STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245629	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at Osseo LLC	501 Second Street Southeast Osseo, MN 55369

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43080 Based on observation, interview, and document review, the facility failed to ensure medications were administered in accordance with physician orders for 10 of 10 residents (R2, R5, R7, R10, R11, R13, R16, R19, R20, R21) who were provided medications outside of ordered parameters by three staff on three separate units. Findings include: Resident Medication Admin Audit Reports identified the following medication order information for [DATE]: -R7: 8:00 a.m. - metformin twice day (BID) with meals for diabetes (DM), metoprolol (cardiac), lorazepam (antianxiety) three times a day (TID), two antipsychotic medications for schizophrenia (haloperidol lactate and quetiapine fumarate), and two bowel medications. -R11: 8:00 a.m. - Lasix and Aldactone for edema, aspirin for stroke prevention, Breo Ellipta inhaler for COPD (Chronic obstructive pulmonary disease)(chronic inflammatory lung disease that causes obstructed airflow from the lungs) and a bowel medication. -R13: 8:00 a.m. - vilazodone with a meal for schizoaffective disorder, metformin with meals BID for DM, glipizide for DM, gabapentin TID for pain, baclofen four times a day (QID) for spasms, Linzess in the morning for irritable bowel syndrome with constipation, cholecalciferol in the morning for vitamin D deficiency, Abilify for schizoaffective disorder, magnesium oxide for low magnesium, Flovent inhaler for COPD, two eye drops for glaucoma, and two bowel medications. -R16: 8:00 a.m. - oxybutynin for bladder, multivitamin, a bowel medication, and a supplement. -R20: 8:00 a.m. - desvenlafaxine in the morning for depression, ferrous sulfate in the morning on even days, Steglatro in the morning for DM, oxybutynin for her bladder, acetaminophen and gabapentin TID for chronic pain, alprazolam for obsessive compulsive disorder and generalized anxiety disorder, Eliquis for clot prevention, and a bowel medication. (continued on next page)

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

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-R21: 8:00 a.m. - spironolactone in the morning for edema, bisacodyl, silodosin, folic acid, and thiamine in the morning, Xarelto for clot prevention, famotidine for Gastroesophageal reflux disease (GERD)(occurs when stomach acid repeatedly flows back into the tube connecting your mouth and stomach), gabapentin TID for pain, an antibiotic for wound infection, quetiapine fumarate TID for psychotic disorder with delusions, and three bowel medications. -R10: 8:00 a.m. - Breo Ellipta inhaler once a day (QD) for asthma and a saline nasal spray for dry nose. -R10: 9:00 a.m. - loratadine in the morning for allergies, vitamin D3 in the morning, Ampyra and Tecfidera delayed release for multiple sclerosis, fluoxetine for depression, aripiprazole for schizoaffective, baclofen TID for spasticity, and a cranberry tablet for bladder infection prevention. -R2: 12:00 p.m. - Darolutamide (antineoplastic) with food and gabapentin (antiseizure) QID for neuropathic pain. -R5: 12:00 p.m. - furosemide (diuretic) 20 mg BID with breakfast and lunch, morphine sulfate 0.25 ml QID for pain or dyspnea, and a medication for cough/secretions. -R19: 12:00 p.m. - methocarbamol QID for muscle spasms. During an interview on [DATE] at 2:42 p.m., R11 stated her medications were provided to her up to two hours late at times. This occurred more in the evening, but also during the day. She was most concerned about the timing of her Ativan (antianxiety) especially as this kept her calm and she counted on that. A Resident Medication Admin Audit Report identified on [DATE], R11's 6:00 a.m. Ativan was administered at 7:23 a.m., and her 12:00 p.m. Ativan was administered at 1:27 p.m. During an interview on [DATE] at 3:21 p.m., R10 stated there were times her medications were provided hours after she expected them which happened more then she thought it should. This occurred during the day and/or the evening shifts. She communicated these concerns to staff and stated, Everyone knows it is an issue. On [DATE] at 9:33 a.m., licensed practical nurse (LPN)-D stood by a mobile medication cart on the first floor next to the nurse's station. The electronic medication administration record's (eMAR) main screen was open and identified red colored resident specific rectangular boxes. LPN-D identified the boxes indicated past due medications. The eMAR identified seven residents were past due for their morning medication(s). The following events occurred: -From 9:35 a.m. to 9:40 a.m., LPN-D prepared and administered insulin to a resident. See F760. -At 9:43 a.m., the eMAR identified all R16's 8:00 a.m. medications were past due. LPN-D started to prepare; however, was unable to locate the oxybutynin. Due to this, he did not administer R16 the medications at that time and proceeded onto the next resident. -From 9:51 a.m. to 10:00 a.m., LPN-D prepared and administered insulin to a resident. See F760. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 10:16 a.m., LPN-C, the second-floor nurse, was asked to display her eMAR screen. The screen identified R7 and R21's 8:00 a.m. oral medications were past due. LPN-C explained R7 informed her he was not ready for them when she initially approached him earlier that morning. He wished to sleep longer. She reapproached him once without success and she planned to reapproach him again in approximately another half hour. LPN-C stated R21 declined her morning medications until she was up for the day, at which time she would take them. R21 typically got up around 11:30 a.m. LPN-C explained she was expected to follow the five rights of medication administration and was allowed one hour or one hour after the scheduled time before a medication was considered late; however, she was also expected to follow the doctor order. If a medication was directed to be given in the morning, which meant from 8:00 a.m. to 10:00 a.m., and was past due, her actions depended on the frequency of administration. If a medication was declined, and scheduled for more than once a day, she was expected to call the doctor for an update and additional direction. She denied R7 or R21's provider was updated as the morning was very busy, and she sent a resident to the hospital emergently. A Resident Medication Admin Audit Reports identified LPN-D provided R10 with her 8:00 a.m. and 9:00 a.m. medications on [DATE], between 10:17 a.m. and 10:20 a.m. A Resident Medication Admin Audit Reports identified LPN-D provided R16 with his 8:00 a.m. medications on [DATE] between 10:23 a.m. and 10:24 a.m. On [DATE] at 10:26 a.m., the eMAR identified all R13's 8:00 a.m. medications were past due. During the prep, the Linzess and Flovent were unable to be found and the brimonidine tartrate eye drop was expired. At 10:46 a.m., LPN-D completed the medication prep and approached R13's room. The door was closed, and staff provided her cares. LPN-D went back to the cart and waited. The following events occurred: -At 10:50 a.m., LPN-D was interviewed while he waited. He stated he was super behind as he was the only nurse on that unit for 25 residents. He denied prior past due medication administrations. There were a lot of tasks to complete, and he was expected to administer medications within 30 minutes in either direction of the administration directed time. He was expected to follow the five rights of medication administration, in which one of them was the right time. Depending on the medication's classification, there were potential risks of past due administration, and thus he was expected to update the manager in these situations. He denied such an update and stated, It is obvious I am behind .someone should know. [Numerous times during the observed medication pass, the unit manager (LPN-A), the director of nursing (DON), and the administrator, walked past LPN-D.] He identified risk factors such as increased pain, drug interactions, decreased absorption, and/or gastrointestinal upset. -At 10:58 a.m., LPN-D reapproached R13's room. Cares continued and he walked back to the cart. -At 11:03 a.m., as LPN-D walked toward R13's room, he walked past R11, who sat in her doorway. She asked about her medications. He informed her he was late, but he would return to her soon and continued to R13's room. He informed R13 he was late when he approached her and administered the medications at 11:03 a.m. He updated her as soon as the ordered eye drop came in, he would administer it. The Linzess and the Flovent were not administered or discussed with her. R11 was not interviewed after as she started to cry and sob. LPN-D stated she just lost a close friend and at times she would display such symptoms with new people. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-At 11:09 a.m., the eMAR identified R11's 8:00 a.m. medications were past due. As LPN-D prepared the medications, R11 sat in her wheelchair by the cart. She stated she needed to go back to her room as she need[ed] to breath. Her respirations were observed to be more rapid, and she was with furrowed brows. The DON, who sat at the nurse's station, brought R11 back to her room. Upon his return, he stated her oxygen saturation was 93 percent and her respirations were 20. In addition, he stated R11 had COPD and her orders were to keep saturations above 88 percent. When in the vicinity, the DON was not updated on the morning's medication pass status. LPN-D was unable to locate the Breo Ellipta despite an extensive search of the cart. -At 11:16 a.m., LPN-D approached R11 who sat in her doorway with oxygen on. She stated she needed a nebulizer as she [was] fighting to breath. She was observed without signs/symptoms of respiratory distress. She asked LPN-D what the medications were that he handed her as they were not the medications she was supposed to get at that time. Once informed they were her 8:00 a.m. meds. She stated, No wonder I am so confused, and injected the medications at 11:17 a.m. R11 was not administered the Breo Ellipta inhaler. As needed (PRN) Ipratropium-Albuterol inhaler was administered at 11:19 a.m. -At 11:26 a.m., the eMAR identified R20's 8:00 a.m. scheduled medications were past due. See F760 for insulin details. LPN-D explained, when he approached R20 earlier that morning, she declined her medications, and since then lacked the time to reapproach her. As he prepared R20's medications, R20 approached the cart. Once prepped, he administered the medications. -Around 12:39 p.m., LPN-D stated a past due medication was anything administered one hour past the eMAR scheduled time. In these situations, he was expected to contact the provider, and/or the unit manager, and follow any provided order directions. He denied he completed these updates, and he stated, The moment I sit down and have some time I will call the provider and update them. Progress notes for R10, R11, R13, R16, and R20 lacked evidence LPN-D communicated with the provider prior to administration of the past due medications for additional orders, or that R11 and R13 had omitted medications. During observation on [DATE] at 1:02 p.m., LPN-C was approached. The eMAR screen identified R2 and R5's 12:00 p.m. medications were past due. She stated she was supposed to have already given R2 his medications; however, another resident required her attention and R5 wanted to wait for lunch before she took her medication. LPN-C was unsure if, or when, R5 ate lunch. She denied she updated the unit manager or the provider. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview on [DATE] at 1:34 p.m., LPN-A stated she expected timely administration as ordered, and/or setup, which meant within one hour before or one hour after the scheduled eMAR time frame. If it was outside of this hour, she expected staff obtained assistance and updated the provider if the past due medication centered around certain medication classes, such as antiseizure, cardiac, warfarin (anticoagulant), due to risks of something bad could happen, or the resident could experience upset stomach, irritable belly issues, or decreased absorption if not given with meals. In addition, she expressed concerns centered around one dose being too close to the next which increased the relevance of provider contact. Challenges with the first-floor med passes were known due to staffing changes that occurred a few weeks ago, and the floor being very heavy in nurse workload. She denied participation in any recent med pass audits. LPN-A updated R20's provider after LPN-D updated her; however, denied knowledge of any additional concerns that morning. Once the morning observations were discussed, she exclaimed, Oh my gosh! That is a lot. I think we need to look at this med pass. She expected the provider to be updated in all the situations due to potential concerns expressed earlier and considered all these situations medication errors due to omission and timeliness. She explained when staff became aware of resident preferences, such as R20's wake time, she expected provider updates to assist with potential med adjustments to accommodate. When interviewed on [DATE] at 4:25 p.m., the DON stated he expected medications to be administered as ordered. The typical one hour before or one hour after administration window applied to most medications; however, anything outside of this and a specific scheduled range (i.e., with meals, before meals, etc.) was considered late, and thus a medication error, and he expected the provider, the unit manager, and himself to be updated right away. In addition, he explained staff were expected to update the provider when they became aware of resident preferences and/or compliance with any medication to adjust the plan of care as there were risks that potentially led to BS spikes, DM complications, and/or hospitalization . The DON identified LPN-D failed to update him that morning of concerns; however, he was updated after the fact. All residents identified were discussed. The DON was unaware of the degree of lateness and stated the provider was expected to be updated and monitoring set up for potential concerns when applicable based on the medication. During interview on [DATE] at 11:10 a.m., LPN-E stated she was expected to follow the five rights of medication administration which included the right time and medications were able to be administered one hour before or one hour after the eMAR scheduled time. If unable to be followed, she was to update the supervisor, and the provider, due to potential impact(s). LPN-E was questioned on past due medication concerns. She explained R19 was in therapy when her medication was due and thus, she planned to administer it after therapy was completed. She identified she did not update the supervisor or the provider. LPN-E reviewed R19's administration details and stated R19's [DATE] 12:00 p.m. medication was administered at 1:53 p.m. During interview on [DATE] at 1:20 p.m., nurse practitioner (NP)-A stated she expected staff followed medication orders to a T. If there were situations that impacted such, she expected to be updated to review for potential medication and/or medication time adjustments. She stated she was not updated yesterday morning about the identified residents; however, staff have since updated her and she worked with staff on potential adjustments. These resident's [DATE] administration observations were discussed. NP-A expressed minimal concerns related to the administration timing. Her concerns revolved more around staff's lack of provider updates. She explained, based on her current knowledge, these residents were free of any adverse impacts related to the events on [DATE]. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	When interviewed on [DATE] at 3:49 p.m., consulting pharmacist (CP) stated she expected medications to be administered as ordered especially as medications ordered to be given with meals was best practice for absorption or gastrointestinal tolerance. Prior to yesterday, CP was unaware of any med pass concerns. She indicated a medication pass audit was completed last summer; however, none since that she was aware of. Discussed involved resident concerns and she expressed some of the situations were not ideal and there were some minimal concerns related to potential impacts; however, she was unaware of any adverse effects experienced by these residents and did not feel these were detrimental to these residents' health or clinically significant. Despite this, she expected these residents' providers to be updated when the administration became past due. A Medication Administration - General Guidelines policy, dated ,d+[DATE], directed medications were to be administered 60 minutes of scheduled times, except before, with or after meal orders, which were administered based on mealtimes.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 43080 Based on observation, interview and document review, the facility failed to ensure insulin (blood sugar regulator) medication was administered in accordance with physician orders for 4 of 4 residents (R9, R15, R18, R20) who were provided insulin outside of ordered parameters and manufacturer recommendations by two staff on two separate units. Findings include: Resident Medication Admin Audit Reports identified the following provider insulin and blood sugar (BS) orders and scheduled time frames for 4/2/24: -R9: Novolog per sliding scale, based on corresponding ordered BS readings, before meals and at bedtime (HS) for diabetes mellitus (DM). The lunchtime Novolog was scheduled for 11:30 a.m. and supper scheduled at 5:30 p.m. -R15: Lispro per sliding scale, based on BS Dexcom 7 (continuous glucose monitoring system) readings, with meals for DM. The morning Lispro was scheduled for 7:30 a.m. with lunch scheduled at 12:30 p.m. -R18: 1. Humalog per sliding scale, based on Libre BS sensor device readings, three times a day (TID) for DM with first dose scheduled for 7:00 a.m. and second dose at 11:00 a.m. 2. Humalog 10 units TID due to DM with first dose scheduled at 7:30 a.m. and second dose at 11:30 a.m. 3. Lantus 66 units in the morning due to DM scheduled for 8:00 a.m. -R20: Humalog 10 units TID due to DM. First dose scheduled for 7:30 a.m. and second dose scheduled for 11:30 p.m. Blood sugars four times a day (QID) with scheduling at 8:00 a.m. and 12:00 p.m. A Lispro/Humalog manufacturer Patient Information fact sheet, dated 07/2023, directed to take the insulin exactly as directed by the healthcare provider. Lispro was a fast-acting insulin which was to be injected within 15 minutes before or right after the meal was started. A NovoLog manufacturer Drug Information insert, dated 2/2023, directed to take the insulin exactly as directed by the healthcare provider. NovoLog was a fast-acting insulin which was to be injected within 5 to 10 minutes before a meal. A Lantus manufacturer Drug Information insert, dated 6/2023, directed to take the insulin exactly as directed by the healthcare provider. Lantus was a long-acting insulin (remained in the body for extended periods of time) and directed to administer the insulin at the same time every day. On 4/2/24 at 9:33 a.m., licensed practical nurse (LPN)-D stood by a mobile medication cart on the first floor. The electronic medication administration record's (eMAR) main screen was open and identified red colored resident specific rectangular boxes. LPN-D identified the boxes indicated past due medications. The eMAR identified seven residents were past due for their morning medication(s). LPN-D denied any of the past due medications were insulin(s). The following events occurred: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 9:35 a.m., LPN-D clicked on R15's red box. Insulin was identified as a past due medication. He explained R15 had yet to eat when he first reviewed the eMAR earlier that morning, and stated, I should be doing it right now. He started to prepare the Lispro insulin and indicated R15's blood sugar (BS) was 188 at 7:45 a. m. Per R15's sliding scale order, he dialed up 8 units. He entered R15's room, explained to her he had her insulin, and administered the insulin at 9:40 a.m. (approximately 2 hours after the BS check). LPN-D did not question R15 on her breakfast intake status, nor did he recheck her BS. R15's room lacked evidence of a breakfast tray or used dishes; however, there was a full glass of darker colored liquid on her bed side tray table. Before leaving R15's room, the surveyor questioned R15 on her breakfast status. She stated she did not eat solid food for breakfast and only drank juice. She was unable to identify exactly when she drank her breakfast juice or how much she consumed. She explained she typically was administered her insulin between 8:00 a.m. and 9:00 a.m. depending on when I get my food. -At 9:51 a.m., LPN-D reviewed R18's eMAR and stated she needed her morning insulin. He indicated R18's BS around 7:45 a.m. was 271 and explained the insulin administration was late as R18's breakfast was not yet delivered at 7:45 a.m., and he became too busy to follow-up on R18's breakfast status. Based on her scheduled and sliding scale Humalog insulin, and scheduled Lantus, he prepared 18 units of Humalog and 66 units of Lantus. He entered R15's room, explained he had her insulin, and administered both insulins at 10:00 a.m. (approximately 2 hours after the BS check). LPN-D did not question R15 on her breakfast intake status, nor did he recheck her BS. A covered food tray was located on R15's tray table and a covered plate was located on a surface just inside her door. Both plates contained untouched breakfast foods. Immediately after LPN-D exited the room, R15 was interviewed. She stated she did not like the main breakfast and requested an alternative (the plate by the door). She had yet to eat; however, she identified she ate some oatmeal around 8:45 [a.m.] or so, which she enjoyed each morning. This typically was not enough to carry her over until lunch and thus she also ate the provided breakfast. She was unsure when she would get to the meal in her room as there were other tasks she wished to do first. R15 stated typically she received her morning insulin between 8:30 a.m. and 8:45 a.m., however, there were times when the insulin was late. She explained 10:00 a.m. was very late. She stated her BS's were typically higher in the morning but when she received late insulin .it messes up the time frame with my lunch time insulin and my [BS] numbers. If I get [the insulin] consistently then my numbers seem to be a little bit better. Despite this, she denied signs and/or symptoms of hypo/hyperglycemia (low/high BS) but commented that because she received her insulin late, and she was going to eat her breakfast late, her noon BS was going to be high. -Between R15's insulin administration at 10:00 a.m., until 10:50 a.m., LPN-D continued to prepare and administer oral medications to the residents identified as past due. -At 10:50 a.m., LPN-D was interviewed while he waited for staff to exit a resident's room that required prepped oral medications. He stated he was super behind as he was the only nurse on that unit, and he was responsible for 25 residents. He denied prior past due insulin administrations. He explained there were a lot of BS and insulin orders, and he was expected to administer the insulin within 30 minutes in either direction of the administration directed time. In addition, he was expected to follow the five rights of medication administration, in which one of them was the right time. He stated, if an insulin was administered past the expected time, there was a risk of hypo/hyperglycemia and thus he was also expected to update the manager in these situations. He denied such an update and stated, It is obvious I am behind .someone should know. [Numerous times during the observed medication pass, the unit manager (LPN-A), the director of nursing (DON), and the administrator, walked past LPN-D.] (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Between 11:03 a.m., until 11:26 a.m., LPN-D continued to prepare and administer oral medications to the residents identified as past due. -At 11:26 a.m., the eMAR identified R20's 7:30 a.m. scheduled Humalog insulin, and 8:00 a.m. BS, along with her 8:00 a.m. oral medications, were past due. LPN-D explained, when he approached R20 earlier this morning, she declined her BS check, along with her medications, and since then lacked the time to reapproach her. As he prepared R20's medications, R20 approached the cart. Medications were administered, and BS at 11:41 a.m. was 145. He instructed R20 to return to her room and he would bring her insulin to her. He did not question R20 on her breakfast or lunch intake status. R20 wheeled herself toward her room. LPN-D initially was unable to locate the insulin. At 11:55 a.m., he returned to the cart with the insulin and prepared it. At 11:58 a.m., he entered R20's room; however, she was in the bathroom, and he exited her room without conversing with her. At 12:08 p.m., 12:16 p.m., and 12:20 p.m., she continued to be in the bathroom and LPN-D did not converse with her. At 12:39 p.m., R20 was administered the Humalog. LPN-D documented the administered insulin for the 11:30 a.m.'s scheduled insulin timeframe and explained he did not want to give R20 double. He explained, because of this, R20's morning insulin was omitted. LPN-D stated a past due medication, which included insulin, was anything administered one hour past the eMAR scheduled time. In these situations, he was expected to contact the provider, and/or the unit manager, and follow any provided order directions. He denied he completed these updates, and he stated, The moment I sit down and have some time I will call the provider and update them. Progress notes for R9, R15, R18, and R20 lacked evidence LPN-D communicated with the provider prior to administration of the past due insulin for additional orders, or that R20's morning insulin was omitted. During interview on 4/2/24 at 1:34 p.m., LPN-A stated she expected medications were administered timely as ordered, and/or setup, which meant within one hour before or one hour after the scheduled eMAR time frame. If outside of this, she expected staff obtained assistance, rechecked BSs closer to the time of administration, and updated the provider if the past due medication centered around certain medication classes, such as insulin, due to the risk of hypo/hyperglycemia that potentially led to dangerous BS levels. In addition, she expressed concerns centered around one dose of insulin too close to the next that increased the relevance of provider contact. Challenges with the first-floor med passes were known due to staffing changes that occurred a few weeks ago and the floor being very heavy in nurse workload. She denied participation in any recent med pass audits. LPN-A updated R20's provider after LPN-D updated her on R20's insulin administration; however, denied knowledge of any additional specific medication concerns that morning. Once the mornings observations were discussed, she exclaimed, Oh my gosh! That is a lot. I think we need to look at this med pass. She expected the provider to be updated in all three insulin situations due to potential concerns expressed earlier and considered all these situations medication errors due to omission and timeliness. In addition, she explained R15 preferred oatmeal and juice for breakfast versus a full breakfast and R20 was not always cooperative with her insulin orders. Based on this knowledge, the provider was expected to be updated on their preferences and insulin compliance to assist with potential med adjustments when staff became aware of such details. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245629	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at Osseo LLC	501 Second Street Southeast Osseo, MN 55369

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When interviewed on 4/2/24 at 4:25 p.m., the DON stated he expected insulin to be administered as ordered. The typical one hour before or one hour after administration window did not apply to insulin as this was a very serious medication. Anything outside of the scheduled range (i.e., with meals, before meals, etc.) was considered late, and thus a medication error, and he expected the provider, the unit manager, and himself to be updated right away. In addition, he explained staff were expected to update the provider when they became aware of resident preferences and/or compliance with any medication to adjust the plan of care as there were risks that potentially led to BS spikes, DM complications, and/or hospitalization . The DON identified LPN-D failed to update him that morning of concerns; however, he was updated after the fact. R15, R18, and R20 insulin administration was discussed. The DON was unaware of the degree of lateness and stated in all three instances the provider was expected to be updated and monitoring set up for potential concerns, especially for R18 as both the morning and noon doses could act together and decrease her BS significantly. During interview on 4/3/24 at 11:10 a.m., LPN-E stated she was expected to follow the five rights of medication administration which included the right time and medications were able to be administered one hour before or one hour after the eMAR scheduled time. If this was unable to be followed, she was to update the supervisor, and the provider, due to potential impact(s). LPN-E was questioned on past due medication concerns. She explained R9 was scheduled at 11:30 a.m. for sliding scale Novolog based on his 11:34 a.m. BS of 174. At 1:54 p.m. (approximately 2.5 hours after BS), R9's Novolog was administered. LPN-E explained R9 was in therapy when the insulin was due and thus, she planned to administer it after therapy was completed, and he had eaten, as it was better to administer insulin when food is around. She felt R9 ate lunch but did not confirm when he ate or how much he ate prior to administering the insulin. She denied she performed a follow-up BS before 1:54 p.m. and identified she did not update the supervisor, the provider, or the ongoing nurse during shift change. LPN-E reviewed R9's evening insulin administration and BS. His BS at 5:13 p.m. was 139 and at 5:22 p.m. he was administered 2 units of Humalog. This timing concerned her a little bit as it was a little bit close and could potentially result in his BS going low. When interviewed on 4/3/24 at 11:45 a.m., registered nurse (RN)-A stated, as the unit manager, she expected staff followed insulin orders especially when insulin was expected to be administered with food. She was unaware on 4/2/24 of any late insulin administration from 4/2/24; however, she discovered potential concern when she ran a report this morning. She had yet to speak with the involved nurse and continued to investigate this. She expected if such events' occurred staff were to contact her or the provider right away due to concerns with hypoglycemia especially if one insulin dose was administered too close to another. During interview on 4/3/24 at 1:20 p.m., nurse practitioner (NP)-A stated she expected staff followed medication orders to a T, which included insulin. She explained insulin was usually ordered to be administered prior to meals and thus was expected to be administered at such times, or at least when they were provided their meal. If there were situations that impacted such, she expected to be updated to review for potential medication and/or medication time adjustments. Related to R9, R15, R18, and R20, she stated she was not updated yesterday morning about their insulin; however, staff have since updated her and she worked with staff on potential adjustments. These resident's 4/2/24 insulin administration observations were discussed. NP-A expressed minimal concerns related to the administration timing and R20's morning omission. Her concerns revolved more around staff's lack of provider updates. She explained, based on her current knowledge, these residents were free of any adverse impacts related to the events on 4/2/24. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When interviewed on 4/3/24 at 3:49 p.m., consulting pharmacist (CP) stated standard insulin administration processes were expected to have a BS check and insulin administration within approximately 15 minutes, or as close to the meal as possible: They are usually done together, but could be administered up to 30 minutes on either end of the meal. This helped to regulate the BS in relation to the meal, thus, staff would need to know when the resident last ate if the resident was provided insulin after the meal. If such processes were unable to be completed, she expected staff to update the provider to assist in BS management. If an insulin were scheduled with a meal and the meal were to be delayed, clinically and practically, the insulin would also be delayed reflecting the meal timing. Depending on how delayed, and based on when the BS was checked, a recheck of the BS would potentially be required to appropriately dose the sliding scale units. Fast acting insulin provided too close to each other was concerning; however, ensuring food was provided with the insulin was more prominent due to the risk of hypoglycemia and/or the resident's medical status and history. Prior to yesterday, CP was unaware of any med pass concerns. She indicated a medication pass audit was completed last summer; however, none since that she was aware of. R9, R15, R18, and R20's insulin observations were discussed. She expressed these were not ideal situations and there were some minimal concerns related to potential hypoglycemia; however, she was unaware of any adverse effects experienced by these residents and did not feel these were detrimental to these residents' health or clinically significant. Despite this, she expected these residents' providers to be updated when the administration became past due. A Medication Administration - General Guidelines policy, dated 4/2018, directed medications were to be administered 60 minutes of scheduled times, except before, with or after meal orders, which were administered based on mealtimes.