DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 6CBI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00126

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245326**

2.STATE VENDOR OR MEDICAID NO.
(L2) **1053700856**

3. NAME AND ADDRESS OF FACILITY
(L3) **ROSE OF SHARON A VILLA CENTER**
(L4) **1000 LOVELL AVENUE**
(L5) **ROSEVILLE, MN** (L6) **55113**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **12/01/2017**

6. DATE OF SURVEY **08/16/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **63** (L18)
13.Total Certified Beds **63** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	63			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Nicole Osterloh, Unit Supervisor 09/06/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 09/06/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
08/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06301
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/31/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245326

September 6, 2018

Administrator
Rose Of Sharon A Villa Center
1000 Lovell Avenue
Roseville, MN 55113

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective August 16, 2018 the above facility is certified for:

63 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 63 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 6, 2018

Administrator
Rose Of Sharon A Villa Center
1000 Lovell Avenue
Roseville, MN 55113

RE: Project Number S5326027, H5326072 and H5326073

Dear Administrator:

On June 20, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 7, 2018 that included an investigation of complaint numbers H5326072 and H5326073 which were unsubstantiated. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On August 16, 2018, the Minnesota Department of Health and the Centers for Medicare & Medicaid Services (CMS) completed a Post Certification Revisit (PCR) and on July 18, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 7, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 16, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 7, 2018, effective August 16, 2018 and therefore remedies outlined in our letter to you dated June 20, 2018, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 6, 2018

Administrator
Rose Of Sharon A Villa Center
1000 Lovell Avenue
Roseville, MN 55113

Re: Project Number S5326027, H5326072 and H5326073

Dear Administrator:

On August 16, 2018 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility to determine correction of orders found on the survey completed on June 6, 2018, that included an investigation of complaint number H5326072 and H5326073, with orders received by you on June 21, 2018.

On August 16, 2018, the Centers for Medicare & Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS), to determine correction of orders found on the survey completed on July 13, 2018, with orders received by you on July 26, 2018.

At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 6CBI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00126

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245326**

2.STATE VENDOR OR MEDICAID NO.
(L2) **1053700856**

3. NAME AND ADDRESS OF FACILITY
(L3) **ROSE OF SHARON A VILLA CENTER**
(L4) **1000 LOVELL AVENUE**
(L5) **ROSEVILLE, MN** (L6) **55113**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **12/01/2017**

6. DATE OF SURVEY **06/07/2018** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **63** (L18)

13.Total Certified Beds **63** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	63			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Christine Bodick-Nord HFE - NE II 07/03/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 07/30/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
08/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06301
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
June 20, 2018

Ms. Lynn Hickey, Administrator
Rose Of Sharon A Villa Center
1000 Lovell Avenue
Roseville, MN 55113

RE: Project Number S5326027, H5326072 and H5326073

Dear Ms. Hickey:

On June 7, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required. In addition, at the time of the June 7, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number H5326072 and H5326073 that was found to be unsubstantiated.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343
Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 17, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by September 7, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 7, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245326	A. BUILDING _____ B. WING _____	C 06/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE OF SHARON A VILLA CENTER	1000 LOVELL AVENUE ROSEVILLE, MN 55113

(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) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on June 4 through June 7, 2018 during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On June 4 through June 7, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An investigation of complaint H5326072 and H5326073 were completed and found not to be substantiated.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in	F 582		7/17/18

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

Electronically Signed | 06/29/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245326	A. BUILDING _____ B. WING _____	C 06/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE OF SHARON A VILLA CENTER	1000 LOVELL AVENUE ROSEVILLE, MN 55113

(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) COMPLETION DATE
F 582	Continued From page 1	F 582		

writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-
(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;
(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245326	A. BUILDING _____ B. WING _____	C 06/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE OF SHARON A VILLA CENTER	1000 LOVELL AVENUE ROSEVILLE, MN 55113

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F 582	Continued From page 2 facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) for 1 of 3 residents (R38) reviewed, whose Medicare A coverage ended and remained in the facility. Findings include: R38's Admission Record, indicated R38 was admitted 5/15/18, and was a current resident. R38's Notice of Medicare Non-Coverage (NOMNC) (CMS-10123) form, signed as received 6/1/18, indicated R38's skilled nursing services would end 6/4/18. R38's medical record was reviewed. The record lacked the correct SNFABN form CMS-1005. R38's record revealed a facility generated form that lacked estimated cost and explanation of financial liabilities. When interviewed on 6/7/18 1:25 p.m., registered nurse (RN-A), stated she was aware of the new form CMS-1005, but some how they used the wrong form. RN-A stated she would be using the	F 582	1. R38 continues to reside at Rose of Sharon a Villa Center in the facility under the Medicaid Payer. 2. Residents who reside at Rose of Sharon a villa center that have Medicare have the potential to be effected by this practice. An audit was conducted for all Medicare residents to ensure that appropriate forms are being provided. 3. Education has been provided to MDS Coordinator, Social Service Director, Business office manager and Administrator on issuing the proper Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) Forms. 4. Administrator or designee will audit weekly x 4 weeks for proper issuance of SNFABN forms. 5. Administrator/Designee will forward results of audits to the QAPI committee monthly x 3 months for continued opportunities for quality improvements.	

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F 582	Continued From page 3 correct form going forward. A policy regarding advance beneficiary notice for residents was requested, but none was provided.	F 582		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		7/17/18

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F 584	Continued From page 4 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure bedside fall mats were clean for 1 of 4 residents (R24) reviewed for environmental concerns. Findings include: During observations on 6/4/18, at 2:31 p.m. R24 was laying in bed, sleeping. Three fall mats were on the floor next to R24's bed. Two of the three mats had multiple white splatter marks across the surface of the mats. During observations on 6/6/18, at 9:14 a.m. R24 was laying in bed, sleeping. Two of the three mats continued to have multiple white splatter marks across the surface of the mats. During observations on 6/7/18, at 12:40 p.m. the fall mats were folded up on the side of the bed. R24 was not in the room. Two of the three mats continued to have multiple white splatter marks across the surface of the mats. During an interview on 6/7/18, at 12:43 p.m. licensed practical nurse (LPN)-A stated nursing assistants, nurses, and housekeeping staff are responsible to ensure fall mats are clean. LPN-A went on to say nursing assistants should clean	F 584	1. R24□s anti-fatigue mat has been cleaned. 2. Residents who reside at Rose of Sharon a Villa Center and whose plan of care indicates that usage of an anti-fatigue mat have the potential to be affected by this practice. Residents who use an anti-fatigue mat have had their mats cleaned and a schedule has been created to ensure regular cleanings. 3. Education has been provided to Housekeeping staff on cleaning fall mats daily and as needed. 4. Administrator or designee will audit twice a week to ensure proper cleaning of fall mats x 4 weeks. 5. Administrator/designee will review audits monthly at QAPI x3 months for continued opportunities for quality improvement.	

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F 584	Continued From page 5 the mats if they are soiled when assisting residents out of bed in the morning. LPN-A entered R24's room. LPN-A stated "Those [floor mats] are soiled." "I didn't notice they were like this when they were down earlier." LPN-A donned gloves and used super sanicloth wipes to wipe down the surface of the fall mats. LPN-A stated the substance on the mats was "tube feeding splatter." The splatter marks were gone from the mats after the cleaning. During an interview on 6/7/18, at 2:09 p.m. the director of nursing (DON) stated she was not aware of who's responsibility it was to clean the floor mats. The DON stated when staff observe the mats to be dirty, the staff are to clean the mats. The facility's policy Housekeeping In-Service, undated, indicated horizontal surfaces are to be disinfected using a solution of properly diluted germicide, sanitize all horizontal surfaces.	F 584		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to reassess and monitor pain for 1 of 1 resident (R12) who reported she had complained of pain and discomfort with use of a gait transfer belt following a fall.	F 697	1. R12 has been re-assessed for pain management and provided a larger sized transfer belt. Current pain management program is effective and care plans have been updated to reflect changes as	7/17/18

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F 697	Continued From page 6 Findings include: R12 's annual Minimum Data Sets (MDS) dated 10/3/17, indicated R12 had physical limitations, weakness, limited range of motion, poor coordination and balance, visual impairment and pain. R12's Care Plan, last revised on 6/6/18, identified limited physical mobility related to Parkinsons disease and that R12 required a bariatric gait belt for all transfers. During interview on 6/6/18 at 1:30 p.m. in a resident council meeting, R12 stated the nursing assistants (NA's) try to strap on transfer belts around her that are to tight, R12 also stated the NA's do not get larger belts that fit and it really hurts. R12 further stated this has been going on since May, that she has been trying to cut down on her eating, so she doesn't gain weight and that the NA's ignore her requests for a larger transfer belt, with excuses of not having larger belts in facility. R12 also stated she has been told by the NA's if they don't use the transfer gait belts they will get written up. R12's progress note, dated 5/3/18, at 3:57 p.m. indicated R12 had a fall when she had lost her footing during a transfer into the wheelchair. Following the fall, the resident complained of pain on her left side and was noted to have an abrasion and pink/purple bruising. X-rays were taken and result were negative for a fracture. R12's progress note, dated 5/4/18, at 3:11 p.m. indicated R12 wanted to use the bathroom but when NA's tried to put on a gait transfer belt, R12	F 697	appropriate. NA-A and NA-B have been educated on using appropriate sized gait belts and reporting pain to the licensed nurse. 2. Residents that reside at Rose of Sharon a Villa Center that need assistance with transfers have the potential to be affected by this practice. Residents that require assistance with transfers via transfer belt and or mechanical lift have been re-assessed to ensure there is not pain with transferring and that appropriate sized belts are being used with care plans updated as appropriate. Resident's that are currently on a Pain Management Program have been re-assessed and care plans have been updated as appropriate. Policy and Procedures have been reviewed and are current. 3. Licensed staff, certified nursing assistants, and clinical leadership have been educated on the Pain Management policy and procedure as well as safe and comfortable transfer technique. 4. DON/Designee will conduct audits in regards to pain with transfers and appropriate transfer equipment 3x/week x 3 weeks, then 1x/week x3 weeks. DON/Designee will forward results of pain managements audits to the QAPI committee monthly x 3 months for continued opportunities for quality improvements.	

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F 697	Continued From page 7	F 697		

refused to wear it. Licensed practical nurse (LPN-B) spoke to R12 reminding her the belt was used for her safety, and if the NA's did not use it they could get in trouble. R12 replied "we're just going to have to risk getting them in trouble because I don't want to use it". LPN-B told R12 she might need to try the sit and stand lift if she did not let NA's use the transfer belt. R12 then allowed the NA's to use the transfer belt.

R12's progress note, dated 5/5/18, at 9:28 a.m. indicated R12 complained of side pain from scrape on side. Some bruising started. Was given Vicodin (pain medication) at 2400 and had some relief of pain and slept well remainder of shift.

R12 progress note, dated 5/6/18 at 3:57 a.m. indicated R12 complained of side pain and requested pain medication. Bruising noted next to scrape, used bed pan and tolerated well. R12 stated she could not sleep due to pain in side.

R12's progress notes dated 5/7/18 at 3:59 a.m. indicated R12 complained of pain on her left side and was medicated with Vicodin at 2400 and ice pack to left shoulder.

R12's facility wound assessment details report was completed on 5/25/18 at 5:28 p.m. the report indicated R12 had a healed abrasion to left ribcage/torso facility acquired. Pain was scored as a 4 on a scale of 0-10 (0 being no pain and 10 the worst pain). However, no further information was included regarding cause of the pain.

During an observation on 6/6/18 at 3:15 p.m. NA-A and NA-B were transferring R12 from her w/c to the toilet. The first gait transfer belt they tried would not go all the way around R12. The

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F 697	Continued From page 8	F 697		

second belt tried did not go through the second metal loop of the buckle and could easy slip off during transfer. R12 stated "see what I mean about the belts being to small". The director of nursing (DON) came into the bathroom and verified the belt being used was to small, to tight, and that the belt being used was unsafe and would cause R12 pain. DON had a new belt, 15 feet long brought into R12 room right with in ten minutes.

When interviewed on 6/7/18 at 1:07 p.m. R12 stated the gait belt buckle made a mark across her chest and rib area when the NA's pulled it off because the belt was so tight. R12 had a healed scrape on chest/rib area measuring seven inches. R12 stated she believed the small belt has been used for approximately 6 weeks. R12 also stated she had told the NA's and told LPN-A the gait belt was to small. R12 stated LPN-A stated it is the only size they had, and that she had to use it. R12 stated LPN-A never did anything about it, and never got a bigger belt. R12 stated she has told everyone who used the small belt that it hurt, was to tight, and the buckle hurt . R12 stated no one listened and just made excuses why they had to use the small belt.

When interviewed on 6/7/18, at 1:42 p.m. NA-D stated she did not normally work with R12. She also stated her training/orientation, including gait belt use, was in the facility by another NA. NA-D stated you put the belt on resident not to tight, but so you can fit two finger in there. NA-D stated she would not use a transfer belt if you could not get the belt through the second belt buckle slot and that they have larger belts at the nurses station if needed.

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F 697	Continued From page 9 When interviewed on 6/7/18, at 1:53 p.m. NA-E stated she was not familiar with R12 as she does not normally work with R12. She went on to state the facility has training every six months and NA-E had transfer belt orientation about three months ago. NA-E stated if she had a belt that was to small she would talk to a supervisor and get a bigger belt, and that sometimes bigger belts are in therapy room downstairs. When interviewed on 6/7/18 LPN-A stated the employee's get training all the time and NA's are required to carry a transfer gait belt with them at all times. LPN-A stated if a belt is to small, "we get a larger belt". LPN-A also stated R12 got a larger belt yesterday because she did not like the one she had, and that P12 said it was to small. LPN-A stated yesterday was the first time she found out that a belt used by the NA's was to small. LPN-A's belt measured 5 feet 9 inches and fit around R12. Manufactures instructions for Sammons Preston gait belts include the belt be wrapped around the patient's waist with the raised buckle seam on the outside in front. After directing the metal tip of the belt through the buckle, place it over the buckles teeth as you adjust the belt, keep in mind that it should remain secure, yet comfortable for the patient, and monitor the gait belts effects on the patients skin, circulation, range of motion etc. The facilities pain management purpose is to observe residents for pain upon admission, quarterly, with a significant change in condition that may cause an onset or increase pain and any time it is suspected a resident is in pain.	F 697		
F 880	Infection Prevention & Control	F 880		7/17/18

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F 880 SS=D	Continued From page 10 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

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F 880	Continued From page 11 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate hand hygiene and glove changes were implemented during personal cares for 1 of 2 residents (R24) reviewed for activities of daily living. Findings included: R24's quarterly Minimum Data Set (MDS), dated	F 880	1. R24's plan of care has been reassessed and education has been provided to NA-A related to infection prevention, incontinence care, catheter care, gloving, and hand hygiene. 2. Resident that reside at Rose of Sharon a villa center that need assistance with incontinent care and catheter care have the potential to be affected by this	

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F 880	Continued From page 12 4/25/18, identified R24 was cognitively impaired. R24 required extensive assistance for bed mobility, dressing, personal hygiene and total assistance for toileting. R24 was always incontinent of bowel and had an indwelling urinary catheter. R24 received nutrition both orally and through a feeding tube. R24's progress notes, dated 5/19/18 and 5/21/18, indicated R24 rolled out of bed onto the safety mattresses (mat) on the floor. During observations on 6/4/18, at 2:59 p.m. nursing assistant (NA)-A and NA-B were in R24's room to assist with incontinence care. R24 was laying in bed. NA-A and NA-B donned (put on) gloves. NA-A and NA-B unfastened R24's incontinent brief. R24 turned onto her right side with cues and with staff assistance. The brief contained a large amount of stool. While NA-B assisted R24 to maintain a side laying position, NA-A used several Procure wipes to clean stool from R24's buttocks. Once clean, NA-A removed the soiled incontinent brief, placing the brief in the garbage next to the bed. NA-A did not remove her gloves or wash her hands. With the same gloves, NA-A grabbed a clean incontinent brief and placed the brief under R24's buttocks. NA-A then picked up a graduate (container) labeled catheter only, and with the same gloves used during incontinent bowel care, unclamped R24's urinary catheter, draining the urine from the catheter bag into the graduate. NA-A re-clamped the catheter. NA-A emptied the urine from the graduate into the toilet. Using the same gloves, NA-A turned on the faucet in the bathroom, added water to the graduate, swirled the water in the graduate, and emptied the water into the toilet. NA-A flushed the toilet. NA-A removed the	F 880	practice. Residents that require incontinence care and or catheter care have received care plan reviews with updates made as appropriate. Policies and Procedures in regards to infection prevention, incontinence cares, catheter care, hand hygiene, and gloving have been reviewed and are current. 3. Licensed nurses and Nursing assistants have received education related to infection prevention, incontinence cares, catheter care, hand hygiene, and gloving. 4. DON/Designee will audit 3 residents 3x/week x 3 weeks, then 1x/week x3 weeks to ensure appropriate care related to appropriate infection prevention, incontinence care, catheter care, hand hygiene, and gloving. DON/Designee will forward all audits to the QAPI committee monthly x 3 months for continued opportunities for quality improvements.	

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F 880	Continued From page 13	F 880		

garbage liner containing the soiled brief and tied off the bag. NA-A walked into the bathroom, removed her gloves and washed her hands.

During an interview on 6/4/18, immediately following the 2:59 p.m. observation of cares, NA-A stated she uses gloves when providing personal cares and washes her hands before and after cares. When asked about changing gloves and washing hands before and after stool incontinence and catheter cares NA-A stated "I forgot this time." NA-A stated "I should have."

During an interview on 6/7/18, at 2:09 p.m., the director of nursing (DON) stated staff should use hand sanitizer and glove before cares. The DON stated staff need to use sanitizer and put on new gloves after incontinent cares. The DON stated staff are to sanitize hands and put on new gloves between incontinent cares and urinary catheter cares.

The facility's policy, Infection Control Standard Precautions Hand Hygiene, undated, indicated "Appropriate hand hygiene is essential in preventing transmission of infectious agents." "Hand hygiene must be performed after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn; immediately after gloves are removed; and when otherwise indicated to avoid transfer of microorganisms to other residents, personnel, equipment and/or the environment." Examples included: Before and after assisting a resident with personal cares. Before and after assisting a resident with toileting. After handling catheters and urinals. After removing gloves. The policy did not address procedure for timing of putting on and taking off gloves.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245326	A. BUILDING _____ B. WING _____	C 06/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE OF SHARON A VILLA CENTER	1000 LOVELL AVENUE ROSEVILLE, MN 55113

(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) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245326	A. BUILDING **01 - MAIN BUILDING 0102** B. WING _____	**06/06/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE OF SHARON A VILLA CENTER	**1000 LOVELL AVENUE ROSEVILLE, MN 55113**

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K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Rose of Sharon Manor was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/29/2018

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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	245326	A. BUILDING **01 - MAIN BUILDING 0102** B. WING _____	**06/06/2018**

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K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Rose of Sharon Manor is a 2-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1968 and was determined to be of Type II(222) construction. In 1992, an addition was constructed to the North side that was determined to be of Type II(222) construction. Because the original building and the 1 addition are of the same type of construction, the facility was surveyed as one building. The building is fully fire sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification The facility has a capacity of 63 beds and had a census of 48 at the time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 930 SS=E	Gas Equipment - Liquid Oxygen Equipment CFR(s): NFPA 101 Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99) This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99) This deficient practice could affect the safety of all (48) the residents, staff and visitors within the Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 6/6/2018, observations and staff interview revealed the following: Found a power strip plugged into an other power strip in the lower level Dietary Storage room. We also found power strips being used in resident room not listed for 1363 UL listed. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 930	1. The Power strip that was plugged into another power strip in dietary storage room has been removed. The non 1363 UL listed power strip has been removed from the identified residents room and replaced with a 1363 UL listed power strip. 2. All residents have the potential to be effected by the deficient practice. All resident rooms were audited for the use of non 1363 UL listed power strips and any found were removed. All areas of the building where power strips are used were audited to ensure no power strips are plugged into other power strips. 3. Administrator/designee will audit 5 resident rooms weekly x 4 weeks for the use of proper 1363 UL listed power strips and to ensure no power strips are plugged into another power strip. Administrator/designee will audit 5 non-resident room areas (offices, storage, etc) weekly x 4 weeks to ensure no power strips are plugged into another power	7/17/18

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K 930	Continued From page 3	K 930	strip. 4. Administrator/Designee will forward results of audits to the QAPI committee monthly x 3 months for continued opportunities for quality improvements.	

Electronically delivered
June 20, 2018

Ms. Lynn Hickey, Administrator
Rose Of Sharon A Villa Center
1000 Lovell Avenue
Roseville, MN 55113

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5326027, H5326072 and H5326073

Dear Ms. Hickey:

The above facility was surveyed on June 4, 2018 through June 7, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number H5326072 and H5326073 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and 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/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Kathleen Lucas, Unit Supervisor at (320) 223-7343 or kathleen.lucas@state.mn.us .

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00126	A. BUILDING: _____ B. WING _____	C 06/07/2018

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 6/4/18 -6/7/18, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to reassess and monitor pain for 1 of 1 resident (R12) who reported she had complained of pain and discomfort with use of a gait transfer belt following a fall. Findings include: R12 's annual Minimum Data Sets (MDS) dated 10/3/17, indicated R12 had physical limitations, weakness, limited range of motion, poor coordination and balance, visual impairment and pain.	2 830	Corrected	7/17/18

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2 830	Continued From page 3 R12's Care Plan, last revised on 6/6/18, identified limited physical mobility related to Parkinsons disease and that R12 required a bariatric gait belt for all transfers. During interview on 6/6/18 at 1:30 p.m. in a resident council meeting, R12 stated the nursing assistants (NA's) try to strap on transfer belts around her that are to tight, R12 also stated the NA's do not get larger belts that fit and it really hurts. R12 further stated this has been going on since May, that she has been trying to cut down on her eating, so she doesn't gain weight and that the NA's ignore her requests for a larger transfer belt, with excuses of not having larger belts in facility. R12 also stated she has been told by the NA's if they don't use the transfer gait belts they will get written up. R12's progress note, dated 5/3/18, at 3:57 p.m. indicated R12 had a fall when she had lost her footing during a transfer into the wheelchair. Following the fall, the resident complained of pain on her left side and was noted to have an abrasion and pink/purple bruising. X-rays were taken and result were negative for a fracture. R12's progress note, dated 5/4/18, at 3:11 p.m. indicated R12 wanted to use the bathroom but when NA's tried to put on a gait transfer belt, R12 refused to wear it. Licensed practical nurse (LPN-B) spoke to R12 reminding her the belt was used for her safety, and if the NA's did not use it they could get in trouble. R12 replied "we're just going to have to risk getting them in trouble because I don't want to use it". LPN-B told R12 she might need to try the sit and stand lift if she did not let NA's use the transfer belt. R12 then allowed the NA's to use the transfer belt.	2 830		

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2 830	Continued From page 4 R12's progress note, dated 5/5/18, at 9:28 a.m. indicated R12 complained of side pain from scrape on side. Some bruising started. Was given Vicodin (pain medication) at 2400 and had some relief of pain and slept well remainder of shift. R12 progress note, dated 5/6/18 at 3:57 a.m. indicated R12 complained of side pain and requested pain medication. Bruising noted next to scrape, used bed pan and tolerated well. R12 stated she could not sleep due to pain in side. R12's progress notes dated 5/7/18 at 3:59 a.m. indicated R12 complained of pain on her left side and was medicated with Vicodin at 2400 and ice pack to left shoulder. R12's facility wound assessment details report was completed on 5/25/18 at 5:28 p.m. the report indicated R12 had a healed abrasion to left ribcage/torso facility acquired. Pain was scored as a 4 on a scale of 0-10 (0 being no pain and 10 the worst pain). However, no further information was included regarding cause of the pain. During an observation on 6/6/18 at 3:15 p.m. NA-A and NA-B were transferring R12 from her w/c to the toilet. The first gait transfer belt they tried would not go all the way around R12. The second belt tried did not go through the second metal loop of the buckle and could easy slip off during transfer. R12 stated "see what I mean about the belts being to small". The director of nursing (DON) came into the bathroom and verified the belt being used was to small, to tight, and that the belt being used was unsafe and would cause R12 pain. DON had a new belt, 15 feet long brought into R12 room right with in ten minutes.	2 830		

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2 830	Continued From page 5 When interviewed on 6/7/18 at 1:07 p.m. R12 stated the gait belt buckle made a mark across her chest and rib area when the NA's pulled it off because the belt was so tight. R12 had a healed scrape on chest/rib area measuring seven inches. R12 stated she believed the small belt has been used for approximately 6 weeks. R12 also stated she had told the NA's and told LPN-A the gait belt was to small. R12 stated LPN-A stated it is the only size they had, and that she had to use it. R12 stated LPN-A never did anything about it, and never got a bigger belt. R12 stated she has told everyone who used the small belt that it hurt, was to tight, and the buckle hurt . R12 stated no one listened and just made excuses why they had to use the small belt. When interviewed on 6/7/18, at 1:42 p.m. NA-D stated she did not normally work with R12. She also stated her training/orientation, including gait belt use, was in the facility by another NA. NA-D stated you put the belt on resident not to tight, but so you can fit two finger in there. NA-D stated she would not use a transfer belt if you could not get the belt through the second belt buckle slot and that they have larger belts at the nurses station if needed. When interviewed on 6/7/18, at 1:53 p.m. NA-E stated she was not familiar with R12 as she does not normally work with R12. She went on to state the facility has training every six months and NA-E had transfer belt orientation about three months ago. NA-E stated if she had a belt that was to small she would talk to a supervisor and get a bigger belt, and that sometimes bigger belts are in therapy room downstairs. When interviewed on 6/7/18 LPN-A stated the employee's get training all the time and NA's are	2 830		

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2 830	Continued From page 6 required to carry a transfer gait belt with them at all times. LPN-A stated if a belt is to small, "we get a larger belt". LPN-A also stated R12 got a larger belt yesterday because she did not like the one she had, and that P12 said it was to small. LPN-A stated yesterday was the first time she found out that a belt used by the NA's was to small. LPN-A's belt measured 5 feet 9 inches and fit around R12. Manufactures instructions for Sammons Preston gait belts include the belt be wrapped around the patient's waist with the raised buckle seam on the outside in front. After directing the metal tip of the belt through the buckle, place it over the buckles teeth as you adjust the belt, keep in mind that it should remain secure, yet comfortable for the patient, and monitor the gait belts effects on the patients skin, circulation, range of motion etc. The facilities pain management purpose is to observe residents for pain upon admission, quarterly, with a significant change in condition that may cause an onset or increase pain and any time it is suspected a resident is in pain. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop /revise policies to ensure residents that have pain are reassessed and educate facility staff on reporting complaints of pain. The DON and/or designee could conduct audit to ensure residents that have pain are reassessed and monitored to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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	00126	A. BUILDING: _____ B. WING _____	C 06/07/2018

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21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure screening of active tuberculin symptoms and tuberculosis testing was completed within 72 hours of admission for 3 of 5 residents (R17, R27, R15) reviewed. Findings include: R15's record revealed admit date of 9/29/17. R15's tuberculin symptom screen was dated 3/9/18. Step one tuberculin skin test (TST) administered 3/9/18, with a step two TST	21426	Corrected	7/17/18

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21426	Continued From page 8 administered 3/28/18. R27's record revealed admit date of 4/28/18. R27's tuberculin symptom screen was not dated. R27's step one TST was administered 5/8/18, step two TST was not completed. R17's record revealed admit date of 4/10/18. R17's tuberculin symptom screen was dated 4/10/18. R17's step one TST was administered 4/10/18. TST document had a handwritten note indicating,"TST was read too soon, would need to start over." TST step one was invalid, no further testing was documented. When interviewed on 6/6/18, at 1:01 p.m. the director of nursing (DON)-A stated, prior to starting this position there was not a process in place for resident screening. DON-A stated she started to create an admission check list, so it will show up on the electronic medication administration record (EMAR), after the admission order is written with in the first twenty-four hours as long as the residents meet the criteria after the screening. DON-A stated she was aware that R17's TST step one would need to be started over and that R27's TST step two was not completed. DON-A could not answer in regards to R15's tuberculosis symptom screen and TST. DON-A went on to say the testing was done prior to starting her position. The Infection Control Resident Immunizations and Vaccinations procedure dated 2015, directed for all new admissions a tuberculin skin test will be done within 72 hours of admission. If the first step is non-reactive, the second test will be administered one to three weeks later. SUGGESTED METHOD OF CORRECTION:	21426		

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21426	Continued From page 9 The facility could develop an auditing system to ensure all residents receive a baseline tuberculin symptom screen and appropriate testing. The don or designee could provide training on TST testing criteria as appropriate. The facility could report findings to the QA Committee to develop a system for ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure bedside fall mats were clean for 1 of 4 residents (R24) reviewed for environmental concerns. Findings include: During observations on 6/4/18, at 2:31 p.m. R24 was laying in bed, sleeping. Three fall mats were on the floor next to R24's bed. Two of the three mats had multiple white splatter marks across the surface of the mats. During observations on 6/6/18, at 9:14 a.m. R24 was laying in bed, sleeping. Two of the three mats	21695	Corrected	7/17/18

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21695	Continued From page 10 continued to have multiple white splatter marks across the surface of the mats. During observations on 6/7/18, at 12:40 p.m. the fall mats were folded up on the side of the bed. R24 was not in the room. Two of the three mats continued to have multiple white splatter marks across the surface of the mats. During an interview on 6/7/18, at 12:43 p.m. licensed practical nurse (LPN)-A stated nursing assistants, nurses, and housekeeping staff are responsible to ensure fall mats are clean. LPN-A went on to say nursing assistants should clean the mats if they are soiled when assisting residents out of bed in the morning. LPN-A entered R24's room. LPN-A stated "Those [floor mats] are soiled." "I didn't notice they were like this when they were down earlier." LPN-A donned gloves and used super sanicloth wipes to wipe down the surface of the fall mats. LPN-A stated the substance on the mats was "tube feeding splatter." The splatter marks were gone from the mats after the cleaning. During an interview on 6/7/18, at 2:09 p.m. the director of nursing (DON) stated she was not aware of who's responsibility it was to clean the floor mats. The DON stated when staff observe the mats to be dirty, the staff are to clean the mats. The facility's policy Housekeeping In-Service, undated, indicated horizontal surfaces are to be disinfected using a solution of properly diluted germicide, sanitize all horizontal surfaces. SUGGESTED METHOD OF CORRECTION:	21695		

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21695	Continued From page 11 The DON or housekeeping supervisor and/or their designee could develop /revise policies for cleaning of residents fall mattresses and educate facility staff on those policies. The DON or housekeeping supervisor and/or designee could conduct resident could audit mat cleanliness to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		