

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245629	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024
NAME OF PROVIDER OR SUPPLIER The Villas at Osseo LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43082</p> <p>Based on document review and interview the facility failed to report to the State Agency (SA) a injury of a hematoma on right leg for 1 of 1 (R1) when reviewed for injury of unknown origin.</p> <p>Findings include:</p> <p>R1's significant change Minimum Data Set (MDS) dated [DATE] indicted intact cognition (13)and diagnosis of acute kidney disease, anxiety disorder, muscle weakness, difficulty walking, need for assistance with personal care, type 2 diabetes mellitus, insomnia, delirium and, acute and chronic respiratory failure with hypercapnia and hypoxia.</p> <p>R1's incident report dated 7/9/24 indicated during AM cares, while the staff assisted the resident with transfer from bed to a wheelchair (W/C), the resident sustained a bruise on her left lower extremities (LLE). Reported indicated the Root cause as full body lift was defective and did not function properly, leading to the incident. Intervention indicated as the full-body lift was removed from the floor and dismantled by maintenance. Another full-body lift was rented. Upper management also purchased a new full-body lift. Resident care plan updated. The resident will need 3 staff members during the transfer. One to guide her leg, one to control the machine, and the other behind the resident with W/C positioning. The care sheet has been updated. Resident updated. The care team and provider updated. Nurses will continue to follow the care plan with care delivery.</p> <p>R1's weekly skin inspection dated 7/11/24 indicated edema remains to right arm, faded bruises to left lower extremities, forehead and left arm. Rest of the skin was intact.</p> <p>R1's progress note dated 7/12/24 indicated at about 10:10 a.m. nursing assistant (NA)-A notified registered nurse (RN)-A that R1 had a lump on her leg and was screaming in pain. R1 was assessed and a swollen lower right extremity (LRE) was noted. R1 rated the pain at 8-10 out of 10. Acetaminophen was administered. Nurse practitioner was updated and ordered to send R1 to the emergency department (ED) for evaluation. R1 agreed and family updated. R1 was later admitted to hospital.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 7/17/24 at 2:48 p.m., administrator indicated they were not aware of how R1 got the LRE injury. Administrator stated the director of nursing was not available to gather further information and was unsure why a report would need to be made to the SA. Administrator stated R1 was not interviewed due to being in the hospital but had told one of the staff her leg hit the hoyer during a transfer. Administrator stated R1 never said staff intentions were to harm her and there was no grievances related to rough cares which led to the decision to not report injury to SA.</p> <p>During interview on 7/18/24 at 9:47 a.m., hospital care coordinator (HCC) stated R1 had a hematoma on her right lower leg at calf area and it was unknown how this injury occurred. HCC stated the hematoma measured 10 centimeters (cm) by 13 cm and had drained 500 milliliters of fluid from the hematoma. HHC stated there was no plan for a discharge as R1 was still not in stable condition.</p> <p>During interview on 7/18/24 at 2:26 p.m. family member (FM) stated she had witnessed a rough transfer on 7/10/24 around 6:10 p.m. when staff transferred R1 from wheel chair to bed. FM recalled staff having R1 in the sling, lifted in the air and hanging low, staff pushed R1 toward the bed, R1 was screaming and her right leg hit a piece of the mechanical lift, adding, that it was the same area where the hematoma was now. FM could not remember which staff assisted in the transfer and that she had met with facility administrator earlier in the week to share this information with her. FM denied any follow up from the facility related to this concern.</p> <p>During an additional interview on 7/18/24 at 3:05 p.m. administrator confirmed meeting with R1's family and discussing initial lift issue but denied the family having any abuse, rough care concerns or grievances.</p> <p>Facility policy titled Abuse/Probation/Vulnerable Adult Policy revised dated March 2024, indicated incidents to be reported was injuries of unknown sources-an injury should be classified as an injury of unknown source when both the following conditions are met: the source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; and, the injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is in an area not generally vulnerable to trauma), or the number of injuries observed at one point in time or the incident of injuries overtime. Suspicion of neglect, exploitation, or misappropriation of resident property must be reported to not later than 2 hours if the incident resulted in serious bodily injury.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43082</p> <p>Based on interview and document review the facility failed to thoroughly investigate an injury of unknown origin (hematoma on right leg) for 1 of 1 resident (R1) reviewed for abuse.</p> <p>Findings include:</p> <p>R1's significant change Minimum Data Set (MDS) dated [DATE] indicted intact cognition (13)and diagnosis of acute kidney disease, anxiety disorder, muscle weakness, difficulty walking, need for assistance with personal care, type 2 diabetes mellitus, insomnia, delirium and, acute and chronic respiratory failure with hypercapnia and hypoxia.</p> <p>R1's care plan dated 6/12/24, indicated R1 required assist of 2 staff with transfer using full body lift, incident on 7/9/24: during transfers, R1 will need 3 staff members. One will guide legs, one will control the machine, other will assist R1 with wheelchair positioning behind her.</p> <p>R1's progress note dated 7/12/24 indicated at about 10:10 a.m. nursing assistant (NA)-A notified registered nurse (RN)-A that R1 had a lump on her leg and was screaming in pain. R1 was assessed and a swollen lower right extremity (LRE) was noted. R1 rated the pain at 8-10 out of 10. Acetaminophen was administered. Nurse practitioner was updated and ordered to send R1 to the emergency department (ED) for evaluation. R1 agreed and family updated. R1 was later admitted to hospital.</p> <p>During interview on 7/17/24 at 12:18 p.m., RN-A stated there was a lump found on R1 leg, when getting R1 ready for the day. RN-A stated she called the NP right away and indicated R1 could not remember what happened. RN-A stated R1 was in pain when her leg was touched or moved. RN-A stated the injury was large, long in length and like a blister but dark in color. RN-A indicated no measurements were taken of the injury. RN-A was not aware if there had been an investigation on how R1 was injured.</p> <p>During interview on 7/17/24 at 3:12 p.m., nursing assistant (NA)-A stated R1 had a injury on her right leg and RN-A was present, did an assessment and R1 went to the ED. NA-A stated R1 was in pain when her leg was moved or touched. NA-A stated R1 did not know how she got injured. NA-A recalled the facility had not called to get more information about this injury.</p> <p>During interview on 7/18/24 at 10:43 a.m., nursing assistant (NA)-B stated she had assisted R1 with her transfer and family was present on 7/10/24. NA-B stated the transfer was normal, not rough and R1 had no complaints of pain when transferred. NA-B recalled seeing R1 bump her leg, when doing cares in R1's bed but added she was not aware how R1 got the large bruise on her right leg and the facility had not interviewed NA-B regarding the injury.</p> <p>During interview on 7/18/24 at 9:47 a.m., hospital care coordinator (HCC) stated R1 had a hematoma on her right lower leg at calf area and it was unknown how this injury occurred. HCC stated hematoma measured 10 centimeters (cm) by 13 cm and had drained 500 millimeters of fluid from the hematoma. HHC added there was no plan for a discharge as R1 was still not in stable condition.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 7/18/24 at 2:26 p.m. family member (FM) stated she had witnessed a rough transfer on 7/10/24 around 6:10 p.m. when staff transferred R1 from wheel chair to bed. FM recalled staff having R1 in the sling and lifted in the air and hanging low, staff pushed R1 toward the bed, she screamed out and her right leg hit a piece of the mechanical lift which was the same area where the hematoma was now. FM could not remember which staff assisted in this transfer and FM stated she had met with facility administrator earlier this week to share this information. FM denied any follow up from the facility related to her care concerns.</p> <p>During interview on 7/18/24 3:05 p.m. administrator stated when an injury of unknown origin occurs an investigation would be completed and that was not completely done. Administrator said usually the director of nursing (DON) leads the investigation, however the DON was not available.</p> <p>DON was attempted to be contact via phone, however no return call was completed during this survey.</p> <p>Facility policy titled Abuse Prohibition/Vulnerable Adult Policy revised date March 2024, indicated an investigation will begin immediately and staff will take immediate and appropriate actions to prevent further abuse, neglect, exploitation, and mistreatment from occurring while the investigation is in progress.</p>