Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 16, 2023

Administrator
The Estates At Roseville LLC
2727 North Victoria
Roseville, MN 55113

RE: CCN: 245105
Cycle Start Date: May 18, 2023

Dear Administrator:

On July 13, 2023, the Minnesota Departments of Health and Public Safety 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.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 12, 2023

Administrator
The Estates At Roseville Llc
2727 North Victoria
Roseville, MN 55113

RE: CCN: 245105
Cycle Start Date: May 18, 2023

Dear Administrator:

On May 18, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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:

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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 August 18, 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 November 18, 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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT ROSEVILLE LLC	2727 NORTH VICTORIA 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 5/15/23 through 5/18/2023 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 ePOC and 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, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 5/15/23 through 5/18/23 a standard recertification survey was conducted at your facility. Complaint investigations were 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: H51052198C (MN92613), H51052197C (MN88716), H51052194C (MN84250), H51052170C (MN90132), H51052195C (MN83997), H51052196C (MN87048). The facility's plan of correction (POC) will serve as your allegation of compliance upon the 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.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/21/2023

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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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 584 SS=E	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		6/21/23

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F 584	Continued From page 2 §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 maintain wheelchairs in clean and sanitary manner for 3 of 4 residents (R14, R38 and R118) reviewed who utilized wheelchairs. This had the potential to affect 29 residents who used a wheelchair. Findings include: R14's admission Minimum Date Set (MDS) dated 3/30/23, indicated significant cognitive impairment with a diagnosis of dementia and dependent on staff for activities of daily living (ADL). On 5/17/23 at 8:00 a.m., R14's wheelchair was observed to be soiled with an unknown substance that was dried and splattered with crumbs on the arms, seat, backrest and wheels. R38's quarterly MDS dated 4/11/23, indicated significant cognitive impairment with a diagnosis of vascular dementia and dependent on staff for ADL's. On 5/17/23 at 8:00 a.m., R38's wheelchair was observed to be soiled with an unknown substance that was dried and splattered with crumbs on the arms, seat, backrest and wheels.	F 584	R14, R38 and R118 wheelchairs were cleaned on 5/17/23. All residents with wheelchairs have the potential to be affected by this citation. A new wheelchair washing procedure and schedule is implemented on 6/13/23 for all wheelchairs to be washed weekly. Nursing staff was re-educated regarding weekly wheelchair washing 6/12/23-6/21 with compliance achieved by 6/21/23. Audit 5 residents/week X 4 weeks conducted daily by DNS and/or Designee to ensure compliance. DNS and/or Designee are responsible for monitoring compliance. The results of these audits will be shared and reviewed at QAPI committee and frequency adjusted accordingly.	

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F 584	Continued From page 3 R118's admission MDS dated 3/29/23, indicated significant cognitive impairment with a diagnosis of dementia and one assist for all ADL's. On 5/17/23 at 8:00 a.m., R118's wheelchair was observed to be soiled with an unknown substance that was dried and splattered with crumbs on the arms, seat, backrest and wheels. During an observation and interview on 5/17/23 at 8:05 a.m., licensed practical nurse (LPN)-A confirmed R14, R38 and R118's wheelchairs were dirty, there was "stuff" all over them. Housekeeping was responsible for washing them on nights. LPN-A stated staff was responsible to fill out a TELS (system used for building maintenance) ticket on the computer when wheelchairs needed cleaning. During an interview on 5/18/23 at 8:27 a.m., administrator stated wheelchairs went to housekeeping at night to be cleaned. There was a system in place, and wheel chair were expected to be cleaned at scheduled times. Staff put in a TELS ticket when they needed to be cleaned sooner. "The residents reside in a dementia unit and can't tell us their needs, so we are responsible to anticipate and meet their needs." A copy of the cleaning schedule and policy were requested, none received.	F 584		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's	F 623		6/21/23

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F 623	Continued From page 4 representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section	F 623		

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F 623	Continued From page 5 must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.	F 623		

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F 623	Continued From page 6 §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to notify the Office of the long-term care Ombudsman of transfers for 2 of 2 residents (R26 and R42) reviewed for hospitalization. Findings include: R26's progress note dated 2/4/23, identified increase in tremors, a congested nonproductive cough, and wheezes bilaterally with oxygen saturations in the 80's. R26 had oxygen applied but continued to be short of breath and was sent to the emergency department (ED) for evaluation per doctor's order. Progress note dated 2/7/23, identified R26 was re-admitted to the nursing home after being hospitalized for pneumonia. R26's medical record lacked evidence the LTC Ombudsman had been notified of hospital transfer R26' progress note dated 3/14/23, identified increased confusion, lethargy (a general state of fatigue that involves a lack of energy and	F 623	Ombudsman was notified via fax with confirmation that R26 and R42 transferred to the hospital. All residents have the ability to be affected by failure to notify Ombudsman of resident transfers to the hospital. Re-education provided to Social Services Director regarding monthly notification, how to pull report that includes the relevant information and fax. Administrator and/or Designee will audit monthly submission notification X 3 months to Ombudsman of residents that transfer to the hospital. Results of the audit findings to be reviewed at QAPI monthly and auditing timing will be adjusted based on the audit results.	

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F 623	Continued From page 7 motivation for physical and mental tasks), respiration rate of 9 and crackles on lung sounds. Progress note dated 3/15/23, identified R26 was re-admitted to the nursing home after being hospitalized for pneumonia. R26's medical record lacked evidence the LTC Ombudsman had been notified of hospital transfer. An Action Summary report, printed 5/17/23, indicated R26 was hospitalized on 2/4/23 and on 3/14/23. Admission/Discharge To/From Report dated for February and March of 2023, was faxed to the ombudsman. However, R26's name was not on the list of transfer out of the facility. On 5/15/23 at 4:58 p.m., R42 stated she had been hospitalized for a cardiac event. Document review revealed on 2/25/23, R42 requested to go the hospital and was sent via EMS (emergency medical service). R42's medical record lacked evidence the Ombudsman was notified of hospital transfer. The Action Summary printed 5/17/23 indicated R42 was transferred to hospital on 2/25/23. The Admission/Discharge To/From Report dated 2/1/23 to 2/28/23 was faxed on 3/3/23 to the Ombudsman. However, R42's name was not on the list of transfers out of facility. On 5/18/23 at 8:46 a.m. the director of social	F 623		

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F 623	Continued From page 8 services (DSS) stated the Admission/Discharge To/From Report was ran monthly and faxed to the Ombudsman. DSS stated R42's name was not on the Admission/Discharge To/From Report. DSS stated the Action Summary report did not get faxed to the ombudsman man with R42's name on it. On 5/18/23 at 9:39 a.m., social worker (SW)-A stated the Admission/Discharge To/From Report was ran for the previous month and faxed to the ombudsman. SW-A stated R26's name was not on the Admission/Discharge To/From Report for February and March of 2023. SW-A confirmed the action summary report was not sent to ombudsman for neither of R26's hospital transfers. On 5/18/23 at 10:21 a.m., DSS stated social services faxed the information to the Ombudsman and R26 and R42 were missed on the report. The facility policy Bed-Holds and Returns dated 5/23 revealed when a resident is temporarily transferred on an emergency basis to an acute care facility, this type of transfer is considered to be a facility-initiated transfer and a notice of transfer must be provided to the resident and resident representative as soon as practicable before the transfer, according to 42 CFR 483.15(c)(4)(ii)(D). Copies of notice for emergency transfers must also still be sent to the ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis, as long as the list meets all requirements for content of such notices.	F 623		
F 677 SS=D	ADL Care Provided for Dependent Residents	F 677		6/21/23

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F 677	Continued From page 9 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 assistance with facial hair removal for 1 of 5 residents (R13) who was dependent on staff for activities of daily living (ADL's). Findings include: The annual Minimum Data Set (MDS) dated 10/28/22, indicated R13 had diagnoses of non-traumatic brain dysfunction and dementia. R13 had impaired cognition and required extensive assistance of one staff with personal hygiene. During an observation on 5/16/23 at 3:05 p.m., R13 was resting in bed with white chin hairs from 1/4 inch to one inch in length. During an observation on 5/17/23 at 7:12 a.m., R13 was dressed and sitting in a wheelchair in the dining room. R13 had white chin hairs from 1/4 inch to one inch in length. During an interview on 5/17/23 at 9:17 a.m., assistant director of nursing (ADON) stated R13's bath day was Tuesday (yesterday). The ADON stated the resident should be shaved on their bath day and the nursing assistant (NA) should document it was completed.	F 677	R13 had facial hair trimmed on 5/17/23. All dependent male and female residents with facial hair have the potential to be affected by this citation. Initiated education for nursing staff that dependent male and female residents with facial hair are clean shaven, unless the resident prefers facial hair. Shaving/Facial Hair audits will complete 5 resident audits X 4 weeks by DNS and/or Designee to ensure residents are clean shaven. DNS and/or Designee are responsible for monitoring compliance. The results of these audits findings will be reviewed at QAPI and will determine any changes in frequency at that time.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	C 05/18/2023

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F 677	Continued From page 10 During an interview on 5/17/23 at 10:02 a.m., NA-A stated nurses shaved the residents and document when it was completed. During an interview on 5/17/23 at 10:05 a.m., ADON stated R13 had chin hairs that were 1/4 inch long needed to be shaved. ADON stated NA's shaved the residents on bath day and when chin hairs were present. At 11:37 a.m. the ADON stated R13 has had no refusals of personal cares. During an interview on 5/17/23 at 10:08 a.m., licensed practical nurse (LPN)-D stated residents should be shaved every day. The facility policy Activities of Daily Living (ADLs)/Maintain Abilities Policy dated 3/31/23 indicated the facility would provide care and services for the following activities of daily living: a. Hygiene -bathing, dressing, grooming, and oral care, b. Mobility-transfer and ambulation, including walking, c. Elimination-toileting, d. Dining-eating, including meals and snacks. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 677		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by:	F 759		6/21/23

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F 759	Continued From page 11 Based on interview, observation, and record review the facility failed to ensure medications were administered in accordance with physician orders and standards of care for 2 of 5 residents (R85 and R81) reviewed for medication administration. A total of 2 of 25 opportunities were in error resulting in an 8% medication error rate. Findings include: R85's quarterly Minimum Data Set (MDS) dated 4/12/23, indicated diagnoses of dementia and depression. R85's order dated 12/9/19, indicated "May crush meds/open capsules and combine all medications during med pass administration. (Refer to DO NOT CRUSH list for exceptions) Put in food/fluids per patients preference and or as needed unless otherwise indicated." R85's care plan printed 5/18/23, indicated "Medications will be changed to dissolvable or liquid form when resident requires", with date initiated 12/13/19. During observation on 5/17/23 at 7:42 a.m., trained medication assistant (TMA)-A prepared medications for R85. TMA-A placed all medications into a medication cup, then a pouch for crushing. TMA-A crushed all medications and placed crushed medications in applesauce to be given to the resident. The crushed medications included bupropion HCL ER (XL) tablet extended release 24 hour (an antidepressant). During an interview on 5/17/23 at 7:55 a.m., TMA-A stated extended release medications	F 759	R85 eMAR and Careplan were updated to reflect DO NOT CRUSH the Bupropion XL and to place it in applesauce/other and administer whole. R81 eMAR was audited to ensure Calcium Carbonate per Standing House Orders (SHO) was documented. All residents on Extended Release and other non-crushable medications and those requiring the use of SHO medications have the potential to be affected. Audited all residents with orders for crushing of medications and receiving non-crushable medication and notation added on the eMAR "DO NOT CRUSH" and/or request the provider to change the form and/or change to an alternative crushable medication where appropriate. Re-education provided to nursing staff that non-curshable medications can not be crushed, they must refer to the DO NOT CRUSH listing. When administered, SHO medications will be documented in the resident's chart. Audits of 5 residents per week X 4 weeks will be completed by DNS and/or Designee to ensure that all medications are administered as ordered, iin the correct form, dose/amount and not crushed if contrainindicated and that the nurse is notified of the need for using the SHO medications and it is docuements on the eMAR and in the Nursing Notes. DNS and/or Designee are responsible for monitoring compliance. The results of	

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F 759	Continued From page 12 should be placed in a separate medication cup and not be crushed. TMA-A confirmed all medications given to R85 were crushed. TMA-A stated HCL ER (XL) tablet extended release should not be crushed.. During an interview on 5/18/23 at 10:22 a.m., the pharmacist recommended bupropion HCL ER not be crushed. "The medication may not maintain the extended-release properties when crushed". The pharmacist stated the medication may wear off sooner than anticipated but could not confirm. The pharmacist expected the bupropion formulation to be adjusted if all R85's medications needed to be crushed. During an interview on 5/18/23 at 11:00 a.m., the assistant director of nursing (ADON) stated she expected an order to say when a medication may be crushed and mixed with other medications. When a resident cannot swallow an extended-release medication whole, the medication was changed to a different type. When extended-release medications were crushed, the medication did not work properly and was received all at once instead of over a period of time. R81's quarterly MDS dated 3/15/23, identified R81 was cognitively intact. R81's Admission Record dated 5/18/23, indicated diagnoses of slow transit constipation and gastro-esophageal reflux disease without esophagitis. R81's Medication Administration Record (MAR) printed 5/17/23, lacked an order for calcium carbonate.	F 759	these audit findings will be reivewed at QAPI and frequency of audits will be adjusted at that time based on the results.	

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F 759	Continued From page 13 During observation and interview on 5/17/23 at 10:50 a.m., TMA-B prepared two calcium carbonate antacid oral tablets and brought to resident R81. R81 chewed and swallowed one calcium carbonate antacid oral tablet and stated she did not want the second tablet. TMA-B disposed the refused medication. TMA-B stated calcium carbonate antacid oral tablet was an as needed order. R81 decided whether to take one or two tablets. During an interview on 5/17/23 at 1:57 p.m., the licensed practical nurse (LPN)-B stated as needed medications were given when residents requested. When standing orders were utilized a few times for a resident, nursing called the doctor for a specific order. Utilized standing orders were placed in the resident's orders and documented. LPN-B confirmed there was no order for the calcium carbonate in R81's orders and administration was not documented. LPN-B stated TMA's were not able to enter orders. LPN-B expected the TMA to tell the nurse to put the standing order in R81's active orders. LPN-B checked and found a list of standing orders within R81's chart which included as needed calcium carbonate antacid tablets. LPN-B stated documentation of as needed orders was important so residents were not overdosed. During an interview on 5/18/23 at 11:00 a.m., the ADON stated standing orders were placed in the MAR. When used for a few days, the physician was updated. The MAR showed documentation of given standing orders. TMAs were required to notify the nurse when standing orders were utilized. Documentation was important because the facility needed to track which medications	F 759		

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F 759	Continued From page 14 were given and the next shift needed to know when the medication was last given. The facility's Standing Orders for Skilled Nursing Facilities with revised date April 2022, identified "Calcium carbonate 500 mg 1 tab PO (chewable) qid prn". The facility's Pharmacy Services for Nursing Facilities policy dated May 2022, indicated: -Refer to crushing guidelines prior to crushing any medication for assurance that it can be pulverized -Crush medications, if indicated by prescriber's order for this resident, only after checking the Medication Crushing Guidelines. However, these guidelines were not specified. -Chart medication administration on Medication Administration Record immediately following each resident's medication administration. -Licensed nurses implement standing orders. -Professional judgment is used in the initiation and administration of standing orders -The order is written following the procedure for verbal prescriber orders in accordance with the policy on prescriber medication orders indicating the source of the order, the abbreviation "s.o." is used to indicate a standing order -Documentation of the situation requiring the use of the standing order is placed in the "Nursing Notes" section of the resident's medical record prior to initiation of the order	F 759		
F 880 SS=E	Infection Prevention & Control 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	F 880		6/21/23

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F 880	Continued From page 15 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 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	F 880		

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F 880	Continued From page 16 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 record review the facility failed to implement appropriate infection prevention and control practices regarding disinfection of glucometer for 1 of 5 residents (R17) who utilized a multi-person use blood glucometer. R17's admission Minimum Data Set (MDS) dated 5/5/2023, identified diagnosis of diabetes mellitus and medication of daily insulin injections. R17's order summary printed 5/22/23, identified "Blood Sugars before meals and at bedtime" with start date of 4/28/23. During observation and interview on 5/15/23 at	F 880	R17 was assessed and no ill effects were noted. All diabetic residents receiving blood glucose monitoring have the potential to be affected. Facility audited and ensured all residents have their own glucometer machine. All residents requireing blood sugar monitoring will have their own personal glucometer. Glucometers will be cleaned and disinfected per manufacturer directions. Re-education was completed with nursing	

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F 880	Continued From page 17 5:43 p.m., licensed practical nurse (LPN)-C applied gloves, checked R17's blood glucose level with glucometer device and removed gloves. She sanitized hands when returned to medication cart. The used glucometer was returned to its basket with other supplies for blood glucose checks. However, LPN-C did not disinfect the glucometer. The basket was replaced into the top drawer of the medication cart. LPN-C proceeded to document R17's blood glucose results and continue onto next task. LPN-C stated the blood glucometer should have been cleaned after R17's blood glucose check. LPN-C wiped glucometer with an alcohol prep pad and placed glucometer back in medication drawer. LPN-C stated other residents used the glucometer. During an interview on 5/18/23 at 11:00 a.m., the assistant director of nursing (ADON) stated staff used bleach wipes and appropriate kill time to disinfect glucometers used for multiple residents. Glucometers used for multiple residents needed to be cleaned and disinfected properly to prevent the spread of blood pathogens. McKesson TRUE METRIX PRO's user manual online undated, indicated: -If dedicating blood glucose meters to a single patient is not possible, the meters must be properly cleaned and disinfected after each use following the guidelines found in Meter Care, Cleaning/Disinfecting. -The blood glucose meter should be cleaned and disinfected after each use to prevent the transmission of blood-borne pathogens. -Instructions identified To Clean: -Make sure meter is off and a test strip is not inserted. -With ONLY PDI Super Sani Cloth Wipes (or	F 880	staff that all residents must have their own glucometer and that it must be cleaned and disinfected per Manufactuerers instructions and directions immediately after use/before returning it for storage. Glucometer audits will be completed on 5 residents per week X 4 weeks by DNS and/or Designee to ensure that each diabetic resident requiring blood glucose monitoring has their own glucometer and that it is cleaned and disinfected per Manufacturers directions with each use. DNS and/or Designee are responsible for monitoring compliance. The results of these auditing findings will be reviewed at QAPI and adjusted in frequentcy accordingly.	

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F 880	Continued From page 18 any disinfectant product with the EPA [Environmental Protection Agency] reg. no. of 9480-4), rub the entire outside of the meter using 3 circular wiping motions with moderate pressure on the front, back, left side, right side, top and bottom of the meter. -Repeat as needed until all surfaces are visibly clean. -Discard used wipes. -To Disinfect: Using fresh wipes, make sure that all outside surfaces of the meter remain wet for 2 minutes. Make sure no liquids enter the Test Port or any other opening in the meter." The facility's Infection Control policy undated and labeled Monarch Healthcare Management Assisted Livings identified: Glucometers used by multiple patients must be cleaned and disinfected in the following manner between patient uses: - Clean the glucometer to remove blood and OPIM by following manufacturer instructions - Disinfect the glucometer by following manufacturer instructions, making sure any product you use is effective against bloodborne pathogens. - Follow disinfection product instructions to make sure it is applied properly and remains on the glucometer for the required amount of time. Always read labels to ensure that you are disinfecting for the correct amount of time; each product is different - Remove gloves, dispose of gloves, and wash hands - Store glucometer appropriately, per manufacturer direction and facility protocol	F 880		

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	245105	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/16/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on May 16, 2023. At the time of this survey, The Estates of Roseville 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 06/21/2023

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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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Estates of Roseville was built in 1965 as a 2-story building without a basement and was determined to be Type II (222) construction. In 1973 a 1-story addition was constructed to the west of the existing building and was determined to be Type II (222) construction. In 1983 a 2 story addition (Woodhill) was constructed to the south of the original building and was determined to be Type II (222) construction. In 1995 a dining room addition was constructed to the south wing of the 1973 addition and was determined to be Type II	K 000		

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K 000	Continued From page 2 (222) construction. The facility has a capacity of 140 beds and had a census of 122 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to maintain Fire Sprinkler System - Installation per NFPA 101 (2012 edition), Life Safety Code, section 9.7.1.1, and NFPA 13 (2010 edition) Standard for the Installation of Sprinkler Systems section 8.1.2, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and	K 351	Facility is maintaining the Fire Sprkinler System Installation of Sprinkler Systems Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection. 6 Sprinkler heads greater than 50 years have been sent in for testing through Summit, if fail testing will	6/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/16/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT ROSEVILLE LLC	**2727 NORTH VICTORIA** **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 351	Continued From page 3 Maintenance of Water-Based Fire Protection Systems, section 5.3.1.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On May 16, 2023, between 9-1 PM, it was revealed by observation that there are fire sprinkler heads in the original building built in 1965, and the addition in 1973 has fire sprinkler heads over the age of 50 years and have not been tested or replaced. An interview with the Facility Administrator, Facility Director of Monarch, verified this deficient finding at the time of discovery.	K 351	be replaced. All residents have the ability to be affected by this deficient finding. Re-education provided to Maintenance Director on ensuring Sprinkler Systems are Inspected, Tested and Maintained for Water-Based Fire Protection for sprinkler heads greater than 50 years. Administrator/and or Designee to audit one time monthly X 1 month Sprinkler System Inspections, Testing and Maintenance for those greater than 50 years old. Results of the audit findings to be reviewed at QAPI monthly and to be adjusted based on the audit results.	