Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 15, 2023

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

RE: CCN: 245326
Cycle Start Date: March 23, 2023

Dear Administrator:

On May 9, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 14, 2023

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

RE: CCN: 245326
Cycle Start Date: March 23, 2023

Dear Administrator:

On March 23, 2023, a 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Renee McClellan, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 June 23, 2023, (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).

In addition, if substantial compliance with the regulations is not verified by September 23, 2023, (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245326	A. BUILDING: _____ B. WING _____	3/23/2023

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 638	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a quarterly "Minimum Data Set (MDS)" was completed in a timely manner for 1 of 1 (R10) resident reviewed for timely assessments. Findings include: Review of R10's "Face Sheet" located in the electronic medical record (EMR) under the "Profile" tab revealed an initial admission date of 04/02/12. Review of R10's quarterly "MDS" located in the EMR under the "MDS" tab with an Assessment Reference Date (ARD) of 11/05/22 revealed it was the last quarterly assessment completed. There was no evidence R10 had another quarterly assessment completed when due in February 2023. During an interview on 03/21/23, at 11:11 a.m. the MDS coordinator (MDSC) confirmed the last quarterly "MDS" for R10 was completed on 11/05/22. MDSC confirmed the resident was to have another quarterly assessment completed on 02/05/23 but missed the assessment by mistake. During an interview on 03/21/23, at 11:19 a.m. with assistant director of nursing (ADON) stated the expectations are for the MDS staff to complete all assessments on time.
F 641	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the accuracy of a "Minimum Data Set (MDS)" for 2 of 2 (R8, R45) residents reviewed for "MDS" accuracy. Findings include: Review of R8's "Face Sheet" located in the electronic medical record (EMR) under the "Profile" tab revealed an initial admission date of 03/23/16. Diagnoses included tobacco use.

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245326	A. BUILDING: _____ B. WING _____	3/23/2023

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	Continued From Page 1

Review of R8's "Care Plan" located in the EMR under the "Care Plan" tab dated 02/28/23, revealed R8 was a safe smoker and would demonstrate safe smoking.

Review of R8's "Smoking Evaluation" located in the EMR under the "Forms" tab dated 01/25/23, revealed the resident identified as a smoker, smokes morning, afternoon , evenings, resident can light own cigarette, no supervision, and no apron was needed. The resident was noted to be able to safely smoke independently. Current smoking care plan reviewed.

Review of the "MDS" located in the EMR under the "MDS" tab with an Assessment Reference Date (ARD) of 01/30/23 revealed in section J, no tobacco use triggered.

Review of R45's "Face Sheet" located in the EMR under the "Profile" tab revealed an initial admission date of 03/18/22.

Review of R45's "Care Plan" in the EMR under the "Care Plan" tab dated 03/16/23, revealed R45 was a smoker.

Review of R45's "Smoking Evaluation" located in the EMR under the "Forms" tab dated 03/19/22, revealed the resident identified as a smoker, smoked less than hourly, resident can light own cigarette, no supervision, no apron was needed. It was noted the resident was able to safely smoke independently.

Review of R45's "MDS" located in the EMR under the "MDS" tab with and ARD of 12/26/22, revealed section J, no tobacco use triggered.

During an interview on 03/22/23, at 12:04 p.m. the MDS coordinator (MDSC) verified R45 wasn't triggered for tobacco use on his quarterly "MDS". MDSC stated it was a mistake because he knew the resident smoked. The MDSC further confirmed R8 was not being triggered for tobacco on the "MDS". MDSC stated he didn't know the resident smoked.

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 03/23/2023

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 On 3/20/23-3/23/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 3/20/23-3/23/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H5326143C (MN00081291) H5326141C (MN00081284) H5326145C (MN00081282) H5326144C (MN00081281) H5326142C (MN00081280) H5326139C (MN00082120) The facility is enrolled in ePOC, therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents. The facility's plan of correction (POC) will serve as your allegation of compliance upon the	F 000		

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

Electronically Signed | 04/20/2023

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 _____ B. WING _____	C 03/23/2023

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F 000	Continued From page 1 Departments 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide nail care for 1 of 1 resident (R16) observed for activities of daily living (ADL). Findings include: R16's significant change Minimum Data Set (MDS) dated 3/16/23, indicated moderately impaired cognition and diagnoses of dementia, chronic kidney disease, and reduced mobility. The MDS further indicated R16 required extensive assistance with all other ADL's except eating in which he was independent. R16's care plan dated 3/7/23, indicated R16 had an actual ADL self-care performance deficit related to impaired mobility with an intervention of one staff participation with personal hygiene.	F 677	1.R16 had his nails cleaned and trimmed. 2.Residents who are dependent on staff for ADL care have the potential to be affected. 3. All nursing staff will be educated on providing nail care. 4. Audits will be done by DON or designee on dependent residents receiving nail care. Audits will be done 5 days a week for 2 weeks, and then twice a week for 2 weeks or until compliance is met. Results of audits will be brought to QAPI for review.	5/3/23

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	245326	A. BUILDING _____ B. WING _____	C 03/23/2023

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F 677	Continued From page 2 During observation on 3/20/23, at 3:29 a.m. R16's fingernails were approximately one fourth to one half inch long with brown matter underneath. R16 stated he wanted to have his nails cut. During observation on 3/21/23, at 11:19 a.m. R16's fingernails had not been clipped and he stated he hoped staff would cut them today because it was his bath day. During interview on 3/22/23, at 8:17 a.m. R16 stated he hadn't received a bath yesterday and no one had cut his nails. Registered nurse (RN)-A verified R16's fingernails nails hadn't been cut and had brown matter underneath them. RN-A stated nursing assistants were responsible to cut the residents nails who were not diabetic and the nurses were responsible to cut the residents nails who were. During interview on 3/22/23, at 8:46 a.m. nursing assistant (NA)-A stated NA's were responsible for cutting the nails of residents who weren't diabetic and nurses were responsible for cutting the nails of residents who were. During interview on 3/22/23, at 11:10 a.m. NA-B stated NA's were responsible for cutting residents nails, unless they are diabetic then the nurses were responsible. During interview on 3/22/23, at 2:40 p.m. the director of nursing (DON) verified R16's fingernails had not been cut and there was brown matter underneath them. The DON stated the NA's were responsible for cutting residents nails who are not diabetic and the nurses were responsible for cutting resident's nails who are	F 677		

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 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 677	Continued From page 3 diabetic. A policy on ADL's was requested but not received.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 2 (R8, R45) residents observed for smoking, used the appropriate receptacles for discarding cigarette butts. Findings include: Review of R8's "Face Sheet" located in electronic medical record (EMR) under the "Profile" tab revealed an admission date of 03/23/16. Review of R8's "Minimum Data Set (MDS)" located in the EMR under the "MDS" tab with an Assessment Reference Date (ARD) of 01/30/23, revealed the resident was cognitively intact. Review of R8's "Smoking Evaluation" located in the EMR under the "Forms" tab dated 01/25/23, revealed the resident was identified as a smoker, smokes morning, afternoon, evenings, resident can light own cigarette, no supervision, no apron was checked. The resident was noted to be able	F 689	1. R8 and R45 were unaffected by breaches in smoking rules. R8 and R45 were educated on the smoking policy. R8 and R45 signed agreements related to facility's smoking rules. 2. All residents that identify as smokers have the potential to be affected. 3. All residents that identify as smokers will have smoking policy re-reviewed with them. All current smokers will sign an agreement that consents to the facility's smoking rules and repercussions of not abiding by them. All staff will be educated on smoking policy and steps to take if they witness residents not following safe smoking practices. 4. Audits will be conducted by NHA/DON/or designee on residents that smoke to ensure they are following facility protocol. Audits will be conducted at various times through the day, at least three times a day, seven days a week for	5/3/23

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F 689	Continued From page 4 to safely smoke independently. Review of R8's "Care Plan" located in the EMR under the "Care Plan" tab dated 02/28/23, revealed R8 was a safe smoke and would demonstrate safe smoking, Observation/interview on 03/20/23, at 2:53 p.m. revealed R8 was in the designated smoking area. When R8 was finished smoking she put the cigarette out on the wheel of her wheelchair and placed the cigarette butt in her pocket. R8 confirmed she put the cigarette out on the wheel of her wheelchair and placed the cigarette butt in her pocket. Review of R45's "Face Sheet" located in the EMR under the "Profile" tab revealed an initial admission date of 03/18/22. Review of R45's "Smoking Evaluation" located in the EMR under the "Forms" tab dated 03/19/22, revealed resident was identified as a smoker, smokes less than hourly, resident can light own cigarette, no supervision, no apron checked. Resident is able to safely smoke independently. Review of the R45's "MDS" located in the EMR under the "MDS" tab with an ARD of 12/26/22, revealed the resident was cognitively intact. Review of R45's "Care Plan" located in the EMR under the "Care Plan" tab dated 03/16/23, revealed R45 was a smoker, resident has history of non-compliance with smoking policy for example smoking in non-designated areas, not putting cigarettes out in smoking receptacles. Instruct resident about the facility policy on smoking: locations, times, safety concerns.	F 689	two weeks. Audits will then be conducted at least once a day, five days a week, for two weeks, and then 3 times a week or until compliance is met. Results of audits will be brought to QAPI by NHA for review.	

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 03/23/2023

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ROSE OF SHARON A VILLA CENTER	1000 LOVELL AVENUE ROSEVILLE, MN 55113

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F 689	Continued From page 5 Observation on 03/20/23, at 2:26 p.m. revealed R45 was sitting outside smoking a cigarette. The resident put the cigarette out on the wall of the facility and placed the cigarette butt in the cigarette pack. Observation on 03/21/23, at 1:10 p.m. with the Assistant Director of Nursing (ADON) revealed R45 was sitting in the smoking area smoking. The resident indicated he did not put the cigarette out on the wall but on the wheel of his wheelchair, the resident demonstrated putting out his cigarette butt on the wheel of his wheelchair and placed the cigarette butt in the cigarette carton. Interview on 03/21/23, at 1:10 p.m. theADON confirmed R45 did not put his cigarette butt in the appropriate receptacle. Review of the facility policy titled, "Resident Smoking Policy" last revised in 10/22, read in pertinent part, " Monarch Healthcare Management is committed to providing the highest level of customer care and service while assuring our residents' needs are being met in a safe manner. It is the intent of this policy to outline the procedure for safe resident smoking including evaluation of residents to determine those who are capable of smoking independently, and to provide a designated smoking area for those residents who choose to smoke. 9. Any residents who do not comply with this policy may lose smoking privileges until re-evaluated and determined to be a safe smoker. The resident may be subjected to discharge if unsafe practices are observed and this resident may endanger themselves or others."	F 689		

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 _____	**03/28/2023**

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
K 000	INITIAL COMMENTS FIRE SAFETY The Minnesota Department of Public Safety conducted an annual Life Safety recertification survey, State Fire Marshal Division, on 03/28/2023. At the time of this survey, Rose of Sharon was found 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Rose of Sharon Manor is a 2-story building with no basement. The building was constructed at two different times. The original building was built in 1968 and was determined to be of Type II(222) construction. In 1992, an addition was constructed to the Northside that was determined to be of Type II(222) construction. Because the original building and the one addition are of the same type of construction, the facility was surveyed as one building. A complete fire sprinkler system protects the building. The facility has a fire alarm system with entire corridor smoke detection, resident rooms, and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 63 beds and had a census of 53 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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 _____	**03/28/2023**

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
K 000	Continued From page 1 MET.	K 000		