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	11/21/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28598 Based on observation, interview and document review, the facility failed to communicate in a dignified manner to 1 of 1 residents (R2) reviewed for dignity. Finding include: R2's admission Minimum Data Set (MDS) dated [DATE], indicated R2 had depression, paraplegia (inability to voluntarily move the lower parts of the body), hemiparesis (one-sided muscle weakness) and hemiplegia (Muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles). The MDS further indicated R2 was cognitively intact, no behaviors and daily preferences were very important. In addition the MDS indicated R2 had impairment to upper and lower extremities on one side, needed maximum assistance with toileting, dressing, mobility and used a wheelchair. R2's Care Plan dated 10/24/24, indicated R2 was a smoker at the facility and was fall risk due to contracture to left ankle. The Care Plan further indicated R2 had a fall on 8/16/24, and staff were to accompany resident after meals to smoking area and back to her room for safety. R2's Nursing Assistant Care Sheet updated 11/15/24, indicated R2 was a high fall risk and staff were to accompany R2 from smoking area after all meals. During observation and interview on 11/19/24, at 10:47 a.m. R2 was observed in her room arguing with nursing assistant (NA)-E about going outside to smoke. When asked R2 what was going on, R2 stated [NA-E] will not take me out to smoke and I have a care conference at 11:00 a.m. Once outside the room, NA-E stated, She can wheel herself to smoke, we don't have to wheel her! R2 then stated NA-E was rude to her. She was asking for was assistance to go out and smoke since she had finished her breakfast and wanted to smoke before her care conference that was scheduled at 11:00 a.m. During interview on 11/20/24, at 10:31 a.m. registered nurse (RN)- A stated R2 had a fall trying to get back in from smoking outside while she was really tired and fell down. RN-A felt they could not take away her smoking privileges so he came up with a plan for staff to assist her after meals back and forth from the outdoor smoking area. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 11/20/24, at 2:27 p.m. director of nursing (DON) stated NA-E's tone and verbiage was not appropriate to use with R2 and as a facility they have been doing training on communication with staff and the residents. Facility Policy Resident Rights dated 1/2024, indicated it is the rights of this facility to uphold the rights of all residents. In addition the Facility provided [NAME] of Rights revised 6/18/19, the facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. In addition the policy indicated the resident has a right to be treated with respect and dignity.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28598 Based on interview and document review, the facility failed to notify resident representative timely following resident falls with injury for 1 of 1 residents (R3) who had been hospitalized twice from falls, one with hip fracture and then a neck fracture. Findings include: R3's admission Minimum Data Set (MDS) dated [DATE], identified R3 had diagnosis of dementia, had mild cognitive impairment, demonstrated no verbal or physical or verbal behaviors, and had no rejection of care episodes. The MDS indicated R3 required partial assistance with activities of daily living, had a fall since admission with no injury, had surgery involving the gastro intestinal (GI) track and received anti-psychotic medications. R3's Care Plan (CP) dated 11/07/24, indicated C3 was at risk for falls related to gall bladder surgery, muscle weakness, unsteadiness on feet, muscles wasting and atrophy in shoulders, dementia. In addition the CP indicated R3 does ambulate self in room. The CP interventions included the following: -Physical therapy (PT) per orders -Follow PT and Occupational (OT) instructions for mobility function. -Keep room clean and free of clutter. -Signs in room and or bathroom reminding resident of [NAME] for assistance. -Keep call-light with in reach. -Follow specific fall prevention plan. -Offer resident to use bathroom Q2-3 hours and as needed (PRN). -toileting plan. R3's CP further indicated C3 had alteration in short and long term memory and impaired decision making skills r/t to memory loss and staff were to remind in a kind manner with direction an redirection, and provide and maintain consistent routine. In addition to staff were to assist with ambulation and movement in and out of bed and transfers. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Incident Review and Analysis dated 10/16/24, at 5:00 a.m. indicated R3 was found on floor by nursing staff next to his bathroom. Resident stated he was going to the bathroom when he tripped and fell . R3 complained of severe left hip pain. Nurse attempted to call [family] but was unable to get through to him. Staff called 911 and patient was sent to hospital. The care plan was being followed at the time of incident. Root Cause Analysis: resident was self-transferring to the bathroom. Intervention: offer to toilet Q 2-3 hours and PRN. There was no indication staff had re-attempted to call R3's personal representative. A Hospital Note dated 10/16/24-10/19/24, indicated R3 was brought in for evaluation of a fall. The note indicated patient had a mechanical fall and landed on left hip, upon arrival in the emergency department x-ray of the left pelvis showed impacted left femoral neck fracture. Patient was admitted for surgical repair. A Incident Review and Analysis dated 11/08/24, at 11:47 p.m. indicated staff found R3 on the floor in a prone position next to the door under his bedside table. Patient transferred himself from bed and was moving using his bedside table when he fell and hit his head. The report indicated R3 had a laceration on his forehead about an inch and half and was bleeding profusely from the cut. In addition the report indicated the root cause analysis: it appeared like resident had self-transferred from bed and was ambulating in room using bedside dresser for support. New intervention upon return from hospital. There was no indication staff had attempted to call R3's personal representative. During interview on 11/20/24, at 4:21 p.m. family member (FM)-A stated he is R3's power of attorney (POA) and his emergency contact, and arrived at the facility every day at 10:30 a.m. and 5:00 p.m. FM-A stated [R3] fell on [DATE], and made a sign that was placed at the night stand which indicated using the red call button and listed his name and phone number. FM-A stated on 10/16/24, in the morning he went to visit [R3] to find he was not in his room and was informed he was in the hospital and had a fall with a hip fracture. FM-A stated he was upset from not being informed of the hospitalization . FM-A stated he informed the nurse at the station and realized the phone number the facility had was incorrect and the correction was made in the computer. In addition FM-A stated he requested for [R3] to be moved closer to the nurses station or to have a bed alarm and the Social Worker (SW) informed him a bed alarm was illegal with the health department and there was no bed available next to the nurses station. FM-A stated R3 had an additional fall during the night of 11/08/24, and arrived to the facility on [DATE], in the morning and was informed [R3] had an additional fall and was at the hospital again. FM-A stated he was then extremity upset and asked the nurse at the station why he was not notified and again was told they tried to reach him but had the wrong phone number. An additional interview on 11/21/24, at 11:45 a.m. with FM-A stated after R3's fall on 11/08/24, FM-A stated [R3] had a broken neck and was in the hospital for three days and they placed a neck brace. In addition they were in the hospital for pain control and rest in bed, and then discharged R3 home with him and with home care. During interview on 11/21/24, at 11:53 a.m. licsensed practical nurse (LPN)-A stated R3 had a fall on 11/08/24, he had hit his head on his bed side table and his forehead was bleeding, the paramedics put a neck brace on him. LPN-A stated after the paramedics were there she went to the computer to call R3's family member and when called a women answered and told her she had the wrong number. LPN-A then stated she informed the day nurse LPN-D to attempt to call R3's family. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 11/21/24, at 2:33 p.m. LPN-D, stated she was informed by LPN-A on 11/09/24, at change of shift around 6:30 a.m. R3 had fell , and she was unable to reach R3's FM-A. LPN-D stated she attempted to call FM-A and a women answered and stated she had the incorrect phone number. LPN-D then stated FM-A arrived around 10:00 a.m. to see R3 and was upset to find he was not at the facility and to find out he was at the hospital. LPN-D stated she informed FM-A the phone number in the system and he corrected her with the right number which she changed and saved in the computer system. During interview on 11/21/24, at 5:12 p.m. with the director of nursing (DON) and administrator, DON stated they had no (POA) paperwork, and no contact information from the hospital when [R3] admitted to them from the hospital. In addition the DON stated he wished FM-A would have just let the nurse know he wanted to be contacted. The administrator provided the writer with information that indicated after the nurse did correct FM-A's phone number after the fall on 10/16/24, but the business office manager (BOM) changed the number again to the incorrect phone number on 10/17/24. Which verified when R3 went to the hospital on 11/09/24, after his fall with a neck fracture, staff again called the incorrect phone number. Facility Policy Resident Rights dated 1/2024, indicated the facility must immediately inform the resident; consult with the resident ' s physician; and notify, consistent with his or her authority, the resident representative(s), when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28598 Based on observation, interview and document review, the facility failed to complete the initial comprehensive assessment using direct observation and communication with the resident for 1 of 1 resident (R3) reviewed for falls. Findings include: R3's admission Minimum Data Set (MDS) dated [DATE], identified R3 had diagnosis of dementia, had mild cognitive impairment, demonstrated no verbal or physical or verbal behaviors, and had no rejection of care episodes. The MDS indicated R3 required partial assistance with activities of daily living, had a fall since admission with no injury, had surgery involving the gastro intestinal (GI) track and received anti-psychotic medications. A Fall Review Evaluation dated 10/21/24, indicated R3 was admitted on [DATE], had a history of multiple falls, received narcotics, psychotropics. The Evaluation further indicated R3 exhibits loss of balance while standing, required bide base of support, frequently incontinent of urine, wandering less than daily and confined to chair daily. R3 lacked to have a Fall Review Evaluation upon admission from 9/27/24. A Incident Review and Analysis dated 9/27/24, at 10:50 p.m. indicated R3 was observed next to his bed no injuries were noted at this time. Resident was not able to verbalize to staff what he was trying to do prior to this fall. Resident needs assistance with one staff for ADL's and toileting d/t muscle weakness, unsteadiness on feet, but continues to self transfer self. Further interventions for scheduled toileting initiated and on last evening rounds if resident is awake to offer toileting assistance. The the root cause of the fall, resident needed to use the bathroom. A Incident Review and Analysis dated 10/06/24, at 10:13 p.m. indicated R3 was found on the floor on 10/06/24 at 2213 outside TCU (transitional care unit) entrance, prior to the fall, Pt kept stating [I need my car key, I left it home]. Resident kept wheeling self around the unit and end up wheeling himself by TCU door, staff was checking on him and discovered he was outside the TCU door sitting in front of wheelchair. A WanderGuard (to alert staff if resident were trying to leave facility) was applied to following the incident. New orders for a UA/UC (laboratory testing to check for a urinary tract infection). Psychotropic medications discontinued by provider and antibiotic ordered by provider. Root cause of resident was having high elevated white blood cell count. During interview on 10/20/24, at 1:49 p.m. the director of nursing (DON) stated the intervention of offering toileting every every 2-3 hours was added due to his re-entry from the hospital after the residents hip fracture and thought he was then non-weight bearing. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 11/21/24, at 1:42 p.m. R3's nurse practioner (NP) stated R3 did receive a UA/UC for suspected urinary tract infection after his fall on 10/06/24, and prescribed an antibiotic prophylactic Cipro on 10/07/24, when the results were received on 10/09/24, as negative the antibiotic was discontinued. In addition the NP did stated R3 was very impulsive and had dementia and felt you could remind him one thing and he would forget, he would have two to three good days and the next would be bad. That was why they suspected he had a UTI (Urinary Tract Infection). A Incident Review and Analysis dated 10/16/24, at 5:00 a.m. indicated R3 was found on floor by nursing staff next to his bathroom. Resident stated he was going to the bathroom when he tripped and fell . R3 complained of severe left hip pain. Nurse attempted to call son but was unable to get through to him. Staff called 911, R3 was sent to hospital, Care Plan was being followed at the time of incident. Root Cause Analysis: resident was self-transferring to the bathroom. Intervention: Offer to toilet every 2-3 hours and as needed (PRN). Hospital Note 10/16/24-10/19/24, indicated brought in for evaluation of a fall. he note indicated patient had a mechanical fall and landed on left hip, upon arrival in the emergency department x-ray of the left pelvis showed impacted left femoral neck fracture. Patient was admitted for surgical repair. During interview on 11/21/24, at 2:46 p.m. licensed practical nurse (LPN)-A stated he completes the MDS's for the residents and the MDS coordinator reviews and the signs them. LPN-A stated a falls assessment should be completed upon admission, re-entry and significant change. LPN-A stated R3 was missing his falls assessment upon admission, and only had a falls assessment when he returned from his hip fracture on 10/21/24. During interview on 11/21/24, at 4:36 p.m. RN-A stated he is the Unit Manager for R3 and in regards to R3's falls, and the floor nurse was to complete the initial fall admission assessment for R3, and it was not completed as it should have. RN-A stated the only falls assessment they have was completed on 10/21/24, when he returned after his fall with a hip fracture R3 had on 10/16/24. A facility policy was requested on Assessment but was not provided.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28598 Based on interview, observation and document review, the facility failed to update the care plan with identified fall interventions for 1 of 3 residents (R3) reviewed for falls. Findings include: R3's admission Minimum Data Set (MDS) dated [DATE], identified R3 had diagnosis of dementia, had mild cognitive impairment, demonstrated no verbal or physical or verbal behaviors, and had no rejection of care episodes. The MDS indicated R3 required partial assistance with activities of daily living, had a fall since admission with no injury, had surgery involving the gastro intestinal (GI) track and received anti-psychotic medications. R3's Care Plan (CP) dated 11/07/24, indicated R3 was at risk for falls related to gall bladder surgery, muscle weakness, unsteadiness on feet, muscles wasting and atrophy in shoulders, dementia. In addition the CP indicated R3 does ambulate self in room. The CP interventions included the following: -Physical therapy (PT) per orders -Follow PT and Occupational (OT) instructions for mobility function. -Keep room clean and free of clutter. -Signs in room and or bathroom reminding resident of [NAME] for assistance. -Keep call-light with in reach. -Follow specific fall prevention plan. -Offer resident to use bathroom Q2-3 hours and as needed (PRN). -toileting plan. R3's CP further indicated R3 had alteration in short and long term memory and impaired decision making skills r/t to memory loss and staff were to remind in a kind manner with direction an redirection. and provide and maintain consistent routine. In addition to staff were to assist with ambulation and movement in and out of bed and transfers. During interview on 10/20/24, at 1:49 p.m. the director of nursing (DON) stated the intervention of offering toileting every Q2-3 hours was added due to his re-entry from the hospital after the residents hip fracture on 10/16/24. Even though that was the intervention of toileting after his 9/27/24, fall. And R3 had an additional fall on 11/08/24, with a neck fracture. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 11/20/24, at 2:08 p.m. director of therapy certified occupational therapist (COTA) stated R3 was very impulsive and they don't use bed or chair alarms in the facility in addition the COTA stated she did not recall any intervention suggestions for R3 in regards to fall interventions. Facility Care Planning Policy revised 11/2024, indicated In accordance with state and federal regulations, each resident will have a person-centered care plan developed by the interdisciplinary team for the purpose of meeting the resident ' s individual medical, physical, psychosocial, and functional needs. In addition the policy indicated the care plan shall be used in developing the resident ' s daily care routines and will be utilized by staff personnel for the purposes of providing care or services to the resident. The plan of care will be utilized to provide care to the resident. The care plan is to be modified and updated as the condition and care needs of the resident changes.