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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: KNYM

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) **106542400**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY 8/29/2013 (L34)
8. ACCREDITATION STATUS: 3 (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)
12/31

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Christle Sandra, HFE NEII 09/20/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 12/20/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00450
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/21/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN# 24-5326

At the time of the standard survey completed July 11, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required. The facility was given an opportunity to correct before remedies were imposed.

On August 29, 2013, a health PCR was completed and found all deficiencies corrected.

However, by the 70th day, LSC deficiencies had not yet been verified. As a result, we recommended the following to the CMS RO for imposition:

Mandatory DOPNA, effective October 11, 2013

The facility was subject to a loss of NATCEP, beginning October 11, 2013 if DOPNA was imposed.

On September 20, 2013, a LSC PCR was completed at this facility and found all deficiencies corrected.

As a result of the LSC revisit, we recommended the following to the CMS RO:

Mandatory DOPNA, effective October 11, 2013, be rescinded.

Since DOPNA did not go into effect, the facility was no longer subject to a loss of NATCEP.

Please refer to the CMS 2567B for both health and life safety code.

Effective August 20, 2013, the facility is certified for 63 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5326 December 20, 2013

Ms. Cherie Camuel, Administrator
Rose of Sharon Manor
1000 Lovell Avenue
Roseville, Minnesota 55113

Dear Ms. Camuel:

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

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

Effective August 20, 2013, the above facility is certified for:

63 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900, St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5147 5847

September 19, 2013

Ms Cherie Camuel, Administrator
Rose of Sharon Manor
1000 Lovell Avenue
Roseville, Minnesota 55113

RE: Project Number S5326022

Dear Ms. Camuel:

On July 23, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 11, 2013. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On August 29, 2013, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 11, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 20, 2013. Based on our visit, we have determined that your facility has achieved substantial compliance with the health deficiencies issued pursuant to our standard survey, completed on July 11, 2013.

However, compliance with the Life Safety Code (LSC) deficiencies issued pursuant to the July 11, 2013 standard survey has not yet been verified. The most serious LSC deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective October 11, 2013. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective October 11, 2013. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 11, 2013. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Rose Of Sharon Manor is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective October 11, 2013. 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. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

A copy of the Post Certification Revisit Form (CMS-2567B) from the August 29, 2013 revisit is enclosed.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Oliver Potts, Chief
330 Independence Avenue, SE
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be

in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 January 11, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

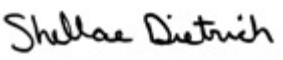
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245326	A. Building B. Wing	8/29/2013

Name of Facility	Street Address, City, State, Zip Code
ROSE OF SHARON MANOR	1000 LOVELL AVENUE ROSEVILLE, MN 55113

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **08/20/2013**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **08/20/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **08/20/2013**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **08/20/2013**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **08/20/2013**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/sd	09/19/13	12841	08/29/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
7/11/2013	

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245326	A. Building 01 - MAIN BUILDING 0102 B. Wing	9/20/2013

Name of Facility	Street Address, City, State, Zip Code
ROSE OF SHARON MANOR	1000 LOVELL AVENUE ROSEVILLE, MN 55113

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0029	Correction Completed **08/20/2013**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By MM/GL	Date: 11/22/2013	Signature of Surveyor: 12424	Date: 09/20/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 7/10/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

November 22, 2013

Ms. Cherie Camuel, Administrator
Rose Of Sharon Manor
1000 Lovell Avenue
Roseville, Minnesota 55113

RE: Project Number F5326021

Dear Ms. Camuel:

On August 29, 2013, we informed you that we recommended to the Region V Office of CMS that the following enforcement remedy be imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective October 11, 2013. (42 CFR 488.417 (b))

Also, we notified you in our letter of September 19, 2013, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 11, 2013.

This was based on the deficiencies cited by this Department for a standard survey completed on July 11, 2013, that included an investigation of complaint number H5326048, and lack of verification of substantial compliance with the Life Safety Code (LSC) deficiencies at the time of our September 19, 2013 notice. The most serious LSC deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On September 20, 2013, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 11, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 20, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 11, 2013, as of August 20, 2013.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of September 19, 2013. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective October 11, 2013, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective October 11, 2013, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective October 11, 2013, is to be rescinded.

In our letter of September 19, 2013, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 11, 2013, due to denial of payment for new admissions. Since your facility attained substantial compliance on August 20, 2013, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us
Enclosure

cc: Licensing and Certification File 5326r2_70DayAllCorrected.rtf

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KNYM

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) **106542400**

3. NAME AND ADDRESS OF FACILITY
(L3) **ROSE OF SHARON MANOR**
(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)

6. DATE OF SURVEY **07/11/2013** (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)
12/31

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
(L37)	63 (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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Karen Beskar, HFE NE II 08/12/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 08/20/2013 (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.
00450
(L31)

30. REMARKS

Posted 8/21/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN# 24-5326

At the time of the standard survey completed July 11, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results.
Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 2826

July 23, 2013

Ms. Cherie Camuel, Administrator
Rose of Sharon Manor
1000 Lovell Avenue
Roseville, Minnesota 55113

RE: Project Number S5326022 and H5326048

Dear Ms. Camuel:

On July 11, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the July 11, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5326048 that was found to be unsubstantiated.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susan Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55108-2970

Telephone: (651) 201-3793
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 20, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

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

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

- Address what measures will be put into place or systemic changes made to ensure that

the deficient practice will not recur;

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

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

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 11, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 11, 2014 (six months after the

identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

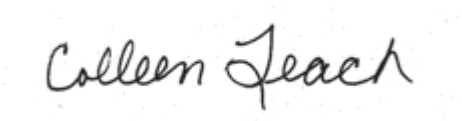
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245326	A. BUILDING _____ B. WING _____	C 07/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. COMPLAINT NOT SUBSTANTIATED: A complaint investigation had been completed at the time of the standard recertification survey. Investigation of complaint H5326048 had been completed and had not been substantiated.	F 000	This plan of correction is not an admission of guilt on behalf of the provider. This plan of correction is being submitted because it is required by law. F246 Resident #107 has been provided with a mirror for shaving, Resident # 9 and #14 have their call lights within reach. All other male residents have been reviewed for mirror needs to facilitate independence with shaving. All residents have call lights within reach. All Staff have been educated about accommodating shaving needs and call lights within reach. DON/Designee will audit 5 male residents and 5 random residents for accommodation of shaving needs and call lights within reach. Audit results will be reviewed at QPI. DOC: August 20, 2013	8/20/13
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, and interview the facility failed to accommodate the needs for 3 of 4 residents in the sample (R107, R14, R9).	F 246		

8/12/13 SER

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Connie Carmel — TITLE: administrator — (X6) DATE: 7-31-13

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

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F 246	Continued From page 1 Findings include: R107's call light was not within reach. During observation and interview, on 7/10/13 at 7:45 a.m., R9 stated that she needed her call light, and said, "many times when they care for me they don't put the call light where I can reach it." The call light was observed to be attached low on the grab bar that was closest to the head of the bed and furthest away from R9. The call light was not in a position for R9 to reach it. R9 said, "this happens a lot and I have to yell for help." On 7/11/13 at 11:15 a.m. R9 was observed in her room in the electric wheelchair. The call light was located on the top of the grab bar and the grab bar was in the up position on the bed. When interviewed, R9 stated that staff forget to put the call light near her at least daily. When asked how she would reach the staff if she needed help she stated, "I either call them using my cell phone or I yell. I don't like it but what else can I do. Its really OK because I can call and yell." When interviewed on 7/11/13 at approximately 10:30 a.m. the director of nursing (DON) was unaware that the call light was not being placed within the residents reach. She further indicated, if there was a problem that the call light was falling down to an area where the resident could not reach it, they will have to come up with a solution to correct that. On 7/11/13 at 11:18 a.m., nursing assistant (NA) -A was interviewed and indicated the call light should always be there. NA-A verified that when	F 246		

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F 246	Continued From page 2 the grab bar is in the down position the call light slides down and when the grab bar is put in the up position you should always check that the call light is accessible. When interviewed on 7/11/13 at 11:25 a.m., licensed practical nurse (LPN)-A was not aware the call light was not within reach on 7/9/13, however she was aware that the resident does call the nurses desk for help at times. She further indicated if the call light was falling down, something would need to be done to assure that it does not. The facility failed to accommodate R 107's choice to shave himself by not providing a mirror at the proper height for R107 to complete the task. Interview with R107 on 7/8/13 at 5:13 p.m. revealed he liked to be clean shaven. R107 was observed to have facial hair of approximately one half inch. R107 indicated the mirror in the bathroom was too high for him to sit in his wheel chair and shave. Review of R107's Nursing Comprehensive Admission Data Collection indicated R107 was alert, oriented to person, place, and time, and speech was clear. Review of R107's care plan directed the staff to provide extensive assistance of one with personal hygiene, which included, shaving, brushing teeth, and washing hands and face. Interview with NA-C on 7/11/13 at 1:40 p.m., indicated that with an electric razor, the resident would be able to shave	F 246		

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F 246	Continued From page 3 himself, and agreed the resident did not have a mirror in the bathroom at a height he could see into to shave. During the environmental tour on 7/10/13 at 9:00 a.m. the mirror in R107's bathroom was observed and the maintenance supervisor and administrator both agreed the height of the mirror would not accommodate a person in a wheelchair to shave. The facility failed to put the call light within reach for R14. R14's most recent Minimum Data Set [MDS] assessment, dated 04/24/2013 indicated she was cognitively intact. R14 required extensive assistance from staff for eating and drinking, bed mobility and locomotion on and off the unit. R14 was totally dependent on staff for transferring herself between surfaces. During initial interview and observation on 07/08/2013 at 4:48 p.m. R14 reported she needed assistance with opening the covered water cup at her bedside table. R14 attempted to reach for the call light, that was between her legs, but was unable to reach it. In a distressed manner with a pained facial expression, R14 reported that it hurt to reach that far for her call light. During observation on 07/09/2013 between 3:46 p.m. to 4:00 p.m. R14 was observed resting in her bed. The call light was on the floor, out of reach of R14.	F 246		

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F 246	Continued From page 4 On 07/10/2013 at 3:23 p.m. the director of nursing [DON] confirmed that a call light should be in reach at all times. It should not be on the floor or positioned where R14 could not reach it. On 07/11/2013 at 9:00 a.m. the DON reported a clip had been placed on R14's call light to ensure that it stayed within her reach. Staff were in process of receiving education on keeping call lights within reach for residents and auditing to make sure all residents had clips on their call lights. On 07/11/2013 at 9:42 a.m. the administrator stated that R14 would be able to use her call light, if it was in reach. No policy was available regarding the placement of call lights.	F 246		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to coordinate care and services for one of three residents (R71) reviewed who received psychotherapy services. Findings include: A review of the resident chart revealed the most	F 309	F309 Resident #71 is having psychological services coordinated with outside psych provider. All residents receiving outside psychological services are having their care coordinated with the outside provider. SS has been re-educated regarding coordination of outside psych services SSD/Designee to audit 4 residents per week to ensure coordination of psychological services. Results of audits will be reviewed at QPI. DOC: August 20, 2013	8/20/13

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F 309	Continued From page 5 recent note from the psychotherapist was dated 04/10/2013. A review of social service progress notes, dated 05/22/2013 to present, revealed no notes indicating facility communication with the psychotherapist. A review of interdisciplinary team progress notes, dated 03/13/2013 to 07/11/2013 revealed no notes indicating facility communication with the psychotherapist. R71's current care plan for Behavioral Symptoms, last updated 05/17/2013, indicated the intervention "Followed by House psychotherapist" Interview on 07/11/2013 at 9:54 a.m. with the licensed social worker (LSW)-A revealed R71 was receiving services from a psychotherapist every other week for about 3 months. When asked how care was coordinated, LSW-A stated he spoke with the psychotherapist to check in regarding R71's progress. He reported that if he documented this, it would be in the social services section of the progress notes. LSW-A reported he had emailed the psychotherapist this week for documentation of her visits as he was unsure if they were available at the facility. He had not previously contacted the psychotherapy office to provide the facility with psychotherapy notes. A follow up interview on 07/11/2013 at 11:12 a.m. with LSW-A and the nurse manager, (RN)-A, confirmed the most recent note from the psychotherapist was from 04/10/2013. RN-A and LSW-A reviewed the chart and could note find progress notes or other documentation regarding facility communications with the psychotherapist. On 07/11/2013, the administrator was asked to provide a copy of a policy regarding coordination	F 309		

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F 309	Continued From page 6 of care with the psychotherapist. No policy was provided. Psychotherapist notes, dated 07/02/2013, 06/19/2013, 06/05/2013 and 05/08/2013 were provided by the facility. Review of the notes on 07/11/2013 at approximately 1:00 p.m., revealed R71 was receiving psychotherapy services for "Social Isolation and General Sadness". Each had a notation at the top of the page, "07/11/2013 12:01 Fax"	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	F329 Resident #44 does have target behaviors and SE monitoring in place. All residents on psychotropic medications have target behaviors and SE monitoring in place. Nursing & SS have been re-educated regarding target behaviors and SE monitoring. DON/Designee to audit 5 residents per week with psychotropic medications to ensure Target Behaviors and SE Monitoring are in place. DOC: August 20, 2013	8/20/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 7	F 329		

This REQUIREMENT is not met as evidenced by:
Based on document review and interview, the facility did not identify individualized target behaviors, monitor individualized target behaviors, or monitor for medication side effects related to psychoactive medication use for 1 of 10 residents (R44) reviewed for unnecessary medication use.

Findings include:

Record review revealed R44's current Physician's Order form contained orders, dated 5/20/13, for risperidone (an antipsychotic) 0.5 mg every morning and 1.5 mg. every evening for bipolar disorder. No target behaviors, monitoring of target behaviors, or monitoring of side effects of this medication could be located in R44's record.

During interview, on 7/11/13, at 9:45 a.m. licensed practical nurse (LPN)-B reviewed the medication and treatment administration records for R44, looking for the target behavior and side effect monitoring, and stated, "She doesn't have it."

When interviewed on 7/11/13, at 12:10 p.m. registered nurse (RN)-A stated that the side effect monitoring sheet for this resident should be in the medication administration record and was not there.

During interview on 7/11/13, at 12:45 p.m. RN-A was asked if this resident should have target behaviors listed and monitored because she is on

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F 329	Continued From page 8 risperidone and RN-A replied that she would expect that this resident would have target behaviors listed and monitored. The facility's 6.2.1 Mood and Behavior Program policy, dated October 2012, read, "1. Upon admission, determine if a Target Behavior/Target Mood is required for the resident. Note: If Target Behavior/Target Mood is required, utilize CareTracker to enter the specific Target Behavior/Mood for the resident..." Policy 6.6.1 Mood and Behavior Program, dated October 2008, read, "Psychoactive Medication...4. Monitor regularly for side effects as indicated on the Psychoactive Medication Symptom Assessment/Plan of Care."	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility's consulting pharmacist did not advise the facility of irregularities in identifying individualized target behaviors, monitoring individualized target behaviors, or monitoring for medication side	F 428	F428 – The pharmacist has reviewed resident #44 for target behaviors and SE monitoring. The pharmacist has reviewed all residents on psychotropic medications to ensure that Target Behaviors and SE monitoring are in place. The pharmacist has been re-educated regarding notification of center for Target Behaviors and SE monitoring. DON/Designee to audit 5 residents per week with psychotropic medications to ensure Target Behaviors and SE monitoring are in place. Audit results will be reviewed in QPI. DOC: August 20, 2013	8/20/13

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	245326	A. BUILDING _____ B. WING _____	C 07/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 9 effects related to psychoactive medication use for 1 of 10 residents (R44) reviewed for unnecessary medication use. Findings include: Record review revealed R44's current Physician's Order form contained orders, dated 5/20/13, for risperidone (an antipsychotic) 0.5 mg every morning and 1.5 mg. every evening for bipolar disorder. No target behaviors, monitoring of target behaviors, or monitoring of side effects of this medication could be located in R44's record. On 7/11/13, at 9:45 a.m. licensed practical nurse (LPN)-B reviewed the medication and treatment administration records for this resident with a surveyor, looking for the target behavior and side effect monitoring, and stated, "She doesn't have it." When interviewed on 7/11/13, at 12:10 p.m. registered nurse (RN)-A stated that the side effect monitoring sheet for this resident should be in the medication administration record and was not there. During interview on 7/11/13, at 12:45 p.m. RN-A was asked if this resident should have target behaviors listed and monitored because she is on risperidone and RN-A replied that she would expect that this resident would have target behaviors listed and monitored. The facility's 6.2.1 Mood and Behavior Program policy, dated October 2012, read, "1. Upon admission, determine if a Target Behavior/Target Mood is required for the resident. Note: If Target	F 428		

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F 428	Continued From page 10 Behavior/Target Mood is required, utilize CareTracker to enter the specific Target Behavior/Mood for the resident..." Policy 6.6.1 Mood and Behavior Program, dated October 2008, read, "Psychoactive Medication...4. Monitor regularly for side effects as indicated on the Psychoactive Medication Symptom Assessment/Plan of Care." The resident's record contained a Medication Regimen Review showing that the consulting pharmacist had completed reviews on 6/11/13 and 7/3/13. A Consultation Report from the consulting pharmacist, dated 6/14/13, detailed the resident's use of risperidone, the requirement for an appropriate diagnosis related to the use of the risperidone, and a request of the facility to provide this diagnosis in the resident's record. On 7/11/13, at 1:33 p.m. an attempt to interview the facility's consulting pharmacist was made via telephone. The consulting pharmacist was not available and a message was left asking if the pharmacist had made any other recommendations regarding this resident's use of risperidone, and if the pharmacist generally reviews target behaviors, behavior monitoring, and side effect monitoring during monthly reviews. The consulting pharmacist left a voice message reply on 7/12/13 at 1:09 p.m., stating that she had also made a recommendation to the facility on 7/3/13 regarding laboratory tests, and that the facility generally does behavior monitoring in the CareTracker system and the medication administration record, with side effect monitoring on the medication administration record.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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F 431	Continued From page 11 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. 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. 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy	F 431	F431 – All medications with change in direction have change stickers on the label, all insulin vials have been marked with date opened, a system is in place for timely destruction of discontinued medications. Nursing staff have been re-educated regarding change of direction stickers, dating insulin vials, and medication destruction. DON/Designee will audit 5 medication cards, 5 insulin vials, and medication room weekly to ensure change of direction stickers, date opened, and timely medication destruction. Audit results will be reviewed in QPI. DOC: August 20, 2013	8/20/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 431	Continued From page 12 review, the facility failed to date insulin pens when opened for 2 of 2 pens checked, and failed to remove 1 of 1 insulin bottle which was outdated and failed to ensure correct labeling for 1 of 2 insulin vials observed during a routine medication pass. This affected 2 of 3 residents observed to received insulin (R88, R43). Findings include: On 7/8/13 at 6:30 p.m., during an observed medication pass, R88 received 20 units of Novolog insulin (an insulin used to control blood sugars in people with diabetes) from a Novolog Flexpen . R88 also had a Lantus (a long acting form of insulin) solostar 100 units/ ml flexpen. Both pens had less that 100 units in the pen, and were not dated when opened. Registered nurse (RN) - C verified the pens were not dated when opened. The Director of Nurses (DON) directed RN -C to remove the pens from the cart and to order new pens from the pharmacy. Review of R88's record on 7/8/13 at 7:00 a.m., revealed the following orders: Insu-Novolog flex pen (3mlx5) 100 u/1ml disp syrin Inject Sub-Q per sliding scale three times daily <180 No insulin 181-220 2 units 221-260 3 units 261-300 4 units 301-340 5 units 341-400 6 units >400 8 units and call MD Insu-Novolog flexpen (3ml x 5) 100 u / 1 ml disp syrin Inject 15 units sub-Q three times daily before	F 431		

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F 431	Continued From page 13 meals Lantus 28 units subq BID On 7/8/13, at 6:23 p.m., R43 received 7 units of Novolog insulin. The label on the bottle directed staff to inject 3 units sub q (subcutaneous) twice daily with lunch and supper. Interview with RN -C about a change in direction sticker, for the insulin vial, RN -C questioned the DON and was instructed to check the current physician orders, and then notify the pharmacy. Review of R43's physician orders indicated the following orders: Insu- novolog (Aspart) 100 u/1ml vl Inject 7 units sub-q twice daily with lunch and dinner. On 7/8/13, at 6:45 p.m., during routine inspection of the medication cart for the East hallway, a vial of Lantus insulin for R43 -was noted to be opened and outdated. Interview with RN C, verified the insulin vial was dated as opened on 6-1-13, and was good for 30 days. The vial was removed from the medication cart. Review of R43's physician orders indicated the following orders Insu-Lantus (glargine) 100u/1ml Inject 10 units sub-q every morning (dx diabetes) Review of the facility policy titled 5.3 Storage and Expiration of Medications, Biological's, Syringes and Needles dated 12/1/07 and last revised 1/1/13 directed the following: 4. Facility should ensure that medications and	F 431		

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F 431	Continued From page 14 biological's: 4.1 Have an Expiration Date on the label; 4.2 Not to be retained longer than recommended by manufacturer or supplier guidelines 5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. 16. Facility should destroy or return all outdated/expired ... medications in accordance with Pharmacy return/destruction guidelines.	F 431		

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

F5326021

PRINTED: 07/23/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245326	A. BUILDING 01 - MAIN BUILDING 0102 B. WING _____	07/10/2013

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Rose of Sharon Manor was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 444 Cedar St., Suite 145 St Paul, MN 55101-5145, or By email to: Barbara.Lundberg@state.mn.us and	K 000	K 029 1. NAC will install a new fire rated motorized non fusible fire damper and controls in the 4" vent above the door in the corridor wall of the Oxygen Storage Room. 2. Proposed completion date August 20, 2013. 3. Director of Maintenance is responsible for monitoring to prevent reoccurrence of the deficiency. 4. Monitoring will be reviewed in QPI.	8/20/13

DC: 8-30-13
EXIT: 7-11-13
PC ok 8-12-13

RECEIVED
AUG - 5 2013
COMPLIANCE MONITORING DIVISION
LICENSE AND CERTIFICATION

RECEIVED
AUG - 9 2013
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Diane Connell	administrator	7-31-13

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

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	245326	A. BUILDING 01 - MAIN BUILDING 0102 B. WING _____	07/10/2013

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K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Rose of Sharon Manor is a 2-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1968 and was determined to be of Type II(222) construction. In 1992, an addition was constructed to the North side that was determined to be of Type II(222) construction. Because the original building and the 1 addition are of the same type of construction, the facility was surveyed as one building. The building is fully fire sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 63 beds and had a census of 55 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour	K 029		

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K 029	Continued From page 2 fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the hazardous rooms in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1 . The deficient practice could affect all residents, staff and visitors within the smoke compartment. Findings include: During the facility tour between 09:00 AM and 2:00 PM on 07/10/2013, observation revealed that there was a new 4 inch vent above the door in the corridor wall of the Oxygen Storage Room next to the nurses station on the 2nd floor that would close only by a fusible link. This deficient practices was confirmed by the facility Administrator (CC) at the time of discovery.	K 029		