent she was having a panic attack. FM-A indicated she contacted the hospice nurse and told them she wanted R1 sent to the hospital and the hospice nurse told her that was okay. FM-A stated it was then that the RN insisted on speaking to the hospice nurse on her cell phone and after she spoke to the hospice nurse told FM-A she was going to administer Ativan (anti-anxiety medication first). FM-A stated the nurse came back and attempted to give R1 the oral medication (pill form) and she told the RN to stop and then called called 911 herself to have R1 sent into the emergency room. FM-A stated once she was in the emergency room she continued to have several more seizures and then passed away there on 3/13/24. In addition, FM-A stated R1 on 3/09/24, R1 had visible blood on her mouth and when she asked what happened staff could not tell her what happened. Additionally, R1 kept telling FM-A the staff were hitting her on the back of the head and and pushing her against the wall over and over. FM-A indicated R1 also told her that again at the hospital that same day. FM-A stated she had received a call from a male staff	F 609		

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F 609	Continued From page 11 at the facility (unknown date and time) who asked what concerns she had and FM-A stated she told him about the bruises, blood on face and staff not wanting to send R1 to the hospital. She also received another call on Monday 3/11/24, where she explained the same concerns but never heard back from the facility. During interview on 4/25/24 at 10:13 a.m., facility consultant director of nursing (DON), stated he was not informed about the family's concerns until the next day on 3/10/24 at 3:18 a.m., in communication from the administrator and at the time he was the unit manager for the transitional care unit (TCU)(not the unit R1 was on). The DON stated he did go to the facility and interview staff and some of the residents to see what was going on, and found there was no signs of any stains on the pillows and from interviews with staff they did not notice any bruising on R1, but did admit to the facility with a bruise on the coccyx. The DON stated they did an internal investigation and found no abuse and no MAARC was filed, although the DON stated he did ask if one should have been filed. The DON further indicated once they did receive the complaint, RN-A was immediately suspended pending their investigation and she was assigned to receive education in change of condition, seizure activity, answering call lights timely and assessments per Human Resources (HR). The DON further wanted to iterate he interviewed five other residents and they had no concerns and they had no indication R1 had any bruising or bleeding on the face, but felt this should have been reported and investigated. Abuse Prohibition/Vulnerable Adult Policy revised 3/2024, indicated The philosophy of Monarch	F 609		

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F 609	Continued From page 12 Healthcare Management is to provide quality long-term care in a loving and caring atmosphere. In accordance with Monarch Healthcare Management philosophy, this plan has been written to comply with Minnesota Statute (626.557) and Federal Guidelines for prevention of maltreatment of vulnerable adults in health care centers, incidents that must to be reported to MDH (Minnesota Department of Health) to include and more: -Injuries of unknown source - an injury should be classified as an "injury of unknown source." when both of the following conditions are met: The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; and, The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is in an area not generally vulnerable to trauma), or the number of injuries observed at one point in time or the incidence of injuries over time. To protect residents against abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends or other individuals, or self-abuse. To promptly report, document and investigate all incidents of alleged or suspected abuse/neglect. To promptly investigate, report and determine probable cause of unknown origin injuries. To identify and remedy any potentially abusive situations.	F 609		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 8, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: 9B2R11

Dear Administrator:

The above facility was surveyed on April 24, 2024 through April 25, 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:

Susie Haben, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

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

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	00733	A. BUILDING: _____ B. WING _____	04/25/2024

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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 4/24/25 and 4/25/24, 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 order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed HE1173353C (MN102684) with a licensing order issued at (1825). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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2 000	Continued From page 2 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		
21825	MN St. Statute 144.651 Subd. 9 Patients & Residents of HC Fac.Bill of Rights Subd. 9. Information about treatment. Residents shall be given by their physicians complete and current information concerning their diagnosis, treatment, alternatives, risks, and prognosis as required by the physician's legal duty to disclose. This information shall be in terms and language the residents can reasonably be expected to understand. Residents may be accompanied by a family member or other chosen representative, or both. This information shall include the likely medical or major psychological results of the treatment and its alternatives. In cases where it is medically inadvisable, as documented by the attending physician in a resident's medical record, the information shall be given to the resident's guardian or other person designated by the resident as a representative. Individuals have the right to refuse this information. Every resident suffering from any form of breast cancer shall be fully informed, prior to or at the time of admission and during her stay, of all alternative effective methods of treatment of which the treating physician is knowledgeable, including surgical, radiological, or chemotherapeutic treatments or combinations of treatments and the risks associated with each of those methods.	21825		5/22/24

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21825	Continued From page 3 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to allow a resident/resident's legal representative to participate in treatment decisions for 1 of 1 resident (R1) who was on hospice, had a seizure and was initially denied access to medical treatment at a hospital. Findings include: R1's minimum data status (MDS) undated, was not completed due to admit date of 3/06/2024 and discharge date of 3/09/2024. R1's Care Plan dated 3/07/24, indicated R1 had malignant carcinoid tumor of the sigmoid colon, restless leg syndrome, chronic obstructive pulmonary disease, anxiety disorder, malignant neoplasm of the rectum stage IV (The earliest stage of colorectal cancers is called stage 0 (a very early cancer), and then range from stages I (1) through IV (4)). In addition, R1's care plan indicated a coccyx wound on buttock staff were directed to turn and reposition every two hours with weekly skin inspections by a nurse. R1's care plan also indicated she had alteration in cognition and was forgetful, on hospice care related to diagnosis of stage IV metastatic rectal cancer, and resident and family will receive comfort cares as desired and verbalize satisfaction with cares received. Staff were directed to maintain communication with hospice and keep them informed of residents condition, keep hospice informed of any changes in condition, involve hospice care workers in care	21825	CORRECTED	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21825	Continued From page 4 conferences. R1's care plan indicated the current Code Status of do not resuscitate (DNR) and directed staff advanced directive in place and will be honored during the review period and to review residents advanced directive as needed per resident and/or family request and staff to follow POLST guidelines. R1's Interdisciplinary Progress Notes (IPN) indicated the following: -On 3/09/24 at approximately 1545 (3:45 p.m.) family called and stated that R1 was having a seizure. Registered Nurse (RN)-A) and RN-B went to R1's room and observed R1's lying on her back with arms straight out and eyes open. When RN-A touched R1 and asked if she was ok, R1 started flaring her arms up and yelling. Writer informed family that hospice will be notified. Family member (FM-A) called hospice from personal cell phone. RN-A then talked to hospice nurse on FM-A phone who stated to administer Ativan (anti-anxiety medication) and monitor. RN-A got the medication and went into R1's room and family notified but insisted to call 911. RN-A attempted to administer as needed Ativan sublingually, but family refused. Family called 911 and R1 was transported to the hospital at 1615 (4:15 p.m.). -On 3/11/24 at 13:17 (1:17 p.m.), note written by director of nursing (DON)-A , (previous DON who no longer works at the facility) indicated, called hospital for update on R1 and spoke to nurse who indicated R1 was admitted and diagnosed with seizures, and skin was emaciated (extreme thinness), and very fragile, coccyx wound present, and had very dry mouth and sores in mouth and not letting staff do oral cares. Hospital nurse reported that R1 will motion and point to	21825		

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	00733	A. BUILDING: _____ B. WING _____	04/25/2024

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21825	Continued From page 5 area for needs. The IPN note further indicated the DON-A called FM-A and she had reported that resident had been telling FM-A of concerns every day and stated R1 had more bruising, stated concerns with length of time for call light answering and coming to shut off call light asking question and not coming back, and on Saturday noted R1 jerking movements and put on call light and nurse came and stated R1 was not having a seizure, that it was a panic attack. FM-A mentioned concerns that R1's leg had not moved in a while and now was jerking. FM-A reported wanting to call 911 and was told staff could not call 911, that hospice needed to be called. FM-A called hospice, nurse spoke with hospice on her phone and RN-A was overheard telling hospice R1 was not having a seizure and it was a panic attack, FM-A reported calling 911. FM-A stated R1 did not have mouth sores prior to this past weekend and bruising on face and arms were new. DON-A thanked FM-A for talking with writer. During interview on 4/24/24 at 1:08 p.m., with R1's family (FM)-A stated R1 passed away in the hospital on 3/13/24. FM-A stated she had arrived at the Nursing Home on 3/09/24, at around 2:30 p.m. to 3:00 p.m. and found R1 was having seizures. FM-A stated the RN at the facility denied R1 was having a seizure and was insistent she was having a panic attack. FM-A indicated she contacted the hospice nurse and told them she wanted R1 sent to the hospital and the hospice nurse told her that was okay. FM-A stated it was then that the RN insisted on speaking to the hospice nurse on FM-A's cell phone and after she spoke to the hospice nurse told FM-A she was going to administer Ativan (anti-anxiety medication first). FM-A stated the nurse came back and attempted to give R1 the oral medication (pill form) and she told the RN to	21825		

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21825	Continued From page 6 stop and then called called 911 herself to have R1 sent into the emergency room. FM-A stated once she was in the emergency room she continued to have several more seizures and then passed away at the hospital on 3/13/24. In addition, FM-A stated R1 on 3/09/24, R1 had visible blood on her mouth and when she asked what happened staff could not tell her what happened. Additionally, R1 kept telling FM-A the staff were hitting her on the back of the head and and pushing her against the wall over and over. FM-A indicated R1 also told her that again at the hospital that same day. FM-A stated she had received a call from a male staff at the facility (unknown date and time) who asked what concerns she had and FM-A stated she told him about the bruises, blood on face and staff not wanting to send R1 to the hospital. She also received another call on Monday 3/11/24, where she explained the same concerns but never heard back from the facility. During interview on 4/25/24 at 10:13 a.m., facility consultant director of nursing (DON), stated he was not informed about the family's concerns until the next day on 3/10/24 at 3:18 a.m., in communication from the administrator and at the time he was the unit manager for the transitional care unit (TCU)(not the unit R1 was on). The DON further indicated once they did receive the complaint RN-A was suspended pending there investigation and she was assigned to receive education in change of condition, seizure activity, answering call lights timely and assessments per Human Resources (HR). Facility lacked evidence in their investigation which identified a failure to allow R1's family timely access to treatment decisions and any follow up communication with the family or	21825		

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21825	Continued From page 7 correction/training with staff. During interview on 4/25/24 at 1:58 p.m., hospice clinical manager (CM)-A stated the triage nurse who spoke to the facility nurse on 3/09/24. CM-A stated according to the emergency room documentation (ED) on 3/09/24, R1 had no history of seizures but was witnessed to have seizures in the ED. During interview on 4/25/24 at 3:00 p.m. RN-A stated she was the nurse working with R1 on 3/06/24, and the family was in the room and called stating R1 was having a seizure and she called LPN-A to come into the room with her. RN-A stated she was trying to get the vital signs of R1 and noticed she was raising her arms but was not certain she was having a seizure. During that time the family picked up her cell phone and called hospice and spoke to the triage nurse and handed me the phone telling me hospice was already on the phone with her. RN-A indicated she spoke to the hospice nurse and communicated R1's vital signs were with in normal range and was not certain it was a seizure and was instructed to give Ativan. RN-A stated she then informed the family and left to get the medication and when she returned to the room, the family was already on the phone with the paramedics. I never even gave the medication or attempted to give the medication to R1. RN-A's interview was inconsistent with IPN note documented for [3/09/24 at approximately 1545 (3:45 p.m.)] where it was stated she attempted to administered the medication but family refused. During interview on 4/26/24 at 2:15 p.m., from a return call made on 4/25/24, the hospice supervisor (HS)-A (for hospice triage nurse which	21825		

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21825	Continued From page 8 was working on 3/09/24), stated a family always had the choice to call 911, in this case, if the seizure had lasted more than five minutes we automatically would say to send them to the hospital, but from the call the seizure did not last five minutes but since the beginning the family was adamant they wanted R1 sent in so the facility nurse should have just stopped and called 911. The family said it was a seizure, and our hospice nurse said yes to call 911 to the family, prior to saying to give Ativan and I could hear it in her voice on the recording and feel our nurse said the right thing. The facility nurse felt it was a panic attack and wanted to give the Ativan first. The HS-A further stated she felt the staff might need some training on patient/family wishes when they are on hospice and still being able to go to the hospital. Facility Policy dated 1/2024, indicated it is the practice of this facility to uphold the rights of all residents. The facility and its staff will follow the below requirements as it relates to resident rights. 1. Residents will be provided with a copy of the Combined Federal and State Bill of Rights in writing via the electronic admissions process. 2. Residents will acknowledge in the electronic admissions packet that they have been given the Combined Federal and State Bill of Rights in writing via the electronic admissions packet. 3. Residents can request a physical copy of the Combined Federal and State Bill of Rights upon admission via the option in the electronic admissions packet or at any time by requesting a copy from social services. 4. The Combined Federal and State Bill of Rights will be posted in the facility in a location accessible to all residents. 5. Current copies of the Combined Federal and State Bill of Rights, in multiple languages, can be	21825		

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21825	Continued From page 9 found at the following website: Patient, Resident and Home Care Bill of Rights - MN Dept. of Health (state.mn.us) SUGGESTED METHOD OF CORRECTION: Administrator and Director of Nursing will need to ensure resident and resident representatives are allowed to make/change decisions related to treatment choices, ensure policies related to resident rights are consistent with these practises, and ensure the polices and procedures include residents on hospice care. All licensed nursing will need to be educated on the policies for treatment decisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21825		