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 04/03/2025
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)
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 observation, interview and document review, the facility failed to notify resident representative timely following resident change of condition for 1 of 1 residents (R2) who had a weight loss of eight pounds in 27 days. Findings include: R2's quarterly Minimum Data Set (MDS) dated [DATE], indicated R2 had cancer, diabetes mellitus, heart failure, seizure disorder and depression. The MDS indicated R2 was cognitively intact with no mood or behavior disorders, was independent with activities of daily living (ADL), including eating. R2's weight was 200 pounds (lbs) indicating, no weight loss with a therapeutic diet. R2's care plan (CP) dated 3/11/24, indicated nutritional problems or potential nutritional problems related to increased nutritional needs due to a diagnosis of malignant neoplasm (cancerous tumor) of left breast, increased protein needs, supplements discontinued by physician, weight stable for 180 days. The care plan directed staff to allow resident sufficient time to eat, evaluate weight changes, obtain and document weights per MD (Doctor of Medicine) orders and facility protocol, provide feeding dining assistance as needed, provide snacks as scheduled and as needed, provide and serve diet as ordered: controlled carbohydrate, regular texture, thin liquids. A faxed order dated 3/14/25, from R2's NP indicated diagnosis of anorexia, to check complete blood count, comprehensive metabolic panel (CMP) (check metabolic function and organs), comprehensive renal panel (CRP) (check kidneys), erythrocyte sedimentation rate (ESR) (test measures how quickly red blood cells settle at the bottom of a test tube, indicating inflammation in the body, with higher rates suggesting increased inflammation), and an abdominal x-ray. No new orders were noted from results. NP visit note dated 3/28/25, indicated R2 had loss of appetite with no recent complaints of nausea, but noted weight loss (although had previously weighed in the 180's); recent labs unrevealing. On 3/04/25, mirtazapine (antidepressant) was stopped and Aricept was started (January 2025). The note indicated on 3/14/25, per nursing, R2 did not have much of an appetite for two days and denied nausea, vomiting and complaints of abdominal pain with palpation to all quadrants no point specific area, overall not feeling well. Consider dose reduction versus stopping Aricept. The 3/28/25, note indicated discussion with family member (FM)-B. (continued on next page)

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

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

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 04/03/2025
NAME OF PROVIDER OR SUPPLIER The Villas at Osseo LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 501 Second Street Southeast Osseo, MN 55369	

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A faxed order dated 3/28/25, from R2's nurse practitioner (NP) indicated diagnosis loss of appetite and anorexia, decrease Aricept to 50 milligrams (mg) oral daily for seven days, then stop toprol XL (high blood pressure medication), start propranolol IR (beta blocker that lowers blood pressure) 40 mg twice daily for tremor and hypertension, and notify if weight is less than 175 lbs. During interview on 4/01/25 at 2:30 p.m., nurse aid NA-D stated R2 had been eating in her room for weeks, refused to go into the dining room and did not want help eating. NA-D stated R2 had been shaking more and believed the nurse practitioner (NP) had made medication changes to help with that. In addition, NA-D indicated R2 just didn't appear to want to eat lately. NA was not aware if anyone from the facility contacted the family. During observation and interview on 4/01/25, at 4:51 p.m. R2 was in her room sitting in her wheelchair when she stated she was having some diarrhea, but that had stopped. R2 stated she has lost some weight but does not know why, adding she was not crazy about the food at the facility. R2 stated she liked hamburgers, fries and soups. During interview on 4/01/25, at 7:38 p.m. R2's family (FM)-B stated the last two times she came to visit R2 past lunch time she had been in bed with the blinds closed in her room and staff told me she did not want to get up. FM-B stated she had noted more confusion and weight loss. FM-B stated she had just visited over the weekend and had to assist R2 with eating due to her shaking so bad, adding she was only notified of her weight loss by the NP on 3/28/25, and the facility had never notified her of R2's weight loss. In addition, FM-B indicated she was not notified of the NP notification for weight loss on 3/14/25, and that labs had been ordered along with an abdominal x-ray. FM-B stated had she been notified sooner of the weight loss she would have brought in supplements and snacks R2 liked and would liked to have talked with the NP sooner about the weight loss. Review of R2's medical record indicated from 3/06/25 to 4/02/25 R2 had a 8.9 lb weight loss. During observation 4/02/25 at 1:40 p.m., R2 was observed alone in her room with her lunch tray in front of her. R2's tray was observed to have a few bites taken from her 4 ounce (oz) garlic and herb baked chicken (approximately 25%), with her rotini pasta salad, lettuce salad with spinach dressing, and 8 oz juice all untouched. R2 stated she was just not hungry today and did not want to eat in the dinning room or have assistance with eating. R2 did not indicated if she was asked by staff if she wanted assistance, and no observation was made of this. During interview on 4/03/25 at 10:14 a.m., registered dietician (RD) stated she assessed R2's weight loss on 3/31/25, and noted a weight loss of 5% over 30 days, indicating she had been in the 180's, then gained towards 200 since November 2024 related to mirtazapine. RD added, mirtazapine was then discontinued on 3/4/25, along with a decreased intake of 50% leading to weight loss. RD stated she contacted the NP but did not contact R2's family about the weight loss, adding she would do that today (4/3/25). That now has been discontinued as of 3/04/25 and has decreased intakes of 50% and she left a message with R2's NP. RD stated she did not talk with R2's family about the weight loss but will call today. RD indicated she made not changes at that time, choosing to monitor and weight for NP to follow up as R2 had been at that weight previously with out concern. Review of R2's progress notes lacked evidence of communication with R2's family related to her weight loss. (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 4/03/25 at 10:59 a.m., licensed practical nurse (LPN)-A unit manager stated the NP saw R2 on 3/28/25, for weight loss and talked to R2's family. LPN-A further stated the NP is usually the one who notified the family of any changes. Notification Of Changes Policy dated 3/2024, indicated It is the policy of this facility that changes in a resident's condition or treatment be shared with the resident and/or the resident representative, according to their authority, and reported to the attending physician or delegate (hereafter designated as the physician). Nurses and other care staff are educated to identify changes in a resident's status and define changes that require notification of the resident and/or their representative, and the resident's physician, to ensure best outcomes of care for the resident.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28598 Based on interview and document review the facility failed to comprehensively assess and implement appropriate pain monitoring to ensure comfort for 1 of 1 residents (R1) reviewed for pain management and whom was non-verbal and unable to communicate their needs. Findings include: R1's admission Minimum data Set (MDS) dated [DATE], had no MDS entries due to death on [DATE]. R1's care plan (CP) dated [DATE], indicated R1 received palliative care (focusing on improving quality of life for those with serious illnesses, during end-of-life care specifically focuses on the final months, weeks, or days of life), pneumonia, obesity due to excess calories, hypertension congestive heart failure, atrial fibrillation and long term use of insulin. In addition, R1's CP indicated he received hospice services as of [DATE], and comfort cares as desired with verbalized satisfaction with cares received. Additionally, R1's CP indicated he had alteration in cognition, mobility, mood and comfort, and directed staff to provide non-pharmacological treatments (address health concerns without relying on medications, encompassing physical therapies, behavioral strategies, and other modalities to improve well-being) for pain relief such as repositioning, rest, massage, as well as pain medication as ordered by physician. In addition, the staff were to encourage resident to verbalize discomfort and monitor for medication side effects. Review of R1's medication administration record (MAR) for [DATE], indicated the following: -HYDROmorphone HCl (also known as Dilaudid) (narcotic pain medication) 10 milligrams (mg)/milliliters (ml), give 0.4 ml by mouth every 4 hours for pain. The order indicated the order was started on [DATE], at 4:00 p.m. and first dose was given at 4:00 p.m. -HYDROmorphone HCl 0.4 mg by mouth every hour as needed for pain and shortness of breath, start date was [DATE] at 2:45 p.m., and first dose was given at 6:56 p.m. -HYDROmorphone HCl liquid give 0.4 mg one mg by mouth every one hour as needed for pain. Start date was [DATE] at 12:30 p.m. and discontinued at 2:11 p.m. on [DATE]. Last dose was given on [DATE], at 9:38 a.m. -HYDROmorphone HCl liquid give 2 mg/ml by mouth every one hour as needed for severe pain start date [DATE], at 12:30 p.m. and discontinued [DATE], at 2:11 p.m. last dose given on [DATE], at 12:17 p.m. R1 went almost four hours without pain medications from 12:17 p.m. to 4:00 p.m., due to medications orders being discontinued prior to the new medication orders transcribed into the computer system. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additional review of R1's [DATE] MAR pain scale from [DATE] and [DATE], nursing staff used a numerical pain scale (is a common tool used to assess pain intensity. It's a 11-point scale ranging from 0 (no pain) to 10 [worst pain imaginable], where patients verbally or in writing select a number that best represents their pain level) despite R1's inability to verbally communicate his pain. R1's MAR also failed to show evidence of an pain scale for R1 after [DATE] at 2:05 p.m. until his passing on [DATE] at 8:10 a.m. [DATE] at 4:33 p.m. Pain Rating of 4 using PAINAD scale (a tool used to assess pain in individuals with dementia or other cognitive impairments who cannot verbally report their pain.) [DATE] at 11:51 p.m. Pain Rating of 0 using PAINAD scale [DATE] at 4:32 a.m. Pain Rating of 5 using PAINAD scale [DATE] at 7:42 a.m. Pain Rating of 5 using PAINAD scale [DATE] at 9:25 a.m. Pain Rating of 2 using Numerical scale [DATE] at 11:37 a.m. Pain Rating of 4 using Numerical scale [DATE] 1:21 p.m. Pain Rating of 7 using Numerical scale [DATE] 1:27 p.m. Pain Rating of 6 using Numerical scale [DATE] 3:58 p.m. Pain Rating of 0 using Numerical scale R1's pain rating (using a numeric scale was documented as 0 for the following times on [DATE]: 4:04 p.m. 5:12 p.m. 6:32 p.m. 7:36 p.m. 8:29 p.m. 9:29 p.m. [DATE] at 1:40 a.m. Pain Rating of 3 using PAINAD scale [DATE] 03:07 a.m. Pain Rating of 1 using PAINAD scale [DATE] at 9:27 a.m. Pain Rating of 3 using Numerical scale [DATE] at 10:45 a.m. Pain Rating of 3 using Numerical scale (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] at 11:19 a.m. Pain Rating of 3 using Numerical scale [DATE] at 12:16 p.m. Pain Rating of 2 using Numerical scale [DATE] at 12:17 p.m. Pain Rating of 5 using Numerical scale [DATE] at 2:05 p.m. Pain Rating of 2 using Numerical scale R1's Hospice Visit Summary dated [DATE] at 9:15 a.m., indicated R1 was seen at the facility by registered nurse (RN)-J (hospice nurse) and indicated upon her visit at the facility she found R1, calling out in pain, wife in tears, with the wife (FM)-A reporting she, has had the call light on for over an hour wanting to request pain medications. The summary indicated RN-J went searching for a nurse to bring R1 some pain medications. A nurse brought R1 his scheduled buccal buprenorphine (long-acting opioid pain medicine, administered to R1 twice a day, a.m. and p.m.) and 2 mg dose of Dilaudid (HYDROmorphone)(narcotic used to treat severe pain) and, at that time, RN-J requested the RN come back again with lorazepam (anti-anxiety medication). R1 was also given Tylenol in yogurt, but he could not swallow it without a lot of effort. Swallow was impaired, with some coughing after medications. The Hospice Visit Summary went on to indicate R1 was very lethargic, had significant congestion and his pain was not controlled. RN-J documented they talked with wife about a scheduled pain medication plan and using medications which are proven to be highly effective for him and RN-J was provided education related to R1's presentation, showing RN-J that R1 was moving to an active dying process. The summary indicated FM-A was sad and cried but listened, she lived nearby but reported to RN-J that she felt she could not leave, otherwise R1 was not given his medications or attention by staff. We (RN-J and FM-A) discussed scheduling medications so staff are required to come in and provide pain medications on a regular basis (orders were as often as hourly if needed). RN-J indicated collaboration with nurse practitioner (NP) regarding medication changes and wrote out new orders. Summary then indicated RN-J reviewed new orders with nurse manager licensed practical nurse (LPN)- D and interim director of nursing (DON) who was going to enter the orders into the system. The medications were ordered by RN-J and facility staff were instructed as to when to expect the medications and to continue using current medication plan until concentrated Dilaudid (HYDROmorphone) arrived. Staff verbalized understanding. RN-J communicated to management the family's distressed related to R1's pain management and perceived lack of concern by nursing staff at facility. The note indicated the LPN-D (nurse manager) will encourage staff to be more attentive. During interview on [DATE] at 9:01 a.m., hospice nurse manager registered nurse (RN)-C stated he received a phone call from FM-A on [DATE], at 3:00 p.m. stating R1 was in pain and had not received any pain medication's for over two hours. RN-C indicated FM-A was upset during the phone call and he immediately attempted to call the (Nursing Home) unit on second floor where R1 was located but no one answered. RN-C then called the facility and finally reached RN-A from the first-floor transitional care unit (TCU) who went upstairs to check on R1. RN-C then stated RN-A informed him the new medication order from 10:00 a.m. had not been transcribed yet (now it was after 3:00 p.m.). Hospice RN-C stated from what he understood the nurse discontinued the previous orders and did not put in the new orders in the computer system, so there was no pain medications to give R1. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on [DATE] at 11:40 a.m., licensed practical nurse (LPN)-A nurse manager for second floor, stated R1 had always been in pain since admission, and he would just scream. RN-C hospice nurse provided new orders which had increased pain medications on [DATE], and the health unit coordinator (HUC) was off that day and LPN-A stated she gave the new orders to LPN- B to put the orders in the computer system. LPN-A stated the staff should still have provided the previous pain medication orders until the new medications arrived to the facility. LPN-A indicated the typical process would by to wait until the new medications arrived to discontinue the old order and input the new orders into the system. LPN-A stated she delegated the orders change to LPN-B that day and was never informed she did not have time to complete the task, adding she was made aware after the order confusion on [DATE] that LPN-B discontinued the order earlier in the day, before starting the new order around 4:00 p.m., leaving R1 with no pain options. LPN-A confirmed that was not the correct procedure and R1 should not have been left with out pain management for that amount of time. During interview on [DATE] at 1:53 p.m., nursing assistant (NA)-T stated she worked with R1 on [DATE], and his pain was severe. NA-T stated every time she would move him or touch him he would get agitated and would groan in pain. NA-T stated R1's wife would cry all day, indicating R1 was in too much pain. NA-T stated she worked 6 a.m. to 2:30 p.m. and informed the nurse of the wife's concerns and assumed the nurse provided pain medications. NA-T denied ever verbally confirming R1 received pain medication, adding R1 had been at the same level of pain since admission so it was hard to tell. During interview on [DATE] at 2:01 p.m., RN-A stated he received a phone call from hospice on [DATE], around 3:00 p.m. and was informed R1 was in pain and they were unable to reach his nurse. RN-A stated he went upstairs to confirm he received his medications. RN-A stated the family was in the room indicating R1 was in pain and wanted him to receive pain medication. RN-A indicated his observation of R1 was that he appeared to be lying comfortably with his legs twitching. RN-A stated he found out LPN-B had discontinued R1's previous orders and did not put in his new medication orders. RN-A stated he informed the pm shift nurse LPN-E to give R1 his pain medications at 3:30 p.m. and at that time his new medications had arrived. RN-A stated the nurses should have given his previous pain medication orders until the new medication arrived (had optional hourly pain medications); R1 should not have had to wait for pain medication. RN-A stated they have started re-educating all the nursing staff starting today on medication transcription and pain monitoring. During interview on [DATE] at 2:09 p.m., LPN-E stated she was the PM nurse for R1 on [DATE], and started at 2:30 p.m. LPN-E indicated upon arrival R1's family immediately asked for pain medication and when they looked at the medication administration record (MAR) there was no pain medication orders and they showed that to the family. LPN-E stated she informed the interim director of nursing, and was told to talk to the unit manager and she directed me to LPN-B who informed me she had discontinued the previous orders and was working on putting in the new orders. LPN-E stated finally around 3:30 p.m. the new medication came in and was able to provide it to R1. LPN-E confirmed she were not aware she could have given the previous medication orders until the new medication arrived since they were discontinued. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on [DATE] at 7:26 p.m., LPN-B stated she was provided the orders for R1 to transcribe from LPN-A nurse manager, and stated they were transcribed late due to having an entire unit of 27 residents herself to care for and did the best she could (not on R1's unit). LPN-B stated she discontinued the orders from [DATE] first around 1:00 p.m. and put in the new orders sometime before 3:00 p.m. before she left for the day. LPN-B stated the new orders were to start Robinul (reduce secretions) 1 milligram (mg) tablet, HYDROmorphone (narcotic to treat severe pain), 10 mg/1 ml, give 0.4 ml/ 4 mg by mouth every four hours for pain and every one hour as needed, Lorazepam (antianxiety) 1 mg by mouth four times a day for anxiety and muscle spasms, in addition 0.5 to 1 mg every four hours as needed for anxiety. During interview on [DATE] at 8:09 p.m., FM-A stated R1 was in a lot of pain while at the facility and had to ask for pain medication every hour due to his shaking and groaning, and on [DATE], at 3:00 p.m. she finally called hospice services since she knew the pain medications were changed at 10:00 a.m., and the facility had not implemented them yet at 3:00 p.m. including LPN-E telling her there was no orders to give pain medications at the start of her shift at 2:30 p.m. FM-A stated she spoke to hospice RN-C who then called the facility and finally things were worked out. FM-A stated R1 never should have gone through so much pain. During interview on [DATE] at 10:34 a.m., LPN- D stated RN-A informed her R1 looked like he was comfortable and was not moaning when he received the phone call from hospice RN-C. In addition, LPN-D stated the nurses were not completing the correct pain rating for R1 and they are in the process of re-educating the nurses for non-verbal residents who are not able to provide a numerical pain rating. In addition, LPN-D verified after the hospice nurse made the medication changes on [DATE], and LPN-B discontinued the previous pain medication orders, the staff no longer rated R1's pain, which was incorrect. LPN-D stated when the LPN-B inputted the new pain medication orders she did not put in to rate the pain, so R1's pain was never rated after [DATE], at 2:05 p.m. which was last rated on a numerical scale with a value of a two. LPN-D stated, because R1 was non-verbal, you can not use a numerical pain rating scale, a non-verbal pain rating scale should have been completed. Additionally, LPN-D indicated she did not even understand how LPN-B or any nurse could have come up with a numerical pain rating for R1. LPN-D added, the nurse working the day shift on [DATE] licensed vocational nurse (LVN)-A, used the numerical scale all shift. During interview on [DATE] at 8:00 a.m., LVN-A stated she worked with R1 on [DATE] and during that day shift R1's FM-A was constantly asking for pain medication all through that shift. LVN-A stated she provided pain medication and anti-anxiety medication approximately three times during her shift. LVN-A did state at the end of her shift a nursing assistant did come up to her requesting pain medication, and she was already busy getting another resident's weight and so had to tell the aide to ask the evening nurse to give the medications. Review of R1's [DATE] MAR revealed on [DATE] LVN-A administered R1's scheduled pain medication Acetaminophen (Acetaminophen Capsule 500 MG, Give 2 capsule by mouth three times a day for pain), at 12:00 p.m. No other pain relieving medication was administered to R1 until LVN-A administered his new order of HYDROmorphone 10 mg/ml Give 0.4 ml by mouth every 4 hours for pain. LVN-A additionally failed to monitor R1's pain, having only documented in his pain scale last at 12:17 p.m. recording a 5 and 2:05 p.m recording a 2 using the incorrect Numeric pain scale. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medication and Transcription Error's policy revised ,d+[DATE], indicated orders for medications and treatments will be transcribed accurately in a timely fashion. In addition the facilities Pain Management Protocol updated [DATE], indicated the purpose is to ensure that residents pain or at risk for pain, have an effective pain management plan in place with individualized interventions that are consistent with the resident goals for comfort.