STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245629	A. BUILDING _____ B. WING _____	06/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE VILLA AT OSSEO	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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to recognize a change in condition and revise interventions related to mobility needs for 1 of 3 residents (R1) reviewed. Findings include: R1's admission Minimum Data Set (MDS), dated [DATE], identified R1 required extensive assistance from two staff for bed mobility and transfers, able to ambulate with assistance from two staff in his room and in the corridor, requiring limited assistance from 1 staff for locomotion on and off the unit, extensive assistance for one staff for dressing, toileting and personal hygiene and being independent with eating after set up by staff. R1's [DIAGNOSES REDACTED]. R1's care plan date initiated 4/16/2020, indicated R1 has actual need for an ADL (activities of daily living) self-care performance deficit related to [MEDICAL CONDITION] and [MEDICAL CONDITION]. Interventions included encourage the resident to use bell to call for assistance and monitor/document/report as needed any changes, any potential for improvement, reasons for self-care deficit, and declines in function. Interventions according to facility Unit 3 Care Guides, undated, included assistance from one staff with dressing, grooming and transfers, assistance from 1 staff for set up with oral care, assistance from 1 staff with toileting, independent with bed mobility. A nurse note dated 4/18/2020, indicated R1 required partial/moderate assistance while transferring, for bed mobility, with dressing, hygiene tasks and toileting. The note also indicated R1 was independent with wheelchair use and eating. Occupational therapy (OT) discharge summary dated 5/28/20, indicated R1 required maximum assistance with dressing upper and lower body, moderate assistance with transfer, maximum assistance with perineal cares and clothing management. Physical therapy (PT) discharge summary dated 5/28/20, R1 required moderate assistance with ambulation and minimal assistance with bed mobility. A nurse note dated 5/28/2020, indicated R1 required partial/moderate assistance while walking, transferring, with bed mobility, wheelchair mobility, dressing and hygiene tasks. The noted also indicated R1 was independent with eating and toileting. A nurse note dated 6/1/20, indicated R1 was 100% dependent for transferring, wheelchair mobility, dressing, hygiene tasks and toileting. This same nurse note indicated R1 required substantial/maximum assist for bed mobility and was independent when eating. A nurse note dated 6/13/20, indicated R1 was 100% dependent for transferring, wheelchair mobility, dressing and toileting. R1 required substantial/maximum assist for bed mobility and partial/moderate assistance for hygiene tasks and eating. While this was a change from the care plan dated 4/16/20, the record failed to include an update to the care plan or other interventions initiated for R1 in response to the change in mobility. During an interview on 6/15/20, at 1:55 p.m. licensed practical nurse manager (LPN)-A stated she was not aware of changes to R1's changes in physical needs for assistance. LPN-A stated she was made aware of the changes when talking with unlicensed staff during this interview. LPN-A stated nurse notes were reviewed each business day from the previous business day. Review of nursing notes was completed during the morning interdisciplinary meeting. Changes are identified and discussed to determine appropriate intervention. LPN-A stated she personally reviewed nurse notes each business day. The facility's Unit 3 Care Guide, (guide used by nursing assistants to provide care) undated, indicated R1 required one staff assistance with dressing, grooming, toileting and transfers. R1 required one staff assistance to set up for oral care. R1 was independent with glasses, hearing aids and adaptive equipment and with bed mobility. During interview on 6/15/20, at 2:59 p.m. certified nursing assistant (CNA)-A stated R1 required two staff assist with transfers and required full assistance with bed mobility. CNA-A stated R1 required full support of staff for transfers and is not safe to transfer with 1 staff assist. CNA-A stated he was aware this is different than what is on the facility Unit Care Guide and he previously told one of the licensed nurses that R1 was too difficult to transfer with one staff and should have two staff for transfers. During interview on 6/17/20, at 11:43 a.m. LPN-B stated the unlicensed staff are supposed to communicate resident changes in condition to the licensed staff. The licensed staff talk with therapy and their supervisor to make them aware of the changes. Changes are documented in the resident record. During interview on 6/17/20, at 11:50 a.m. LPN-A stated licensed staff are expected to notify the resident's physician, their supervisor and the on call nurse when there is a change in the resident's condition. Licensed staff are also supposed to pass the information on to the next shift during report. She stated the CNA's have brought resident change information directly to her. During interview on 6/17/20, at 12:30 p.m. director of nurse (DON) stated since LPN-A was made aware of R1's change in physical need, a referral to physical therapy was made on 6/15/20, and an assessment by physical therapy was completed the same day. Based on the assessment, R1's transfer assistance was changed to indicate he required a mechanical lift to assist with standing, for transfers. The facility's Reposition in Chair, Algorithm 4, undated, states during any patient transferring task, if any caregiver is required to lift more than 35 pounds of a patient's weight, then the patient should be considered to be fully dependent and assistive devices should be used.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **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** Based on observation, interview and record review, the facility failed to ensure call light was in reach for 1 of 2 residents (R2) who was assessed to be at high risk for falls. Findings include: R2's annual Minimum Data Set (MDS), dated [DATE], indicated R2 had moderate cognitive impairment and required extensive assistance from two staff for bed mobility and dressing, total assistance from two staff for transfers and toilet use, extensive assistance from one staff for locomotion on/off the unit and personal hygiene and supervision after set up for eating. R2 [DIAGNOSES REDACTED]. R2's Fall Risk assessment dated [DATE], indicated R2 is high risk to fall based on identified factors including generalized weakness and limited/poor mobility; altered elimination (incontinence, nocturia-excessive urination at night, and frequency); use of anti-epileptic medication; receiving 9 or more medications. R2's care plan indicated resident is at risk for falls due to decreased mobility, cognitive impairment, does not walk, hoyer lift, wheelchair main mode of mobility. Interventions on care plan: ensure bed brakes are locked, ensure footwear fits properly, Hoyer lift for all transfer with assist of 2. Resident is totally dependent on 1 staff for locomotion using wheelchair on and off the unit. During observation on 6/15/20, at 1:31 p.m. call light was not within R2's reach. The call light was clipped to a privacy curtain which was placed behind R2's wheelchair. R2 was seated in her wheelchair three feet away from the privacy curtain and call light. During interview on 6/15/20, at 1:31 p.m. R2 stated she was supposed to push something to call for help, a button, I guess. But it isn't on my table so I'm not sure how I would call for help. When explained where call light was located, R2 was unable to propel self in wheelchair to get to call light. During observation on 6/15/20, at 2:41 p.m. call light remained clipped to privacy curtain which was placed behind R2's wheelchair. R2 remained in wheelchair three feet away from the

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

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.

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) privacy curtain and call light. R2 was not able to reach the call light where it was located. During observation on 6/15/20, at 3:09 p.m. CNA(certified nursing assistant)-B entered R2's room. Call light had not been turned on. Call light remained clipped to the privacy curtain which was placed behind R2's wheelchair. R2 remained in the wheelchair. CNA-B left the room without moving the call light to within R2's reach. During interview on 6/17/20, at 11:50 a.m. LPN(licensed practical nurse)-A stated every resident should have a call light within reach. If staff walked into a resident's room and they don't have their call light, they need to give it to the resident and let the nurse know. The nurse will then investigate to determine who did not place the call light and re-education will be provided. During interview on 6/17/20, at 1 p.m. director of nursing (DON) stated everyone should have a call light. They should be accessible to residents at all times-within their reach. If staff notices no call light, they should place it within the resident's reach and notify a nurse. The nurse should ask for the reason the resident didn't have the call light and determine if further intervention is needed. DON stated she checks all rooms when she is in them, as do the nurse managers. During interview on 6/17/20, at 4:20 p.m. RN(registered nurse)-A stated every resident should have a call light within their reach. If unlicensed staff finds a resident without their call light, they need to let a nurse know. RN-A stated she investigate why the resident did not have their call light and report it to her supervisor. Although a policy was requested, related to call lights none was provided.