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	01/24/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 43080 Based on observation, interview and document review, the facility failed to protect one of one residents (R4) from abuse and neglect when R4 was deprived of her care planned bed mobility and transfer needs, while she voiced pain and signs of distress, visibly struggled with these movement activities, and was placed in apparent unsafe laying and seated positions. These actions resulted in a fall for R4 where she sustained a distal femur fracture that required hospitalization and surgical intervention. The facility implemented corrective action based on their investigation and so the deficient practice was issued at an immediate jeopardy (IJ) past non-compliance. The IJ at F600 began on 1/17/25 (Friday), after R4 was deprived of care planned bed mobility and transfers, along with additional staff support, despite her voiced complaints of pain and signs of distress, visible struggles with these movement activities and placement in apparent unsafe laying and seated positions, and when transferred by staff in a non-care planned approach. This resulted in harm with required medical interventions. The administrator and the director of nursing (DON) were notified of the past non-compliance IJ on 1/24/25 at 4:00 p.m. Based on the facility's implemented corrective actions to prevent recurrence, prior to the abbreviated survey, this was issued at past non-compliance. Findings include: R4's quarterly and state optional Minimum Data Sets (MDS), both dated 12/18/24, identified R4 was free of communication impairments; however, was moderately cognitively impaired. R4 was provided extensive physical assist of two staff for bed mobility and transfers, and she was diagnosed with the following: cerebrovascular accident (stroke), right sided hemiplegia (total or nearly complete paralysis), anxiety, depression, severe morbid obesity, generalized muscle weakness, abnormality of gait and mobility, along with the need for assist with personal cares. R1's face sheet identified additional diagnoses of aphasia (language ability impairments due to brain damage) chronic pain syndrome with history of right femoral (upper end of thigh bone) head fracture and right lateral fibula (lower leg bone) malleolus (ankle bone) fracture. R4's comprehensive care plan, dated 2/27/24, and reflective of 1/17/25, identified an initiated potential for alteration in blood formation and coagulation Focus related to the use of anticoagulation (decreased clotting) medication. An intervention directed staff to encourage R4 to avoid bumping herself. (continued on next page)

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

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	01/24/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R4's comprehensive care plan, dated 2/27/24, and reflective of 1/17/25, identified an alteration in mobility related to stoke and right-sided weakness Focus with a goal for her to move safely within her environment. The interventions directed staff to help with bed mobility to sit up, boost up, and to get feet in and out of bed, along with a standing lift with one staff per therapy for transfers. R4's comprehensive care plan, dated 4/29/24, and reflective of 1/17/25, identified an alteration in cognition Focus related to difficulty finding and/or expressing her words, impaired thought processes with diagnoses of stroke and aphasia. Interventions directed to allow R4 time to communicate her needs and wants and to provide her with cues, reorientation, and supervision as needed. R4's comprehensive care plan, dated 4/29/24, and reflective of 1/17/25, identified R4 was a vulnerable adult due to her decreased cognitive function, aphasia, chronic pain, and decreased physical abilities with a goal to remain free of abuse and/or neglect. Interventions directed staff to explain cares prior to providing, monitor for signs of emotional distress, and follow the facility's vulnerable adult policy. Additionally, an intervention directed staff were to be educated as needed to ensure cares were provided in a gentle, unrushed, and thorough manner. R4's comprehensive care plan, dated 5/14/24, and reflective of 1/17/25, identified an initiated fall risk Focus related to a stroke with right hemiparesis, diabetes, aphasia, morbid obesity, obsessive impulsive disorder, chronic pain syndrome, generalized anxiety disorder, neuropathy, the need for assistance with transfers, bed mobility, and toileting. R4's goal was to be safe and free from falls with directives to follow therapy instructions for mobility function and to follow R4's specific fall prevention plan. This intervention allowed for specifications; however, this intervention was not specified. A Therapy Communication Form, dated 7/11/24, directed R4's transfers out of bed required a mechanical standing lift. R4's Care Guide (nursing assistant care plan), identified R4 was a fall risk, required assist of one staff for repositioning and bed mobility, required assist of one for dressing with directives to GO SLOW, and required assist of one staff and a Standing Lift to get out of bed. R4's electronic medical record Task (staff documentation) section, identified a task for the nursing assistants to sign off each shift that indicated Transferring: Standing Lift A1 (assist of one). R4's nursing and provider progress notes from 1/15/25, identified R4 complained of lower right leg pain with her pointing from her hip down her leg. A pain that she was unable to describe, and which was unable to be reproduced by the provider. R4 requested several times to go to the hospital. With hospital transfer prep, R4's weight was identified to be 211.4 pounds. R4 returned that evening in which scans completed on R4's right leg were negative for abnormal findings. A nursing progress note, dated 1/17/25, identified a nursing assistant [NA-B], called the nurse to R4's room and stated R4 was lowered to the floor during a transfer. R4 stated she, 'fell ,' when the nurse asked her what happened. R4 stated, 'Yes,' when asked if she was okay. Range of motion was completed and R4 denied pain. R4 was transferred with a full body lift into her wheelchair and went out to smoke; however, when she came back inside, she requested pain medication due to right lower ankle pain. (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	01/24/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A facility provided interview with NA-B, dated 1/17/25, identified NA-B stated she tried to get R4 dressed while R4 was seated edge of bed. As she tried to get R4's pants on, she had to slowly lower R4 to the floor, due to R4's sliding off the bed. NA-B denied noting any injuries toward R4 or that R4's legs were bent back or trapped underneath her. NA-B stated she lowered R4 to the floor, placed a pillow under her head, and went for help. The DON educated NA-B that R4 was an assist of one with a mechanical stand lift for transfers which NA-B stated she was unaware of; however, she only dressed R4. NA-B showed the DON where the Care Guides were located, and she was knowledgeable about lifts. A nursing progress note, dated 1/21/25, identified that on 1/17/25 at 10:40 a.m., R4 was transferred to the emergency department for right leg pain after being lowered to the floor by staff. An Orthopedic Operative Note, dated 1/20/25, identified a diagnosis of Peri-implant right supracondylar distal femur fracture. R4 underwent an open reduction internal fixation of this fracture with plate and screw construct. An Incident Review and Analysis form, dated 1/21/25, identified R4's 1/17/25 fall which occurred at 9:38 a.m. The nature of the incident indicated the fall was from bed and that R4 was lowered to the floor. An Incident Analysis identified R4 was in bed prior to the incident and getting ready for the day with the assistance of a nursing assistant where the nursing assistant transferred R4 from the bed to her wheelchair (w/c). The IDT (interdisciplinary team) met and determined the root cause of the fall was the nursing assistant did not follow the plan of care for mechanical stand lift transfers. On 1/20/25, a facility reported incident (FRI) was reported to the state agency (SA). The report identified R4's husband talked with the DON and stated the nursing assistant was rough with [R4] prior to her fall and he had camera footage from the event. On 1/23/25 at 12:01 p.m., video footage was reviewed with the administrator and the DON. The video revealed the following: -The video started at 8:42:39 a.m., where R4 was on her back in bed. She laid flat, across the bed toward the bed's left edge. Her left buttock region was on the mattress edge and both legs hung over the edge where her feet, encased in shoes, appeared on or very close to the floor. Due to a pillow on the floor, her actual foot position against the floor was blocked from view. R4 held onto the left grab bar with her left hand and appeared to be trying to sit herself up. R4 wore shorts, which were not completely pulled up and exposed the right side of her upper hip incontinence product region, and a shirt that was hiked up under her breasts allowed her entire abdominal area to be exposed. NA-B stood on the left side of the bed, approximately a foot or so from R4, between R4 ' s legs and the grab bar. NA-B's left hand was on her left hip and her right arm location was blocked by her body as she was sideways to the camera. NA-B did not speak to R4 but looked her direction. There was no evidence a stand lift was in R4's room. (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	01/24/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-At 8:42:41 a.m., R4 made a grunting type of noise, and continued to attempt sitting up unassisted. During this action, R4 started to slide off the mattress edge. In response, NA-B quickly approached R4, blocked R4 ' s left leg with her leg with enough force that the mattress pushed a few inches toward the right side of the bed frame, pushed on the left side of R4's abdominal area, and stated quickly, Lie down, lie down, lie down, as she pointed to the head of the bed. Immediately after, she placed one of her palms under each of R4's back upper legs and swiftly picked up R4's legs and swung them to the center of the bed where she let go. Due to gravity, this caused R4's right lower leg (calf to ankle) to fall and flop onto the leg's right side, onto two pillows located at the end of the bed. The lower leg bounced up when it first connected with the top pillow. -At 8:42:57 a.m., immediately after R4's legs contacted the bed, NA-B placed her hands on R4's outer left knee region and outer abdominal side area and forcibly pushed R4 more onto her right side, toward the right side of the bed, close to the bed edge. R4 did not remain on her side, and she started to roll onto her back. In response, NA-B placed her left palm on R4's lower left hip region and her upper left area. As she started to forcibly push R4 again onto her right side, she adjusted her right palm to R4's lower left back region, stated, Lie down, and while she held her onto her right side, she aggressively started to pull up R4's shorts, and finished with the use of both her hands. At this time, NA-B looked toward the camera. Once R4's pants were adjusted in the back, NA-B placed her right palm on R4's left hip and pushed quickly on R4's hip, enough to cause R4 to slightly rock toward the right, and she left go. NA-B then stepped away from the bed. -At 8:43:05 a.m., R4 started to roll back onto her back and started to use her left hand to adjust the front of her shorts. NA-B stated to R4 with increased tone and attitude, You are not getting out, as she held her hand above R4's body and shook a hand with a pointed finger side to side. NA-B directed, Move up, move up. R4 again attempted to reposition herself in bed. -At 8:43:20 a.m., R4 pointed at NA-B with her left pointer finger and then pointed at the wall that housed the camera; however, was not heard to make any verbalizations. NA-B failed to respond to R4's gesture. She then again started to attempt self-positioning. Almost right away, NA-B demanded, Get into the bed, go to the side, as she pointed with her hand to the right side of the bed and then patted R4's right outer hip area three times. Again, pointed to the right side of the bed and vocalized, Go to the side. R4 attempted to use her left leg, which was flat against the left side bed frame, while NA-B again pointed to the right side and stated quickly, Again. As R4 made a type of grunting noise, NA-B looked over R4, toward R4's right side and reached for R4's right hand/arm which she quickly removed from under R4's side, as R4 made a grunting type of noise, swung it out to the edge of the mattress, and set it down. NA-B instructed, Go again, and again pointed toward the side of the bed. As R4 again made grunting noises, NA-B used her left palm to swat R4's left hip region twice, which was heard when contact was made, and again instructed, Go again, while she pointed. Next, she stated, Push, as she made pushing motions with both hands. As R4 attempted to reposition, NA-B again stated, Again, push .more. R4 again attempted and made grunting type noises. NA-B elevated her tone and more forcibly stated, More, More. NA-B looked toward the camera. (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	01/24/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-At 8:43:57 a.m., R4 stated words that could not be made out, but which ended with the word okay. NA-B responded, It is not okay, you will fall down. She then proceeded to state to R4, More, and gestured toward the right side of the bed. R4 readjusted her body slightly with her left leg and NA-B then instructed her to, Bring your legs down and she motioned with a sweeping arm toward her legs and then the floor. Next, NA-B picked up a pillow that was on the floor and flung it over the top of R4 toward a pile of additional pillows located on the other side of the bed, adjacent to the headboard. -At 8:44:15 a.m., without any communication towards R4, NA-B grabbed onto R4's left shin area and forced it off the bed. When she let go, after it landed on the bed frame, the foot slipped off. NA-B then grabbed R4's right lower shin region and forcibly pulled the leg toward the bed edge, where R4's right heel hit her left knee, and she dropped it over the edge. R4's outer right lower leg/ankle region hit on the bed frame. During these actions, R4 cried out, OW. NA-B remained quiet, without any communication toward R4. NA-B then grabbed onto each of R4's knees and attempted to readjust them so that R4's feet were closer to the floor; however, R4's w/c was in the way which required NA-B to let go of R4 and adjust its placement. -At 8:44:27 a.m., after NA-B adjusted the w/c, she grabbed onto R4's left upper thigh with both of her hands and wrenched R4's leg up and toward the grab bar as R4 continued to lay flat on the bed. R4 made a grunting noise. NA-B spoke to R4; however, this was not understood. NA-B kept her left upper leg up against R4's left upper leg and grabbed onto R4's right lower arm/wrist area with both her hands and started to pull R4 into a seated position. R4 held onto the grab bar with her left hand. As NA-B and R4 struggled to get R4 seated, NA-B placed her right arm around R4's upper shoulder area while still holding her right arm. R4 grunted as they continued to struggle with the action. During this process, the mattress continued to slide toward the right and once R4 was relatively seated, she overall sat on the bed frame. At the same time, her right lower leg started to tremor up and down five or so times. -At 8:44:46 a.m., once R4 was seated, NA-B let go of her and stepped back. R4 sat on the bed frame, right arm hung down to her side, her right foot off to the right side a few inches. R4 made a grunting noise. R4 pointed to her w/c with her left pointer finger. NA-B made quick elevated toned verbalizations and bilateral closed fisted circular hand motions in front of R4; however, they were not understood due to the quickness of the speech and motions. After verbalizing, R4 started to adjust her sleeveless shirt; however, NA-B swatted the side of R4's right abdominal area twice, which could be heard when contact made, swung her hands, palm up to about R4's face level, and stated, You can remove it, as she brought her hands to R4's shirt, grabbed the shirt by the bunched up bottom and tugged the shirt from under R4's bilateral breasts without further direction or allowing R4 to assist. R4 stated, Oh, and something else unrecognizable. Next, NA-B grabbed R4's right wrist area with her right hand and the shirt bottom with her left and yanked R4's arm out of the arm hole, up over R4's head, and pulled it off R4's left arm without holding onto the arm or without communication to R4. -At 8:45:10 a.m., R4 started to position herself, as if she was going to stand, after she slightly adjusted her left foot so that it was more in front of her and stated, Ow. Her left hand was on the mattress and her right foot was about a foot or so from her left foot off to the side. NA-B stepped closer to R4, grabbed a hold of her right forearm area. R4 then sat back more onto the bed frame and grabbed onto the grab bar. NA-B brought R4's right foot forward and to the side so that it was more in line with R4's body without any forewarning or instructions. R4 stated, I can't. NA-B swung her hands out to the sides and stated with frustration, Than what should I do .I can't let you sit. (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	01/24/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-At 8:45:32 a.m., as R4 again appeared to position herself as if she was going to try standing, NA-B stood directly in front of R4, grabbed the w/c and positioned it on the right side of R4, bumping the w/c into R4's left leg, did not engage the right w/c break, and demanded, Stand up. We will get in your chair, as NA-B pointed toward the w/c. -At 8:45:41 a.m., NA-B grabbed R4 by the back of the shorts, and without providing R4 with any additional directions or communication, or application of a transfer belt, started to force R4 toward the w/c with a pivoting type of motion. Due to the angle, NA-B's right-hand placement could not be observed. R4 hung onto the grab bar. When NA-B moved R4 enough so that R4's buttocks were moved off the bed frame, R4's shorts significantly stretched out from NA-B's grip, R4's right leg could be seen bending under her weight, and R4 instantly started to fall to the floor. During this fall, R4 banged her left side on the bed frame and R4 started to make crying sounds of distress. R4's hand could be seen not holding onto R4. R4's left leg view was blocked by the w/c; however, R4's right leg could be seen underneath her, bent at the knee and the top of her shoe flush with the floor. R4 continued to cry out in distress. NA-B made no verbalizations towards R4. -At 8:45:47 a.m., NA-B pushed the w/c away from them, and positioned herself behind R4. From this angle, R4's left shoe could be seen as if it was directly under R4's buttocks and her right leg shin area was flush against the floor. NA-B instructed R4 to sit, provided R4 with no further directions, grabbed R4 by the shoulders, and applied force to pull her back towards her so that R4's basically sat on her calves. R4 continued to cry out in distress. -At 8:45:54 a.m. NA-B, without speaking to R4, grabbed R4's right leg by the calf region with both hands and pulled the leg from underneath her. R4 cried out, OW. Next, again without providing R4 with directions, grabbed R4 again by the shoulders and forced her back farther so that she was seated more on her buttocks versus her legs. R4 continued to cry out. NA-B reached over R4, as R4 leaned back, and extended R4's right leg further away from her body. NA-B guided R4 into more of a laying position and told her, It's alright. Lie down. When R4 stood up and moved, R4's right leg was bent at the knee about 90 degrees from her body with the right inner ankle flush with the floor. Next, NA-B reached over R4, grabbed her right calf with her right hand and brought R4's leg closer to her left leg. NA-B and R4 remained quiet; however, R4 could be heard breathing heavy. NA-B placed a pillow under R4's head and stated something unintelligible. -At 8:46:32 a.m., NA-B moved and R4's bilateral legs were both visualized. R4's left leg was bent at the knee with her shoe bottom flat on the floor; however, her right upper back leg was flush with the floor, her lower leg was bent at the knee with the back of the knee and the entire bottom portion of her leg flush to the floor, which included the inner ankle. As NA-B moved the w/c away from R4, the w/c hit R4 which elicited a distressed sound from R4. NA-B did not acknowledge the action or R4's distressed vocalization. As NA-B walked toward the door, R4 made a distressed sound. NA-B turned around and stated what sounded like, I am coming, walked toward the door, opened it, and called out to someone at 8:46:47. R4 again started to cry out in distress as the video ended. The total video recording was four minutes and 14 seconds. (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	01/24/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-During the video, from 8:42 a.m. to 8:46:47 a.m., for a total of four minutes and 14 seconds, NA-B was in R4's room attempting to get R4 up for the morning and transferred to her w/c. During this time, NA-B moved R4 with unnecessary roughness, did not alter her approach despite R4's complaints of pain, especially when pain was caused by NA-B's actions, repeatedly instructed R4 to position in manners she was unable to, along with positioned R4 into unsafe positions while in bed and while seated edge of bed, used demeaning gestures, actions, and direction towards R4, all without requesting, or attempting to get, more assistance for an unsafe situation. Additionally, NA-B proceeded to attempt a non-care planned bed to w/c transfer for R4 without a transfer belt, despite R4's care plan indicating the need to use a mechanical standing lift, in which R4 fell to the ground. -Immediately after the video was observed, the DON stated he was taken back by the video when he first saw it, after the husband provided it to them. The administrator also stated she was definitely taken back. The administrator stated NA-B was rough with [R4 ' s] care and she was not providing services in a manner that met their standards and expectations. The DON confirmed and verbalized I do not think anyone's standards. The DON indicated after hearing the audio, You can clearly tell [R4] was in pain throughout that. Additionally, he identified NA-B's actions did not change during the encounter, even after R4 made verbalizations of distress. He expected NA-B would have stopped the cares, asked for assistance, and verified R4 's transfer assist needs as safety always was expected. Both expected staff followed the care plan, or the care guides, and staff were expected to carry them with them. An Ad Hoc QAPI & Internal 4 Point Plan of Correction, dated 1/21/25, identified a meeting was held with leadership. The Findings/Summary/Notes section indicated, As evidenced by video footage, [NA-B] willfully treated [R4] with disrespect and failed to deliver care and services that aligns with her responsibilities as a professional care giver, and in a manner that is expected without our organization. [NA-B] transferred [R4] with an A1 (assist of 1) without a gait belt, when [R4's] plan of care states she is to transfer with a mechanical stand. Due to this, [R4] was lowered to the floor, resulting in her legs being pinned beneath her. [R4] was sent to the hospital due to excessive pain, where an x-ray indicated she sustained a right distal femur fracture .[NA-B] remains suspended pending investigation. Facility investigation initiated. A follow-up facility provided interview with NA-B, dated 1/22/25, identified R4 wished to smoke and thus NA-B started to get her ready. She explained she moved R4's legs into position so R4 could sit edge of bed as R4 always pivots into her [w/c]. R4 was having difficulty so she placed R4's legs back onto the bed. She pulled R4 up with the other hand and had to try multiple times. NA-B had to supplement R4 with her own body. She pulled R4's pants up. R4 was not stable so she lowered R4 to the ground and called for help. NA-B identified she should have checked the care plan and did not know R4 required the use of a mechanical stand lift. After, NA-B was shown the video. When asked her thoughts, NA-B stated, 'the video is as it is.' NA-B denied she was rough with R4; however, stated, 'noticed my tone was off, I could have taken it easier with my tone of voice.' NA-B stated R4 was larger, and she had to use more of her own strength to move R4. She was ashamed she did not use the care plan as she should have known R4 was a standing lift for transfers but stated, 'Never occurred to me that she is [a mechanical stand lift], I should have looked.' As R4 remained at the hospital during the abbreviated survey, R4 was not interviewed. (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	01/24/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	When interviewed on 1/23/25 at 1:10 p.m., NA-B identified abuse as a deliberate hurting of a resident, and neglect pertained to not taking care of a resident when they needed staff to. She was expected to treat residents with as much love as she could. NA-B stated she overall does not review the care guides, especially for R4, as she knows her so well. She only reviewed these when there was a new admission, or she worked on another unit and was unfamiliar with the resident. She denied that she carried these care guides with her when she worked; however, now knows this was expected to decrease risks such as what occurred with R4. NA-B identified she was not aware R4 required a lift to help her stand on 1/27/25 when she transferred her, especially in light that when she has had assistance from other staff, they also did not use the lift. NA-B explained her reasoning for how she managed R4 's legs was due to her attempts to decrease pain for R4 associated with the leg movements as this often-caused R4 discomfort. Additionally, she explained R4 was very heavy, and she had to position herself to use her strength. Even when moving R4's legs, she had to apply force or they will not move. Furthermore, she explained she did not use a transfer belt when she transferred R4 as she did not want the transfer belt to injure R4's skin as R4 preferred to take off her top while seated edge of bed, assist her into her w/c after R4 stood up, (by grabbing the back of her shorts and helping her into the w/c as she held onto the grab bar), be brought to the closet, and then once she picked out her top for the day, the top would be applied. NA-B stated if at any time there were concerns with safety during cares, she was expected to get assistance; however, when she worked with R4 that day, her co-worker was busy answering lights. NA-B explained, what was witnessed related to the movement of R4 's legs, and her verbalizations and hand actions towards R4 was done for R4 's safety and for R4 to understand her. She denied abusing or neglecting R4 and stated, I would never hurt her. I would never do anything with the camera there. NA-B stated she worked the remainder of the day on 1/17/25, 1/18/25, 1/19/25, and 1/20/25 until she was sent home that day. During an interview on 1/23/25 at 2:42 p.m., R4's family member (FM)-A, identified himself as R4's husband. Initially, FM-A stated, It irked me very bad when I first saw [the video], and he was disappointed in the care R4 received. He explained he felt NA-B's actions seemed lackadaisical, lacked compassion, and she did not use proper transfer techniques. FM-A explained NA-B should have prepared herself better to improve the transfer's success and a transfer belt should have been used. He stated the aide tried to transfer R4, but R4 slipped off the bed, R4 appeared to turn her ankle which took away support, she fell and broke her femur right above the knee. FM-A stated it could have been much worse. FM-A was unsure of R4's care planned transfer intervention(s); however, he did not think she was care planned for a lift as when he visited with R4, approximately two times a week, and staff transferred her, they transferred her like the gal did on the video. He denied recent observations of staff using the lift. Despite FM-A's lack of R4's care planned interventions; he expected staff to follow intervention directives to help prevent R4 from getting hurt. When interviewed on 1/24/25 at 2:10 p.m., the medical director (MD) stated abuse was anything that did not respect the autonomy of the resident and neglect centered around not paying attention to the resident's needs or providing those needs. He was aware of R4's incident and the facility's follow-up which substantiated the abuse occurred; however, he had yet to personally review the video footage. MD explained this was a horrible situation and there was no tolerance for such situations. He expected staff to follow the plan of care to decrease the risk of resident harm. The IJ began on 1/17/25, and was corrected on 1/20/25, and issued at past non-compliance, after the facility implemented a plan that included the following actions: -An internal investigation was initiated. (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	01/24/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-An Ad Hoc QAPI meeting was held. -NA-B was placed on suspension. -An OHFC report was filed, along with a police report. -Staff education with associated quiz was initiated regarding Abuse, Safe Patient Handling, Resident Rights, and Care Planning. -Observation transfer and resident treatment audits were initiated. -Like resident care plans and care guides were reviewed to ensure current reflection of transfer needs. A Safe Resident Handling Program policy, dated 3/2020, directed the policy was to be followed whenever a resident required assistance in moving. When residents received assisted care, the assistance was to be provided in a manner that was safe to both the resident and the employee, and which was in accordance with that resident's care plan. The policy directed when mechanical lifting equipment was determined to be necessary for lifting/moving a resident, the lift was to be used in all circumstances unless absolutely necessary i.e. emergency situations. In addition, the policy directed gait (transfer) belts were to be used during stand pivot transfers. A Fall Prevention and Management policy, dated 2/2024, identified one of its purposes directed to implement fall prevention interventions to attempt to prevent resident falls or to attempt to minimize fall complications. An Abuse Prohibition/Vulnerable Adult Policy, dated 3/2024, identified the facility's philosophy was to provide quality long-term care in a loving and caring atmosphere. Its purpose was to protect residents against abuse by anyone. The policy described mistreatment as inappropriate treatment of a resident; neglect as a failure to provide goods and services to a resident which were necessary to avoid physical harm, pain, mental anguish, or emotional distress; abuse as a willful infliction of injury, pain, or mental anguish and included deprivation of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Willful meant the staff acted deliberately, not that the staff must have intended to inflict injury or harm. A Care Planning policy, dated 11/2024, identified the care plan was developed for the purpose of meeting the resident's individual medical, physical, psychosocial, and functional needs. The care plan was to be utilized by staff for the purposes of providing care or services to the resident.

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	01/24/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43080 Based on observation, interview and document review, the facility failed to ensure adequate supervision to prevent an elopement (leaves premises or a safe area without authorization or necessary supervision) were provided to 1 of 3 residents (R1), who was at risk for elopement, utilized a wanderguard (elopement signaling device), and who had history of independent wanderguard removal. This resulted in immediate jeopardy (IJ) for R1 when she left the facility without staff knowledge and was outside for approximately 30 minutes exposed to lower temperature weather and unsafe conditions. The facility implemented corrective action based on their investigation and so the deficient practice was issued at IJ, past non-compliance. The IJ began on 1/11/25 (Saturday), after R1 removed her wanderguard, exited the facility's front door, was outside for approximately 30 minutes in 17-degree weather, was not immediately assessed upon reentry to the facility, the provider, family, and managerial staff were not alerted to the elopement for an investigation to occur in a timely manner, and another wanderguard was not immediately applied to R1 to decrease any increased risk(s) for additional elopement(s). The administrator, director of nursing (DON), and the regional nurse consultant were notified of the IJ on 1/23/25 at 4:29 p.m. The IJ was removed on 1/11/25, prior to the start of the survey, when the facility implemented corrective action, and was therefore issued at past noncompliance. Findings include: R1's quarterly Minimum Data Set, dated dated [DATE], identified R1 was moderately cognitively impaired with diagnoses of chronic obstructive pulmonary disease (COPD) and chronic respiratory failure, diabetes, arthritis, history of transient cerebral ischemic attack (TIA), anxiety, depression, post traumatic distress disorder (PTSD), schizophrenia, unsteadiness on feet, muscle weakness, and abnormality of gait and mobility. R1 required oxygen, was enrolled in hospice services, and was identified to have range of motion limitations to bother her upper extremities. An MDS Alarm section lacked evidence R1 utilized a Wander/elopement alarm to monitor her movements and/or to alert staff when movement was detected. R1 was able to propel her w/c independently while in the facility. Provider and nursing progress notes, all dated 11/4/24, identified the provider was updated R1 went out the front door that morning due to attempts to find the smoking patio and as a result the provider identified R1 was at risk for elopement. Nursing indicated R1 was found outside in the front of the building, smoking in the inner doorways, and thus an elopement risk. Due to this, a wanderguard was placed on R1's right wrist to alert staff of her attempts to go outside unassisted and to help ensure safety of not getting lost and eloping. R1's comprehensive care plan identified that on 11/4/24 a Risk for Elopement care plan was initiated. Interventions included: right wrist wanderguard which was to be monitored for proper functioning, door alarms will be answered promptly, family will be kept informed, and R1 would be invited to activities of her choosing. R1's November 2024 TAR, identified the wanderguard monitoring directed orders were discontinued on 11/22/24. (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	01/24/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's comprehensive care plan for elopement risk remained unchanged despite this discontinuation. A nursing progress note dated 12/23/24 at 2:03 p.m., identified R1 wandered into other 's rooms and attempted to get her coat on to go outside after she took cigarettes from another resident. Due to her pacing and wandering in the w/c, a wanderguard was placed on her left ankle for safety. R1's 12/23/24 Elopement Risk Evaluation identified a score of 7 (potential for elopement). R1's Order Summary Report identified an order was initiated on 12/23/24 to monitor the left ankle wanderguard placement every shift. A nursing progress note dated 12/27/24, identified R1's wanderguard was moved to her right wrist due to lower extremity edema. R1's Order Summary Report identified an order was initiated on 12/27/24 to monitor the right wrist wanderguard placement every shift and the every shift left ankle wanderguard monitoring was discontinued. R1's January 2025 TAR identified the following: -From 1/1/25, through 1/10/25, an order, initiated 12/23/24, which directed staff to check a left ankle wanderguard functioning and expiration date every evening shift was signed off by seven different nurses despite documentation this was removed on 12/27/24, and applied to her right wrist. -From day shift on 1/1/25, through the night shift on 1/10/25, the 12/27/24 initiated order to monitor the right wrist wanderguard identified documented nurses' initials without any Chart Codes/Follow Up Codes that identified concerns with the monitoring. A Medication Admin Audit Report identified LPN-A signed the TAR on 1/10/25 at 11:50 p.m., that R1's right wrist wanderguard placement directive was completed. A nursing progress note dated 1/11/25 at 6:47 a.m., identified R1 was found outside at 5:30 a.m., down the street about a block away. R1 was crying and stated, oh I don't know what I am doing help me I'm lost. No wanderguard was found on R1. The nurse kept R1's coat. No additional information was documented related to post-elopement processes/actions. A nursing progress note dated 1/11/25 at 1:17 p.m., identified a wanderguard was on R1's right wrist. An email dated 1/13/25, from the administrator to another company employee, identified LPN-A's statement during the investigation. LPN-A stated, the wanderguard had been off for several days to my knowledge. I told [nurse manager] about it a week and a half ago. LPN-A explained R1 was found yelling out, was brought back into the facility, did not have oxygen on her w/c, and R1 was only outside for about five minutes. The statement did not include any information related to actions LPN-A took to decrease R1's attempt at continued elopements. (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	01/24/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A provider progress note dated 1/13/25, identified R1 exited from the front of the facility over the weekend when she attempted to go to the back patio to smoke and did not realize she was not in the right place. R1 previously had a wanderguard on but at some point, was able to get it removed unbeknownst to staff. A new wanderguard was placed that day on R1's wheelchair. A nursing progress note dated 1/13/25 at 3:40 p.m., identified staff found R1 without a wanderguard on her wrist that afternoon. Staff were unable to locate the wrist wanderguard but the wanderguard to her w/c continued. Once approached on the missing wanderguard, R1 pulled the wanderguard, which had an intact strap, from an unidentified location. R1 stated she slipped it off and hid it because she did not like it. A new wanderguard was placed to her right wrist. R1's medical record lacked evidence, until 1/13/25, that a wanderguard was identified on R1's w/c, or that the w/c wanderguard was monitored; however, an email dated 1/11/25, from the DON to administration, identified he placed a wanderguard on R1's w/c the day of the elopement. An Osseo Weather History report, provided by the facility, dated 1/11/25, identified at 5:53 a.m. the temperature was 17 degrees Fahrenheit. On 1/22/25, video footage was reviewed with the DON. The video started on 1/11/25 at 4:13 a.m. and identified R1 was in a wheelchair (w/c) outside of her room which was located two rooms down from the nurse's station and main lobby area. Between 4:13 a.m. and 5:36 a.m., R1 propelled her w/c to and from another resident's room twice, to and from her room a couple times, to and from the hallway that led to the smoking area exit doorway and interacted with the staff at the nurse's station. At 5:36 a.m., R1 propelled herself to the front door, engaged the handicapped door button, propelled herself into the front entryway vestibule, and then exited the front door once that door opened. R1 wore pants, shoes, and a coat. No staff were observed by the nurse's station. At 5:55 a.m., another resident, whom R1 had earlier visited with, exited the front doors and returned shortly after. At 6:01 a.m., licensed practical nurse (LPN)-A exited the front doors and returned at 6:02 a.m. At 6:03 a.m., LPN-A and another staff exited the front doors and returned with R1 at 6:05 a.m. Per observation on 1/22/25, the sidewalk distance to where R1 was approximately found (toward the end of the facility), was approximately 72 feet, which ended by a sidewalk egress ramp to the road. When interviewed on 1/22/25 at 10:11 a.m., R1 was overall oriented and remembered the surveyor from a previous interaction. A wanderguard was secured properly on her right wrist and there was another on the bottom of her w/c. R1 identified she was an outdoor person and initially denied going outside unsupervised; however, when her elopement was brought up, she acknowledged the incident and explained she was trying to go outside for some fresh air and to smoke; however, once outside she became lost, could not turn the w/c around, and was having the hardest time getting to where I was going. R1 was unable to remember where she was found after she went outside. R1 identified she had removed the wanderguard at times so she could go smoke. Prior to the elopement, she thought maybe she had removed them twice before and placed them in one of her drawers. She denied recent attempts to go outside unescorted as the alarms go off whether or not you take them off or not, so why take it off. (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	01/24/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/22/25 at 1:53 p.m., the DON stated he expected the wanderguards were physically visualized for placement and functionality every shift based on the TAR order directives. The nurses' digital signature on the TAR was an indication the task was completed and he expected this to be truthful. If a wanderguard was not found, he expected staff to replace the wanderguard and to notify him and the administrator to ensure an investigation was started to determine cause and follow-up intervention(s). Post-elopement, he expected the resident's safety to be ensured, an assessment completed to determine any injury concerns, and appropriate notifications completed, such as to the provider and himself. The DON explained, on 1/11/25, he received a text message from the nurse manager after she came upon R1's elopement progress note. This was the first time he had ever been updated on any of R1 elopements and/or a missing wanderguard. He came into work that morning, ensured R1's safety and that she was free of injury, placed a wanderguard on R1 and another on her w/c, and started the investigation. The DON explained R1's memory waxes and wanes and her confusion fluctuated. The time frame of the incident occurred during her normal smoking time. During the investigation, it was assumed R1 removed her wanderguard sometime between the evening shift on 1/10/25 (Friday), as another nurse reported she responded to R1 that evening when she responded to the smoking patio door alarm and found R1 by the door, to the time she eloped; however, when he interviewed LPN-A after the elopement, LPN-A stated R1 had not had the wanderguard on for several days. Staff attempted to find the missing wanderguard but were unsuccessful. When interviewed on 1/22/25 at 3:08 p.m., the administrator stated during her interview with LPN-A, LPN-A thought R1's wanderguard was off after R1's elopement and identified she had not been physically checking the wanderguard. The administrator identified she did not follow up with additional questions to LPN-A as to her reason(s) for not checking the wanderguard but documenting that she had. The administrator expected the wanderguards to be checked every shift as directed. If a wanderguard was found missing, she expected the wanderguard to be replaced immediately and for her and the DON to be updated so they could initiate an investigation. The administrator identified she was aware R1 had historically removed her wanderguard as the nurse manager reported this during a past clinical meeting and informed them, she had replaced it. She was unable to remember exactly when this meeting occurred but thought maybe a week or two prior to R1's elopement. She was unable to identify steps taken at that time to investigate the missing wanderguard and/or any additional interventions initiated to decrease the risk of R1 again removing it. She stated there really were no continued concerns as staff documented it was on and visually checked. (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	01/24/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/22/25 at 3:28 p.m., LPN-A stated she was expected to monitor wanderguards every shift to ensure placement and functionality. Functionality was tested using a specific wand type device. If the device was not found, or not functioning, she was expected to replace it or report it to the nurse manager; however, LPN-A identified she was initially never showed where to find the extra wanderguards and she reported these were locked up without the ability for her to access them. Since R1's incident, she now knows where to locate them, and she has access. When an elopement occurred, which she explained was when someone was lost for a period or just left with attempts to run away, she was expected to report it right away. LPN-A explained she did not look at R1's exit from the facility as an elopement as she thought R1 just tried to follow a friend out to smoke and got turned around. LPN-A identified she located R1 at the end of the building - not passed it but very close, and it appeared R1 could not get back in. When found, R1 was a little upset, and asked for help as she got confused. LPN-A stated R1 knew how to remove the wanderguard as, per reports, staff had to put it on her many times. That night, post-elopement, she realized R1's wanderguard was not on. She denied that she placed another due to the belief she did not have access to them, and she did not update management as she did not initially feel this was an elopement event. LPN-A identified she was unsure if she checked that night for placement and functioning, despite her initials on the TAR. Additionally, she identified with the two previous wanderguard checks on 1/8/25 and 1/9/25, maybe one of the nights the wanderguard was there but she could not say for sure that both nights it was. LPN-A stated she had found R1's wanderguard off at least twice prior to this incident. LPN-A explained at one point she found the wanderguard on R1's dresser, and with the other missing wanderguard observation she was unable to find the wanderguard. When found on the dresser, she updated the nurse manager. With the other, she was unsure if she updated anyone. LPN-A stated, when she updated the nurse manager, she was informed R1 kept removing them and this was not something new. When interviewed on 1/23/25 at 2:20 p.m., registered nurse (RN)-A stated R1 was a very high risk for elopements due to her recent elopement, attempted episodes of going outside to smoke unescorted, and her history of being found without the wanderguard on, typically when it was applied to her wrist. She acknowledged she had found R1's wanderguard missing during checks and had to replace it, at other times she was aware, based on other staff statements, they replaced it as they also had found it missing. She explained one of these episodes the nurse manager replaced it. During the past non-compliance IJ issuance on 1/23/25 at 4:29 p.m., the administrator stated the w/c wanderguard was placed on 1/11/25; however, after they talked with corporate, the monitoring for this was not put into place as they were concerned this monitoring would alert R1 there was a wanderguard on her w/c and they did not want her attempting to remove it. When interviewed on 1/24/25 at 2:10 p.m., the medical director (MD) stated, if a resident were to remove their wanderguard, he expected at a minimum, increased monitoring would be initiated, and staff would be alerted to be on the lookout for this continued action. MD was aware of R1's elopement as administration updated him and a QAPI (quality assurance performance improvement) meeting was held. An interview was attempted with the nurse manager; however, was unsuccessful due to her being out of the county at the time of the abbreviated survey. The IJ began on 1/11/25, and was corrected on 1/11/25 and issued at past non-compliance, after the facility implemented a plan that included the following actions: (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	01/24/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-An internal investigation was initiated. -LPN-A was placed on suspension. -An OHFC report was filed, and a Risk Management and Incident review and analysis was initiated. -R1's skin was assessed (no injuries observed), an elopement risk evaluation was completed (a score of 7), behavioral monitoring for emotional distress and exit seeking behavior was initiated, her care plan was reviewed and updated, provider and family notification were completed, she was placed on 15-minute checks, and a wanderguard was placed on her right wrist and w/c. -All wanderguards were tested for functionality. -Staff education with associated quiz was initiated regarding elopement policy and procedure, including interventions, response, and reporting. -Wanderguard placement audits were conducted on the 3 residents identified for wanderguard use. -All resident Elopement Evals were reviewed to ensure up to date. -An Ad Hoc QAPI meeting was held. The facility was free of additional elopements and the corrective actions were verified through documentation review and staff interviews. An Elopement Policy, dated 6/2023, identified the facility was committed to providing a safe environment for all resident and to ensure each resident had appropriate safety precautions in place. To prevent elopements, staff were directed to observe each shift that each resident's bracelet alarm/device (wanderguard) was in place and that the device batteries were checked according to manufacturer's direction. The policy also directed, for those residents at risk for elopement, documentation was to include all attempts to elope, full observation/visualization after an elopement for any injuries or new symptoms or conditions which may have developed, all actions taken to find the resident, that all parties were notified, and that the wanderguard was in place and functioning when applicable. If a resident was not located on their assigned unit, the charge nurse was to notify the administrator or nursing supervisor. Additionally, the post-elopement assessment was to be completed after the resident was located and returned to the unit and included observed behavior or resident statements, objective data, underlying illnesses or diagnosis, physical appearance, and general appearance. Furthermore, the family and the physician were to be updated.