



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 2, 2026

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

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

Dear Administrator:

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

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

As authorized by CMS the remedy of:

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

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 Therefore, the NATCEP prohibition is rescinded.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

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

Feel free to contact me if you have questions.

Sincerely,

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

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 2, 2026

Administrator

The Villas at Osseo LLC

501 Second Street Southeast

Osseo, MN 55369

Re: Reinspection Results

Event ID: 234FE6-H2

Dear Administrator:

On August 4, 2026, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 10, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Holly Zahler, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

Office: 651-201-4384

Email: holly.zahler@state.mn.us

An equal opportunity employer.



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 23, 2026

Administrator

THE VILLAS AT OSSEO LLC

501 SECOND STREET SOUTHEAST

OSSEO, MN 55369

RE: CCN: 245629

Cycle Start Date: June 4, 2026

Dear Administrator:

On June 23, 2026, we informed you that we may impose enforcement remedies.

On June 10, 2026, 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 actual harm that was not immediate jeopardy (Level G), 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:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 8, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 8, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 8, 2026.

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 \$13,343, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by July 8, 2026, 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 8, 2026. 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:

Annette Winters, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 December 4, 2026 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:

tamika.brown@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 tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You

are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 23, 2026

Administrator

THE VILLAS AT OSSEO LLC

501 SECOND STREET SOUTHEAST

OSSEO, MN 55369

Re: State Nursing Home Licensing Orders

Event ID: 234FE6-H1

Dear Administrator:

The above facility survey was completed on June 10, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Annette Winters, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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

Please feel free to call me with any questions.



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 6/8/26 – 6/10/26, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H56292844C / MN3015078 The following complaints were reviewed. H56292761C/ MN260461056, H56292845C / MN3027625, & H56292789C / MN3034870 with a deficiencies issued at F600 AND F584 Deficient practice was identified related to incidental finding at F656 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.			F0000			07/05/2026
F0600 SS = G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the			F0600	F600 s/s G The process for satisfying this requirement has been reviewed and revised as needed to ensure residents are free from resident-to-resident abuse. Residents of the facility have the potential to be affected if this requirement is not met. Resident-to-resident altercation occurred on		07/05/2026

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0600 SS = G	Continued from page 1 resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on interview, and record review the facility failed to ensure residents were free from resident to resident abuse for 5 of 5 residents (R3, R5, R6, R7, & R8) reviewed when R1 had physically assaulted R3 and R5 and verbally assaulted all five residents resulting mental anguish and multiple police visits. Findings include: R1's admission Minimum Data Set (MDS) dated 3/12/26 indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 14 indicating R1 was cognitively intact. R1 did not exhibit any behaviors and did not refuse cares. R1 used a walker and/or a cane for ambulation. He was independent with eating, putting on and taking off footwear, personal hygiene, rolling in bed, sitting to lying and lying to sitting. He required set-up assistance with sitting to standing, dressing and toileting. R1's pertinent diagnoses were metabolic encephalopathy (the brain does not function normally because of a medical condition), hypokalemia (low potassium levels), alcohol dependence, nicotine dependence, personality disorder and altered mental status. R3's annual MDS dated 5/20/26 indicated R3 spoke Ukrainian and required an interpreter. R3's BIMS score was 15 indicating no cognitive impairment. R3 had no behaviors identified. R3 used a wheelchair for ambulation. She required moderate assistance with toileting hygiene, upper body dressing and transferring. She required maximum assistance with lower body dressing. R3's pertinent diagnoses were paraplegia (paralysis of legs and lower body), anxiety, psychotic disorder, and post-traumatic stress disorder. R5's quarterly MDS dated 3/17/26 indicated R5 had a BIMS score of 15 indicating she was cognitively intact. R5 used a wheelchair for ambulation. No behaviors were identified. R5 was independent with			F0600	Continued from page 1 5/28/26 with R1 and R3. Staff responded appropriately by ensuring residents were immediately separated and safe; then assessed for injury. Following the altercation, R1 and R3 were placed on Q15 minute checks and titrated to hourly checks throughout the weekend. R1 was placed on supervised smoking due to location of incident. DON educated R1 of supervised smoking expectations, de-escalation and behavior towards other residents. R3 was educated on de-escalation techniques. Emotional distress monitoring was implemented for both R1 and R3. R3 had no documented emotional distress following the altercation. R1's Care Plan was reviewed with necessary communication to VAO staff on interventions. Police intervention initiated, and on June 1, 2026, following receipt of the Police Report, the Administrator and Director of Nursing immediately initiated an investigation into the resident-to-resident altercation involving R1, R5, R6, R7, and R8. R1 was placed on 1:1 supervision to ensure safety to residents of the facility and prevent further incidents. R1 had medications reviewed by the Nurse Practitioner (NP) and Associated Clinic of Psychology (ACP) Psychiatrist who prescribed new medications with guardians' approval. A meeting was held between the Director of Nursing and the Medical Director on 6/8/26 to discuss R1's continued verbal aggression towards staff and implemented interventions. The Medical Director agreed with current interventions in place. The Director of Nursing also spoke with the Medical Director regarding R1 on 6/22/26 and 6/24/26. Interviews were completed with identified like-residents, with no further concerns identified or concerns shared.		07/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0600 SS = G	Continued from page 2 hygiene, upper body dressing and transferring. Her pertinent diagnoses were depression, wedge compression fracture of her T5-T6 vertebrae (the front of the bone collapse and causes a wedge shape), chronic pain and alcohol abuse. R6's quarterly MDS dated 3/13/26 indicated R6 had a BIMS score of 15 indicating she was cognitively intact. No behaviors were identified. R6 was independent with dressing, personal hygiene, and transferring. She was dependent on toileting hygiene. Her pertinent diagnoses were depression, encounter for surgical aftercare following surgery of the digestive system, irritability and anger, impulsiveness and other symptoms and signs with cognitive functions and awareness. R7's quarterly MDS dated 5/6/26 indicated R6 had a BIMS score of 12 indicating she had moderate cognitive impairment. No behaviors were identified. R7 used a wheelchair for ambulation. R7 required maximum assistance with dressing and toileting hygiene and moderate assistance with transferring. Her pertinent diagnoses were depression, anxiety, displacement fracture of the right lower leg, nicotine dependent, and borderline personality disorder (severe emotional instability). R8's quarterly MDS dated 4/23/26 indicated R8 had a BIMS score of 15 indicating she was cognitively intact. No behaviors were identified. She used a wheelchair for ambulation. R3 required moderate assistance with upper body dressing, maximum assistance with lower body dressing and personal hygiene and transfers. Her pertinent diagnoses were depression, multiple sclerosis, insomnia, and muscle weakness. A police report dated 5/28/26 at 5:22 p.m. indicated two officers were dispatched to the facility for a disturbance between two residents. Call notes indicated in the smoking lounge back patio a male and a woman fighting and yelling at each other. Officers arrived on scene and spoke with R1, who was very uncooperative when trying to get information about what happened. He stated a female had hit his hat off and he became upset because it was a hat from a Reservation and they started arguing, He stated he never hit anyone and was just minding his own business. An officer spoke			F0600	Continued from page 2 Social Services met with the impacted residents (R1, R3, R5, R6, R7, and R8) to check in and assess any ongoing emotional distress. Care plans were reviewed and revised as needed. ACP was offered. ACP notified of altercation and completed on-site visits with Residents who consented. R1 discharged from the facility on 6/26/26. VAO Staff members were educated on the Monarch Healthcare Abuse Prohibition and Vulnerable Adult policy, with emphasis on recognizing signs of resident-to-resident abuse and the importance of immediate reporting and intervention. Additionally, staff were instructed to monitor interactions between R1 other residents closely, reporting any concerning behaviors immediately to ensure resident safety and well-being. Resident Council Meeting was held on 6/3/26, where the Director of Nursing spoke to Residents about the Monarch Healthcare Abuse Prohibition and Vulnerable Adult Policy, notifying staff of altercations and de-escalation techniques. Compliance audits will be completed to ensure residents are free from resident-to-resident abuse weekly for four (4) weeks, and monthly thereafter for two (2) months. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. Administrator or designee is responsible party. Corrective action will be completed by 7/5/26		07/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0600 SS = G	Continued from page 3 with a staff member, the business officer manager who was able to interview R3 in Russian. She stated R1 had been swearing at R3 and staff along with other residents at the facility. R3 stated R1 pulled her hair, and she would have hit him because every day he said profanities to everyone. Officers told both parties involved to stay away from each other and informed staff to keep them separated. The police supplemental report dated 5/30/25 at 6:15 a.m. indicated on 05/28/2026 at approximately 5:22 p.m. two officers were dispatched to the facility due to a fight that was occurring in the back smoking patio. Upon arrival, R1 was in a wheelchair and across the street from the patio where the alleged fight happened. Officers tried talking to R1, but he appeared to be intoxicated by the smell of the odor of consumed alcoholic beverages, and he had red blood shot eyes. R1 was very uncooperative with officers and made several comments about this being his land and that he could go anywhere he wanted to. He also told officers that his hat was knocked off his head and that no one disrespects a Reservation hat like that. At this point another officer went to speak to the other party involved (R3). R1 later said that R3 was a "white Bitch" and that she had told him to get "his black ass out of this country" and that he told her he was not black and was red. This was when R3 walked up to him and slapped his hat off his head. A short time later, the officers were advised that R3 did not speak English and that things never got physical, but she did intend to pull R1's hair and that is when his hat fell off. R1 was told R3 did not speak English and asked why he told me she had said those things to the officer. R1 stated that he does not need to understand anyone's language to know what they are saying to him. At that point officers advised both parties to stay away from each other, which they agreed. A facility investigation document, undated, by the business office manager indicated on 5/28/26, around 5:30 p.m. the admission coordinator, the culinary director, and the business office manager were called up to the patio due to a resident altercation. They walked out to the smoking patio and in the far corner saw R1. R1 stated R3 grabbed his hat and threw it down on the floor. He stated she			F0600			07/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0600 SS = G	Continued from page 4 did this because she was racist against Native Americans. He continued to swear throughout the conversation, stating that he was here before all of them. They went back inside to meet with R3 and found her coming out of the elevator. She stated that R1 had been verbally abusing all the women at the facility, residents and staff included. She stated she did not touch his hat; it flew off because she pulled his hair and slapped him. She then followed the staff outside, where they saw two police officers speaking to R1 by the next to the assisted living door. One officer walked over and took R3's statement with the business office manager translating. R3 told the officer that she pulled R1's hair and slapped him, and that if staff had not intervened, she would have punched him as well. R5 told the officer that she would be calling the police until they did something about R1. The officer who was talking to R1 walked over to the smoking patio door, discussed the situation with the other officer. They came to the staff to say that their hands were tied because R1 was in their custody. Police officer report dated 05/29/2026 at 6:51 p.m. indicated an officer was dispatched to a disturbance at the facility. R11 reported that a native man in the wheelchair, referring to R1, had been out on the smoking patio harassing the other residents, calling them "bitches, hoes and cunts". He also stated that he went over to the assisted living behind the facility to hang out with a resident over there and she provided alcohol to him. The officer went over to the smoking patio where he was given the following information from the following residents: -R5 stated to the officer that R1 had been hostile to the residents and staff at the facility by yelling at everyone, calling them "Fucking Cunts". R5 stated R1 was trying to kick her from his wheelchair. R5 was standing behind her wheelchair when R1 kicked her wheelchair causing it to jam her into the stomach. R5 then stated that R1 fell over from all the kicking. R5 stated that this all happened 1 hour before the officer arrived. -R6 stated to the officer that R1 had been verbally threatening her and calling her a "Cunt". R6 stated			F0600			07/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0600 SS = G	Continued from page 5 that on 05/28/2026 R1 had told her "I am going to kill you, you fucking cunt" he also told her that he had people in the city that will take care of her. R6 stated that she had been worried that R1 would act on those threats and had trouble sleeping that night. -R7 stated to the officer that R2 had been cursing everyone out the last couple of days and called her a "Bitch, Cunt and whore". R7 stated R1 was going to try and shove her wheelchair but ended up kicking R5's wheelchair to the point that the wheelchair went into R5's stomach. -R11 stated to the officer that R1 has been very hostile and threatening. He stated that R1 told him to get away from him or he would beat him up when he was not near him. R11 stated R1 called him "white boy" and all sorts of other derogatory names and told him to get off his land. R1 had threatened to beat him up and kill him multiple times. -All the residents then stated R1 had been telling everyone that all the land because he was native, they needed to get off his land, and he could do whatever he wanted. -R8 stated to the office that R1 threatened to beat up R11 and has been calling everyone derogatory names. -The officers requested an emergency medical hold for a mental health evaluation due to the recent involvements of combative and disruptive assaultive conduct causing fear of death and bodily harm to other residents resident in the facility. Dispatch requested an ambulance to the facility. An Officer arrived on scene and completed the Emergency Medical Hospitalization form. R1's nursing note dated 5/28/26 at 6:40 p.m. indicated today at around 5:30 pm, writer was called and informed that there is an outburst between two residents. As reported by resident from room R3 and translated by the Business Manager. R3. stated that while attempting to access the elevator, resident R1 repeatedly blocked her path while yelling insults, cursing, and using profane language including multiple "F" words. Resident R3 further reported that the verbal confrontation escalated into a physical altercation which continued to the smoking zone, during which both residents pulled each other's hair and slapped one another. R3 continued to report that the same happened yesterday in the smoking zone with the same resident but did not generate to physical outbursts, At the time this note was			F0600			07/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0600 SS = G	Continued from page 6 entered, R1 did not provide his version of events and continued yelling and using inappropriate language toward staff and others present. Due to the escalation and aggressive behavior displayed, police were contacted by one of the residents who had witnessed and responded to the facility. The social worker, business manager, and dietary director were present and witnessed the collection of statements from involved parties and witnesses. R3 was able to be separated for safety. R1 was very aggressive and could not agree to go to his room to calm the situation. The situation was reported to the on-call nurse manager, and monitoring will continue. Further follow-up and assessment will be completed as needed. R1's nursing note dated 5/29/26 at 8:43 p.m. indicated from around 4:00 p.m. R1 exhibited combative and disruptive behavior, this included yelling profanities, making both verbal and physical threats toward staff and other residents. R1 was noted using abusive language in the hallway and in the smoking zone area, he was more verbally aggressive when approached regarding facility rules and safety measures. Multiple attempts were made to redirect and de-escalate the situation were not effective. Resident remains noncompliant with the required supervised smoking and any attempts to remind him about them were futile, he repeatedly went out to smoke without staff supervision. Staff continued to monitor residents closely, provided verbal redirection, and reinforced facility expectations. Manager on duty was notified, On-call provider was updated via vital care, and she ordered 1-time 50 mg trazadone. R1's nursing note dated 5/29/26 at 8:57 p.m. indicated the writer was called to the smoking area, upon getting there, writer noted the R1 seated on the ground, residents (witnesses) who were smoking reported that he was trying to charge at one of them but slipped off his wheelchair, R1 was verbally aggressive, yelling at staff and refusing assistance. A skin tear was noted on the right shin, bleeding present. Staff attempted multiple times to assess the injury, provide first aid, and assist R1 from the ground; however, R1 repeatedly refused all attempts and continued to use hostile language toward staff. Charge nurse and provider updated. R1's nursing note dated 5/29/26 at 9:09 p.m. indicated at around 8:20 pm, writer was notified that one of the residents had contacted law enforcement			F0600			07/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0600 SS = G	Continued from page 7 with concerns of the R1's behaviors towards them. Police responded to the facility and assessed the situation, took statements from both staffs and residents, the police contacted emergency medical services and R1 was evaluated on-site, due to aggressive behavior and safety concerns, R1 was transported for further psychiatric and medical evaluation. R1's family did not answer when contacted. R1's nursing note dated 5/29/26 at 9:31 p.m. indicated staff was called to the smoking area, upon getting there, writer noted R1 on the ground, residents (witnesses) who were smoking reported R1 was trying to charge at one of them but slipped off his wheelchair, resident was noted to be verbally aggressive, yelling at staff and refusing assistance. A skin tear was bleeding on the right shin. Staff attempted multiple times to assess the injury, provide first aid, and assist the resident from the ground; however, R1 repeatedly refused all attempts and continued to use hostile language toward staff. The charge nurse and the provider were updated. R1's hospital note dated 5/30/26 at 1:59 a.m. indicated R1 arrived at the emergency department at 8:47 p.m. related to a fall from a wheelchair. R1 had a history of alcohol dependence, major depression, and personality disorder, cerebrovascular accident with residual deficits and hypertension. R1 reported he ran over a rock and fell backwards in his wheelchair striking the wall, hitting his head, his shine and lost consciousness. An x-ray was taken of his leg, and a head scan was completed with no concerns for injury. R1 was discharged back to the facility. R1's nursing note dated 5/31/26 at 10:12 p.m. indicated hourly safety checks were completed. R1 spent most of the evening outside in the smoking area. R1's nursing note dated 6/1/26 indicated the interdisciplinary team (IDT) met to discuss R1's behavior and recent police report received. R1 was placed on 1:1 staff/resident supervision for behavior management and safety. The DON notified the provider. The facility investigation on 6/1/26 documented by the culinary director indicated an unidentified			F0600			07/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0600 SS = G	Continued from page 8 culinary aide called the culinary director to come out to the patio as two residents were having an altercation. All three members in the business office reported to the scene. R3 had already left the patio area and was back upstairs. R1 remained on the patio. He was very agitated about the situation. R1 claimed that R3 grabbed his hat off his head and threw it to the ground. He stated R3 was racist against Native Americans. He stated his people fought and died on this land; they were here first. He continued to speak with many obscenities, calling R3 a "bitch" and a "cunt". He even threw his own hat on the floor numerous times in demonstration for the event that occurred. The three staff members all tried to deescalate the situation. R1's obscenities turned towards the three of them. Telling them that we do not belong here. His people were here first. The staff attempted to ask the residents on the patio about the incident, but they were too afraid to comment on the situation. Staff went inside the facility as R1 had settled down a bit. He remained on the patio, and R3 was on her way back out to the patio. R3 spoke with the business office manager who spoke Russian about the situation. They all headed back out to the patio when staff noticed the police were present. The social worker (SW)-A joined them to gather information on the situation. The business office manager translated R3's statement to the police officer. The other officer was meeting with R1 across the parking lot. R5 stated that she would continue calling the police on R1 until he was taken away. The officer suggested they try to keep the residents separated. The staff had a quick team call in the social worker's office to discuss interventions involving R1's guardian. A facility investigation report documented on 6/1/26 by the admission coordinator indicated on 5/28/26 at approximately 5:20 pm, the Culinary Director received a call from one of her staff members requesting immediate assistance for a resident altercation that was taking place on the smoking patio. The director asked for assistance go with her as they did not know the severity of the situation. When the three staff arrived at the patio other staff had already intervened. R1 was still on the smoking patio, visibly upset. When trying to get R1's statement of the incident, he was rambling about being a Native American and "being here first". He stated that R3 ripped his hat off and threw it on the ground calling her a "cunt and fucking bitch". He continued to use offensive language throughout the conversation, avoiding direct answers to the questions he was being asked about the incident, continuously calling R3 a "cunt" and "fucking bitch"			F0600			07/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0600 SS = G	Continued from page 9 and repeating "I'm Native American and was here first!" Staff told R1 that she wanted to listen and get his story but requested that he speak respectfully. R1 responded by telling them to "shut the fuck up" and called them "fucking cunts". The three staff then went to exit that patio and asked other residents that were on the patio if they saw what happened. They stated yes but were scared to speak with R1 on the patio. They went inside to speak with R3, meeting her at the back entrance as she was exiting the elevator. The business office manager translated for (SW)-A. During their conversation she saw two police officers pull into the back parking lot, speaking to R1 in the courtyard of the assisted living. R5's social service note dated 6/1/26 at 8:23 p.m. indicated Social Services (SS) followed up with the resident regarding a police report involving R1. R5 confirmed the report and answered yes/no when asked whether she felt safe at the facility, because of R1. She stated that the involved resident did not personally threaten her. R5 denied emotional distress or suicidal thoughts but reported feeling "mentally stressed." SS reassured R5 and informed her of current interventions, which she indicated were helpful. TR5 declined psychological services. BIMS score: 15/15, indicating intact cognition. PHQ-9 score: 2/27-indicating minimal depression. SS will continue to support R5. R6's SS note dated 6/1/26 at 8:20 p.m. indicated Social Services followed up with R6 due to a police report involving R1. R6 confirmed the report, stating, "he's all talk," but added, "I think he could hurt me, but not my family." R6 reported feeling afraid of R1 when alone with him on the smoking patio. R6 denied emotional distress, stated she feels safe at the facility, and is doing well, but became teary when asked for consent to notify her daughter (POA). R6 declined to notify any of her family members, stating, "I trust you people at the facility that you will take care of things." The SS provided reassurance and reviewed current interventions, which the resident appreciated and noted helped her a lot. R6 utilizes psych services with ACP. BIMS score: 15/15, indicating intact cognition. PHQ-9 score: 0/27, indicating no depression. R1's nursing progress note dated 6/8/26 at 1:59 a.m. indicated R1 was physically very aggressive, hit staff twice, smoked in his room and was exit seeking when told doors were locked at 11:00 p.m. Cigarette			F0600			07/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0600 SS = G	Continued from page 10 butts were removed from his room. He was loud and aggressive to the point disturbing other residents. A virtual call was placed to on call Medical Doctor (M.D.) to request a transfer order. The order was received and R1 was sent to the hospital for behavioral disturbance. Upon interview on 6/9/26 at 9:40 a.m. the culinary director stated one of her staff called her on 5/28/26 to ask for her assistance as there was a resident-to-resident altercation on the patio. She stated R3 left the area and R1 was still on the patio upset. The other residents stayed very quiet. She did not interview any of the residents. She stated she was aware that R1 was put on 15-minute staff checks for a day, then 30-minute staff checks for a day, and the hourly staff checks for a day. She stated she was not aware of R1's altercation on 5/29/26. Upon interview on 6/9/26 at 11:17 a.m. via professional Russian interpreter R3 stated R1 assaulted all the woman with very rude and cursing American words. She stated staff did follow-up with her and told her R1 would have staff with him all day, but that had not stop him for still cursing at the staff and residents. In a subsequent interview on 9/10/26 at 9:30 a.m. she stated the following evening R1 threw a chair outside. She was not certain which resident it was meant to hit but it was thrown in the direction where the residents were sitting. In addition, R1 disturbed her sleep as he is up all hours of the night going down the hallway, cussing loudly at the staff who are following him. R3 felt safe at the facility but stated her anger had worsened when R1 started with his abusive actions. Upon interview on 6/9/26 at 11:37 a.m. R5 stated she called the police when R1 and R3 were fighting and would continue to call the police even though staff had asked her to notify them. She stated the facility plans did not work as R1 still cussed at residents and residents did not feel safe. He attempted to kick her and her wheelchair got pushed into her stomach. She did not have any pain and stated no bruise occurred. In a subsequent interview on 9/10/26 at 11:22 a.m. she stated R1 threw a chair and yelled at her on the evening of 6/9/26. R1 was upset because he thought she was calling the police on him trespassing on the assisted living property. R5 stated R1 would sit on the facilities edge of the property and get alcohol from his girlfriend at the assisted living and the 1:1 staff would not intervene.			F0600			07/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0600 SS = G	Continued from page 11 She stated she would feel safer if R1 was gone. R5 and her friends make sure they use the buddy system when going to smoke in case R1 showed up. Upon interview on 6/9/26 at 12:10 p.m. nursing assistant (NA)-A stated she had worked as the 1:1 staff with R1 and it is difficult to tell if he is cussing and screaming at staff or residents because he yells at everyone in his vicinity. Upon interview on 6/9/26 at 12:30 p.m. R6 stated about two weeks ago R1 got right in her face and yelled he was going to kill her and her family. R6 stated she has had trouble sleeping. She was concerned about her family because she felt R1 “had people” who could kill them, but she told herself over-and-over that he did not know her family to calm herself down and attempt to sleep, but he could have someone hurt her. “He is threatening.” Upon interview on 6/9/26 at 12:44 p.m. R1 stated he had been uptight and frustrated because he wanted to move. He stated he was confused and denied anyone bothering him. R6 stated his mind spins, and he did not know what to do. The woman is probably scared of him. He never used to be like “that.” He never treated girlfriends the way he treated the women at the facility. R6 stated his reason was pent-up frustration. He had been in jail and prison, and nobody followed him around 24 hours a day. If staff continued to follow him, he would lash out and fight someone even worse than he had already. He stated his frustrations come from the Native American people being ridiculed for 300 years. Upon interview on 6/9/26 at 1:35 p.m. R7 stated she has been assaulted and harassed by R1 multiple times. Just yesterday she mentioned to R1 that his girlfriend was not allowed on the facilities property anymore and R1 got right up in her face and called her a “fucking cunt”, that he was going to kill her and to stop calling police on him because he owned the land. R7 stated she feared R1. Upon interview on 6/10/26 at 8:45 a.m. the business office manager stated she did not know R3 well but had interpreted for her a few times. She stated R3 was a very angry woman due to her injury and past history . R3 stated to her that the situation with R1 exacerbated her anger and she wanted to protect the			F0600			07/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0600 SS = G	Continued from page 12 older women at the facility because they were vulnerable and like mothers to her. Upon interview on 6/10/26 at 11:19 a.m. SW-A stated the facility was trying to relocate R1. She stated R3 had anger issues, and she had calmed down, however she had been more frustrated with incidents involving R1. R5 had increased anxiety after the incident as she was the other one physically assaulted by R1. SW-A is continuing to give her support. R6 told the SW that everyone wants R1 out of the facility, she felt safe, but not alone with him. She felt R1 might “do something”, but killing was a bluff. (SW)-A did not speak with R7 that the Administrator summer intern did. R8 was just hospitalized for her own drinking so it was hard to identify her thoughts following the verbal abuse and witnessing abuse by R1. Upon interview on 6/10/26 at 1:32 p.m. R1’s Nurse Practitioner stated she had attempted to put a 72-hour hold on R1 at the hospital, but the hospital sent him back each time within hours. She asked what the state of Minnesota was doing with residents like R1 who have disruptive behaviors and the facility had exhausted all efforts. Who was to take care of this type of individual, shouldn’t the state have facilities for them? Upon interview on 6/10/25 at 2:55 p.m. NA-B stated he had worked with R1 on 6/9/26 and witnessed him throwing a chair, which was toward the residents, but he was not able to indicate who it was directly meant for; however, he felt it was to R5 because R1 then shouted and cussed at her on the outside patio. R1 continued to yell at staff and residents even with his 1:1 in place. Upon interview on 6/10/26 at 3:10 p.m. the director of nursing (DON) stated the first incident with R1 the facility put him on 15-minute staff checks for 24 hours, then 30-minute staff checks for 24 hours, and finally hourly staff checks for 24 hours. Upon his second incident the staff placed him on 1:1 staff supervision. He was aware that R1 continued to be aggressive with hitting and cussing at staff but was denied any knowledge of continued aggression with the residents. A facility policy titled Abuse Vulnerable Adult Policy with a revision date of 11/2025 indicated the			F0600			07/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0600 SS = G	Continued from page 13 purpose was 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.			F0600			07/05/2026
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;			F0584	R4 was discharged from the facility. Housekeeping performed a thorough deep cleaning of this resident room, including the windowsill, furniture, wardrobe, and bathroom. Maintenance repaired or removed damaged furnishings, including the bedside table and rusted bed frame, and addressed chipped and peeling surfaces. The bathroom received enhanced cleaning and odor treatment. Pest control was informed of ants being seen on windowsill, without evidence of ants inside the facility while onsite. All residents have the potential to be affected if this requirement is not met. Resident rooms were audited to identify damaged furniture, peeling surfaces, cleanliness concerns, persistent odors, and evidence of pest activity. Any concerns were documented for Maintenance prompt follow-up. The facility implemented a standardized Admission Room Readiness Checklist requiring inspection of each room prior to resident admission. The checklist must be completed by the Admissions Coordinator or designee with any area(s) of opportunity immediately addressed by the appropriate department. The facility also implemented: Routine environmental rounds conducted jointly by the Administrator, Housekeeping, and Maintenance. Enhanced housekeeping procedures for odor management and cleaning of resident rooms and		07/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0584 SS = D	Continued from page 14 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to maintain a clean comfortable homelike environment for 1 of 3 residents (R4) reviewed for home like environment. Findings include: R4's admission Minimum Data Set (MDS) dated 6/4/26 was not completed as R4 was only at the facility for approximately 24 hours. R4's nursing progress note dated 6/4/25 at 5:55 p.m. R4 was admitted from the hospital via emergency medical services accompanied by family member (FM)-A. R4 required assistance of one staff member for mobility and daily care needs. R4 was nonverbal. A video uploaded date of 6/5/26 at 10:30 a.m. revealed R4's window with two black ants crawling along the windowsill. A facility grievance form dated 6/8/26 indicated the date of Incident: 6/4/2026. Specific Location Where Incident Occurred: Resident room, entrance. Incident Description: Resident admitted to facility 6/4/26. Family members had complaints alleging that there was no staff to greet them immediately upon arrival. They expressed concern that there was not an air conditioner (AC) unit in the room. They expressed that the resident often swung his legs out of bed, and it is enough force to cause him to fall out of bed. They were concerned that he would not be offered thicken fluids as often as he should be. They were concerned that the staff would not keep the head of his bed elevated. Family alleged that he was not served breakfast. They had had other miscellaneous complaints such as the paint chipping in the drawers, broken nightstand drawer, smell of bathroom, etc. Family alleged to the director of nursing (DON) that there were ants in the room and			F0584	Continued from page 14 shared bathrooms. Ongoing preventative maintenance inspections of resident room furnishings and equipment. Education was provided to Housekeeping regarding Deep Cleaning Responsibilities and promptly reporting maintenance concerns. Environmental audits will be completed, which include confirming deep cleans were completed up to facility standards and maintenance concerns addressed. In addition, every newly admitted resident room will be audited for completion of the Admission Room Readiness Checklist prior to occupancy. Audits will be completed weekly x4 then monthly x2. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. Administrator or Designee is the responsible party. Completion Date: 7/5/2026		07/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0584 SS = D	Continued from page 15 questioned mouse droppings in wardrobe drawer. Upon observation on 6/8/26 at 11:15 a.m. the room R4 was in had two beds and two bedside tables. The bed closest to the door had rust on the bed frame. The bedside table next to the bed R4 used had paint peeling in the top drawer. The bottom panel in the middle drawer was detached from one of the sides. The middle drawer also had visible stains and peeled paint. The bottom drawer did not have a bottom panel attached anymore. R4's wardrobe drawer was covered with small black dry flakes and chunks of irregular shapes and sizes, with the largest approximately 2 millimeters x 2 millimeters, they crumbled upon wiping a few with a Kleenex. There was no odor in the drawer. R4's bathroom, a shared bathroom with two male residents in the next room had a strong stale urine odor. The interior windowsill had dirt along the length of the windowsill. It appeared to be dirt as upon wiping a small area with a Kleenex the color was dark grey; it wiped away easily and left a clean surface underneath. Upon interview on 6/8/28 at 1:18 p.m. FM-A stated R4 was on hospice with only a short time of life remaining and the room he was admitted to was unlivable. She stated she saw ants crawling on the windowsill, the room was hot, but the staff brought a fan. She could not put R4's clothing items away in the drawers because the bedside table was broken, dirty, and had chipped paint. The wardrobe drawer was full of mouse droppings. The odor coming from the bathroom was so strong she kept the door shut however she still could not dismiss the odor. Due to no other option she had to leave R4 there overnight but had him discharged the following day due to her environmental concerns. She stated she had other care concerns, but she felt those could have been taken care of once the staff got to know R4. Upon observation and interview on 6/8/26 at 3:18 p.m. licensed practical nurse (LPN)-A the assistant director of nursing observed R4's where she witnessed the broken drawers, the peeled paint and debris in the drawers, rust on the bed frame, the dirty windowsills, and the odor. She stated she did receive a grievance from R4's family about the environment of the room and stated rooms are supposed to be checked prior to admission. Upon interview on 6/8/26 at 4:33 p.m. registered nurse (RN)-A, a hospice nurse stated she did not go			F0584			07/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0584 SS = D	Continued from page 16 into any of the drawers in R4's room so she did not have any knowledge of those conditions. She did notice the room was warm and there was a heavy urine odor permeating. Upon observation and interview on 6/9/26 at 9:15 a.m. the Administrator observed the bathroom and agreed there was a urine odor. Upon interview on 6/10/26 at 9:18 a.m. R9 the resident who had a shared bathroom with R4 stated he did not need to use the bathroom notice. He did notice an odor when his roommate used the bathroom or when the door was open. Upon interview on 6/10/26 at 9:25 a.m. R10 the resident who also shared the bathroom with R4 stated he did use the bathroom and noticed an increase in odor over the past weeks as the weather got hotter. Upon observation on 6/10/26 at 9:35 a.m. the bathroom had a lemon cleansing odor along with the stale urine odor. Upon observation and interview on 6/10/26 at 9:46 a.m. the Administrator agreed the urine odor still existed and stated the facility would need to use a deodorizer in the bathroom. A policy for safety and homelike environment was requested; however, none were provided.			F0584			07/05/2026
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or			F0656	F656 s/s D: - The process for satisfying this requirement has been reviewed and revised as needed to ensure residents who require 1:1 staff supervision with specific interventions are care planned appropriately. -All residents in the facility who require 1:1 staff supervision with specific interventions have the potential to be affected if this requirement is not met. - R1's plan of care was immediately reviewed and revised by the interdisciplinary team to include		07/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0656 SS = D	Continued from page 17 maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to develop the care plan for 1 of 1 resident (R1) review for care plan. R1 was placed on 1:1 staff supervision with specific interventions that were not on added to his care plan. Findings include: R1's admission Minimum Data Set (MDS) dated 3/12/26 indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 14 indicating R1 was cognitively intact. R1 did not exhibit any behaviors and did not refuse cares. R1 used a walker and/or a cane for ambulation. He was independent with			F0656	Continued from page 17 appropriate interventions. - Review completed to ensure R1 had appropriate interventions regarding increased supervision in both the nursing orders and CNA care tasks prior to onsite review. - R1 has since been discharged from the facility. -The plan of care for all residents who require 1:1 staff supervision with specific interventions was reviewed and revised as needed to ensure compliance and are appropriately followed. This is isolated and no other residents have been on 1:1's nor does anyone else fit these criteria. -Necessary VAO staff have received education on care planning 1:1 staff supervision with specific interventions utilizing Monarch Healthcare policy and procedure. -Compliance and monitoring to ensure 1:1 staff supervision with specific interventions is care planned will be completed via audits three (3) times per week for two (2) weeks; two (2) times per week for two (2) weeks; weekly for two (2) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI, with any deficient practice corrected at the time of occurrence. -Director of Nursing or designee is responsible party. -Corrective action will be completed on or before 7/5/26.		07/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0656 SS = D	Continued from page 18 eating, putting on and taking off footwear, personal hygiene, rolling in bed, sitting to lying and lying to sitting. He required set-up assistance with sitting to standing, dressing and toileting. R1's pertinent diagnoses were metabolic encephalopathy (the brain does not function normally because of a medical condition), hypokalemia (low potassium levels), alcohol dependence, nicotine dependence, personality disorder and altered mental status. R1's care plan dated 6/9/26 indicated R1 was At risk for alteration in mood and behavior r/t dx including Metabolic Encephalopathy, Alcohol Dependence, Depression, Personality Disorder Unspecified. Behaviors: -resident, at times, prefers to eat meals in his room. -like to take longer naps. -history of refusing care. -frequently ruminates on leaving the facility -mood disturbance is characterized by irritability and agitation consistent with his personality d/o and depression symptoms. -occasional verbal outburst -potential for physical aggression. -denial of his current health condition and need for a structured facility. Staff was encouraged to use a patient-centered, non-confrontational approach, collaborative language, validation of the resident's perspective, participation in decision-making, and reinforcement of his progress toward independence. R1's interventions were:			F0656			07/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0656 SS = D	Continued from page 19 MDS section D/PHQ 9 (depression screening) will be conducted per regulation and PRN. Monitor and document mood state/behaviors upon occurrence. Praise positive behaviors [All] Approach in a calm manner and provide resident with choices as appropriate Redirect as needed (prn). If resident becomes anxious, remove from crowded area. utilization of social supports. Staff to visit with resident one on one during cares and prn. Provide emotional support, validation, and comfort measures prn. Monitor Target Behaviors per protocol. PSYCHOSOCIAL WELL-BEING CARE PLAN: Alteration in psychosocial well-being r/t adjustment to placement and current health condition. Resident is Native American, Red Lake Nation. The resident has a supportive and involved family; the guardian recommended an ALF closer to the family. The resident has a strong desire for independence. Autonomy is a central value and motivating factor in recovery. Emphasize autonomy by offering choice whenever possible (e.g., scheduling daily activities and aspects of care) to promote a sense of control. Will monitor safety concerns and evaluate PRN: smoking, elopement, suicide risk Introduce resident to staff and residents. Encourage resident to attend activities of interest for socialization and enjoyment. Will provide 1:1 visits to encourage verbalization of feelings, offering support and reassurance, PRN.			F0656			07/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0656 SS = D	Continued from page 20 Will invite resident and family to care conferences quarterly. Will monitor and respond to unmet needs Encourage utilization of social supports. Will monitor mood state, refer PRN Will monitor adjustment and relationship issues in facility R1's care plan did not indicate R1 was receiving around the clock 1:1 staff supervision or specific interventions regarding the supervision. A facility investigation report dated 5/29/26 indicated 1:1 staff supervision was initiated on R1 upon the Administrator receipt of the police report. The intradisciplinary team (IDT) would re-assess and titrate. On interview on 6/10/25 at 3:38 p.m. the director of nursing (DON) stated after R1's first physical and verbal altercation he was placed on 15-minute staff checks for 24 hours, then 30 minute checks for 24 hours and finally hourly checks for 24 hours. When R1 had his second altercation he was placed on 1:1 staff supervision around the clock. R1 was upset with the supervision, so staff was to sit outside of his door and go with him wherever he went throughout the facility and outside. A facility policy regarding care planning was not obtained.			F0656			07/05/2026

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/8/26 – 6/10/26, 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(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed with no licensing orders issued.			20000			07/06/2026

Office of Primary Care and Health Systems Management

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
20000	Continued from page 1 H56292761C/ MN260461056, H56292845C / MN3027625, & H56292844C / MN3015078 The following complaints were reviewed. H56292789C / MN3034870 with a licensing order issued at (ST21665) 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. 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.			20000			07/06/2026
21665	Physical Environment CFR(s): MN Rule 4658.1400			21665	R4 was discharged from the facility. Housekeeping performed a thorough deep cleaning		07/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
21665	Continued from page 2 A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to maintain a clean comfortable homelike environment for 1 of 3 residents (R4) reviewed for home like environment. Findings include: R4's admission Minimum Data Set (MDS) dated 6/4/26 was not completed as R4 was only at the facility for approximately 24 hours. R4's nursing progress note dated 6/4/25 at 5:55 p.m. R4 was admitted from the hospital via emergency medical services accompanied by family member (FM)-A. R4 required assistance of one staff member for mobility and daily care needs. R4 was nonverbal. A video uploaded date of 6/5/26 at 10:30 a.m. revealed R4's window with two black ants crawling along the windowsill. A facility grievance form dated 6/8/26 indicated the date of Incident: 6/4/2026. Specific Location Where Incident Occurred: Resident room, entrance. Incident Description: Resident admitted to facility 6/4/26. Family members had complaints alleging that there was no staff to greet them immediately upon arrival. They expressed concern that there was not an air conditioner (AC) unit in the room. They expressed that the resident often swung his legs out of bed, and it is enough force to cause him to fall out of bed. They were concerned that he would not be offered thicken fluids as often as he should be. They were concerned that the staff would not keep the head of his bed elevated. Family alleged that he was not served breakfast. They had had other miscellaneous complaints such as the paint chipping in the drawers, broken nightstand drawer, smell of bathroom, etc. Family alleged to the director of nursing (DON) that there were ants in the room and questioned mouse droppings in wardrobe drawer.			21665	Continued from page 2 of this resident room, including the windowsill, furniture, wardrobe, and bathroom. Maintenance repaired or removed damaged furnishings, including the bedside table and rusted bed frame, and addressed chipped and peeling surfaces. The bathroom received enhanced cleaning and odor treatment. Pest control was informed of ants being seen on windowsill, without evidence of ants inside the facility while onsite. All residents have the potential to be affected if this requirement is not met. Resident rooms were audited to identify damaged furniture, peeling surfaces, cleanliness concerns, persistent odors, and evidence of pest activity. Any concerns were documented for Maintenance prompt follow-up. The facility implemented a standardized Admission Room Readiness Checklist requiring inspection of each room prior to resident admission. The checklist must be completed by the Admissions Coordinator or designee with any area(s) of opportunity immediately addressed by the appropriate department. The facility also implemented: Routine environmental rounds conducted jointly by the Administrator, Housekeeping, and Maintenance. Enhanced housekeeping procedures for odor management and cleaning of resident rooms and shared bathrooms. Ongoing preventative maintenance inspections of resident room furnishings and equipment. Education was provided to Housekeeping regarding Deep Cleaning Responsibilities and promptly reporting maintenance concerns. Environmental audits will be completed, which include confirming deep cleans were completed up to facility standards and maintenance concerns addressed. In addition, every newly admitted resident		07/05/2026

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
21665	Continued from page 3 Upon observation on 6/8/26 at 11:15 a.m. the room R4 was in had two beds and two bedside tables. The bed closest to the door had rust on the bed frame. The bedside table next to the bed R4 used had paint peeling in the top drawer. The bottom panel in the middle drawer was detached from one of the sides. The middle drawer also had visible stains and peeled paint. The bottom drawer did not have a bottom panel attached anymore. R4's wardrobe drawer was covered with small black dry flakes and chunks of irregular shapes and sizes, with the largest approximately 2 millimeters x 2 millimeters, they crumbled upon wiping a few with a Kleenex. There was no odor in the drawer. R4's bathroom, a shared bathroom with two male residents in the next room had a strong stale urine odor. The interior windowsill had dirt along the length of the windowsill. It appeared to be dirt as upon wiping a small area with a Kleenex the color was dark grey; it wiped away easily and left a clean surface underneath. Upon interview on 6/8/28 at 1:18 p.m. FM-A stated R4 was on hospice with only a short time of life remaining and the room he was admitted to was unlivable. She stated she saw ants crawling on the windowsill, the room was hot, but the staff brought a fan. She could not put R4's clothing items away in the drawers because the bedside table was broken, dirty, and had chipped paint. The wardrobe drawer was full of mouse droppings. The odor coming from the bathroom was so strong she kept the door shut however she still could not dismiss the odor. Due to no other option she had to leave R4 there overnight but had him discharged the following day due to her environmental concerns. She stated she had other care concerns, but she felt those could have been taken care of once the staff got to know R4. Upon observation and interview on 6/8/26 at 3:18 p.m. licensed practical nurse (LPN)-A the assistant director of nursing observed R4's where she witnessed the broken drawers, the peeled paint and debris in the drawers, rust on the bed frame, the dirty windowsills, and the odor. She stated she did receive a grievance from R4's family about the environment of the room and stated rooms are supposed to be checked prior to admission. Upon interview on 6/8/26 at 4:33 p.m. registered nurse (RN)-A, a hospice nurse stated she did not go into any of the drawers in R4's room so she did not have any knowledge of those conditions. She did notice the room was warm and there was a heavy			21665	Continued from page 3 room will be audited for completion of the Admission Room Readiness Checklist prior to occupancy. Audits will be completed weekly x4 then monthly x2. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. Administrator or Designee is the responsible party. Completion Date: 7/5/2026		07/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT OSSEO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 501 SECOND STREET SOUTHEAST , OSSEO, Minnesota, 55369			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
21665	Continued from page 4 urine odor permeating. Upon observation and interview on 6/9/26 at 9:15 a.m. the Administrator observed the bathroom and agreed there was a urine odor. Upon interview on 6/10/26 at 9:18 a.m. R9 the resident who had a shared bathroom with R4 stated he did not need to use the bathroom notice. He did notice an odor when his roommate used the bathroom or when the door was open. Upon interview on 6/10/26 at 9:25 a.m. R10 the resident who also shared the bathroom with R4 stated he did use the bathroom and noticed an increase in odor over the past weeks as the weather got hotter. Upon observation on 6/10/26 at 9:35 a.m. the bathroom had a lemon cleansing odor along with the stale urine odor. Upon observation and interview on 6/10/26 at 9:46 a.m. the Administrator agreed the urine odor still existed and stated the facility would need to use a deodorizer in the bathroom. A policy for safety and homelike environment was requested; however, none were provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.			21665			07/05/2026