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	06/04/2026

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 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** Based on interview and document review, the facility failed to notify the physician and or the resident representative timely for 2 of 3 residents (R1,R4) reviewed for change in condition. Findings include:R1's hospital Discharge summary dated [DATE], identified R1's primary diagnoses included type two diabetes mellitus, acquired absence of right leg below knee (BKA), acute on chronic left lower extremity (LLE), rheumatoid arthritis with rheumatoid factor, and peripheral vascular disease.R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 had no cognitive impairment and was receiving a pain medication.R1's care plan dated 5/8/26 identified a focus of alteration in comfort related to left lower extremity pain with staff interventions included providing non-medicinal forms of pain relief such as positioning, rest, massage, etc; administering pain medication as ordered by the provider, and documenting the effectiveness of the pain medication.On 5/21/26 at 6:55 a.m., R1's progress note indicated the resident complained of pain and was administered oxycodone 10 mg as needed (PRN) along with acetaminophen (Tylenol). The documentation further indicated R1 was transferred to the hospital per family request for pain control. However, review of the clinical record did not evidence whether the administered pain interventions were effective or whether R1's response to the medications was assessed and communicated to the provider timely prior to transfer.Review of the provider call logs dated 5/20/26 through 5/21/26 showed no evidence the provider was notified regarding R1's missed doses of ordered hydromorphone, reports of unmanaged pain, and transfer to the hospital for pain control.R4's hospital Discharge summary dated [DATE], identified R4's primary diagnoses included confusion, frequent falls, dementia, chronic low back pain, and generalized weakness.R4's admission Minimum Data Set (MDS) dated [DATE], indicated R4 had severe cognitive impairment and required partial/moderate assistance for toileting and transfers.R4's care plan dated 10/6/25 identified a focus of alteration in mood and behavior, resident expresses agitation during cares. Staff interventions included monitor and document mood state/behaviors upon occurrence, if resident becomes anxious, remove from crowed area, reorientation, and supervision as needed. Keep MD or PA informed of changes.R4's x-ray results right wrist, two views dated 10/19/25 at 7:14 p.m., identified R4 had a distal ulnar fracture.R4's incident review and analysis, dated 10/20/25, indicated that on 5/18/25 at approximately 12:00 p.m., R4 attempted to stand and ambulate without assistance. Staff instructed the resident to sit down for safety; however, R4 became agitated and forcefully slammed her right hand/arm onto a chair in the lunchroom, resulting in a major injury. The injury was characterized by redness and swelling of the right hand. Although the incident resulted in a major injury, the record did not indicate whether the resident's representative was notified at the time of the incident.On 10/18/2025 at 10:39 p.m., a progress note documented that R4 was observed to have swelling and redness in the right wrist area. The note indicated the provider was notified. However, a review of R4's medical record did not contain documentation demonstrating that the resident's representative was notified of the change in condition or the incident. During an interview on 6/3/26 at 10:39 a.m., Nurse Practitioner (NP-A) stated R1 was experiencing severe pain in the left lower extremity (LLE). (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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NP-A explained, on 5/20/26, the treatment plan was revised to transition R1 from oxycodone 10 mg to hydromorphone 4 mg every four hours in an effort to achieve better pain control. NP-A further stated she faxed the new medication order to the pharmacy and confirmed the facility had been notified of the change. NP-A indicated she was unable to locate documentation in R1's medical record verifying hydromorphone 4 mg had been administered as ordered. Additionally, NP-A stated she could not confirm whether the on-call provider had been notified when R1 experienced a change in condition.During an interview on 6/2/26 at 2:25 p.m., Family Member (FM)-A stated she had never received a phone call or any update from the facility regarding R1's change in condition.During an interview on 6/2/26 at 2:43 p.m., FM-B stated R1 called him at approximately 4:00 a.m. on 5/21/26. According to FM-B, R1 was crying in pain, appeared to be in poor condition, and begged him to come get her and take her to the hospital.During an interview conducted on June 2, 2026, at 4:04 p.m., FM-C stated she arrived at the facility at approximately 5:00 a.m. on May 21, 2026, and found R1 lying in a fetal position in bed, crying and complaining of pain. FM-C reported she requested staff send R1 to the hospital for evaluation. FM-C stated, after waiting approximately 45 minutes without any action being taken, she called 911 to have R1 transported to the hospital.During an interview conducted on 6/4/26 at 11:01 a.m., FM-D stated he did not recall receiving a call from the facility regarding R4's 5/18/25 incident involving a right wrist injury. FM-D further stated he was not informed of R4's increased agitation or resistance to care on 5/18/25.During an interview on 06/03/26 at 11:19 a.m., Registered Nurse (RN-A) stated she was not aware of R1's hydromorphone 4 mg one-time order. RN-A confirmed R1 was experiencing ongoing pain related to her wound and expressed frustration. RN-A stated she was unclear whether the existing oxycodone 10 mg order should have been discontinued and whether the hydromorphone 4 mg every 4 hours was intended to replace the oxycodone order. RN-A explained she did not notify the provider regarding R1's ongoing pain or whether oxycodone 10 mg was not effective and to request further directions.During an interview on 6/4/26 at 4:04 p.m., the Director of Nursing (DON) stated staff were expected to immediately report any change in condition or resident concern to the provider. The DON stated that he could not locate documentation indicating whether R4's representative had been notified. The DON further explained that when the incident occurred, the nurse should have timely assessed R4, administered pain medication, notified the provider, and contacted the resident's family. The DON confirmed also the provider was not notified when R1 experienced a change in condition.Notification of Changes Policy dated 3/2024 directed the facility staff to make appropriate and timely notification to the physician and delegated non-physician practitioner and notification to the resident representative when there is a change in the resident's condition that may require physician intervention.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 provide pain management in accordance with the resident's new physician's orders to a resident experiencing pain for 1 of 3 residents (R1) reviewed for medication administration. Findings include:R1's hospital Discharge summary dated [DATE], identified R1's primary diagnoses included type two diabetes mellitus, acquired absence of right leg below knee (BKA), acute on chronic left lower extremity (LLE), rheumatoid arthritis with rheumatoid factor, and peripheral vascular disease.R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 had no cognitive impairment and was receiving pain medications.R1's care plan dated 5/8/26 identified a focus of alteration in comfort related to left lower extremity pain with staff interventions included providing non-medicinal forms of pain relief such as positioning, rest, massage, etc; administering pain medication as ordered by the provider, and documenting the effectiveness of the pain medication.R1's physician order dated 5/20/26 instructed:- to discontinue oxycodone 10 mg.-to administer hydromorphone (use to manage moderate to severe pain) 4mg per mouth (po) one time only for left foot pain.-to start hydromorphone 4 mg po every 4 hours as needed for left foot pain.Review of May 2026 medication administration record (MAR) showed R1 did not receive any doses of hydromorphone 4 mg from 5/20/26 through 5/21/26.R1's medication incident report dated 5/21/26 at 11:45 a.m., indicated the facility failed to timely transcribe the hydromorphone 4 mg every four hours as needed order and failed to transcribe the hydromorphone 4 mg one-time order as per physician's order on 5/20/26.R1's progress note dated 5/21/26 at 6:55 a.m., indicated R1 had complained of pain and was administered oxycodone 10 mg as needed (PRN) along with acetaminophen (Tylenol). The note further indicated R1 was transferred to the hospital per family request for pain control. However, review of R1's clinical record did not evidence whether the administered pain interventions were effective or whether R1's response to the medications was assessed and documented prior to transfer.During an interview on 06/03/26 at 11:19 a.m., Registered Nurse (RN-A) stated she was not aware of R1's hydromorphone 4 mg one-time order. RN-A reported R1 was frustrated regarding her wound and was consistently experiencing pain. RN-A further stated she was uncertain whether the previously ordered oxycodone 10 mg should have been discontinued and whether hydromorphone 4 mg every four hours was intended to replace it.During an interview conducted on 6/3/26 at 1:49 p.m., RN-C stated when a resident reports pain, nursing staff should assess the location of the pain and determine the severity using a 0 (no pain) to 10 (severe pain) scale. RN-C further stated non-pharmacological interventions should be offered prior to administering pain medication. She added the nurse should reassess the resident at a later time to evaluate the effectiveness of the intervention. RN-C explained she was unable to locate documentation indicating why hydromorphone 4 mg was not administered to R1 as ordered. RN-C confirmed failure to administer hydromorphone 4 mg to R1 as prescribed constituted a medication error.During an interview on 6/3/26 at 10:39 a.m., Nurse Practitioner (NP-A) stated she expected the nurse to administer the one-time dose order immediately as prescribed. NP-A explained R1 was experiencing severe pain in the left lower extremity (LLE) and the treatment plan was to transition from oxycodone 10 mg to hydromorphone 4 mg every four hours to achieve improved pain control. NP-A further stated she faxed the new order to the pharmacy and confirmed the facility was aware of the change. However, NP-A indicated she was unable to locate documentation in R1's medical record confirming hydromorphone 4 mg had been administered as ordered.During an interview on 6/4/26 at 4:04 p.m., the Director of Nursing (DON) stated he expected nurses to follow physician orders. The DON confirmed the hydromorphone 4 mg one-time dose, as well as the hydromorphone 4 mg every four hours, were not administered as ordered on 5/20/26. The DON further stated RN-A did not return his call for interview.The Pain Management Protocol dated 3/23/2025 directed the provider to order appropriate medication interventions to address individuals' pain and for the staff to evaluate and (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	report how much and how often the resident utilizes PRN pain medication. It also directed staff to notify the provider if the prescribed medications are not available or there is a delay in obtaining the medication.

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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 record review, the facility failed to timely transcribe the physician's new orders to initiate a pain management therapy for 1 of 3 residents (R1) reviewed for medication administration. Findings include:R1's hospital Discharge summary dated [DATE], identified R1's primary diagnoses included type two diabetes mellitus, right leg below knee amputation (BKA), acute on chronic left lower extremity (LLE), rheumatoid arthritis with rheumatoid factor, and peripheral vascular disease.R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 had no cognitive impairment and was receiving a pain medication.R1's physician order dated 5/20/26 instructed:- to discontinue oxycodone 10 mg.- to administer hydromorphone (use to manage moderate to severe pain) 4mg per mouth (po) one time only for left foot pain.-to start hydromorphone 4 mg po every 4 hours as needed for left foot pain.R1's facility physician orders that were transcribed into electronic health record (EHR) did not include orders for hydromorphone 4 mg one time only or hydromorphone 4 mg every 4 hours as needed per physician order dated 5/20/26.Review of R1's physician orders dated 5/20/26 revealed that orders for hydromorphone 4 mg one-time dose and hydromorphone 4 mg every 4 hours as needed (PRN) were not transcribed into the facility's EHR, resulting in the EHR not accurately reflecting the physician's prescribed medication orders.Review of May 2026 medication administration record (MAR) showed R1 did not receive any doses of hydromorphone 4 mg as prescribed from 5/20/26 through 5/21/26.Review of R1's medication incident report dated on 5/21/26 at 11:45 a.m. revealed the facility failed to accurately and timely transcribe physician orders for hydromorphone. Specifically, a physician order dated 5/20/26 for hydromorphone 4 mg every four hours as needed (PRN) was not transcribed in a timely manner, and a separate one-time order for hydromorphone 4 mg was not transcribed as ordered. As a result, the facility failed to ensure physician medication orders were implemented according to prescribed directions.R1's progress note dated 5/21/26 at 6:55 a.m., indicated R1 had complained of pain, she was administered oxycodone as needed, Tylenol, and was transferred to the hospital per family request for pain control.During an interview on 6/3/26 at 9:31 a.m., pharmacy technician (pharm tech)-A stated R1's hydromorphone 4 mg was delivered to the facility on 5/20/26 at 6:00 p.m. Pharm Tech-A explained a registered nurse (RN)-A signed for receipt of the medication at the time of delivery.During an interview on 6/3/26 at 11:19 a.m., RN-A stated medications were administered per physician orders. RN-A recalled receiving R1's hydromorphone 4 mg delivery on 5/20/26 and securing it in the narcotic book. However, she did not recall receiving the one-time physician order for the medication. RN-A explained she did not transcribe the hydromorphone 4 mg order into the EHR and did not co-sign the order for R1 on 5/20/26.During an interview on 6/3/26 at 4:44 p.m., RN-B explained new physician orders must be transcribed into the EHR and cosigned by a second nurse before becoming available in the MAR for administration. RN-B further stated medications will populate in the MAR for administration based on the documented start date entered during transcription.During an interview on 6/3/26 at 9:08 a.m., a nurse practitioner (NP)-A stated one-time dose medications are expected to begin on the day they are ordered. NP-A reported she was at the facility on 5/20/26 when she found R1 crying in pain. After assessing R1, NP-A issued new orders for a one-time dose of hydromorphone 4 mg, discontinued oxycodone 10 mg, and initiated hydromorphone 4 mg every four hours for left leg pain. NP-A further stated on 5/21/26, the director of nursing (DON) informed her that the 5/20/26 orders had not been transcribed into the EHR, and R1 had been sent to the hospital at the family's request for pain management.During an interview conducted on 6/4/26 at 4:04 p.m., the DON confirmed R1's new physician orders dated 5/20/26 were not entered into the EHR until 5/21/26. This delay occurred after R1 had already been transferred to the hospital for pain management. The order for hydromorphone, which was scheduled to begin on 5/20/26 at 6:00 p.m., was not initiated as ordered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	As a result, R1 experienced a delay in receiving the prescribed medication, resulting in missed doses.The Medication and Treatment Orders policy dated 2/2024 instructed orders for medications and treatment will be transcribed accurately and in a timely manner. Orders must include:Name and strength of the drug.Number of doses, start and stop date, and/or specific duration of therapy.Dosage and frequency of administration.Route of administration.Clinical condition or symptoms for which the medication is prescribed; andAny interim follow-up requirements.