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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KBTC

## 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 10/25/2021 (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

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 :
Sarah Grebenc, Unit Supervisor 10/19/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 10/25/2021 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 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
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
October 25, 2021

CMS Certification Number (CCN): 245326

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 October 19, 2021 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered
October 25, 2021

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

RE: CCN: 245326
Cycle Start Date: September 1, 2021

Dear Administrator:

On September 24, 2021, we notified you a remedy was imposed. On October 25, 2021 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 19, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 24, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of September 24, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 24, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 19, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KBTC

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| **3. Termination** | **4. CHOW** |
| **5. Validation** | **6. Complaint** |
| **7. On-Site Visit** | **9. Other** |
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5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **12/01/2017**

6. DATE OF SURVEY **09/01/2021** (L34)

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FISCAL YEAR ENDING DATE: (L35)
**09/30**

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To (b) :

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**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 | | | |
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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 :
Magdalene Jares, HFE NE II 10/19/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 10/26/2021 (L20)

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

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

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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
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OTHER
07-Provider Status Change
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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
September 24, 2021

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

RE: CCN: 245326
Cycle Start Date: September 1, 2021

Dear Administrator:

On September 1, 2021, a survey was completed at your facility by the Minnesota Department(s) 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 delivered CMS-2567, whereby significant corrections are required.

## REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 24, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 24, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 24, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for

new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

## NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by October 24, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Rose Of Sharon A Villa Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 24, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

## 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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

## DEPARTMENT CONTACT

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

Sarah Grebenc, 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: sarah.grebenc@state.mn.us
Office: (651) 201-3792 Mobile (651)238-8786

## 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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

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 March 1, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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,

Kamala Fiske-Downing

Kamala Fiske-Downing

Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112  Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

| STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs | PROVIDER # 245326 | MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | DATE SURVEY COMPLETE: 9/1/2021 |
|---|---|---|---|

| 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 623** | Notice Requirements Before Transfer/Discharge<br>CFR(s): 483.15(c)(3)-(6)(8)<br><br>§483.15(c)(3) Notice before transfer.<br>Before a facility transfers or discharges a resident, the facility must-<br>(i) Notify the resident and the resident's 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.<br>(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<br>(iii) Include in the notice the items described in paragraph (c)(5) of this section.<br><br>§483.15(c)(4) Timing of the notice.<br>(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.<br>(ii) Notice must be made as soon as practicable before transfer or discharge when-<br>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;<br>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;<br>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;<br>(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<br>(E) A resident has not resided in the facility for 30 days.<br><br>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:<br>(i) The reason for transfer or discharge;<br>(ii) The effective date of transfer or discharge;<br>(iii) The location to which the resident is transferred or discharged;<br>(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;<br>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;<br>(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<br>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address |

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 _____ | 9/1/2021 |

| 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 623** | Continued From Page 1 |

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.

§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 provide a written notice for transfer/discharge for 1 of 1 residents (R58) reviewed for hospitalizations.

Findings include:

R58's quarterly Minimum Data Set (MDS) dated 8/13/21, indicated R58 had moderately impaired cognition and had diagnoses of cerebral vascular accident (stroke), dementia, and weakness.

R58's progress note dated 8/4/21, at 9:00 a.m. indicated R58 was sent to the hospital on 7/29/21, due to a change in vital signs and altered mental status.

R58's medical record lacked evidence of a written transfer notice was given to R58 or the family representative.

During an interview on 9/1/21, at 11:20 a.m. social worker (SW) stated they were still getting used to providing a written transfer form for residents or their family representative. The SW verified a written transfer form was not completed for R58.

The facility Bed Hold and Return Guidelines policy dated 4/25/19, indicated the facility will provide the resident/family representative a written notification of the transfer and the reason for the transfer.

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| | 245326 | A. BUILDING _____ B. WING _____ | C 09/01/2021 |

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

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| E 000 | Initial Comments<br><br>On 8/29/21, through 9/1/21 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.<br><br>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<br><br>On 8/29/21 to 9/1/21, a standard recertification survey was conducted at your facility. In addition, complaint investigations were conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaint was found to be SUBSTANTIATED:<br>H5326117C (MN00051393), however NO deficiencies were cited due to actions implemented by the facility prior to survey.<br><br>The following complaints were found to be UNSUBSTANTIATED:<br>H5326110C(MN00055312), H5326111C(MN00054474), H5326112C (MN00053752/MN00053786), H5326113C (MN00053708), H5326114C(MN00051940), H5326115C (MN00052229), H5326116C (MN00051611) and H5326118C (MN00047390).<br><br>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 | 10/06/2021

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|---|---|---|---|---|
| F 000 | Continued From page 1<br>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.<br><br>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 554 SS=D | Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)<br><br>§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to determine if the practice of self-administration of medications (SAM) was safe for 2 of 2 residents (R8, R16) who was observed to have medications at bedside without an order to self-administer.<br><br>Findings include:<br><br>On 8/29/21, at 4:16 p.m. during an interview R8 dumped out a small medication cup on her bedside tray table with 10 medications. R8 stated these were her 8:00 a.m. medications. R8 stated she had not taken them because she was afraid to take them. R8 then stated there were at least three pills that did not look like the medications she received on prior mornings. R8 said she was going to ask the nurse about it later. Furthermore, during the interview an observation was made of | F 554 | This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to determine if the practice of self-administration of medication (SAM) was safe for 2 of 2 residents (R8, R16) who ws observed to have medication at bedside without an order to self-administer.<br>*R8 no longer resides at the facility. R16 continues to resident at the facility. R16's care plan was reviewed and updated as appropriate. R8 and R16 experienced no adverse outcomes from the deficient practice.<br>*Residents who self-administer medications have received evaluations, order reviews, and care plans updates as needed to assure appropriateness of | 10/19/21 |

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| F 554 | Continued From page 2<br>three plastic medication cups with 15 (milliliter) ml of a light-yellow fluid on her nightstand. When asked, R8 stated the liquid was her Lactulose (a medication used to prevent complications of liver disease) that she had not taken from previous unknown dates.<br><br>R8's admission Minimum Data Set (MDS) dated 6/2/21, noted R8 to have intact cognition. R8's diagnoses obtained from the face sheet printed 9/1/21, included alcohol dependence with withdrawal, contusion of right lower leg, and alcoholic cirrhosis of the liver.<br><br>R8's medication administration record (MAR) listed medications as administered at 8:00 a.m. on 8/29/21, included:<br>-Baclofen 5 (milligram) mg tablet one time a day for muscle spasms.<br>-Folic Acid 1 mg tablet one time a day for supplement.<br>-Furosemide 40 mg table one time a day for edema per liver doctor.<br>-Multivitamin Plus Iron tablet two tablets one time a day for supplement.<br>-Naltrexone HCl 50 mg one time a day for alcoholism, if unable to tolerate, ok to discontinue.<br>-Omeprazole capsule delayed release, 20 mg one time per day for GERD.<br>-Spironolactone 100 mg tablet one time a day for diuretic.<br>-Thiamine HCl 100 mg tablet one time a day for alcoholic cirrhosis of the liver.<br>-Rifaximin 550 mg tablet two times a day for liver cirrhosis.<br>-Lactulose Solution 10 gram (GM)/15 ml give 15 ml three times a day for alcoholic cirrhosis. | F 554 | self-administration of medication.<br>*Education will be provided by DON/Designee to licensed nurses and TMA on the policy and procedure for allowing self-administration of medications for residents. Care plans and provider orders updated to identify those who have SAM in place. IDT will evaluate appropriateness of continued self-administration of medication for each resident on a quarterly basis or with change in condition.<br>*DON/Designee will complete audits on 4 residents per week for 3 weeks, then 2 residents per week for an additional 3 weeks to ensure SAM assessment are complete and followed. Audits to be conducted by DON/designee.<br>*Audit findings to be presented to QAPI by DON or designee for 3 months to evaluate for trends and need for continued auditing and monitoring. | |

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|---|---|---|---|---|
| F 554 | Continued From page 3 | F 554 | | |

On 8/29/21, at 4:36 p.m. registered nurse (RN)-B was observed enter R8's room and put another plastic medication cup on her tray table with 15 mL of the yellow liquid, RN-B stated the medication he left on the table was Lactulose and RN-B left the room. R8 did not take the medication while RN-B was in the room.

On 8/30/21, at 9:12 a.m. three plastic medication cups with 15 mL Lactulose were observed on R8's nightstand.

On 8/31/21, at 9:55 a.m. three plastic medication cups with 15 mL of Lactulose were observed on R8's nightstand.

When interviewed on 8/31/21, at 10:58 a.m. licensed practical nurse (LPN)-A stated there were no residents on this unit that self-administered their medications.

On 8/31/21, at 11:09 a.m. LPN-A verified the cups on R8's nightstand and stated, "looks kind of like her Lactulose". LPN-A then removed the medications and disposed them.

When interviewed on 9/1/21, at 10:47 a.m. director of nursing (DON) indicated she expected that R8 would have a SAM assessment completed. The DON stated she would expect a nurse to ask why a resident did not take their medication and to follow up with them.

During an observation on 9/1/21, at 1:20 p.m. a 34 ounce (oz) prescription bottle of Vashe wound cleanser was observed on R16's television stand. During review of the medical record, R16 lacked physician orders for the use of Vashe wound cleanser.

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| F 554 | Continued From page 4<br><br>R16's admission MDS dated 6/17/21, noted R16 to have severely impaired cognition, extensive assistance of two people and mechanical lift for transfers. R16's discharge to hospital MDS indicates R16 had an unstageable pressure ulcer. R16's diagnoses obtained from the face sheet printed 9/1/21, include metabolic encephalopathy (impaired brain function), subarachnoid hemorrhage (stroke), acute respiratory failure.<br><br>When interviewed on 9/1/21, at 1:24 p.m. RN-B stated the bottle of cleanser was in R16's room because it is used for R16's wound care. RN-B also stated all wound supplies are kept in resident rooms. RN-B then opened the top drawer to the television stand and a loaf of non-sterile gauze along with a dermal wound cleansing spray were observed.<br><br>When interviewed on 9/1/21, at 1:32 p.m. DON stated all prescriptions should be locked in a nurse's cart.<br><br>The facilities policy title Self-Administration of Medication Management indicated a resident may only self-administer medications after the IDT (Interdisciplinary Team) has determined which medications may be safely self-administered. | F 554 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in | F 684 | | 10/19/21 |

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|---|---|---|---|---|
| F 684 | Continued From page 5<br>accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to follow physician orders of keeping the head of the bed (HOB) 30 degrees or higher for 1 of 1 residents (R16) who received nutrition via G-tube (a tube inserted through the abdomen into the stomach) reviewed for quality of care.<br><br>Findings include:<br><br>R16's admission Minimum Data Set (MDS) dated 6/17/21, identified R16 to have severely impaired cognition, and required extensive assistance of two people with a mechanical lift for transfers. R16's diagnoses obtained from the face sheet printed 9/1/21, include metabolic encephalopathy (impaired brain function), subarachnoid hemorrhage (stroke), acute respiratory failure.<br><br>During a continuous observation on 8/31/21, at 7:21 a.m. R16 was noted to be in bed with his tube feeding running, the head of bed (HOB) was at 15 degree elevation.<br><br>On 8/31/21, at 7:25 a.m. nursing assistant (NA)-D entered R16's room to drop off linens and immediately exited.<br><br>On 8/31/21, at 7:40 a.m. R16's tube feeding began to beep.<br><br>On 8/31/21, at 7:44 a.m. NA-C entered R16's room to turn off the machine and then exited to notify the nurse at the nursing station. | F 684 | This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow physician orders of keeping the head of the bed 30 degrees or higher for 1 of 1 residents (R16) who received nutrition via G-tube (a tube inserted through the abdomen into the stomach) reviewed for quality of care.<br>*R16 continues to reside at the facility. An assessment was completed on R16 that did not show any adverse reactions. R16's plan of care has been updated as appropriate.<br>*Residents that receive tube feeding have the potential to be affected by this practice. These residents were assessed with no adverse events noted. Care plans for these were reviewed and updated.<br>*DON/Designee completed education to licensed nurse, TMAs, and CNAs regarding elevation of the head of the bed. Nursing assistant care guide sheets were updated to identify residents who have tube feeding and the need to elevate the head the bed.<br>*Residents with tube feeding will be audited weekly for 3 weeks, then monthly for 3 months to ensure head of bed is elevated per facility. Audits to be conducted by DON/designee.<br>*Audit findings to be presented to QAPI by DON or designee for 3 months to evaluate for trends and need for continued auditing | |

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| F 684 | Continued From page 6<br><br>On 8/31/21, at 7:46 a.m. NA-D entered R16's room and told R16 she would notify the nurse of the tube feeding beeping. NA-D did not elevate the HOB.<br><br>On 8/31/21, at 7:48 a.m. licensed practical nurse (LPN)-A entered the room. When interviewed, LPN-A stated R16's HOB was "almost flat" and it should be elevated to 45 degrees.<br><br>A physician order dated 7/16/21, directed R16's HOB should be elevated to at least 30 degrees or more to prevent aspiration.<br><br>When interviewed on 8/31/21, at 11:59 a.m. NA-C stated residents that had tube feedings should have the HOB elevated to "at least" 30-45 degrees.<br><br>When interviewed on 8/31/21, at 12:16 p.m. NA-D stated residents that have tube feedings should have the HOB elevated to 45 degrees.<br><br>When interviewed on 9/1/21, at 10:55 a.m. director of nurses (DON) stated residents that had tube feedings needed to have the HOB elevated to 45 degrees or as ordered by the physician to prevent aspiration. | F 684 | and monitoring. | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent | F 686 | | 10/19/21 |

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|---|---|---|---|
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|---|---|---|---|---|
| F 686 | Continued From page 7<br>pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to provide timely assistance with repositioning for 1 of 1 resident (R24) at risk for skin breakdown.<br><br>Findings Include:<br><br>During continuous observation of R24 on 8/31/21, which began at 7:21 a.m. until 11:26 a.m. (4 hours and 5 minutes), R24 remained in the wheelchair, watched television in the area in front of the nursing station, ate breakfast, looked out the window, participated in exercise, and attended church service.<br><br>R24 diagnoses obtained from admission record printed on 8/31/21, included alcoholic cirrhosis of liver with ascites (abdominal swelling), type 2 diabetes mellitus with diabetic nephropathy, mild cognitive impairment, benign prostatic hyperplasia without lower urinary tract symptoms, and localized edema.<br><br>The admission Minimum Data Set (MDS) dated 4/13/21, indicated R24 had severe cognition impairment. The MDS further indicated the functional status of R24 was extensive assist of one person with transfers and bed mobility,was frequently incontinent of bladder, and was at risk | F 686 | This REQUIREMENT is not met as evidence by: Based on observation, interview and document review the facility failed to provide timely assistance with repositioning for 1 of 1 resident (R24) at risk for skin breakdown.<br>*R24 continues to reside at the facility. R24 received a skin assessment that did not reflect any skin impairments. Care plan was reviewed with updated made to ensure appropriate interventions to prevent skin breakdown.<br>*Resident who were identified at risk for skin breakdown using the Braden Scale score of 15 or below are at risk of being affected by this practice. These residents were assessed care plans were reviewed and interventions were put in place as appropriate to prevent skin breakdown.<br>*DON/Designee provided education to Licensed Nurses and CNAs about following resident's skin protection plans of care.<br>*DON/Designee to complete audits on 4 residents per week for 3 weeks, then 2 residents per week for an additional 3 weeks to ensure preventative skin interventions are in place. Audits to be conducted by DON/designee. | |

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|---|---|---|---|---|
| F 686 | Continued From page 8<br>for skin breakdown.<br><br>R24's care plan dated 3/29/21, indicated R24 was at risk for impairment to skin integrity related to incontinence, altered mental status, psychotropic medication use, and dementia with behavioral disturbance.<br><br>Review of R24's risk assessment dated 7/6/21, indicated a Braden (evidenced based tool that provides a scale to identify potential categories that would contribute to conditions for breakdown) score of 16 which indicated R24 was at risk for skin breakdown. In addition, a review of the facility's skin protection guideline dated 7/7/21, indicated, a plan of care will be developed based on known predicting factors for skin breakdown.<br><br>Review of the nursing assistant's care guide sheet indicated, transfer with assist of one and turn and reposition with assist of one, however the care guide did not direct how often R24 was to be repositioned.<br><br>On 8/31/21, at 11:18 director of nursing (DON) stated if a resident was a check and change, the expectation would be that it would be done every two to three hours.<br><br>On 8/31/21, at 11:26 a.m. nursing assistant (NA)-C assisted R24 to the bathroom. R24 was incontinent of bowel and bladder. R24's skin did not have reddened areas. | F 686 | *Audit findings to be presented to QAPI by DON or designee for 3 months to evaluate for trends and need for continued auditing and monitoring. | |
| F 690 SS=D | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that | F 690 | | 10/19/21 |

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|---|---|---|---|---|
| F 690 | Continued From page 9<br>resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to provide timely toileting for 1 of 1 resident (R24) reviewed for bowel and bladder. | F 690 | This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide timely toileting for 1 of 1 resident (24) reviewed for bowel | |

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| F 690 | Continued From page 10<br>Findings Include:<br><br>During continuous observation of R24 on 8/31/21, which began at 7:21 a.m. until 11:26 a.m. (4 hours and 5 minutes), R24 remained in the wheelchair, watched television in the area in front of the nursing station, ate breakfast, looked out of the window, participated in exercise, and attended church service.<br><br>R24 diagnoses obtained from admission record printed on 8/31/21, included alcoholic cirrhosis of liver with ascites (abdominal swelling), type 2 diabetes mellitus with diabetic nephropathy, mild cognitive impairment, benign prostatic hyperplasia without lower urinary tract symptoms, and localized edema.<br><br>The initial Minimum Data Set (MDS) dated 4/13/21, indicated that R24 had severe cognition impairment. The MDS further indicated the functional status of R24 was extensive assist of 1 person with transfers and bed mobility, and R24 was frequently incontinent of bladder.<br><br>The care plan for R24 dated 3/29/21, indicated R24 had stress incontinence related to (r/t) bladder weakness with the goal to remain free from skin breakdown due to incontinence and brief use. The interventions for R24 included to clean peri-area with each incontinence episode. The care plan further indicated R24 was at risk for impairment to skin integrity related to incontinence, altered mental status, psychotropic medication use, and dementia with behavioral disturbance.<br><br>Review of the nursing assistant's care guide sheet indicated toilet 2 wheeled walker (ww) and | F 690 | and bladder.<br>*R24 continues to reside at the facility. R24 received a bowel and bladder assessment and care plan was updated to reflect changes. R24 is being toileted per Plan of Care.<br>*Residents who experience incontinence of bowel or bladder have the potential to be affected by this practice. Residents identified as incontinent of bowel or bladder through their MDS assessment were evaluated, care plans reviewed and updated as appropriate.<br>*DON/designee to complete education to nurses and CNAs regarding following residents' individualized toileting plans of care.<br>*DON/Designee will complete audits on 4 residents per week for 3 weeks, then 2 residents per week for an additional 3 weeks to ensure residents' toileting plan of care is being followed. Audits to be conducted by DON/designee.<br>*Audit findings to be presented to QAPI by DON or designee for 3 months to evaluate for trends and need for continued auditing and monitoring. | |

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| | 245326 | A. BUILDING _____ B. WING _____ | C 09/01/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 690 | Continued From page 11<br>contact guard assist pericare each time. There was no indicated of how often R24 was to be toileted.<br><br>Review of R24's bowel evaluation dated 7/6/21, R24 required physical assist to toilet and was check and change. Review of R24's bladder evaluation dated 7/6/21 indicated R24 had stress incontinence and required check and change.<br><br>On 8/31/21, at 11:18 director of nursing (DON) stated if a resident was a check and change, the expectation would be that it would be done every 2-3 hours.<br><br>On 8/31/21, at 11:26 a.m. nursing assistant (NA)-C assisted R24 to the bathroom. R24 was incontinent of both bowel and bladder. | F 690 | | |
| F 732 SS=C | Posted Nurse Staffing Information<br>CFR(s): 483.35(g)(1)-(4)<br><br>§483.35(g) Nurse Staffing Information.<br>§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:<br>(i) Facility name.<br>(ii) The current date.<br>(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br>(A) Registered nurses.<br>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).<br>(C) Certified nurse aides.<br>(iv) Resident census.<br><br>§483.35(g)(2) Posting requirements. | F 732 | | 10/19/21 |

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| F 732 | Continued From page 12<br>(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.<br>(ii) Data must be posted as follows:<br>(A) Clear and readable format.<br>(B) In a prominent place readily accessible to residents and visitors.<br><br>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.<br><br>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to accurately post staff actual hours worked on the daily posting. This had the potential to affect all 60 residents who resided in the facility and visitors.<br><br>Findings include:<br><br>During comparison review of daily schedules and daily facility posting of staff hours, from 8/11/21, until 8/31/21, the daily posting of nursing hours reflected more hours than actually staffed for the night shift. Each night shift was staffed to two nurses and was a combination of registered nurses (RN) and licensed practical nurses (LPN).<br><br>Upon review; on 8/11/21, scheduled assignments noted one RN and one LPN, the corresponding | F 732 | This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to accurately post staff actual hours worked on the daily posting. This had the potential to affect all 60 residents who resided in the facility and visitors.<br>*Staff posting has been updated to reflect accurate and actual hours worked on the daily positing.<br>*Residents who reside in the facility and visitors to the facility have the potential to be affected by this practice. Staff posting is reviewed daily for accuracy.<br>*The staffing coordinator, charge nurse adn DON were educated on the requirement of the nursing hours posting and how to complete the posting correctly. | |

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| F 732 | Continued From page 13<br>staff posting indicated there was one RN and two LPN's that worked the overnight shift. This occurred again on the following dates: 8/12/21, 8/16/21, 8/17/21, 8/18/21, 8/20/21, 8/21/21, 8/22/21, 8/23/21, 8/24/21, 8/25/21, 8/26/21, and 8/31/21.<br><br>Upon review; on 8/13/21, scheduled assignments noted one RN and one LPN, the corresponding staff posting indicated there was two RN's and one LPN that worked the overnight shift. This occurred again on the following dates: 814/21 and 8/19/21.<br><br>Upon review; on 8/15/21, the scheduled assignments noted to have two RN's, the corresponding staff posting indicated there were three RN's that worked the overnight shift. This occurred again on the following dates: 8/27/21, 8/28/21, and 8/29/21.<br><br>Upon review; on 8/30/21, the scheduled assignments noted two LPN's, the corresponding staff posting indicated there were three LPN's that worked the overnight shift.<br><br>During an interview on 9/1/21, at 3:06 p.m. the administrator acknowledged the staff posting was not done correctly and the number of nursing hours were incorrect, some nurses were counted twice when they should have been counted once. | F 732 | *The Administrator/designee will audit the staff posting 5 days a week for 3 weeks to assure compliance with the posting requirement, then weekly for 3 weeks.<br>*Audit findings to be presented to QAPI by administrator monthly 3 months to evaluate for trends and need for continued auditing and monitoring. | |
| F 761 SS=E | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the | F 761 | | 10/19/21 |

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|---|---|---|---|---|
| F 761 | Continued From page 14<br>appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to properly secure medications in 1 of 1 treatment cart observed for medication storage.<br><br>Findings include:<br><br>During an observation on 8/31/21, at 8:20 a.m. the treatment cart was unlocked and unattended by staff. The cart was located outside of the medication room in the hallway across from the nurse's station and at the intersection of the three resident rooms hallways. During the observation, multiple residents walked passed as they returned to their rooms from breakfast and to go outside. At 9:30 a.m. the cart remained unlocked | F 761 | This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to properly secure medication in 1 of 1 treatment cart observed for medication storage.<br>*Medication and treatment carts have been reviewed, are in good working condition, and remain locked when left unattended. No resident were affected by the deficient practice.<br>*Residents who reside at the facility have the potential to be affected by this deficient practice.<br>*Licensed staff were educated on ensuring medication and treatment carts | |

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| F 761 | Continued From page 15<br>until registered nurse (RN)-A walked and locked the treatment cart.<br><br>During observation on 9/1/21, at 8:48 a.m. the treatment cart was unlocked and unattended. The cart was located outside of the medication room in the hallway across from the nursing station and at the intersection of the three resident hallways. During this time RN-B and RN-C were at their medication carts located across from the treatment cart and had their backs turned away and unable to observe the treatment cart.<br><br>During observation on 9/1/21, at 9:55 a.m. RN-B walked into the medication room and had not noticed the unlocked treatment cart.<br><br>During an interview on 9/1/21, at 10:10 a.m. RN-C verified the treatment cart was unlocked. RN-C stated the cart contained dressing supplies and some creams. Upon review of the cart with RN-C, a tube of Careall ultra strength muscle rub and Bacitracin ointment were found in the top drawer. RN-C verified a provider order was needed for the medications found in the cart. RN-C also stated the treatment cart had to be locked when not in use.<br><br>During an interview on 9/1/21, at 10:46 a.m. RN-B stated the treatment cart contained dressing supplies and extra prescription creams or ointments. RN-B stated each nurse had a key and the treatment cart was locked when not in use.<br><br>During an interview on 9/1/21 at 12:03 p.m. the director of nursing (DON) stated all prescription medications had to be secured. The DON further stated the treatment cart was typically locked and | F 761 | are locked when left unattended.<br>*Don/Designee will audit 4 times per week to assure cart is locked for three weeks, then weekly for 3 weeks. Audits to be conducted by DON/designee.<br>*Audit findings to be presented to QAPI by DON or designee for 3 months to evaluate for trends and need for continued auditing and monitoring. | |

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| F 761 | Continued From page 16<br>any cart that contained medications was to be locked.<br><br>A facility Medication Storage in the Facility policy dated 4/2018, indicated only licensed nursing personnel, pharmacy personnel, or staff lawfully authorized to administer medications had access to the medication supply. | F 761 | | |
| F 880 SS=E | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify | F 880 | | 10/19/21 |

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|---|---|---|---|---|
| F 880 | Continued From page 17<br>possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document | F 880 | This REQUIREMENT is not met as | |

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| F 880 | Continued From page 18<br>review, the facility failed to ensure Centers for Disease Control (CDC) guidance and Minnesota Department of Health (MDH) Covid recommendations were followed for eye protection being used by facility staff while in resident care areas. In addition failed to ensure proper sanitizing of re-useable equipment reviewed for infection control.<br><br>Findings include:<br><br>Minnesota Department of Health (MDH) COVID-19 PPE Grid for Congregate Care Settings dated 6/30/21, in accordance with the CDC, indicated health care workers with face to face contact with residents.<br><br>On 8/30/21, at 2:16 p.m. nursing assistant (NA)-F was observed enter the unit and wore a surgical mask with no eye protection, used the stairway and then went past R24 who was seated at the wheelchair outside the nursing station as she entered the nursing station. NA-F then was observed leave the nursing station went past R24 again and left the unit still with no eye protection.<br><br>During interview 8/30/21, at 2:21 p.m. NA-F stated she was supposed to have a face shield or eye wear on when she came up to the floor/unit. She then stated she thought she had brought it to the floor when she got to the floor but it was not with her.<br><br>On 8/30/21, at 2:43 p.m. NA-J was observed coming out of R6's room and was noted to only be wearing a surgical mask without eye protection. NA-J then went down the East hallway towards the nursing station where multiple staff were and past several resident rooms however, | F 880 | evidenced by: Based on observation, interview, and document review, the facility failed to ensure Centers for Disease Control (CDC) guidance and Minnesota Department of Health (MDH) Covid recommendations were followed for eye protection being used by facility staff while in resident care areas. In addition, failed to ensure proper sanitizing of re-useable equipment reviewed for infection control.<br>Personal Protective Equipment (PPE) R24, R6, R10, R30, R58, R45, R462, and Residents that reside on the west unit were cared for by staff who were not wearing proper eye protection. Listed residents were assessed and did not experience adverse outcomes.<br>Residents who reside in the facility have the potential to be affected by this deficient practice.<br>A root cause analysis was completed by the infection preventionist and governing body to identify the knowledge gaps that resulted in in the deficiency and develop an intervention to correct.<br>The infection preventionist, DON, and DCO reviewed the policies and procedures for donning/doffing PPE during COVID-19 with current guidelines to include crisis standard of care, contingency standard of care, and standard care.<br>The infection preventionist, DON, and DCO reviewed policies regarding standard and transmission-based precautions.<br>Education will be provided to all staff on standard infection control practices, transmission-based precautions, | |

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| F 880 | Continued From page 19<br>no staff reminded her she did not have eye protection. NA-J then went down the South hallway and passed R370 who ambulated with therapy staff still without eye protection and less than 6 feet distance and was not reminded she did not have eye protection. NA-J then went into the linen closet got a lift sheet then came down the hallway past the nursing station and at this time surveyor asked about eye protection and NA-J stated she forgot to wear it but then proceeded to go down the East hallway and then entered R6's room and shut the door.<br><br>On 8/30/21, at 2:46 p.m. surveyor entered R6's room and observed NA-J who stood over R6 who required assistance out of bed. At this time surveyor intervened and asked NA-J to get eye protection to protect the resident. R6 stated she did not know the staff was supposed to wear the eye wear to protect them. NA-J then was observed going down the entire South hallway past resident rooms then came back and left the floor through the stairway. During this observation registered nurse (RN)-G and RN-B were observed in the area but never reminded NA-J to wear eye protection of offered it.<br><br>On 8/31/21, at 8:36 a.m. during breakfast meal distribution the nutritional service director (NSD) was observed wearing a surgical mask but the eye wear (goggles) were on top of her head. During the observation the NSD was standing over residents R10, R30 and R58 as she collected the meal tickets which was less than 6 feet.<br>-At 8:39 a.m. the NSD came out of the kitchen approached and stood over R45 and R462 who both sat in the wheelchairs as she collected the meal tickets from the table. At this time NA-C | F 880 | appropriate PPE use, donning/doffing of PPE. Training will include attestation statement of completion. Training will include a competency test. Residents and their representatives will receive education on facility infection prevention and control. Training will be completed by Infection preventionist/designee.<br>The DON/designee will conduct audits on: donning/doffing PPE with transmission-based precautions; source control masking for staff, visitors, and residents; proper use of gowns to ensure PPE is in use; aerosolized generating procedures to ensure PPE is in use. Audits will be completed on all shifts 4 times per week for 1 week, then twice per week for 1 week once compliance is met. Audits will continue until 100% compliance is met on source control masking for staff, visitors, and residents.<br>The DON, infection preventionist, or designee will review the results of audits and monitoring with QAPI.<br>Completion date 10/19/2021.<br>Equipment/Environment<br>R16 was assessed did not experience any adverse outcomes.<br>Residents who require re-useable equipment have the potential to be affected by this deficient practice.<br>A root cause analysis was completed by infection preventionist and governing body to identify the problem that resulted in in the deficiency and develop an intervention to correct.<br>The infection preventionist, DON, and DCO reviewed the policy regarding disinfecting multiuse/shared | |

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| F 880 | Continued From page 20<br>approached the same table however she never reminded the NSD that her eye protection was on top of the head.<br>-At 8:41 a.m. the NSD was observed deliver food plates to R10 and R58. As NSD stood over the residents to put the plates down, the surveyor intervened and asked her to put the eye wear down. The NSD then stated she did not realize she did not have them on.<br><br>On 8/31/21, at 9:15 a.m. to 9:31 a.m. the housekeeping (HK) staff was observed cleaning resident rooms down the West unit/hallway however, was observed to be wearing a surgical mask with regular reading glasses as she went in and out of rooms with residents.<br><br>On 8/31/21, at 9:33 a.m. the director of nursing (DON) verified the housekeeping staff was wearing reading glasses "I see that." The DON then approached the housekeeping staff and asked her to get proper eye protection.<br><br>During interview on 8/31/21, at 9:40 a.m. housekeeping staff stated she knew she was supposed to wear the eye wear or face shield when in resident care areas however, the face shield made her hot and the safety glasses fogged up and she was not able to see. The surveyor reminded her these were recommendations by CDC and the State Health Department to keep the residents and staff safe.<br><br>On 9/01/21, at 11:47 a.m. the DON stated she expected all staff to wear appropriate personal protective equipment (PPE) which included eye wear and a medical mask when working when working with residents and in resident care areas where residents were. | F 880 | equipment/items to ensure they meet CDC guidance for disinfection in health care facilities and following disinfection product manufacturer directions fur use including contact time.<br>Education will be provided to all staff responsible for resident care equipment and environment on the facility□s policies and procedures for proper disinfection, including following manufacturer direction for use. Each staff person must demonstrate competency at the conclusion of the training.<br>The DON/designee will audit proper cleaning and disinfection of resident use equipment/environmental cleaning on all shifts everyday for one week, then may decrease frequency as determined by compliance.<br>The DON, infection preventionist, or designee will review the results of audits and monitoring with QAPI. | |

| 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 09/01/2021 |

| 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 880 | Continued From page 21<br><br>The facility Guideline for standard and Transmission based Precautions policy revised 11/09/2020, directed staff to follow standard precautions and to wear appropriate PPE to all resident care to prevent the spread of infections in accordance with CDC requirements.<br>During an observation on 8/31/21, at 12:03 p.m. NA-D wiped the mechanical lift with an alcohol-free adult peri wipe following the transfer of R16 from his bed to wheelchair. R16 placed his right hand on a bar of the lift several times throughout the transfer. When asked, NA-D stated she should have used an alcohol based wipe to disinfect the lift.<br><br>When interviewed on 9/1/21, at 3:03 p.m. the DON stated the proper wipes for equipment would be one that contains bleach and that the use of an adult peri wipe was not adequate for infection control.<br><br>The facility's policy dated 5/8/2020, stated non critical items (items that come in contact with intact skin and not mucous membranes) should be disinfected with ethyl or isopropyl alcohol (70-90%), germicidal detergent solution or quaternary ammonium germicidal detergent solution. | F 880 | | |

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|---|---|---|---|
| | 245326 | A. BUILDING **01 - MAIN BUILDING 0102**<br>B. WING _____ | **09/02/2021** |

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

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 09/02/2021. At the time of this survey, Rose of Sharon A Villa Center 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.<br><br>Rose of Sharon Manor is a 2-story building with no basement. The building was constructed at two 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 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.<br><br>The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection, resident rooms, and spaces open to the corridors that are monitored for automatic fire department notification.<br><br>The facility has a capacity of 63 beds and had a census of 60 at the time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is MET. | K 000 | | |

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

Electronically delivered
September 24, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: KBTC11

Dear Administrator:

The above facility was surveyed on August 29, 2021 through September 1, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. 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:

Sarah Grebenc, 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: sarah.grebenc@state.mn.us
Office: (651) 201-3792 Mobile (651)238-8786

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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

| 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 09/01/2021 |

| 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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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>On 8/29/21, through 9/1/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed | 2 000 | *****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statute, section 144A.10, this correction order has | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| 2 000 | Continued From page 1<br>these orders, and identify the date when they will be completed.<br><br>The following complaint was found to be SUBSTANTIATED:<br>H5326117C (MN00051393), however NO deficiencies were cited due to actions implemented by the facility prior to survey.<br><br>The following complaints were found to be UNSUBSTANTIATED:<br>H5326110C(MN00055312), H5326111C(MN00054474), H5326112C (MN00053752/MN00053786), H5326113C (MN00053708), H5326114C(MN00051940), H5326115C (MN00052229), H5326116C (MN00051611) and H5326118C (MN00047390). | 2 000 | 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.<br><br>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.<br><br>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. | |
| 21375 | MN Rule 4658.0800 Subp. 1 Infection Control; Program<br><br>Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. | 21375 | | 10/19/21 |

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| 21375 | Continued From page 2<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure Centers for Disease Control (CDC) guidance and Minnesota Department of Health (MDH) Covid recommendations were followed for eye protection being used by facility staff while in resident care areas. In addition failed to ensure proper sanitizing of re-useable equipment reviewed for infection control.<br><br>Findings include:<br><br>Minnesota Department of Health (MDH) COVID-19 PPE Grid for Congregate Care Settings dated 6/30/21, in accordance with the CDC, indicated health care workers with face to face contact with residents.<br><br>On 8/30/21, at 2:16 p.m. nursing assistant (NA)-F was observed enter the unit and wore a surgical mask with no eye protection, used the stairway and then went past R24 who was seated at the wheelchair outside the nursing station as she entered the nursing station. NA-F then was observed leave the nursing station went past R24 again and left the unit still with no eye protection.<br><br>During interview 8/30/21, at 2:21 p.m. NA-F stated she was supposed to have a face shield or eye wear on when she came up to the floor/unit. She then stated she thought she had brought it to the floor when she got to the floor but it was not with her.<br><br>On 8/30/21, at 2:43 p.m. NA-J was observed coming out of R6's room and was noted to only be wearing a surgical mask without eye protection. NA-J then went down the East hallway | 21375 | Reviewed and corrected | |

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

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| 21375 | Continued From page 3 | 21375 | | |

towards the nursing station where multiple staff were and past several resident rooms however, no staff reminded her she did not have eye protection. NA-J then went down the South hallway and passed R370 who ambulated with therapy staff still without eye protection and less than 6 feet distance and was not reminded she did not have eye protection. NA-J then went into the linen closet got a lift sheet then came down the hallway past the nursing station and at this time surveyor asked about eye protection and NA-J stated she forgot to wear it but then proceeded to go down the East hallway and then entered R6's room and shut the door.

On 8/30/21, at 2:46 p.m. surveyor entered R6's room and observed NA-J who stood over R6 who required assistance out of bed. At this time surveyor intervened and asked NA-J to get eye protection to protect the resident. R6 stated she did not know the staff was supposed to wear the eye wear to protect them. NA-J then was observed going down the entire South hallway past resident rooms then came back and left the floor through the stairway. During this observation registered nurse (RN)-G and RN-B were observed in the area but never reminded NA-J to wear eye protection of offered it.

On 8/31/21, at 8:36 a.m. during breakfast meal distribution the nutritional service director (NSD) was observed wearing a surgical mask but the eye wear (goggles) were on top of her head. During the observation the NSD was standing over residents R10, R30 and R58 as she collected the meal tickets which was less than 6 feet.
-At 8:39 a.m. the NSD came out of the kitchen approached and stood over R45 and R462 who both sat in the wheelchairs as she collected the

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| 21375 | Continued From page 4 | 21375 | | |

meal tickets from the table. At this time NA-C approached the same table however she never reminded the NSD that her eye protection was on top of the head.
-At 8:41 a.m. the NSD was observed deliver food plates to R10 and R58. As NSD stood over the residents to put the plates down, the surveyor intervened and asked her to put the eye wear down. The NSD then stated she did not realize she did not have them on.

On 8/31/21, at 9:15 a.m. to 9:31 a.m. the housekeeping (HK) staff was observed cleaning resident rooms down the West unit/hallway however, was observed to be wearing a surgical mask with regular reading glasses as she went in and out of rooms with residents.

On 8/31/21, at 9:33 a.m. the director of nursing (DON) verified the housekeeping staff was wearing reading glasses "I see that." The DON then approached the housekeeping staff and asked her to get proper eye protection.

During interview on 8/31/21, at 9:40 a.m. housekeeping staff stated she knew she was supposed to wear the eye wear or face shield when in resident care areas however, the face shield made her hot and the safety glasses fogged up and she was not able to see. The surveyor reminded her these were recommendations by CDC and the State Health Department to keep the residents and staff safe.

On 9/01/21, at 11:47 a.m. the DON stated she expected all staff to wear appropriate personal protective equipment (PPE) which included eye wear and a medical mask when working when working with residents and in resident care areas where residents were.

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| 21375 | Continued From page 5<br><br>The facility Guideline for standard and Transmission based Precautions policy revised 11/09/2020, directed staff to follow standard precautions and to wear appropriate PPE to all resident care to prevent the spread of infections in accordance with CDC requirements.<br><br>During an observation on 8/31/21, at 12:03 p.m. NA-D wiped the mechanical lift with an alcohol-free adult peri wipe following the transfer of R16 from his bed to wheelchair. R16 placed his right hand on a bar of the lift several times throughout the transfer. When asked, NA-D stated she should have used an alcohol based wipe to disinfect the lift.<br><br>When interviewed on 9/1/21, at 3:03 p.m. the DON stated the proper wipes for equipment would be one that contains bleach and that the use of an adult peri wipe was not adequate for infection control.<br><br>The facility's policy dated 5/8/2020, stated non critical items (items that come in contact with intact skin and not mucous membranes) should be disinfected with ethyl or isopropyl alcohol (70-90%), germicidal detergent solution or quaternary ammonium germicidal detergent solution.<br><br>SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee could monitor to assure proper PPE is worn to prevent the potential spread of infections. The DON or designee could monitor to ensure staff was wearing appropriate PPE during care as recommended by the State Agency to prevent the spread of Covid-19. The DON or designee could educate staff and perform audits to ensure the | 21375 | | |

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| 21375 | Continued From page 6<br>policies are being followed.<br><br>Time Period for Correction: Twenty-one (21) days. | 21375 | | |
| 21426 | MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control<br><br>(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.<br><br>(b) Written compliance with this subdivision must be maintained by the nursing home.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure 6 of 6 employees were appropriately screened and tested for Tuberculosis (TB) upon hire before working directly with residents according to the State Tuberculosis screening guidelines reviewed for | 21426 | Reviewed and corrected | 10/19/21 |

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| 21426 | Continued From page 7<br>TB.<br><br>Findings include:<br><br>A list of new hires in the last six months was provided by the facility and were identified as staff who worked with residents in different departments at the facility. During the review of the personnel TB information, it was revealed:<br><br>The personnel file for nursing assistant (NA)-G with a hire date of 8/11/21, revealed although NA-G had completed both step one and two Tuberculin Skin Testing (TST) within 90 days of hire, NA-G had not completed a symptom screen upon hire at the facility on 8/11/21, to rule out active TB before beginning to provide direct care per State guidelines.<br><br>The personnel file for licensed practical nurse (LPN)-B with a hire date of 8/11/21, revealed the file lacked documentation of a negative TB symptoms screening and a negative Interferon Gamma Release Assay (IGRA-blood test) or 1st and 2nd steps TST or chest x-ray before beginning to provide direct care to rule out active per State guidelines.<br><br>The personnel file for registered nurse (RN)-F with hire date of 8/18/21, revealed the file lacked documentation of a negative TB symptoms screening and a negative IGRA or 1st and 2nd steps TST or chest x-ray before beginning to provide direct care to rule out active TB per State guidelines.<br><br>The personnel file for NA-H with hire date of 6/30/21, revealed the file lacked documentation of a negative TB symptoms screening and a negative IGRA or 1st and 2nd steps TST or chest | 21426 | | |

| 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 09/01/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| 21426 | Continued From page 8 | 21426 | | |

x-ray before beginning to provide direct care to rule out active TB per State guidelines.

The personnel file for NA-I with hire date of 3/10/21, revealed the file lacked documentation of a negative TB symptoms screening and a negative IGRA or 1st and 2nd steps TST or chest x-ray before beginning to provide direct care to rule out active TB per State guidelines.

The personnel file for social services designee (SSD) with hire date of 5/19/21, revealed the file lacked documentation of a negative TB symptoms screening and a negative IGRA or 1st and 2nd steps TST or chest x-ray before beginning to provide direct care to rule out active TB per State guidelines.

On 8/31/21, at 1:14 p.m. the director of nursing stated she was working on getting the employee screening as the staff who was responsible was not at the facility at this time. She then stated she had reached out to the individual staff who had been selected to review the TB screening and test to get the information but had only heard from one staff. The DON further stated she had also reached out to human resources and she had been informed they too did not have the TB documentation for the staff. The DON further stated the staffing coordinator was responsible for maintaining and making sure the staff was properly screened for TB before providing direct care.

On 9/1/21, at 2:54 p.m. during the quality assurance program improvement meeting with the DON and the facility administrator, the DON stated TB screening was discussed on the first day of orientation with the staff and what was testing was appropriate for each staff and the

| 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 09/01/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| 21426 | Continued From page 9<br>staffing coordinator was responsible to make sure the staff are all properly screened before being allowed to work. The administrator stated she had been made aware of the lack of documentation.<br><br>On 9/1/21, at 4:40 p.m. no additional information was provided.<br><br>Minnesota Department of Health Temporary Changes to Tuberculosis Requirements dated July 2013, directed the following:<br>"There are two methods available to screen for TB infection: the tuberculin skin test (TST) and the<br>Interferon Gamma Release Assay (IGRA).<br>· All reports or copies of TST or IGRA results and any related chest X-ray and medical evaluations<br>should be maintained in the employee ' s record.<br>· TST documentation should include the date of the test (i.e., month, day, year), the number of millimeters of induration (if no induration, document "0" mm) and interpretation (i.e., positive or<br>negative).<br>· HCWs should be encouraged to keep copies of the results of their TB screening for future use..."<br><br>The facility Mycobacterium Tuberculosis revised November 6, 2019 directed that all health care personnel should receive a baseline individual TB symptom screening and TB testing (TB blood test or TST) upon hire.<br><br>SUGGESTED METHOD OF CORRECTION: The infection control nurse (ICN), director of nursing (DON) and/or designee could review policies and procedures related to the screening and testing | 21426 | | |

| 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 09/01/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| 21426 | Continued From page 10<br>for tuberculosis for employees. Facility staff could be educated on the TB regulations, symptom screening, and the two-step Mantoux process. The ICN, DON and/or designee could audit staff personnel files to ensure compliance. The ICN, DON and/or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring.<br><br>TIME PERIOD FOR CORRECTION: Twenty one-(21) days. | 21426 | | |
| 21565 | MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin<br><br>Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to determine if the practice of self-administration of medications (SAM) was safe for 2 of 2 residents (R8, R16) who was observed to have medications at bedside without an order to self-administer.<br><br>Findings include:<br><br>On 8/29/21, at 4:16 p.m. during an interview R8 dumped out a small medication cup on her | 21565 | reviewed and corrected | 10/19/21 |

| 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 09/01/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| 21565 | Continued From page 11 | 21565 | | |

bedside tray table with 10 medications. R8 stated these were her 8:00 a.m. medications. R8 stated she had not taken them because she was afraid to take them. R8 then stated there were at least three pills that did not look like the medications she received on prior mornings. R8 said she was going to ask the nurse about it later. Furthermore, during the interview an observation was made of three plastic medication cups with 15 (milliliter) ml of a light-yellow fluid on her nightstand. When asked, R8 stated the liquid was her Lactulose (a medication used to prevent complications of liver disease) that she had not taken from previous unknown dates.

R8's admission Minimum Data Set (MDS) dated 6/2/21, noted R8 to have intact cognition. R8's diagnoses obtained from the face sheet printed 9/1/21, included alcohol dependence with withdrawal, contusion of right lower leg, and alcoholic cirrhosis of the liver.

R8's medication administration record (MAR) listed medications as administered at 8:00 a.m. on 8/29/21, included:
-Baclofen 5 (milligram) mg tablet one time a day for muscle spasms.
-Folic Acid 1 mg tablet one time a day for supplement.
-Furosemide 40 mg table one time a day for edema per liver doctor.
-Multivitamin Plus Iron tablet two tablets one time a day for supplement.
-Naltrexone HCl 50 mg one time a day for alcoholism, if unable to tolerate, ok to discontinue.
-Omeprazole capsule delayed release, 20 mg one time per day for GERD.
-Spironolactone 100 mg tablet one time a day for diuretic.

| 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 09/01/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| 21565 | Continued From page 12<br>-Thiamine HCl 100 mg tablet one time a day for alcoholic cirrhosis of the liver.<br>-Rifaximin 550 mg tablet two times a day for liver cirrhosis.<br>-Lactulose Solution 10 gram (GM)/15 ml give 15 ml three times a day for alcoholic cirrhosis.<br><br>On 8/29/21, at 4:36 p.m. registered nurse (RN)-B was observed enter R8's room and put another plastic medication cup on her tray table with 15 mL of the yellow liquid, RN-B stated the medication he left on the table was Lactulose and RN-B left the room. R8 did not take the medication while RN-B was in the room.<br><br>On 8/30/21, at 9:12 a.m. three plastic medication cups with 15 mL Lactulose were observed on R8's nightstand.<br><br>On 8/31/21, at 9:55 a.m. three plastic medication cups with 15 mL of Lactulose were observed on R8's nightstand.<br><br>When interviewed on 8/31/21, at 10:58 a.m. licensed practical nurse (LPN)-A stated there were no residents on this unit that self-administered their medications.<br><br>On 8/31/21, at 11:09 a.m. LPN-A verified the cups on R8's nightstand and stated, "looks kind of like her Lactulose". LPN-A then removed the medications and disposed them.<br><br>When interviewed on 9/1/21, at 10:47 a.m. director of nursing (DON) indicated she expected that R8 would have a SAM assessment completed. The DON stated she would expect a nurse to ask why a resident did not take their medication and to follow up with them. | 21565 | | |

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|---|---|---|---|
| | 00126 | A. BUILDING: _____ B. WING _____ | C 09/01/2021 |

| 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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|---|---|---|---|---|
| 21565 | Continued From page 13<br><br>During an observation on 9/1/21, at 1:20 p.m. a 34 ounce (oz) prescription bottle of Vashe wound cleanser was observed on R16's television stand. During review of the medical record, R16 lacked physician orders for the use of Vashe wound cleanser.<br><br>R16's admission MDS dated 6/17/21, noted R16 to have severely impaired cognition, extensive assistance of two people and mechanical lift for transfers. R16's discharge to hospital MDS indicates R16 had an unstageable pressure ulcer. R16's diagnoses obtained from the face sheet printed 9/1/21, include metabolic encephalopathy (impaired brain function), subarachnoid hemorrhage (stroke), acute respiratory failure.<br><br>When interviewed on 9/1/21, at 1:24 p.m. RN-B stated the bottle of cleanser was in R16's room because it is used for R16's wound care. RN-B also stated all wound supplies are kept in resident rooms. RN-B then opened the top drawer to the television stand and a loaf of non-sterile gauze along with a dermal wound cleansing spray were observed.<br><br>When interviewed on 9/1/21, at 1:32 p.m. DON stated all prescriptions should be locked in a nurse's cart.<br><br>The facilities policy title Self-Administration of Medication Management indicated a resident may only self-administer medications after the IDT (Interdisciplinary Team) has determined which medications may be safely self-administered.<br><br>SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for self administration of medication according to | 21565 | | |

| 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 09/01/2021 |

| 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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| 21565 | Continued From page 14<br>evidence based practices/procedures. Nursing staff could be educated as necessary to the importance of ensuring the resident is capable of administering their own medications initially, quarterly, annually, or with a change to a resident's physical or mental ability to do so. Nursing staff could also ensure there is a physician's order in place, prior to a nurse/medication aide administering medication. The DON or designee, could audit any/all resident's medical records, to ensure compliance with appropriate medication administration. The DON or designee could take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty one (21) days. | 21565 | | |
| 21610 | MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage<br><br>Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to properly secure medications in 1 of 1 treatment cart observed for medication storage.<br><br>Findings include:<br><br>During an observation on 8/31/21, at 8:20 a.m. the treatment cart was unlocked and unattended | 21610 | Reviewed and Corrected | 10/19/21 |

| 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 09/01/2021 |

| 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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|---|---|---|---|---|
| 21610 | Continued From page 15 | 21610 | | |

by staff. The cart was located outside of the medication room in the hallway across from the nurse's station and at the intersection of the three resident rooms hallways. During the observation, multiple residents walked passed as they returned to their rooms from breakfast and to go outside. At 9:30 a.m. the cart remained unlocked until registered nurse (RN)-A walked and locked the treatment cart.

During observation on 9/1/21, at 8:48 a.m. the treatment cart was unlocked and unattended. The cart was located outside of the medication room in the hallway across from the nursing station and at the intersection of the three resident hallways. During this time RN-B and RN-C were at their medication carts located across from the treatment cart and had their backs turned away and unable to observe the treatment cart.

During observation on 9/1/21, at 9:55 a.m. RN-B walked into the medication room and had not noticed the unlocked treatment cart.

During an interview on 9/1/21, at 10:10 a.m. RN-C verified the treatment cart was unlocked. RN-C stated the cart contained dressing supplies and some creams. Upon review of the cart with RN-C, a tube of Careall ultra strength muscle rub and Bacitracin ointment were found in the top drawer. RN-C verified a provider order was needed for the medications found in the cart. RN-C also stated the treatment cart had to be locked when not in use.

During an interview on 9/1/21, at 10:46 a.m. RN-B stated the treatment cart contained dressing supplies and extra prescription creams or ointments. RN-B stated each nurse had a key and the treatment cart was locked when not in

| 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 09/01/2021 |

| 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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|---|---|---|---|---|
| 21610 | Continued From page 16<br>use.<br><br>During an interview on 9/1/21 at 12:03 p.m. the director of nursing (DON) stated all prescription medications had to be secured. The DON further stated the treatment cart was typically locked and any cart that contained medications was to be locked.<br><br>A facility Medication Storage in the Facility policy dated 4/2018, indicated only licensed nursing personnel, pharmacy personnel, or staff lawfully authorized to administer medications had access to the medication supply.<br><br>SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of medications. Nursing staff could be educated as necessary to the importance of properly securing medications. The DON or designee, along with the pharmacist, could conduct audits on a regular basis to ensure compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty one (21) days. | 21610 | | |
| 21925 | MN St. Statute 144.651 Subd. 29 Patients & Residents of HC Fac.Bill of Rights<br><br>Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest | 21925 | | 10/19/21 |

| 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 09/01/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| 21925 | Continued From page 17<br>the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to provide a written notice for transfer/discharge for 1 of 1 residents (R58) reviewed for hospitalizations.<br><br>Findings include:<br><br>R58's quarterly Minimum Data Set (MDS) dated 8/13/21, indicated R58 had moderately impaired cognition and had diagnoses of cerebral vascular accident (stroke), dementia, and weakness.<br><br>R58's progress note dated 8/4/21, at 9:00 a.m. indicated R58 was sent to the hospital on 7/29/21, due to a change in vital signs and altered mental status.<br><br>R58's medical record lacked evidence of a written transfer notice was given to R58 or the family representative. | 21925 | No plan of correction required | |

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|---|---|---|---|
| | 00126 | A. BUILDING: _____ B. WING _____ | C 09/01/2021 |

| 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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|---|---|---|---|---|
| 21925 | Continued From page 18<br><br>During an interview on 9/1/21, at 11:20 a.m. social worker (SW) stated they were still getting used to providing a written transfer form for residents or their family representative. The SW verified a written transfer form was not completed for R58.<br><br>The facility Bed Hold and Return Guidelines policy dated 4/25/19, indicated the facility will provide the resident/family representative a written notification of the transfer and the reason for the transfer.<br><br>SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review and/or develop policy and procedures that written notification was provided to the resident and their representative before a transfer. The facility could educate staff on these policies and audit periodically. The results of these audits will be reviewed by the quality assessment committee to ensure compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty One (21) days | 21925 | | |