Electronically Delivered

April 23, 2025

Licensee
Osseo Gardens Assisted Living
525 2nd Street Southeast
Osseo, MN 55369

RE: Project Number(s) SL21206016

Dear Licensee:

On March 28, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on January 29, 2025. This follow-up survey verified that the facility is in substantial compliance.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter with your organization's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

JMD

Electronically Delivered

March 5, 2025

Licensee
Osseo Gardens Assisted Living
525 2nd Street Southeast
Osseo, MN 55369

RE: Project Number(s) SL21206016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 29, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at

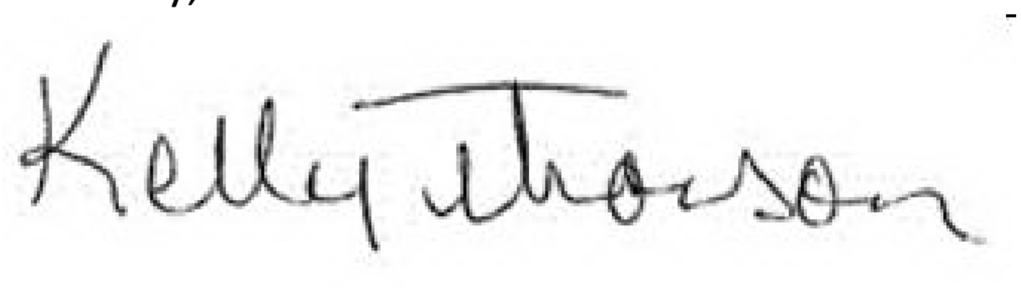
the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21206	A. BUILDING: _____ B. WING _____	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OSSEO GARDENS ASSISTED LIVING	525 2ND STREET SE OSSEO, MN 55369

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL21206016-0 On January 27, 2025, through January 29, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 35 residents all of whom received services under the Assisted Living Facility license. An immediate correction order was identified on January 28, 2025, issued for SL21206016-0, tag identification 1290. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 27, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 650 SS=E	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for two of three employees (unlicensed personnel (ULP)-B, ULP-R). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 650		

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0 650	Continued From page 4 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-B ULP-B was hired on March 29, 2022, to provide direct care services to residents. On January 28, 2025, at 8:52 a.m., the surveyor observed ULP-B apply a FarrowWrap (compression treatment) to R1's left leg. ULP-B's personnel file lacked the following required content: - training: - setting up medications for an unplanned time away from home. - competency evaluation that included: - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - dressing and assisting with toileting; - range of motion and positioning; - setting up medications for an unplanned time away from home; and - FarrowWraps. On January 28, 2025, at 9:30 a.m., ULP-B stated they were trained and watched by a nurse prior to independently completing the FarrowWrap treatment on a resident. On January 29, 2025, at 8:30 a.m., ULP-B stated	0 650		

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0 650	Continued From page 5 the nurse trained and watched them complete hair care, oral care, toileting, dressing, range of motion, and setting up medications for residents leaving the facility for a period of time prior to completing the tasks independently at the facility. ULP-R ULP-R was hired on November 8, 2023, as a cook and transitioned to an ULP position on April 24, 2024, to provide direct care services to residents. ULP-R's personnel file lacked the following required content: - training: - setting up medications for an unplanned time away from home. - competency evaluations that included: - setting up medications for unplanned time away from home; and - FarrowWraps. On January 29, 2025, at 9:10 a.m., ULP-R stated they received training, and a nurse watched them complete the competencies listed above prior to completing the tasks independently at the facility. On January 29, 2025, at 10:20 a.m., assisted living director (ALD)-D stated they were unable to locate any FarrowWrap training or competency evaluations listed above for ULP-B and ULP-R. ALD-D stated they were responsible for the employee record. ALD-D stated the licensee had experienced employee turnover which may have contributed to the lost documents. On January 29, 2025, at 10:47 a.m., regional director of clinical services (RDOCS)-C stated they were unable to locate ULP-B's training or competency evaluation on FarrowWraps in	0 650		

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0 650	Continued From page 6 ULP-B's record or in the R1's home care medical record. RDOCS-C stated the licensee "typically" trained the ULP and then completed a competency evaluation any treatments provided by the licensee. RDOCS-C stated the licensee had a protocol for FarrowWraps. RDOCS-C stated they were holding a staff meeting to complete training and competency evaluations on FarrowWrap with staff on January 30, 2025. The licensee's 4.05 Employee Records policy dated August 1, 2021, indicated employee records would include records of all training and in-service education required and/or provided including record of competency testing as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding	0 680		

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0 680	Continued From page 7 missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated EPP binder, lacked evidence of the following required content: - considered emerging infectious diseases; - strategies that addressed facility and community based risks including staffing surges and shortages; - missing resident plan and a quarterly review of the missing resident plan;	0 680		

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0 680	Continued From page 8 - process for emergency plan (EP) collaboration; - alternative sources of energy to maintain sewage and waste disposal; - policies and procedures (P/P) for medical documents; - emergency contact information; and - methods for sharing information. On January 29, 2025, at 10:09 a.m., assisted living director (ALD)-D stated they updated the EPP as time allowed. ALD-D stated the EPP was "less than desirable." ALD-D stated when they began employment, the EPP documentation they could find was not complete, and they were unable to find a majority of the content. ALD-D stated they addressed the issue about the incomplete EPP during the licensee's quality management meeting. ALD-D stated the licensee experienced multiple turnovers with employees which contributed to the EPP not being completed as it took multiple employees to complete the plan. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance dated August 1, 2021, indicated the licensee had in place an effective and compliant EPP. In addition, the intent was the plan would be aligned with the Centers for Medicare and Medicaid Services state operational manual Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780		

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0 780	Continued From page 9 for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	0 780		

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0 780	Continued From page 10 a large portion or all of the residents). The findings include: On January 28, 2025, at approximately 10:30 a.m., the surveyor toured the facility with director of maintenance (DOM)-E During the tour, the surveyor observed the following: When smoke alarms were tested for interconnection by the licensee, the smoke alarms installed in units 29 and 30 did not actuate. The dwelling unit smoke alarms were not interconnected as required by statute. During the facility tour interview on January 28, 2025, DOM-E acknowledged the observation while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain all furnishings, and equipment	0 800		

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OSSEO GARDENS ASSISTED LIVING	525 2ND STREET SE OSSEO, MN 55369

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 11 in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 28, 2025, at approximately 10:30 a.m., the surveyor toured the facility with director of maintenance (DOM)-E. The following was observed. GENERAL MAINTENANCE: The water closets in units 5, 31, and 33 had caulking that was peeling, missing, and was not properly sealed to the floor allowing the potential of water damage and unsanitary conditions. Emergency lighting did not work outside of unit 16 when testing was initiated. During the facility tour interview on January 28, 2025, DOM-E verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		

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0 810	Continued From page 12	0 810		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire	0 810		

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0 810	Continued From page 13 safety and evacuation plan with the required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 28, 2025, at approximately 11:30 a.m., director of maintenance (DOM)-E. provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP failed to include the following: The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On January 28, 2025, DOM-E stated they understood the area of their policy that was incomplete and would work on bringing the policy into compliance.	0 810		

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0 810	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study clearance was submitted and received in affiliation with the assisted living health identification number (HFID#) for two of 21 employees (unlicensed personnel (ULP)-F, resident store coordinator (RSC)-G). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was	01290	During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	

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01290	Continued From page 15 issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-F ULP-F was hired on March 30, 2015, to provide direct care services to residents. ULP-F's record included a background clearance letter affiliated the licensee's former comprehensive license HFID#28288 completed May 2, 2019. ULP-F's Time Sheet Summary dated January 12, 2025, through January 25, 2025, indicated ULP-F worked eight different shifts between the two dates from 3:00 p.m., to 11:30 p.m. ULP-F's Service Recap- By Staff dated January 27, 2025, indicated ULP-F assisted R4 with medication administration on January 27, 2025. RSC-G RSC-G was hired on April 9, 2013, to assist with managing the licensee's in-house store and to assist residents with obtaining personal items from local stores. RSC-G's Time Sheet Summary dated January 17, 2025, through January 24, 2025, indicated RSC-G worked six hours on January 17, 2025. On January 28, 2025, at 1:55 p.m., the surveyor observed the licensee's Minnesota Department of Human Services (DHS) NETStudy 2.0 (a web-based system used to submit background study requests) roster for health facility	01290		

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01290	Continued From page 16 identification number (HFID#) 21206 and observed ULP-F and RSC-G were "In Process" as of January 28, 2025. On January 28, 2025, at 2:19 p.m., regional licensed assisted living director (RLALD)-H stated ULP-G and RSC-G's background studies were submitted to be completed on January 28, 2025, during the survey. RLALD-H stated when they were printing out the NETStudy 2.0 Roster they noticed the two employees were not listed. RLALD-H stated ULP-F and RSC-G's employee file contained background study clearance letters however, when the licensee changed from comprehensive license to an assisted living license in 2021, they did not resubmit a background study for ULP-F and RSC-G. The surveyor discussed seven additional employees that were not listed on the employee roster with regional director of clinical services (RDOCS)-C, assisted living director (ALD)-D, and RLALD-H. RDOCS-C stated the other seven employees worked for a sister facility or a contracted agency and they would work on providing the surveyor background study clearances related to those employees. On January 28, 2025, at 2:15 p.m., the surveyor observed NETStudy 2.0 website and observed the following: - HFID#28288 was inactive; - RSC-G was affiliated to the licensee's former comprehensive license HFID#28288 on June 13, 2018, and was separated from the licensee on November 21, 2021. RSC-G was affiliated to the licensee's current HFID#21206 on January 28, 2025, during the survey, and supervision was required to work at the facility; - ULP-F was separated from the licensee's former comprehensive license HFID#28288 on	01290		

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01290	Continued From page 17 July 4, 2018, and again on November 21, 2021. ULP-F was affiliated to the licensee's current HFID#21206 on May 17, 2023, and was separated from the roster June 1, 2023. A DHS letter dated June 1, 2023, addressed to the licensee indicated ULP-F was separated because fingerprints and photo were not provided in the time required. The letter directed the licensee to immediately remove ULP-F from their position. ULP-F was re-affiliated to the licensee's roster HFID#21206 on January 28, 2025, during the survey, and supervision was required to work at the facility. On January 28, 2025, at 4:11 p.m., RLALD-H stated the licensee conducted a background study when employees were hired and then sent them home to complete training via EduCare (a training software program) until the background clearance letter was received. RLALD-D stated background studies were the responsibility of the directors of the facility. RLALD-D stated they have had four or five directors prior to ALD-D. RLALD-D stated all corporate facilities were instructed to conduct new background studies when their licenses converted to assisted living licensure. RLALD-D stated they were not sure how some of the background studies "slipped through". ALD-D and RLALD-D both stated they were unaware the licensee received a letter indicating ULP-F must be removed from their position. RLALD-D stated the agent, regional, and assisted living directors all had access to NETStudy 2.0. The licensee's 4.02 Background Studies policy dated August 1, 2021, indicated using the Minnesota (MN) NETStudy online program, the licensee would initiate a background study on all employees being considered for hire. Prior to	01290		

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01290	Continued From page 18 receiving the results of the background study new hires shall not be permitted to interact or provide services to residents except under the direct supervision of another qualified staff member. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01530 SS=E	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;	01530		

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01530	Continued From page 19 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a supervisor of direct-care employees received at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date for one of one nurse (licensed practical nurse (LPN-A). In addition, the licensee failed to ensure direct-care staff received at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date for one of two direct care employees (unlicensed personnel (ULP)-R). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: LPN-A LPN-A was hired on November 11, 2024, to provide oversite to ULP, and to provide direct care services to residents. LPN-A undated EduCare (a training software program) transcript included five hours and 15 minutes of dementia care training completed between January 7, 2025, and January 20, 2025. On January 28, 2025, at 1:55 p.m., assisted living	01530		

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01530	Continued From page 20 director (ALD)-D stated since LPN-A's date of hire, LPN-A worked 313.75 regular hours and 1.5 hours of overtime. ULP-R ULP-R was hired on November 8, 2023, as a cook and transitioned to a ULP position on April 24, 2024, to provide direct care services to residents. ULP-R's undated EduCare transcript included seven hours and 45 minutes of dementia care training completed between January 19, 2024, and June 20, 2024. On January 29, 2025, at 10:22 a.m., ALD-D stated dementia care training for employees were conducted via EduCare modules. ALD-D stated they did not know how many hours of dementia training employees were supposed to receive. On January 29, 2025, at 8:39 a.m., the surveyor observed LPN-A on the computer completing a dementia care training while completing other tasks in the nursing office. On January 29, 2025, at 10:51 a.m., regional director of clinical services (RDOCS)-C stated the licensee provided eight hours of initial dementia care training and two hours annually. RDOCS-C stated they did not know why the two employees listed above did not receive the initial eight hours of dementia care training. RDOCS-C stated the licensee had multiple leadership changes that may have impacted the two employees from receiving the full training. The licensee's 5.3 Dementia Training policy dated August 1, 2021, indicated supervisors of direct care staff would complete eight hours of initial	01530		

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01530	Continued From page 21 dementia care training within 120 hours of employment start date. In addition, direct care employees would complete eight hours of initial training within 160 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by:	01640		

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01640	Continued From page 22 Based on observation, interview, and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident or resident's designated representative to document agreement on the services to be provided for one of four residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 admitted to the licensee on December 6, 2023, and began receiving assisted living services. On January 28, 2025, at 7:51 a.m., 8:11 a.m., and 9:30 a.m., the surveyor observed ULP-B complete blood glucose monitoring with use of the libre sensor on R3. R3's Individualized Treatment and Therapy Plan dated January 28, 2025, included blood glucose monitoring four times per day using the libre sensor and if sensor was not functioning to use a finger stick and a glucometer. R3's Service Plan (Waiver)-Addendum to contract signed January 12, 2024, indicated R3 received assistance with activities, bathing, toileting, dressing, grooming, housekeeping, laundry, behavior management, meals, medication	01640		

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01640	Continued From page 23 assistance, safety checks, and recording of oxygen, pulse, respirations, temperature, and weight. R3's service plan lacked blood glucose monitoring. On January 27 a.m., at 9:40 a.m., regional director of clinical services (RDOCS)-C stated registered nurses (RN) develop and maintain the service plan. RDOCS-C stated RNs would review the assessment and would revise the service plan if there were any new services that needed to be provided. On January 29, 2025, at 12:57 p.m., assisted living director (ALD)-D stated the blood glucose monitoring should have been on R3 service plan, and they were unaware of why it was missed. The licensee's 6.08 Service Plan policy dated August 1, 2021, indicated the service plan would include a description of the services that were to be provided based on the most recent assessment and resident preferences. In addition, service plan revisions shall include a signature or other authentication by the licensee and by the resident or resident's representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident.	01820		

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01820	Continued From page 24 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted to the licensee on June 27, 2023, and began receiving assisted living services. R1's diagnoses included chronic kidney disease stage 3, morbid obesity, lymphedema, diabetes mellitus type 2 with diabetic neuropathy, and peripheral vascular disease. R1's Addendum to Contract - Wavier - MN signed November 11, 2024, indicated R1 received assistance with activities, bathing, skin monitoring, toileting, dressing, elevation of lower legs, escorts, housekeeping, laundry, behavior management, medication administration, blood glucose monitoring, and vital sign monitoring. On January 28, 2025, at 8:52 a.m., the surveyor observed ULP-B administer oxybutynin extended release (ER) 10 milligrams (mg) to R1.	01820		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OSSEO GARDENS ASSISTED LIVING	525 2ND STREET SE OSSEO, MN 55369

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01820	Continued From page 25 R1's prescriber order signed January 6, 2025, indicated "Stop Oxybutynin ER - this is a falls risk." R1's Med Admin Summary -Actual - Month dated January 1, 2025, through January 31, 2025, included oxybutynin ER 10 mg take one tablet by mouth daily. The medication was administered once daily from January 1, 2025, to January 27, 2025, indicating R1 received oxybutynin for 20 days after it was discontinued. On January 28, 2025, at 10:38 a.m., licensed practical nurse (LPN)-A stated R1 received a new order to start Gemtesa however, the medication was not covered by insurance. LPN-A stated they continued the oxybutynin on R1's medication administration record and were going to discontinue oxybutynin once Gemtesa arrived at the facility. LPN-A stated they called the pharmacy multiple times related to Gemtesa and called the prescriber to clarify if oxybutynin should continue until Gemtesa arrived. The surveyor requested documentation of the conversation held with the prescriber. LPN-A was unable to find any documentation within R1's medical record to show the prescriber wanted oxybutynin to continue. On January 28, 2025, at 11:07 a.m., the surveyor observed LPN-A contacting the prescriber for an order to continue oxybutynin until Gemtesa arrived at the facility. R1's prescriber order signed January 28, 2025, during the survey, read, "OK to continue Oxybutynin as prescribed until Gemtesa received. Discontinue Oxybutynin once Gemtesa able to be started."	01820		

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01820	Continued From page 26 On January 29, 2025, at 10:58 a.m., regional director of clinical services (RDOCS)-C stated they were unable to locate an order to resume and/or continue oxybutynin until Gemtesa was received by the pharmacy. RDOCS-C stated there was a lack of communication between R1's primary doctor and specialty doctor. RDOCS-C stated, "from what I can see that order should have been discontinued" however, LPN-A told them they clarified the order with the provider but "I did not find any evidence on our end that that occurred." The licensee's 7.16 Medication & Treatment Orders - Implementing policy dated August 1, 2025, indicated medication orders received by the licensee must be implemented within 24 hours. The licensee's 7.17 Medication & Treatment Orders - Receiving dated August 1, 2025, indicated all orders for medications must be dated and signed by the provider. In addition, verbal orders received from a prescriber must have the RN/LPN: - record and sign the order; - a record of the verbal order would be kept in the resident record; and - all verbal orders received would be written and then forwarded to the prescriber for the prescriber's signature. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for	01890		

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01890	Continued From page 27 immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to discard expired medication for two of 24 residents (R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On January 27, 2025, at 10:31 a.m., the surveyor observed the licensee's medication carts with unlicensed personnel (ULP)-S and observed the following expired medications: - R4's Anucort HC 25 milligram (mg) suppositories with an expiration date of January 3, 2025; and - R5's ondansetron 4 mg with an expiration date of December 12, 2024. ULP-S stated if they found an expired medication they would notify the nurse. On January 29, 2025, at 11:00 a.m., regional director of clinical services (RDOCS)-C stated ULP were trained to check the expiration dates of	01890		

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01890	Continued From page 28 medications and provide the expired medications to the nurse. RDOCS-C stated nurses were supposed to complete a weekly cart audit to remove expired medications from the medication cart. RDOCS-C stated the nurse who was responsible for the cart audits was a newer employee and was still learning the process. The licensee's 7.23 Medication Disposal policy dated August 1, 2021, indicated expired medications managed by the licensee would be disposed of according to the accepted practices of the Minnesota Board of Pharmacy and the label from the containers would be destroyed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that	01940		

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01940	Continued From page 29 will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a current treatment or therapy management plan to include all required content for one of three residents (R1) who received blood glucose monitoring. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted to the licensee on June 27, 2023, and began receiving assisted living services. R1's diagnoses included chronic kidney disease	01940		

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01940	Continued From page 30 stage 3, morbid obesity, lymphedema, diabetes mellitus type 2 with diabetic neuropathy, and peripheral vascular disease. R1's Addendum to Contract - Wavier - MN signed November 11, 2024, indicated R1 received assistance with activities, bathing, skin monitoring, toileting, dressing, elevation of lower legs, escorts, housekeeping, laundry, behavior management, medication administration, blood glucose monitoring, and vital sign monitoring. On January 28, 2025, at 8:52 a.m., the surveyor observed unlicensed personnel (ULP)-B complete blood glucose monitoring on R1. R1's blood glucose was 97 milligrams per deciliter (mg/dl). R1 stated they felt nausea, and they should switch from insulin to oral diabetic medication because their blood glucose levels ran low. ULP-B stated they would retrieve orange juice and toast for R1. ULP-B reported to the nurse R1's complaint of nausea and blood glucose level to the nurse on the way to the facilities kitchen. R1's prescriber order signed November 12, 2024, included blood glucose monitoring four times per day. R1's Med Admin Summary - Actual - Month printed January 27, 2025, lacked information related to blood glucose monitoring. R1's ongoing assessment dated November 20, 2024, included staff would monitor blood glucose per instruction on medication list and blood glucose was 200 on November 20, 2024. R1's Individual Treatment and Therapy Plan as of January 27, 2025, R1 received blood glucose monitoring four times per day by ULP, ULP wear	01940		

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01940	Continued From page 31 gloves, ULP were to monitor and record blood glucose, and licensed practical nurse (LPN) supervised the prescriber's order. R1's individual treatment plan comprised of multiple documents lacked procedures for notifying a registered nurse or appropriate health professional when a problem arises with blood glucose monitoring. On January 28, 2025, at 9:30 a.m., ULP-B stated when a resident's blood glucose was below 100 mg/dl they provided the resident orange juice to help "spike" the blood glucose level. ULP-B stated their normal practice was to recheck the blood glucose three times to see if the blood glucose level rouse and if the level was still below 100 mg/dl they would contact the nurse for further instructions. ULP-B stated they were trained to administer insulin if blood glucose was above 100 mg/dl. ULP-B stated there was not any documentation related to blood glucose parameters in R1's medical record for when they should contact a nurse. On January 29, 2025, at 1053 a.m., regional director of clinical services (RDOCS)-C stated the licensee's protocol was to place parameters into the RTasks (a documenting software program) of when to call the nurse if the blood glucose was out of range. RDOCS-C stated ULP were trained to contact a nurse if the blood glucose was below 85 mg/dl or above 200 mg/ml. RDOCS-C stated they were unaware of why R1's record lacked procedures for when to notify a nurse. The licensee's 7.15 Medication & Treatment - Administration & Delegation policy dated August 1, 2021, indicated when administration of a treatment or therapy was delegated or assigned	01940		

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01940	Continued From page 32 to an ULP the licensee would ensure the registered nurse has specified in writing, specific instruction for each resident and documented those instructions in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to specify in writing, specific instructions for each resident and to document those instructions in the resident	01950		

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01950	Continued From page 33 record. This resulted in a FarrowWrap application (compression treatment) treatment error for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted to the licensee on June 27, 2023, and began receiving assisted living services. R1's diagnoses included chronic kidney disease stage 3, morbid obesity, lymphedema, diabetes mellitus type 2 with diabetic neuropathy, and peripheral vascular disease. R1's Addendum to Contract - Wavier - MN signed November 11, 2024, indicated R1 received assistance with activities, bathing, skin monitoring, toileting, dressing, elevation of lower legs, escorts, housekeeping, laundry, behavior management, medication administration, blood glucose monitoring, and vital sign monitoring. R1's prescriber order signed November 12, 2024, included staff to apply FarrowWrap in the morning and take off at night. R1's Service Recap Summary - Month dated January 1, 2025, through January 31, 2025, included FarrowWrap 8:00 a.m. and FarrowWrap 8:00 p.m. The document indicated the service	01950		

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01950	Continued From page 34 was completed daily from January 1, 2025, through January 27, 2025. The document lacked specific instructions on how to complete the FarrowWrap treatment. On January 28, 2025, at 8:52 a.m., the surveyor observed ULP-B apply a FarrowWrap to R1's left leg from R1's knee to ankle, which resulted in the wrap overlapping incorrectly in the wrong direction. ULP-B's record lacked training and a competency evaluation related to FarrowWraps. On January 28, 2025, at 9:30 a.m., ULP-B stated the nurse trained them to apply the FarrowWrap at the knee and work the wrap down to the ankle. ULP-B stated they were watched by a nurse prior to independently completing the treatment on a resident. On January 28, 2025, at 10:13 a.m., licensed practical nurse (LPN)-A stated ULP's did not complete treatments without prior training. LPN-A stated ULP were trained by the nurse or by a physical therapist from home care. LPN-A stated the FarrowWrap should be applied starting at the ankle and working the wrap up to the knee. On January 29, 2025, at 10:20 a.m., assisted living director (ALD)-D stated they were unable to locate ULP-B's competency evaluation for FarrowWraps. On January 29, 2025, at 10:47 a.m., regional director of clinical services (RDOCS)-C stated they were unable to locate ULP-B's training or competency evaluation on FarrowWraps. RDOCS-C stated the licensee "typically" trained the ULP and then completed a competency	01950		

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01950	Continued From page 35 evaluation for any treatments provided by the licensee. RDOCS-C stated the licensee had a protocol for FarrowWraps, and they were holding a staff meeting to complete training and competency evaluations on FarrowWraps with staff on January 30, 2025. The licensee's Delegated Procedures - Medication/Treatment - FarrowWraps policy dated December 18, 2024, read,"3. Staff unwrap the leg piece and lay wrap on the floor, behind the leg, with label side facing up. When properly donned the white label will be located just below the knee crease. The shortest bands will be closest to the ankle. 4. Staff take each side of the band closest to the ankle and pull forward, wrapping the band around the lowest part of the leg and secure with the Velcro fastner (sic). If wearing a footpiece (sic), the bottom band should over lap the top of the foot piece. 5. Staff repeat with each band moving up the leg with approximately a 50 % over lap on the band before. Smooth out any wrinkles as you go." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.	02310		

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02310	Continued From page 36 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for one of two residents (R2) who utilized oxygen. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On January 29, 2025, at 11:01 a.m., regional director of clinical services (RDOCS)-C stated R2 was able to adjust their own oxygen and staff ensured R2 did not exceed the oxygen liters being administered, equipment was stored appropriately, filters on the oxygen tanks were maintained, and oxygen tubing was not kinked. RDOCS-C stated oxygen tanks should be stored in a rack and vertical away from other things that could be knocked over and concentrators should be stored three feet away from the wall. On January 29, 2025, at 11:25 a.m., the surveyor observed nine portable cylinder oxygen tanks, two concentrators, one large filling oxygen cylinder, and one home fill machine located in R2's apartment. Four of the nine portable fill tanks were not stored properly in noncombustible racks in R2's apartment.	02310		

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02310	Continued From page 37 On January 29, 2025, at 11:15 a.m., assisted living director (ALD)-D stated they did not realize how many oxygen tanks were in R2 room because R2 ordered their own oxygen from the company. ALD-D stated they were going to contact the oxygen company to get a rack for the oxygen cylinders. The licensee's 7.40 Oxygen policy dated August 1, 2021, indicated oxygen cylinders and vessels must remain upright at all times. Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, recommended cylinders be secured with chains or racks to prevent cylinders from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure unlicensed personnel ((ULP)-B) followed appropriate	02320		

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OSSEO GARDENS ASSISTED LIVING	525 2ND STREET SE OSSEO, MN 55369

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02320	Continued From page 38 treatment administration procedures related to blood glucose monitoring. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B was hired on March 29, 2022, to provide direct care services to residents. ULP-B's record included a competency evaluation for blood glucose monitoring and insulin pen administration dated March 29, 2022. On January 28, 2025, at 7:13 a.m., the surveyor observed ULP-B prepare eight units (u) of insulin lispro and 55 u of Lantus for R3. ULP-B entered R3's room to administer morning medication and insulins however, R3 was using the bathroom. ULP-B exited R3's room, placed medications into an envelope marked with R3's information and placed insulin pens next to it in the medication cart. On January 28, 2025, at 7:44 a.m., the surveyor observed ULP-B conduct a blood glucose monitoring on R3. R3's blood glucose level was 80 milligrams per deciliter (mg/dl). ULP-B provided a to-go meal to R3 and stated they would return to R3 and recheck their blood glucose level after they were done eating. In addition, ULP-B stated R3's blood glucose was	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21206	A. BUILDING: _____ B. WING _____	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OSSEO GARDENS ASSISTED LIVING	525 2ND STREET SE OSSEO, MN 55369

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02320	Continued From page 39 too low to administer insulin. On January 28, 2025, between 7:53 a.m. and 8:10 a.m., ULP-B administered medication to two residents. ULP-B did not notify the nurse of R3's low blood glucose level. On January 28, 2025, at 8:11 a.m., the surveyor observed ULP-B conduct blood glucose monitoring on R3. R3's blood glucose level was 73 mg/dl. ULP-B inquired if R3 ate and R3 stated they ate breakfast. ULP-B stated to R3 they would retrieve orange juice from the kitchen for them. ULP-B stated they were going to give R3 orange juice and if their blood glucose level was still low, they would notify the nurse. ULP-B retrieved two cups of orange juice. The surveyor observed R3 consume one of the two cups prior to exiting R3's room. On January 28, 2025, from 8:21 a.m. to 9:22 a.m., ULP-B continued to pass medications and complete other tasks on residents. ULP-B did not notify a nurse on R3's blood glucose levels. On January 28, 2025, at 9:24 a.m., the surveyor observed ULP-B gather R3's morning medications and insulins from the medication cart. ULP-B entered R3's room, R3 was lying in bed and ULP-B called out to R3 multiple times without response. ULP-B approached the bed and touched R3 to awaken them. ULP-B completed blood glucose monitoring, and R3's blood glucose level was 89 mg/dl. ULP-B stated they would alert the nurse to see what they want them to do with the insulin. ULP-B provided R3's oral medications and exited the room. On January 28, 2025, at 9:30 a.m., ULP-B stated when a resident's blood glucose was below 100	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21206	A. BUILDING: _____ B. WING _____	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OSSEO GARDENS ASSISTED LIVING	525 2ND STREET SE OSSEO, MN 55369

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02320	Continued From page 40 mg/dl they provided the resident orange juice to help "spike" the blood glucose level. ULP-B stated their normal practice was to recheck the blood glucose three times to see if the blood glucose level increased, and if the level was still below 100 mg/dl they would contact the nurse for further instructions. ULP-B stated they were trained to administer insulin if blood glucose was above 100 mg/dl. ULP-B stated there was not any documentation related to blood glucose parameters in R1's medical record for when they should contact a nurse. On January 28, 2025, at approximately 10:00 a.m., the surveyor observed ULP-B notify licensed practical nurse (LPN)-A of R3's blood glucose readings. On January 28, 2025, at 10:13 a.m., LPN-A stated they received hold parameters for insulin lispro for R3 from the prescriber who was currently at the facility. LPN-A stated R3 did not have parameters on the insulin prior to the new order. LPN-A stated they believed ULP should contact a nurse if a blood glucose reading was under 70 mg/dl or above 350 mg/dl. LPN-A stated they had never seen written instructions on this however, they believed staff were trained to do this. LPN-A stated they were a newer employee with the licensee. On January 29, 2025, at 1053 a.m., regional director of clinical services (RDOCS)-C stated the licensee's practice was to place parameters into the RTasks (a documenting software program) of when to call the nurse when the blood glucose was out of range. RDOCS-C stated ULP were trained to contact a nurse if the blood glucose was below 85 mg/dl or above 200 mg/ml. RDOCS-C stated ULP were trained to reach out	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21206	A. BUILDING: _____ B. WING _____	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OSSEO GARDENS ASSISTED LIVING	525 2ND STREET SE OSSEO, MN 55369

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02320	Continued From page 41 to a nurse and then provide three grams (g) of sugar if a blood glucose reading was below 85 mg/dl. In addition, RDOCS-C stated if a blood glucose level was over 200 mg/dl the ULP were trained to provide water and encourage a resident to walk. RDOCS-C stated it was not the licensee's procedure to recheck a blood glucose three time prior to contacting a nurse. RDOCS-C stated insulins were only held if the provider placed hold parameters on the insulin or if a resident's blood glucose was under 85 mg/dl the nurse would make the decision if the insulin should be held. RDOCS-C stated the nurse would typically hold fast acting insulin if the blood glucose rating was below 100 mg/dl. The licensee's EduCare (a training software) training document slides dated 2017 indicated a nurse should be notified when blood glucose is at a dangerous level, when it is too low, or too high. The licensee's Condition Change - When to Call the Nurse policy dated December 20, 2024, indicated ULP should contact a nurse if the blood glucose is less than 85 or greater than 300. The licensee's 7.31 Blood Sugar Testing - Single Equipment Use policy dated August 1, 2021, indicated ULP should document the results of the reading and notify the registered nurse (RN) of any unusual results. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Minnesota Department of Health

3333 Division St #212
St. Cloud
320 223-7300

Type: Full
Date: *01/27/25*
Time: 10:30:00
Report: 1051251019

Food and Beverage Establishment Inspection Report

Location:
Osseo Gardens Assisted Living
525 2nd Street Se
Osseo, MN55369
Hennepin County, 27

Establishment Info:
ID #: 0037565
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7633154869
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

4-900 Protecting Clean Items

4-903.12A

MN Rule 4626.0960A Discontinue storage of food, clean equipment, linens, utensils, or single-service and single-use articles in locker rooms; toilet rooms; garbage rooms; mechanical rooms; under unshielded sewer lines; under leaking water lines or sources of condensation or moisture; under open stairwells; or under other sources of contamination.

AT TIME OF INSPECTION, SINGLE-SERVICE ITEMS WERE STORED UNDER THE PIPE LINES IN THE BASEMENT.

Comply By: 01/28/25

Surface and Equipment Sanitizers

Chlorine: = 100 PPM at Degrees Fahrenheit
Location: DISHMACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 164 Degrees Fahrenheit - Location: SPAGHETTI NOODLES
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 37 Degrees Fahrenheit - Location: CUT WATERMELON
Violation Issued: No

Type: Full
Date: *01/27/25*
Time: 10:30:00
Report: 1051251019
Osseo Gardens Assisted Living

Food and Beverage Establishment Inspection Report

Process/Item: Walk-In Cooler
Temperature: 39 Degrees Fahrenheit - Location: SHREDDED CHEESE
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	1

MET WITH NURSE EVALUATOR, ASHLEY CREWS.

DISCUSSED THE FOLLOWING WITH THE DIETICIAN MANAGER, PAMELA:

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURE
HANDWASHING & GLOVE USE

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1051251019 of 01/27/25.

Certified Food Protection Manager Coby E. Williams

Certification Number: FM85175 Expires: 09/12/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Pamela Brooks
Dietician Manager

Signed: Kai Yang
Kai Yang
Public Health Sanitarian 1
St. Cloud
320 640-3532
Kai.Yang@state.mn.us

Report #: 1051251019

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health

3333 Division St #212
St. Cloud

No. of RF/PHI Categories Out	0	**Date**	01/27/25
No. of Repeat RF/PHI Categories Out	0	**Time In**	10:30:00
Legal Authority MN Rules Chapter 4626		**Time Out**	

Osseo Gardens Assisted Living	**Address** 525 2nd Street Se	**City/State** Osseo, MN	**Zip Code** 55369	**Telephone** 7633154869
License/Permit # 0037565	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN OUT	PIC knowledgeable; duties & oversight		
2	IN OUT N/A	Certified food protection manager, duties		
	Employee Health			
3	IN OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN OUT	Proper use of reporting, restriction & exclusion		
5	IN OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	IN OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7	IN OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	IN OUT N/O	Hands clean & properly washed		
9	IN OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	IN OUT	Food obtained from approved source		
12	IN OUT N/A N/O	Food received at proper temperature		
13	IN OUT	Food in good condition, safe, & unadulterated		
14	IN OUT N/A N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	IN OUT N/A N/O	Food separated and protected		
16	IN OUT N/A	Food contact surfaces: cleaned & sanitized		
17	IN OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN OUT N/A N/O	Proper cooking time & temperature		
19	IN OUT N/A N/O	Proper reheating procedures for hot holding		
20	IN OUT N/A N/O	Proper cooling time & temperature		
21	IN OUT N/A N/O	Proper hot holding temperatures		
22	IN OUT N/A	Proper cold holding temperatures		
23	IN OUT N/A N/O	Proper date marking & disposition		
24	IN OUT N/A N/O	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT N/A	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	IN OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	IN OUT N/A	Food additives: approved & properly used		
28	IN OUT	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	IN OUT N/A	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
		Safe Food and Water		
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44	X	Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 01/27/25

Inspector (Signature) Glen Mann