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	02/06/2026

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 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** Based on interview and document review the facility failed to ensure non-pharmacological (non-pharm) interventions were attempted/offered and documented prior to the administration of as needed (PRN) narcotic medications for 1 of 3 residents (R3) reviewed for pain. Findings include: R3's diagnoses list dated 2/6/26 included fracture of right femur (upper leg bone), hypotension (low blood pressure), and low back pain. R3's admission Minimum Data Set (MDS) dated [DATE] indicated R3 did not have cognitive impairment. R3 had occasional pain that interfered with day-to-day activities, therapy, and sleep.R3's care plan dated 1/30/26 indicated a focus of alteration in comfort related to right femur fracture and low back pain with interventions included provide non-medicinal forms of pain relief such as positioning, rest, massage, etcetera (etc.).R3's provider order dated 1/30/26 instructed oxycodone-acetaminophen (a combination pain relieving medication) tablet 10-325 milligrams (mg). Give 1 tablet every 6 hours as needed for chronic pain (the order did not specify the location of the chronic pain). R3's medication administration record (MAR) for February 2026 indicated R3 received oxycodone-acetaminophen 17 times. The MAR also included a task for non-pharmacological pain interventions: no intervention needed, ice, heated blankets, massage repositioning, music, essential oils, food or drink, relaxation breathing; document interventions every shift. The corresponding recorded entries were once per shift versus prior to administration of the PRN Oxycodone. Documented non-pharmacological pain interventions indicated R2 was offered food 20 times and repositioning one time. No other information was included on the MAR. R3's record between 1/30/26 through 2/6/26 did not include comprehensive pain assessments that would include location and pain characteristics. Further, although R3's nursing notes identified the date and time the medication was administered they did not include what, if any, non-pharm interventions had been attempted or offered prior to the narcotic being administered. Additionally, when non-pharmacological interventions were documented R3's record did not identify the effectiveness of the interventions attempted/offered. During an interview on 2/6/2026 at 9:51a.m., R3 stated ice and repositioning help with managing the pain to her leg. Staff will bring her ice if she asks for it, but they do not offer it before a pain pill.? During an interview on 2/6/2026 at 11:15 a.m., registered nurse (RN)-A stated when a resident reported pain the nurse should assess location of pain, ask the resident to rate their pain on a scale of 0 (no pain) to 10 (worst pain ever) and offer non-pharm interventions like repositioning. If the non-pharm interventions did not help with the pain or the resident refused, the nurse should offer ordered PRN medication based on the stated pain scale number. A nurse should document administration of the medication, all interventions offered/refused and follow-up information if the medication was effective or not.? During an interview on 2/6/2026 at 12:40 p.m., RN-B stated when a nurse assessed a resident for pain, the nurse should ask when the pain started, where is it located, rate the pain on a scale from 1-10, and what has worked in the past to relieve pain. The nurse should offer non-pharm before offering medication. A nurse should document in the (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245629	A. Building B. Wing	02/06/2026

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PRN medication note where the pain was located, the pain rating and what was offered. The nurse should go back to the resident later to see if the medication was effective. During an interview on 2/6/26 at 3:13 p.m., nurse practitioner (NP)-A stated when a resident has pain, the nurse should start with conservative treatment like repositioning, ice, heat, and topical medication. If conservative treatments were not effective in relieving pain, then the nurse should offer PRN medication based on the resident's pain scale. Documentation of all interventions is important so nurses and providers can look back to see what had been effective in managing the resident's pain. During an interview on 2/6/26 at 5:26 p.m., director of nursing (DON) stated when a resident was experiencing pain, a nurse should ask the resident to describe the pain, where the pain is located, and what had relieved their pain in the past. The nurse could use non-pharm interventions like ice or a warm pack. Non-pharm interventions and the resident's pain rating should be included in the PRN medication administration note. The non-pharm documentation completed one time per shift was not directly tied to a PRN medication administration. DON reviewed R3's medical record and confirmed there were no indications of non-pharm interventions offered, attempted or refused prior to PRN narcotic administration. The Pain Management Protocol dated 12/2025 instructed staff will provide the elements of a comforting environment and appropriate physical and complementary interventions; for example, local heat or ice, repositioning, massage, and the opportunity to talk about chronic pain.

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	02/06/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to accurately transcribed a physician order with a start date for 1 of 3 (R2) residents reviewed for medication administration. Findings include: R2's diagnoses list dated 2/6/26 included gas gangrene (a bacterial infection) and foot ulcer (an open sore on the foot). R2's hospital discharge order dated 1/25/26 instructed new medication: amoxicillin-pot clavulanate (an antibiotic) 875-125 milligrams (mg). Give 1 tablet two times a day. Stop taking on 2/3/26. R2's physician order dated 1/25/26 was consistent with the hospital discharge order; amoxicillin-pot clavulanate 875-125 milligrams (mg). Give 1 tablet two times a day, stop taking on 2/3/26. R2's admission Minimum Data Set (MDS) dated [DATE] indicated R2 did not have cognitive impairment. The MDS identified R2 was administered an antibiotic. R2's January and February medication administration records (MAR) identified the physician order for Amoxicillin however; the MARs identified a start date of 1/26/26 with an evening shift administration time. Further identifying R2 missed the evening dose on 1/25/26 and the morning dose on 1/26/26 which was not consistent with the physician order that directed to start the medication on 1/25/26. During an interview on 2/6/26 at 2:11 p.m., pharmacist (pharm) stated R2's amoxicillin-pot clavulanate was delivered on 1/25/26. A resident's medication should start on day of admission unless there is a provider order with a specific start date. During an interview on 2/6/26 at 2:42 p.m., registered nurse (RN)-C stated medications are administered according to the medication administration record. Any medications that are due on a specific shift will be listed under the resident name. A medication will not populate to be administered until after the transcribed start date. During an interview on 2/6/26 at 12:40 p.m., RN-B stated the first time R2 received amoxicillin-pot clavulanate was on 1/26/26 in the evening. RN-B confirmed R2's amoxicillin-pot clavulanate should have started on 1/25/26. During an interview on 2/6/26 at 3:13 p.m., nurse practitioner (NP)-A stated medications should start on day of admission unless the order indicated a specific start date. The provider should be notified of any missed doses so the order can be extended if necessary. NP-A did not recall being notified of the two missed doses. During an interview on 2/6/26 at 5:26 p.m., director of nursing (DON) stated R2's order for amoxicillin-pot clavulanate was not transcribed accurately. The order should have started on 1/25/26 not 1/26/26 which resulted in two missing doses. The Medication and Treatment Orders policy dated 2/2024 instructed orders for medications and treatments will be transcribed accurately and in a timely manner. Orders must include: a. Name and strength of the drug. b. Number of doses, start and stop date, and/or specific duration of therapy. c. Dosage and frequency of administration. d. Route of administration. e. Clinical condition or symptoms for which the medication is prescribed; and f. Any interim follow-up requirements