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	05/07/2025

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35569 Based on observation, interview and document review the facility failed to ensure staff followed five rights of medication administration for 1 of 3 residents (R1) reviewed for significant medication errors. R1 received five times the prescribed dose of Methadone for three days (nine shifts) which impaired her speech, ability to verbalize needs and consume nutrition. This resulted in an immediate jeopardy (IJ) for R1. The IJ began on 4/26/25, when the facility staff administrating R1's medication failed to compare the written order on the Medication Administration Record (MAR) with the prescription label on the physical bottle of Methadone before administration which resulted in R1 receiving five times the prescribed dose of Methadone nine times over the course of three days. The IJ was identified on 5/7/25, and the administrator was notified of the IJ on 5/7/25 at 1:45 p.m. The immediate jeopardy was removed on 5/1/25, and the deficient practice was corrected prior to the start of the survey and was therefore issued at past noncompliance. Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], identified moderate cognitive impairment and indicated she received scheduled and as needed pain medication. The MDS indicated R1 had frequent pain that occasionally affected sleep and day to day activities and received opioid (a class of drugs that relieve pain, but can also cause side effects, dependence, and overdose) medications. Diagnosis included Multiple Sclerosis (MS), open wounds, paraplegia, and pain. R1's care plan dated 4/20/25, identified an alteration in comfort related to MS, polyneuropathy and wound cares. The care plan directed staff to assess for pain, document effectiveness of pain medication and administer pain medications as ordered by the physician. R1's prescription medication bottle dated 3/27/25, indicated Methadone SOL (solution) 10 milligrams (mg)/5 milliliters (ml) directed 10 ml (20 mg) by mouth three times daily. R1's Physician Order details dated 4/11/25, Methadone HCL (hydrochloride) oral solution 10 mg/5 ml. Give 30 mg by mouth three times daily for pain. Give 30 mg = 15 ml. R1's prescription medication bottle dated 4/25/25, indicated Methadone 10 mg/ml. Take three ml by mouth three times daily which equals, 30 mg. (continued on next page)

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

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's MAR April 2025 indicated Methadone HCL oral solution 10 mg/5 ml. Give 30 mg. R1's narcotic record hand written by staff, indicated Methadone 10 mg/ml. Drug dosage indicated 15 mg. Directions: Take 15 ml's three times daily. The record indicated the transcribing staff member failed to identify the change of dosage on the prescription bottle. The record indicated staff gave the following amounts: 4/26/25 at 10:00 a.m., 15 ml, equal to 150 mg. (five times the prescribed dose). 4/26/25 at 12:00 p.m., 15 ml, equal to 150 mg. (five times the prescribed dose). 4/26/25 at (unable to read), 15 ml, equal to 150 mg. (five times the prescribed dose). 4/26/25 at 7:41 a.m., 15 ml, equal to 150 mg. (five times the prescribed dose). 4/27/25 at 12:00 p.m., 15 ml, equal to 150 mg. (five times the prescribed dose). 4/27/25 at 8:00 p.m., 15 ml, equal to 150 mg. (five times the prescribed dose). 4/28/25 at (unable to read), 15 ml, equal to 150 mg. (five times the prescribed dose). 4/28/25 at 12:00 p.m., 15 ml, equal to 150 mg. (five times the prescribed dose). 4/28/25 at 8:00 p.m., 15 ml, equal to 150 mg. (five times the prescribed dose). A Medication Error Reconciliation Form dated 4/30/25, indicated on 4/26/25 at 10:00 a.m. and 12:00 p.m., agency staff administered Methadone based on supply bottle from hospice which had a different concentration than previous bottle and administered wrong dose from old discontinued medication bottle. Nurse did not follow the five rights of medication administration (right drug, right patient, right dose, right route, right time.) Nurse educated on five rights of medication administration. A Medication Error Reconciliation Form dated 4/30/25, indicated on 4/26/25 at 8:41 p.m. and 4/29/25 at 8:00 a.m. and 12:00 p.m., registered nurse (RN)-A administered Methadone based on supply bottle from hospice which had a different concentration than previous bottle on hand administered wrong dose from old discontinued medication bottle. Nurse did not follow the five rights of medication administration. Nurse educated on five rights of medication administration. A Medication Error Reconciliation Form dated 4/30/25, indicated on 4/27/25 at 7:41 p.m., 12:00 p.m. and 8:00 p.m., licensed practical nurse (LPN)-A administered Methadone based on supply bottle from hospice which had a different concentration than previous bottle on hand administered wrong dose from old discontinued medication bottle. Nurse did not follow the five rights of medication administration. Nurse educated on five rights of medication administration. A Medication Error Reconciliation Form dated 4/30/25, indicated on 4/28/25 at 7:38 a.m., 12:00 p.m. and 8:00 p.m registered nurse (RN)-B administered Methadone based on supply bottle from hospice which had a different concentration than previous bottle on hand administered wrong dose from old discontinued medication bottle. Nurse did not follow the five rights of medication administration. Nurse educated on five rights of medication administration. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's Progress Notes identified the following: 4/30/25, Nurse practitioner and hospice notified of medication concern. 4/30/25, Hospice nurse returned call regarding Methadone dosing, stated to continue to monitor for adverse reactions. R1 had been in active decline with changes in intakes, ability to tolerate meals or activity with therapeutic recreation. 4/30/25, R1 was weak, not much activity occurred. R1 did not eat, just took sips of water. 4/30/25, Hospice routine visit note indicated writer was alerted to change of condition by hospice aide. R1 displayed exertion to respond to yes or no questions. Hospice nurse and aide to start daily visits. 4/30/25, R1 was lethargic at beginning of shift. Awake at supper and requested food. R1 ate 15% of food and drank 40 cubic centimeters (cc) [a teaspoon is typically equal to about 5 cc of fluid] this shift. 5/1/25, R1 unable to take oral medications due to weakness and decline. 5/1/25, Hospice nurse visit: Upon arrival, R1 in bed sleeping, did not open eyes to verbal or physical stimuli. Respirations even with periods of apnea (the temporary cessation of breathing). All extremities cold to touch. Family member (FM) questioned if medication concern contributed to decline which writer was unable to provide an answer. 5/1/25, R1's verbal communication has declined. 5/2/25, Update to FM given. Notified R1 was unable to tolerate oral medications, not eating or able to tolerate oral intakes due to decline. During observation on 5/6/25 at 2:28 p.m., R1 was laying in bed with staff seated next to her bed. Upon introduction, R1 made a verbalization that sound like Ahhhh, but no words spoken. During interview on 5/6/25 at 3:45 p.m., R1's significant other (SO) stated the facility had told him the concentration of Methadone came in higher that it was supposed to be and no one had caught it. The SO said R1, went way down hill real fast and said prior to the medication error R1 was able to speak and now could not. The SO stated R1 had stopped eating and had trouble swallowing since the medication error occurred. The SO stated he was the person who visited R1 regularly as her family resided in another state. During interview on 5/7/25 at 8:28 a.m., LPN-A stated R1's Methadone order had increased from a previous order. LPN-A said they received a new bottle of Methadone which indicated 30 mg but said the concentration had changed and the staff had not noticed. LPN-A said staff followed the direction on the MAR but not the bottle. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview on 5/7/25 at 8:41 a.m., the hospice RN stated they had received an e-mail from the facility about the error but it had gone to a different department than nursing. The hospice RN said she learned about the medication error via text from the hospice physician. The hospice RN stated the facility explained the staff had been giving the wrong dose of the Methadone due to not looking at the bottle. On 5/7/25 at 9:51 a.m., the director of nursing (DON) was interviewed along with the vice president of clinical operations (VPCO) for the Hospice agency. The DON stated the medication error was discovered during the afternoon medication count on 4/30/25. The DON said she was notified of the errors on 5/1/25 and completed the medication error forms along with LPN-A. The DON stated as soon as they learned about the error the nurses involved received immediate education. The DON stated the nurses had not followed the five rights of medication administration. The VPCO said R1 had been placed back on final moments which include daily nurse and aide visits, due to the medication error. The VPCO stated prior to the error it had been many months since R1 had received final moments care. The VPCO said R1 remained on final moments due to decreased appetitive, not eating/drinking as much and decline in verbalizations. During interview on 5/7/25 at 10:35 a.m., when asked about the significance of receiving five times the dose of methadone, the pharmacy consultant (PC) stated with any opioid medication there was a concern for respiratory depression, sedation, confusions or a potential overdose, which was a more life threatening situation. The CP said Methadone had a longer half life (indicates how long it takes for a drug to be removed from your body) which made it trickier to determine how long it would take for someone to return to their baseline following an over dose. The CP said typically it took from 24 - 36 ish hours but fluctuated with patients which was why changes were made slowly. The CP stated she considered the medication error to be significant. During interview on 5/7/25 at 11:33 a.m., nursing assistant (NA)-A and NA-B were interviewed. NA-A stated during the last two weeks, R1 had not been eating very much and would only drink fluids. NA-A said prior to a few weeks ago R1' appetite was normal. NA-B indicated when recently came into work R1's speech was unable to be understood which was a change from previously and said now R1 would not eat. NA-A said the speech had changed in the last week and said R1 was no longer speaking and would just look at him. During interview on 5/7/25 at 11:38 a.m., LPN-A said she had noticed R1 had been sleeping a lot more. LPN-A stated initially she had not realized it was related to the medication errors. LPN-A stated a couple weeks ago was R1's last good day. LPN-A said since the medication errors occurred R1 was eating less, drinking less and was more lethargic and said R1's speech used to be so clear but now required so much effort to get words out. An undated, untitled facility procedure directed staff to review the five rights, three times prior to medication administration. The past noncompliance immediate jeopardy began on 4/26/25. The immediate jeopardy was removed 5/1/25, and the deficient practice corrected after the facility implemented a systemic plan that included the following actions: (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Immediate education was provided to the nurses involved in the medication errors to include: Medication administration and transcription, the five rights of medication administration and ensuring medication labels match physician orders along with contacting pharmacy or physician for clarification. - All nurses received education related to medication types, prevention of errors, high risk medications and compliance with national safety standards. - R1's Pain medication management was reviewed for accuracy along with ensuring the label on the bottle matched the physician ordered in the medical record. - All like residents have had their orders reviewed and liquid medication labels reviewed to ensure labels on bottles match the orders in the medical record. - Compliance audits were initiated.