#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

		AID CERTIFIC						ID: LCV7		
	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY	AGENCY			Facility ID: 0	0126
1. MEDICARE/MEDICAID PROVIDER N	VO.	3. NAME AND ADI (L3) ROSE OF SH						4. TYPE OF ACTION	ON: <u>7 (</u> L	8)
(L1) <b>245326</b> 2.STATE VENDOR OR MEDICAID NO.		(L4) 1000 LOVEL						1. Initial		tification
(L2) <b>1053700856</b>		(L5) ROSEVILLE				(L6) 55113		3. Termination 5. Validation	4. CHO 6. Comp	
5. EFFECTIVE DATE CHANGE OF OW	NERSHIP	7. PROVIDER/SUE	PLIER CATEGORY	7	02	(L7)		7. On-Site Visit	9. Other	
(L9) 07/01/2015		01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CL	IA	8. Full Survey Afte	er Complaint	
6. DATE OF SURVEY 08/10	<b>)/2016</b> (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF					(1.0.5)
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC			FISCAL YEAR END	ING DATE:	(L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPI	CE		12/31		
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS:							
From (a):		X A. In Complian	nce With		And/Or A	pproved Waive	rs Of The	Following Requirements	<u> </u>	
To (b) :		Program Ree	-		2.	Technical Pers	sonnel	6. Scope of S	Services Limit	
		Compliance	Based On:			24 Hour RN		7. Medical D	Director	
12.Total Facility Beds	63 (L18)	1. A	acceptable POC		4.	7-Day RN (Ru	iral SNF)	8. Patient Ro	om Size	
13.Total Certified Beds	63 (L17)	B. Not in Com	pliance with Program	L	5.	Life Safety Co	ode	9. Beds/Room	n	
			and/or Applied Waive		* Code:	<b>A</b> *		(L12)		
14. LTC CERTIFIED BED BREAKDOWN	Ī				15. FACILI	ITY MEETS				
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (	(1) or 1861 (j) (	1):	(L15)		
63										
(L37) (L38)	(L39)	(L42)	(L43)							
16. STATE SURVEY AGENCY REMARK	KS (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):		I					
17. SURVEYOR SIGNATURE		Date :			18. STATE	SURVEY AGE	ENCY API	PROVAL	Date:	
Mary Beth Lac	ina, HFE NE	EII	08/10/2016	(L19)	Kate	JohnsTc	on, Pr	ogram Specia	1 <u>list</u> 08/	24/2016 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RE	GIONAL	OFFICE (	OR SINGLI	E STAT	E AGENCY		
19. DETERMINATION OF ELIGIBILITY	<i>t</i>	20. COM	IPLIANCE WITH C	IVIL	21.	1. Statement	of Financia	al Solvency (HCFA-2572)	)	
X 1. Facility is Eligible to Par	ticipate	RIGH	ITS ACT:			<ol> <li>Ownership</li> <li>Both of the</li> </ol>		nterest Disclosure Stmt (H	ICFA-1513)	
2. Facility is not Eligible										
	(L21)									
22. ORIGINAL DATE	23. LTC AGREEMI	ENT 2	4. LTC AGREEME	NT	26. TERM	INATION ACT	TION:		(L30)	
OF PARTICIPATION	BEGINNING	DATE	ENDING DATE	3	<u>VOLUNTA</u>	RY	00	INVOL	UNTARY	
08/01/1986					01-Merger,				o Meet Health/Sa	afety
(L24)	(L41)		(L25)			faction W/ Rein		nt 06-Fail t	o Meet Agreeme	nt
25. LTC EXTENSION DATE:	27. ALTERNATIVI	E SANCTIONS				nvoluntary Tern		OTHER		
	A. Suspension of	of Admissions:			04-Other Re	eason for Withdr	awal		ider Status Chan	ge
(L27)			(L44)					00-Activ	ve	
	B. Rescind Sus	pension Date:	(1.45)							
			(L45)							
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMA	RKS				
	( <b>1</b> .00)	06301		<i>a</i>						
	(L28)			(L31)						
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (	OF APPROVAL DAT	Έ	Post	ted 09/01/20	16 Co.			
	(1.22)	07/27/2016		(T 22)	DETERS	muttor	DDDC	(7A ¥		
	(L32)			(L33)	DETERM	AINATION A	APPROV	VAL		



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245326 August 24, 2016

Mr. Dennis Decosta, Administrator Rose of Sharon Manor 1000 Lovell Avenue Roseville, MN 55113

Dear Mr. Decosta:

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 July 20, 2016 the above facility is certified for or recommended 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.

Rose of Sharon Manor August 24, 2016 Page 2

Sincerely,

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered August 24, 2016

Mr. Dennis Decosta, Administrator Rose of Sharon Manor 1000 Lovell Avenue Roseville, MN 55113

RE: Project Number S5326025

Dear Mr. Decosta:

On June 30, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 10, 2016 that included an investigation of complaint number H5326055, H5326057, H5326058, H5326060, H5326061, H5326063, H5326064, & H5326065. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On August 10, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on July 27, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 10, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 20, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 10, 2016 and therefore remedies outlined in our letter to you dated June 30, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Rose of Sharon Manor August 24, 2016 Page 2

Sincerely,

X ate ton

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure cc: Licensing and Certification File

# **POST-CERTIFICATION REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
245326 <sub>Y1</sub>	B. Wing	Y2	8/10/2016	Y3
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).

ITEI	м		DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix	F0165		Correction	ID Prefix	F0225		Correction	ID Prefix	F0226		Correction
Reg. #	483.10(f)(1)		Completed	Reg. #	483.13( - (4)	c)(1)(ii)-(iii), (c)(2)	Completed	Reg. #	483.13(c)		Completed
LSC			07/20/2016	LSC			07/20/2016	LSC			07/20/2016
ID Prefix	F0242		Correction	ID Prefix	F0282		Correction	ID Prefix	F0309		Correction
Reg. #	483.15(b)		Completed	Reg. #	483.20(	k)(3)(ii)	Completed	Reg. #	483.25		Completed
LSC			07/20/2016	LSC			07/20/2016	LSC			07/20/2016
ID Prefix	F0312		Correction	ID Prefix	F0313		Correction	ID Prefix	F0315		Correction
Reg. #	483.25(a)(3)		Completed	Reg. #	483.25(	b)	Completed	Reg. #	483.25(d)		Completed
LSC			07/20/2016	LSC			07/20/2016	LSC			07/20/2016
ID Prefix	F0412		Correction	ID Prefix	F0441		Correction	ID Prefix			Correction
Reg. #	483.55(b)		Completed	Reg. #	483.65		Completed	Reg. #			Completed
LSC			07/20/2016	LSC			07/20/2016	LSC			
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #			Completed	Reg. #			Completed	Reg. #			Completed
LSC				LSC			-	LSC			
REVIEWE STATE AG		REVIEWE (INITIALS	<sup>id вү</sup> <sup>)</sup> SR/KJ	date 08/24/2	2016	SIGNATURE OF SU	JRVEYOR	30921		date 08/10	/2016
REVIEWE CMS RO	D BY	REVIEWE (INITIALS		DATE		TITLE				DATE	
<b>FOLLOWI</b> 6/10/2010	JP TO SURVEY CO	OMPLETED	ON			ANY UNCORRECTE ED DEFICIENCIES					5 🗌 NO

# **POST-CERTIFICATION REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 0102		DATE OF REVISIT	
245326 y	B. Wing	Y2	7/27/2016	Y3
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).

ITE	м	DATE	ITEM			DATE	ITEM			DATE
Y4		Y5	Y4			Y5	Y4			Y5
ID Prefix Reg. #		Correction	ID Prefix Reg. #	NFPA 1	01	Correction	ID Prefix Reg. #	NFPA 101		Correction
-		Completed				Completed	-			Completed
LSC	K0018	07/20/2016	LSC	K0020		06/30/2016	LSC	K0025		06/30/2016
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 1	01	Completed	Reg. #	NFPA 101		Completed
LSC	K0034	06/30/2016	LSC	K0046		06/30/2016	LSC	K0050		06/30/2016
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 1	01	Completed	Reg. #	NFPA 101		Completed
LSC	K0052	06/30/2016	LSC	K0056		07/18/2016	LSC	K0062		07/06/2016
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 1	01	Completed	Reg. #	NFPA 101		Completed
LSC	K0064	06/30/2016	LSC	K0076		06/30/2016	LSC	K0144		06/30/2016
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #			Completed	Reg. #			Completed
LSC	K0147	06/30/2016	LSC				LSC			
REVIEWE STATE AG		REVIEWED BY (INITIALS) TL/KJ	date 08/24/2	2016	SIGNATURE OF SU		424		date 07/	27/2016
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE		TITLE				DATE	
FOLLOW	JP TO SURVEY CO	DMPLETED ON			ANY UNCORRECTE					6 🗌 NO



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered August 24, 2016

Mr. Dennis Decosta, Administrator Rose of Sharon Manor 1000 Lovell Avenue Roseville, MN 55113

Re: Reinspection Results - Project Number S5326025

Dear Mr. Decosta:

On August 10, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 10, 2016, that included an investigation of complaint number H5326055, H5326057, H5326058, H5326060, H5326061, H5326063, H5326064, & H5326065, with orders received by you on July 5, 2016. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

#### STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building		DATE OF REVISI	Т
00126	B. Wing	Y2	8/10/2016	Y3
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 State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITE	м		DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix	20565		Correction	ID Prefix	20830		Correction	ID Prefix	20840		Correction
Reg. #	MN Rule 4658.04 Subp. 3	05	Completed	Reg. #	MN Rul Subp. 1	e 4658.0520	Completed	Reg. #	MN Rule 4658.0520 Subp. 2 B	0	Completed
LSC			07/20/2016	LSC			07/20/2016	LSC			07/20/2016
ID Prefix	20910		Correction	ID Prefix	20920		Correction	ID Prefix	21390		Correction
Reg. #	MN Rule 4658.05 Subp. 5 A.B	25	Completed	Reg. #	MN Rul Subp. 6	e 4658.0525 B	Completed	Reg. #	MN Rule 4658.080 Subp. 4 A-I	0	Completed
LSC			07/20/2016	LSC			07/20/2016	LSC			07/20/2016
ID Prefix	21426		Correction	ID Prefix	21830		Correction	ID Prefix	21880		Correction
Reg. #	MN St. Statute 14 Subd. 3	4A.04	Completed	Reg. #	MN St. Subd. 1	Statute 144.651 0	Completed	Reg. #	MN St. Statute 144 Subd. 20	.651	Completed
LSC			07/20/2016	LSC			07/20/2016	LSC			07/20/2016
ID Prefix	21980		Correction	ID Prefix	21995		Correction	ID Prefix			Correction
Reg. #	MN St. Statute 62 Subd. 3	26.557	Completed	Reg. #	MN St. Subd. 4	Statute 626.557 a	Completed	Reg. #			Completed
LSC			07/20/2016	LSC			07/20/2016	LSC			
ID Prefix			Correction	ID Prefix			_ Correction	ID Prefix			Correction
Reg. #			Completed	Reg. #			Completed	Reg. #			Completed
LSC				LSC			_	LSC			
REVIEWE STATE AG		REVIEWE (INITIALS		date 08/24/2	2016	SIGNATURE OF S		0921		date 08/	/10/2016
REVIEWE CMS RO	D BY	REVIEWE (INITIALS	D BY	DATE		TITLE				DATE	
FOLLOW	JP TO SURVEY CO	OMPLETED	ON				ED DEFICIENCIES 3 (CMS-2567) SENT				s 🗌 no

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

	MEDICARE/MEDICAID ( PART I - TO BE COMPLE							D: LCV7
					E SURVEY.	AGENCY		Facility ID: 00126
<ol> <li>MEDICARE/MEDICAID PROVIDER NO (L1) 245326</li> </ol>	).		DRESS OF FACILIT IARON MANOR	Y			4. TYPE OF ACTION:	<u>2 (</u> L8)
2.STATE VENDOR OR MEDICAID NO.		(L4) 1000 LOVEI	LL AVENUE				1. Initial 3. Termination	<ol> <li>Recertification</li> <li>CHOW</li> </ol>
(L2) <b>1053700856</b>		(L5) ROSEVILLE	e, MN		(1	L6) <b>55113</b>	5. Validation 7. On-Site Visit	6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE OF OWN	ERSHIP	7. PROVIDER/SU	PPLIER CATEGORY			(L7)	8. Full Survey After Co	
(L9) 07/01/2015		01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA	6. Full Survey After Cu	mpianit
<ol> <li>DATE OF SURVEY 06/10/2</li> <li>ACCREDITATION STATUS:</li> </ol>		02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/IID	14 CORF 15 ASC		FISCAL YEAR ENDING	DATE: (L35)
0 Unaccredited 1 TJC	(L10)	04 SNF	07 A-Kay 08 OPT/SP	12 RHC	16 HOSPIC	Œ	12/31	
2 AOA 3 Other								
11LTC PERIOD OF CERTIFICATION From (a) :		10.THE FACILITY A. In Complia	IS CERTIFIED AS:		And/Or An	annound Weiwers Of The	Following Requirements:	
From (a) : To (b) :		Program Re			-	Technical Personnel	6. Scope of Serv	
		Compliance				24 Hour RN	7. Medical Direc	
12 T-4-1 E	(1.19)	1. A	Acceptable POC		4.	7-Day RN (Rural SNF)	8. Patient Room	Size
12. Total Facility Beds 13. Total Certified Beds	<ul><li>63 (L18)</li><li>63 (L17)</li></ul>	X P. Not in Com	pliance with Program		5. 1	Life Safety Code	9. Beds/Room	
15. Iotal Certified Beds	<b>UD</b> (E17)		and/or Applied Waive		* Code:	B*	(L12)	
14. LTC CERTIFIED BED BREAKDOWN		1			15. FACILIT	TY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1	l) or 1861 (j) (1):	(L15)	
63								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARKS	S (IF APPLICABLE S	HOW LTC CANCELI	LATION DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE S	SURVEY AGENCY AP	PROVAL	Date:
Mohammed Fat	ty, HFE NE	II	07/15/2016	(L19)	Kate J	ohnsTon, Pr	ogram Specialis	<u>ot</u> 07/26/2016 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RE	GIONAL	OFFICE O	OR SINGLE STAT	EAGENCY	
19. DETERMINATION OF ELIGIBILITY			IPLIANCE WITH CI	VIL			al Solvency (HCFA-2572)	
1. Facility is Eligible to Parti	cipate	RIGI	HTS ACT:			<ol> <li>Ownership/Control I</li> <li>Both of the Above :</li> </ol>	nterest Disclosure Stmt (HCFA	A-1513)
2. Facility is not Eligible	(1.21)							
	(L21)							
22. ORIGINAL DATE	23. LTC AGREEMI	ENT	24. LTC AGREEME	NT	26. TERMI	NATION ACTION:	(	L30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DATE		VOLUNTAR		INVOLUNI	TARY
08/01/1986					01-Merger, C			eet Health/Safety
(L24)	(L41)		(L25)			action W/ Reimbursemer	tt 06-Fail to M	eet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIVI					ason for Withdrawal	OTHER 07 Provider	Status Change
	A. Suspension of	of Admissions:	(L44)				00-Active	Status Change
(L27)	B. Rescind Sus	pension Date:	· · /					
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARI	KS		
		06301						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	DETERMINATION	OF APPROVAL DAT	E	Posted	07/27/2016 Co.		
	(L32)			(L33)	DETERM	INATION APPRO	VAL	

<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;

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

<u>Informal Dispute Resolution</u> - 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:

Susanne Reuss, Unit Supervisor Minnesota Department of Health Licensing and Certification Program Health Regulation Division P.O. Box 64900 85 East Seventh Place, Suite 220 St. Paul, Minnesota 55164-0900 Telephone: (651) 201-3793 Fax: 651-215-9697

## **OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 20, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 20, 2016 the following remedy will be imposed:

Rose of Sharon Manor June 30, 2016 Page 3

• Per instance civil money penalty. (42 CFR 488.430 through 488.444)

# 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.

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.

Rose of Sharon Manor June 30, 2016 Page 4

### 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 September 10, 2016 (three months

after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 10, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

# INFORMAL DISPUTE RESOLUTION

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

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

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

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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.

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

ate Compton

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure cc: Licensing and Certification File

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		245326	B. WING			06/	10/2016
AME OF F	ROVIDER OR SUPPLIER	φ. σαμα		ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
OSE OF	SHARON MANOR				00 LOVELL AVENUE DSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 000	INITIAL COMMENT	rs	FO	00			
	as your allegation of Department's accept	of correction (POC) will serve of compliance upon the otance. Your signature at the age of the CMS-2567 form will tion of compliance.	ser				
	revisit of your facilit validate that substa	acceptable POC, an on-site y may be conducted to Intial compliance with the en attained in accordance with	7/15/	16	:		
	A standard recertific June 6, 7, 8, 9, 10,	cation survey was conducted 2016.					
		plaint investigations were also ne of the standard survey:			Submission of this plan of co does not constitute an admiss the provider of any fact or co	ion by	
	H5326057 was fou H5326058 was fou F225, F226	nd to be substantiated at F315 nd to be substantiated at F309 nd to be substantiated at			set forth in this statement of c This plan is being submitted it is required by law.	leficiency	
	F165, F225, F226 H5326061 was fou	nd to be substantiated at nd not to be substantiated nd to be substantiated at					
	H5326064 was fou F309, F225, F226	nd to be substantiated at nd to be substantiated at			RECEIV	ED	
F 165 SS=D		TO VOICE GRIEVANCES SAL	F 1	65	JUL 1120	16	
	discrimination or re	ht to voice grievances without prisal. Such grievances <del>espec</del> t to treatment which has	-		COMPLIANCE MONITORI LICENSE AND CERTI		Z

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.

		AND HUMAN SERVICES & MEDICAID SERVICES			FORMA	4PPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE	SURVEY PLETED
		245326	B. WING _		06/1	0/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 LOVELL AVENUE ROSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 165	been furnished as v furnished. This REQUIREMEN by: Based on interview facility failed to ens made by the facility voice grievances w residents (R3, R81) grievance. Findings include: R3 filed 3 concerns treatment. R3 was assessed a to the minimum dat 3/25/16. R3 was interviewed reported grave con (NA-B) who was "a ago. R3 expressed NA-B and that the facility mistreat follow up. R3 confider department becaus follow up. R3 confider the facility mistreat not taken seriously	AT is not met as evidenced y and document review, the ure that prompt efforts were to ensure resident rights to ithout reprisal affecting 2 of 3 o in the sample who filed a with the facility of improper as cognitively intact according ta set (MDS) quarterly review I on 6/7/16, at 10:33 a.m. and cern about nursing assistant busive" to R3 several months "fear and retaliation" from facility did not take the concern er stated, "My heart ached at [NA-B] did." R3 expressed at to go to the social service se does not trust there will be ded seeing other residents in ed and that the residents are	F 16	<ul> <li>F165</li> <li>R (3) OHFC report has been com regarding resident concern 06/0 Employee (NA-B) is no longer an at the facility.</li> <li>R (81) Resident Concern Report documented on 06/09/2016 and investigation is in process.</li> <li>Resident rights will be reviewed resident council meeting includi Zero tolerance policy on fear of residents will be encouraged to back with facility management. concerns regarding facility emplose investigated and documented accordingly. Employee intervent including any education or discipactions up to and including term will be documented in the HR pefiles.</li> </ul>	9/2016 emplo was during ng facil reprisal share fo Resider oyees v d iions, olinary iination	ities I. All eed nt will
	roommate (R78) re assistants, R78 rep	n., interview with R3's garding help from the nursing ported that "[NA-B] plays mind 78 verified having issues with				

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ID PLAN C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE COM	SURVEY
		245326	B. WING		0.04	0/2040
	PROVIDER OR SUPPLIER	243320	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP		0/2016
	F SHARON MANOR			1000 LOVELL AVENUE ROSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
F 165	Continued From pa	ge 2	F 16	55		
	they are saying from Document review of Report, from R3 rea retaliation from card to flirt while working [NA-B] took me in t the toilet and said, my life is my life. I h did not take me to I someone else took always retaliates if Although administra that the roommate interviewed, there winformation regardi Administration char assignment so that R3, however, there education and/or le member, there was	NA-B would not take care of was no documented earning report for the staff no documented statement		<ul> <li>Staff has received education abuse neglect policy includes tolerance of residents' for a complete Response.</li> <li>IDT team to complete Response.</li> <li></li></ul>	luding zero ear of reprisal. completed on c d for prompt andom Call ligh lway 3 times and one time a. it resident all light respons aring Partner	all. t
	there was no repor pending investigation On 6/9/16, at 3:00 the Resident Conce at this time, filed a NA-B was suspend Document review of Concern Report, w 3/13[16] I asked [N	care givers NA-B or NA-L and t filed with the State Agency on. p.m. administration reviewed ern Report from 3/15/16, and report to the State Agency. led pending investigation. of the 3/15/16, Resident ritten by R3 read, "On Sunday A-A] to put me in bed bc/ hurt. [NA-A] said "No" bc/ it		according to resident co Results of the Caring Pa be reviewed monthly fo trending during the QAR identification of areas o or designee will monito concern reports and HR regarding employee per address accordingly.	rtner surveys w r tracking and PI process for f opportunity. I r for resident files for trends	ED

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	CON	<b>NPLETED</b>
		245326	B. WING _		06	/10/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ROSE O	F SHARON MANOR			1000 LOVELL AVENUE ROSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETIC DATE
F 165	but never did. My ta come get me for lui Eventually I started was wet, I needed for R8.1 completed a R corroborate R3's co coming in from the screaming with [R3] me. As I was comin help, [licensed prace phone and called for from somewhere in came up the back of that wing. [R3] said Although the Resid Disposition read, "S between peers whe the unit. Staff educ allow coverage/Resid documentation of the administrator wroted during daily rounds being met." There is support this intervee R81 completed and on 3/15/15, which r especially, it takes lights. I am entirely bathroom needs, g cannot operate my The disposition wri "Writer will perform Writer will monitor regarding call light	ablemate [R5] asked [NA-F]to nch but [NA-F] refused. to yell for help bc/ my bed to be changed. I was hungry." tesident Concern Report to oncern and wrote, "I was outside and [R3] was ] call light on help me, help ng up the hallway to get [R3] ctical nurse (LPN-A)] got on the or east aides. [NA-A] came the west wing and [NA-B] stairs. There were no aides on this went on for 20 minutes." ent Concern Report under Staff educated to communicate en going on break or leaving ated to coordinate breaks to sident cares." there was no				

Facility ID: 00126

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/30/2016 APPROVED 0938-0391			
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		245326	B. WING			06/10/2016				
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE							
ROSE OI	SHARON MANOR				1000 LOVELL AVENUE ROSEVILLE, MN 55113					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE			
F 165	p.m. verified there very support the intervery documentation wass On 5/9/16 R3 wrote which read, " When aide on my hall [NA- [NA-B] working here residents? I feel as [NA-B] have not be example, when [NA- toilet." The investig administrator read, assignments on the agreed with the cha- worked with that re- allegations 4/6/16 fr resident per policy and also resident a assignments. Write monitor resident we 4/21/16-No concern A review of the faci- titled, Concern-Res- center provides res- members with an u- concern procedure each and every res- right to express the directly to the center verbally or in writing family that they car- fear of discrimination During an interview 6/9/16, at 3:00 p.m.	dministrator on 6/9/16, at 3:00 was no documentation to ntions occurred as no a implemented. a Resident Concern Report [NA-B] is assigned as the -B] refuses to help me. Why is e if [NA-B] can refuse to help if my past complaints about en taken seriously, for -B] left me naked on the ation report completed by the "Administrator changed e hall. Resident requested and ange on 4/6/16. [NA-B] has not sident since 4/6/16. Previous ollowed up with. Employee and protocol. Unsubstantiated greed with change in caregiver er assigned BOM BH to ell being 4/17/16 thru n reported." lity policy dated, July 2015, sident/Family, read, "The idents and their family ninhibited resident/family . The procedure is such that ident and/or family has the ir grievance or concerns er's administration either g. Assure the resident and/or voice their concern without	F	165						

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245326	B. WING			06/ <sup>,</sup>	10/2016
NAME OF F	PROVIDER OR SUPPLIER	, , , , , , , , , , , , , , , , , , ,			TREET ADDRESS, CITY, STATE, ZIP CODE		
ROSE OF	SHARON MANOR				000 LOVELL AVENUE ROSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 165	• • • • •	ge 5 sumentation was implemented.	F1	65			
	surveyor and report evening in recent m self-medicated with facility nurse to call medical care. R81 that evening that hi called, but a facility medical director an and R81 refused th not want to take op facility administratic appropriate care re never been told of a R81 did not remem the names of the st When interviewed of director of nursing of R81 had been in Document review of was asked about th and R81 was prese there was document this incident and sh documentation of th because R81 had re incident or the staff that there had been	on 6/8/16, at 2:10 p.m. the (DON) stated that this concern vestigated. of R81's record showed no nvestigation of this incident. a 6/9/16, at 11:21 a.m. the DON he investigation of this incident ent. The DON was asked if intation of the investigation of he stated that there was no he investigation of this incident not been sure of the date of the f involved. R81 then stated in a meeting regarding this					
	incident that includ medical director, a	ed himself, the DON and the nd R81 had been upset with r at this meeting because the					

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391								
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		245326	B. WING		06/1	0/2016			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			STREET ADDRESS, CITY, STATE, ZIP CODE       1000 LOVELL AVENUE       ROSEVILLE, MN 55113       ID     PROVIDER'S PLAN OF CORRECTION       PREFIX     (EACH CORRECTIVE ACTION SHOULD BE       CROSS-REFERENCED TO THE APPROPRIATE       DEFICIENCY)					
F 165 F 225 SS=E	medical director sa not recall the incide DON was asked by a meeting regarding herself, R81, and the confirmed that the re did not recall the da place in recent wee was true that he did involved in the incide names, but he had nursing that one of accent specific to a DON confirmed that of the nurses involved has that type of acc 483.13(c)(1)(ii)-(iii), INVESTIGATE/REI ALLEGATIONS/INT The facility must not been found guilty o mistreating residen had a finding enter registry concerning of residents or misa and report any knot court of law agains indicate unfitness for other facility must er involving mistreatme including injuries of misappropriation of	d at that meeting that he did nt being investigated. The the surveyor if there had been g this incident that included he medical director and she meeting did take placeshe ate, but believed that it took ks. R81 then stated that it I not want to get the nurses lent into trouble by telling their previously told the director of the nurses involved had an nurse at the facility. The t R81 had mentioned that one red in the incident had a ccent and that a facility nurse ent. (c)(2) - (4) PORT DIVIDUALS at employ individuals who have f abusing, neglecting, or ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a t an employee, which would or service as a nurse aide or o the State nurse aide registry	F 16	F225 R(3) R (54) R (81) and R (5) hav grievance reports reported, inve	estigate ise/Neg vith ED a '2016. itten up ing ED e residen he ED on the ED on follow u d within ll be ndividua l comple	lect and on nt r ts up. 5 al. eted			

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 245326 B. WING 06/10/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1000 LOVELL AVENUE **ROSE OF SHARON MANOR** ROSEVILLE, MN 55113 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Any concern regarding abuse, neglect, F 225 Continued From page 7 F 225 mistreatment, or injury of unknown origin to other officials in accordance with State law through established procedures (including to the will be reported immediately to ED and State survey and certification agency). DON with follow up by writer to report to The facility must have evidence that all alleged state agency if appropriate and to be violations are thoroughly investigated, and must investigated thoroughly prevent further potential abuse while the investigation is in progress. Facility staff has completed education The results of all investigations must be reported regarding Resident concern and Abuse/ to the administrator or his designated Neglect policy and procedure. representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the Social Services will review resident incident, and if the alleged violation is verified concern log monthly for tracking and appropriate corrective action must be taken. trending during QAPI meetings monthly. ED/ designee will audit resident concerns 3 This REQUIREMENT is not met as evidenced x week for 4 weeks, then weekly for 4 by: weeks, and then ongoing monthly through Based on document review and interview, the facility failed to ensure that all alleged violations the QAPI process. involving injuries of unknown origin, or alleged violations of mistreatment neglect and abuse Alleged date of compliance: July 20, 2016. were reported to the administrator immediately, reported immediately to the state agency and thoroughly investigated for 4 of 5 residents (R3, R54, R81, R5) reviewed for incidents. Findings include: R3 filed 3 concerns with the facility of improper treatment. R3 was assessed as cognitively intact according to the minimum data set (MDS) quarterly review 3/25/16.

FORM CMS-2567(02-99) Previous Versions Obsolete

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/30/2016 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		PLE CONSTRUCTION G	(X3) DATI	(X3) DATE SURVEY COMPLETED	
		245326	B. WING	;		06/10/2016		
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
ROSE OF	SHARON MANOR			1	1000 LOVELL AVENUE ROSEVILLE, MN 55113			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 225	During the initial res 6/7/16, at 10:33 a.n about nursing assis to R3 several mont and retaliation" from not take the concer "My heart ached aff did." R3 doesn't fee service department will be follow up. R3 residents in the fac residents are not ta Interview with R3's a.m., R78 reported games with us." R [NA-B] but that they they are saying from Document review of Report, from R3 re retaliation from car to flirt while working [NA-B] took me in the the toilet and said, my life is my life. I I did not take me to	sident (R3) interview on h. reported grave concern stant (NA-B) who was abusive hs ago. R3 expressed "fear in NA-B and that the facility did in seriously. R3 further stated, ter [NA-B] did what [NA-B] el confident to go to the social is because does not trust there 3 confided seeing other ility mistreated and that the		228				
	There was no evide immediately notifed a thorough investig administration wrot that roomate and n documentation lact findings. The repor assignments were	complaints are made." ence the administrator was d, the State agency notified or lation completed. Although te on the investigation report heighbors were interviewed, ked evidence of the interview t idenfied that staff members changed so that NA-B would b, however, there was no						

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		AND HUMAN SERVICES				FOR	D: 06/30/2016 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245326	B. WING	i		06/10/2016	
NAME OF F	PROVIDER OR SUPPLIER	t, or the transference of the	L		TREET ADDRESS, CITY, STATE, ZIP CODE		
ROSE OI	SHARON MANOR				000 LOVELL AVENUE COSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 225	member, there was obtained from the o there was no report pending investigation On 6/9/16, at 3:00 p reviewed the Resid 3/15/16, and at this agency. NA-B was investigation. R54 sustained an it 3/7/16, between 6:3 sustained a skin ter- between 11:00 a.m 2/24/16 a 10 cm br right inner thigh of report to the admin investigation. According to a doc Record, onset date with unspecified de disturbances, contr delusional disorder not due to a substa condition. R54 was assessed impairment accord (MDS) assessmen Document review of Investigation State on 3/7/16, betweer	tion and learning for the staff s no documented statement care givers NA-B or NA-L and t filed with the state agency on. op.m. administration again lent Concern Report from time, filed a report to the state suspended pending njury of unknown origin on 30 a.m. and 7:00 a.m., ar of unknown origin on 3/7/16, and 11:30 a.m. and on uise was discovered on R54's unknown origin that lacked a istrator, state agency and an ument titled, Admission e, 10/1/15, R54 was diagnosed ementia with behavioral racture unspecified hand, s, and unspecified psychosis ance or known physiological as severe cognitive ing to the minimum data set t completed 2/20/16. of a form titled, Witness ment, an incident that occurred a 6:30 a.m. and 7:00 a.m. a left shoulder that looked very	F	225			

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		AND HUMAN SERVICES				FORM	06/30/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245326	B. WING			06/10/2016	
NAME OF F	PROVIDER OR SUPPLIER	• • • • • • • • • • • • • • • • • • • •			TREET ADDRESS, CITY, STATE, ZIP CODE		
ROSE OI	SHARON MANOR				000 LOVELL AVENUE COSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 225	Continued From pa	ige 10	F	225			
	Investigation Stater (NA-B) read, "On th a.m. I went to [R54 breakfast. After sha left shoulder looked (registered nurse R [R54] room to check Document review of Investigation Stater (NA-A) read, "I didn co-worker that [NA- for [R54's] morning shoulder wasn't rig informed the charg the shoulder." Document review of Investigation Stater 3/8/16, from an inc read, "Nurse called see residents shou shoulder seem diffe There was no docu administrator was i documented evider origin was reported Document review of notes, dated 3/7/16 was called to dining observed to be ble right hand. [family f and informed about site updated, nurse Documentaion lack	of a form titled, Witness ment, from nursing assistant he 7th of March, around 6:30 ] room to get [R54} dressed for aving [R54], I realize that [R54] d different, so I called the nurse RN-G) to pls (please) come to ek [R54] out." of a form titled, Witness ment, from nursing assistant n't see it but I was told by my -B] went to dress the resident in meal and notice that resident th so [NA-B] immediately e nurse to come and accessed of a form titled, Witness ment, from RN-G, dated ident that occurred 3/7/16 I to residents room in AM to alder. Upon assessment left erent, but I wasn't sure why." umented evidence that the informed immediately and no note that the injury of unknown a to the state agency. of the form titled, Progress 5, at 7:30 a.m. read, "Nurse g area this am, Resident was eding from an open area on member F-B] was contacted it skin tear via phone. NP on a manager updated." ked evidence that the informed immediately					

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DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE &					FORM	: 06/30/2016 APPROVED . 0938-0391	
	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED	
	245326	B. WING	i		06/	10/2016	
NAME OF PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·			STREET ADDRESS, CITY, STATE, ZIP CODE			
ROSE OF SHARON MANOR				1000 LOVELL AVENUE ROSEVILLE, MN 55113			
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
the state agency was When interviewed on administrator verified immediately of the inj occurred 3/7/16. Rev Report indicated the 3/8/16 of R54's shoul and the state agency 12:30 p.m., according Confirmation of subm MDH. Review of 54's progr on, "2/24/16, Observe faded yellow bruise u thigh-unknown etiolog (signs/symptoms) of turned on rounds. [sig no evidence that the immediately called to to the state agency a On 3/14/16, at 11:36 interviewed and unak investigation and sub bruise to the upper in etiology. Document review of Policy addressed, Inj and read, "Classify a source" when both of met. The source of the by any person or the the source of the inju- because of the exten	of unknown origin and that a notified.	F	225	5			

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	FORMA	APPROVED 0938-0391					
STATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			(X3) DATE	
		245326	B. WING			06/10/2016	
NAME OF F	PROVIDER OR SUPPLIER	Construction of the Constr	in the second		TREET ADDRESS, CITY, STATE, ZIP CODE 000 LOVELL AVENUE		
ROSE OI	SHARON MANOR				ROSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	Continued From pa injuries over time."	ge 12	F 2	225			
	surveyor and report regarding a concert months he had che nitro tablets, and as after-hours clinic fo was informed later after-hours clinic wa nurse had called th received an order for medication because opiates. R81 state administration about care related to this told of a resolution remember the date of the staff involved When interviewed of director of nursing of R81 had been in Document review of documentation of in During interview or was asked about th and R81 was prese there was document this incident and sh documentation of t because R81 had re incident or the staff that there had been incident that includ	on 6/8/16, at 2:10 p.m. the (DON) stated that this concern					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	4PPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245326	B. WING			06/1	0/2016
	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 000 LOVELL AVENUE ROSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	the medical director medical director sa not recall the incide DON was asked by a meeting regarding herself, R81, and the confirmed that the id did not recall the da place in recent wee was true that he did involved in the incide names, but he had nursing that one of accent specific to a DON confirmed that of the nurses involved has that type of accent specific to a DON confirmed that of the nurses involved has that type of accent R5's quarterly Minin 12/31/15, revealed R5 had an allegation facility failed to follow allegation of abuse During the initial re 11:33 a.m. R5 exprise with nursing assistat "ball her out", tells should stay away fit should eat. R5 indi- her boss and is ver On 6/8/16, at 9:18 working today in th NA-B had not both she talks to the soor	r at this meeting because the id at that meeting that he did ent being investigated. The r the surveyor if there had been g this incident that included ne medical director and she meeting did take placeshe ate, but believed that it took eks. R81 then stated that it d not want to get the nurses dent into trouble by telling their previously told the director of the nurses involved had an a nurse at the facility. The at R81 had mentioned that one ved in the incident had a ccent and that a facility nurse cent. mum Data Set (MDS) dated R5 was cognitively intact. on of verbal abuse and the bow their policy regarding the sident interview on 6/7/16, at ressed a verbal abuse concern ant (NA)-B. R5 stated NA-B will R5 who to talk to and who R5 rom. RN-B will also tell R5 she cated she feels NA-B acts like		225			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/30/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245326	B. WING			06/10/2016	
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ROSE OF	SHARON MANOR				000 LOVELL AVENUE OSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 225	Continued From pa more helpful.	ge 14	F	225			
	mostly complained	a.m. SSD stated R5 had about other residents, was not laints with nursing assistants.					
	came into her room told R38 she did no	a.m. R5 stated when R38 n offering pizza last night R5 of want any. Then NA-B came 5 out and told R5 not to talk to					
	occurred with NA-E ago, R5 reported it director of nursing	a.m. R5 stated when incident approximately three months to the Administrator and (DON) and was informed they it right away, yet R5 felt					
	stated she recalled take her medication like NA-B makes h will state knows sh further indicated N	a.m. nursing assistant (NA)-E NA-B would remind R5 to ns. NA-E indicated R5 feels er take medications, but R5 e needs to take them. NA-E A-B tells R5 to eat and will blood sugar doesn't get too low.					
		2 a.m. DON stated she was sues between R5 and NA-B.					
	administrator state incident between R retract statements by R81. The admir	08 a.m. when interviewed, the d he was informed about an 35 and NA-B, but R5 wanted to because they were influenced histrator stated R5 had not problems with NA-B.					
		resident concern report dated R5 was uncomfortable with					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVE CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039									
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION		E SURVEY PLETED		
		245326	B. WING			06/	10/2016		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 1000 LOVELL AVENUE				
ROSE OF	SHARON MANOR				ROSEVILLE, MN 55113				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 225 F 226 SS=E	NA-B around and ta Resolution and disp "advised to always present when intera Review of facility's 3/20/16, indicated N approach and sugg residents for a peri- satisfaction on daily QA. NA-B's assignt possible in best inter behaviors. Review of facility per Prevention and Re Mistreatment, Negl of Unknown Source Resident Property, written, or gestured disparaging and de or their families or regardless of their disability." "Mental/Emotional Includes, but is not harassment, and the deprivation." 483.13(c) DEVELC ABUSE/NEGLECT The facility must de policies and proceed	alk was intimidating. position indicated NA-B was have another staff member acting with R5." resident concern report dated NA-B was advised regarding jestion made to switch od of time and would monitor y rounds and caring partners ments were changed when erest of all parties and policy dated July 2015 and titled porting: Resident ect, Abuse, Including Injuries e, and Misappropriation of revealed "Verbal abuse is oral, d language that includes erogatory terms to the resident within their hearing distance age, ability to comprehend or Abuse limited to, humiliation, hreats of punishment or DP/IMPLMENT C, ETC POLICIES evelop and implement written		225					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SUR COMPLETE         NAME OF PROVIDER OR SUPPLIER ROSE OF SHARON MANOR       245326       B. WING       06/10/20         IDENTIFICATION NUMBER:       STREET ADDRESS, CITY, STATE, ZIP CODE       06/10/20         IDENTIFICATION NUMBER:       STREET ADDRESS, CITY, STATE, ZIP CODE       06/10/20         IDENTIFICATION NUMBER:       STREET ADDRESS, CITY, STATE, ZIP CODE       06/10/20         IDENTIFICATION NUMBER:       STREET ADDRESS, CITY, STATE, ZIP CODE       06/10/20         IDENTIFICATION NUMBER:       STREET ADDRESS, CITY, STATE, ZIP CODE       06/10/20         IDENTIFICATION NUMBER:       STREET ADDRESS, CITY, STATE, ZIP CODE       06/10/20         IDENTIFICATION NUMBER:       STREET ADDRESS, CITY, STATE, ZIP CODE       06/10/20         IDENTIFICATION NUMBER:       STREET ADDRESS, CITY, STATE, ZIP CODE       06/10/20         IDENTIFICATION NUMBER:       STREET ADDRESS, CITY, STATE, ZIP CODE       06/10/20         IDENTIFICATION NUMBER:       STREET ADDRESS, CITY, STATE, ZIP CODE       06/10/20         IDENTIFICATION       STREET ADDRESS, CITY, STATE, ZIP CODE       06/10/20         IDENTIFICATION       STREET ADDRESS, CITY, STATE, ZIP CODE       06/10/20         IDENTIFICATION <td< th=""><th>INTED: 06/30/2016 FORM APPROVED 1B NO. 0938-0391</th></td<>	INTED: 06/30/2016 FORM APPROVED 1B NO. 0938-0391
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         ROSE OF SHARON MANOR       1000 LOVELL AVENUE         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL         TAG       PREFIX         REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX         F 226       Continued From page 16         This REQUIREMENT is not met as evidenced       F 226         F 226       F226	(X3) DATE SURVEY COMPLETED
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)       COM COM COM         F 226       Continued From page 16       F 226       F 226         This REQUIREMENT is not met as evidenced by:       F 226       F226	06/10/2016
ROSE OF SHARON MANOR         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG       ID       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COM         F 226       Continued From page 16       F 226       F 226       F 226       F 226         This REQUIREMENT is not met as evidenced by:       F 226       F 226       F 226       F 226	
WHY IS       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COM IS         F 226       Continued From page 16       F 226         This REQUIREMENT is not met as evidenced by:       F 226	
This REQUIREMENT is not met as evidenced F226 by:	BE COMPLETION
by:	
<ul> <li>facility failed to ensure that all alleged violations involving injuries of unknown origin, or alleged violations of mistreatment, neglect and abuse were reported to the administrator immediately, reported to the state agency and thoroughly investigated for 4 of 5 residents (R3, R54, R81, R5) reviewed for incidents.</li> <li>Findings include:</li> <li>Document review of the facility policy dated, July 2015, and titled Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including injuries of Unknown Source, and Misapropriation of Resident Property, read, "The center requires centers to report these alleged violations to the Executive Director and DON/designee immediately." Immediately means as soon as possible but not to exceed 24 hours after discovery of incident, in the absence of a shorter state time frame requirements. Prevention 1. Ensure implementation of prevention techniques in the center including, but not limited to: Ongoing supervision of residents</li> </ul>	estigated se/Neglect vith ED and 2016. tten up on ng ED resident te ED or n reports follow up. within 5 be
and staff. Observation of care delivery.         Observation and recognition of signs of staff         burnout. Observation and recognition of signs of         resident to resident and/or resideent -to-staff         frustration of stress.         Document review of the policy dated July 2015,         titled, Investigation Protocol, in Summary directed         staff to meet with the complaining party. Interview         and take notes, Plan the investigation. Review         accused employee's file.Interview the accused	n sheet Page 17 of 53

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		245326	B. WING	i		06/10/2016		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
				1000 LOVELL AVENUE				
KUJE U	ROSE OF SHARON MANOR				ROSEVILLE, MN 55113			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 226	<ul> <li>employee. Listen carefully and take notes on the Who, What, When, Where, Why and How needed to establish facts of the situation. Review all of the interviews and supporting information. Complete an investigation summary and make recommendations. Follow up with the complaining party and if necessary any reporting agencies.</li> <li>Document review of the facility July 2015, Abuse Policy addresses, Injuries of Unknown Source and read, "Classify as an "injury of unknown source" when both of the following conditions are met. The source of the injury was not observed by any person or the resident could not explain the source of the injury. The injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time, or the incidence of injuries over time."</li> <li>R3 filed 3 concerns with the facility of improper treament.</li> <li>R3 was assessed as cognitively intact according to the minimum data set (MDS) quarterly review 3/25/16.</li> <li>During the initial resident (R3) interview on 6/7/16, at 10:33 a.m. revealed grave concern about nursing assistant (NA-B) who was abusive to R3 several months ago. R3 expressed "fear and retaliation" from NA-B and that the facility did not take the concern seriously. R3 further stated, "My heart ached after [NA-B] did what [NA-B] did." R3 doesn't feel confident to go to the social</li> </ul>		F	TAG CROSS-REFERENCED TO THE APP		JLD BE OPRIATE COMPLÉTION DATE all completed final review. , neglect, known origin to ED and to ED and to report to and to be education and Abuse/ e. esident king and ags monthly. ent concerns 3 ekly for 4 onthly through		
	and retaliation" fror	n NA-B and that the facility did						
	did." R3 doesn't fee	el confident to go to the social						
		t because does not trust there						
		3 confided seeing other ility mistreated and that the						

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/30/2016 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245326	B. WING			06/	10/2016	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
ROSE OF SHARON MANOR					000 LOVELL AVENUE ROSEVILLE, MN 55113			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 226	REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 18 residents are not taken seriously. R3's roomate (R78) was interviewed 6/7/16 at 10:45 a.m., and reported that "[NA-B] plays mind games with us." R78 verified having issues with [NA-B] but that there is no one to listen to what they are saying from management in this facility. Document review of a 4/6/16, Resident Concern Report, from R3 read, "I have had 2 incidents of retaliation from care recently. 1. I told [NA-L] not to flirt while working. In response, the next day [NA-B] took me in the bathroom, left me naked on the toilet and said, '[NA-L] life is [NA-L] life and my life is my life. I have a life at home.' 2. [NA-B] did not take me to lunch after that so by the time someone else took me my lunch was cold. [NA-B] always retaliates if complaints are made." Although administration wrote on the investigation roomate and neighbors were interviewed, the information lacked evidence of the interview findings. Although administration changed the staff members assignment so that NA-B would not take care of R3, there was no documented education and learning for the staff member, there was no documented statement obtained			226				
	no evidence that the immediately, report that a thorough inv On 6/9/16, at 3:00 reviewed the Resic 3/15/16, and at this State Agency. NA- investigation.	e administrator was informed ted to the State agency and estigation occurred. p.m. administration again lent Concern Report from s time, filed a report to the B was suspended pending						
	they are saying from Document review of Report, from R3 rea- retaliation from car- to flirt while working [NA-B] took me in to the toilet and said, my life is my life. I he did not take me to someone else took always retaliates if Although administra- roomate and neigh information lacked findings. Although a staff members assis not take care of R3 education and lear there was no document from the care giver no evidence that the immediately, repor- that a thorough inv On 6/9/16, at 3:00 reviewed the Resico 3/15/16, and at this State Agency. NA- investigation.	m management in this facility. of a 4/6/16, Resident Concern ad, "I have had 2 incidents of e recently. 1. I told [NA-L] not g. In response, the next day he bathroom, left me naked on '[NA-L] life is [NA-L] life and have a life at home.' 2. [NA-B] funch after that so by the time me my lunch was cold. [NA-B] complaints are made." ation wrote on the investigation bors were interviewed, the evidence of the interview administration changed the ignment so that NA-B would by there was no documented ning for the staff member, mented statement obtained s NA-B or NA-L. There was he administrator was informed ted to the State agency and estigation occurred. p.m. administration again lent Concern Report from a time, filed a report to the						

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#### **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 245326 B. WING 06/10/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1000 LOVELL AVENUE ROSE OF SHARON MANOR** ROSEVILLE, MN 55113 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) F 226 Continued From page 19 F 226 3/7/16, between 6:30 a.m. and 7:00 a.m., sustained a skin tear of unknown origin on 3/7/16, between 11:00 a.m. and 11:30 a.m. and on 2/24/16 a 10 cm bruise was discovered on R54's right inner thigh of unknown origin that lacked immediate notification to the administrator, a report to the state agency and a thorough investigation. According to a document titled, Admission Record, onset date, 10/1/15, R54 was diagnosed with unspecified dementia with behavioral disturbances, contracture unspecified hand, delusional disorders, and unspecified psychosis not due to a substance or known physiological condition. R54 was assessed as severe cognitive impairment according to the minimum data set (MDS) assessment completed 2/20/16. Document review of form titled, Witness Investigation Statement, on 3/7/16, between 6:30 a.m. and 7:00 a.m. R54 had a left shoulder that looked very different from the right shoulder. Document review of a form titled, Witness Investigation Statement, from nursing assistant (NA-B) read, "On the 7th of March, around 6:30 a.m. I went to [R54] room to get [R54] dressed for breakfast. After shaving [R54], I realize that [R54] left shoulder looked different, so I called the nurse (registered nurse RN-G) to pls (please) come to [R54] room to check [R54] out." Document review of a form titled, Witness Investigation Statement, from nursing assistant (NA-A) read, "I didn't see it but I was told by my coworker that [NA-B] went to dress the resident

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 06/30/2016

FORM APPROVED

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 245326 B. WING 06/10/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1000 LOVELL AVENUE** ROSE OF SHARON MANOR ROSEVILLE, MN 55113 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 226 Continued From page 20 F 226 for [R54's] morning meal and notice that resident shoulder wasn't right so [NA-B] immediately informed the charge nurse to come and accessed the shoulder." Document review of a form titled, Witness Investigation Statement, from RN-G read, "Nurse called to residents room in AM to see residents shoulder. Upon assessment left shoulder seem different, but I wasn't sure why." There was no documented evidence that the administrator was informed immediately and no documented evidence that the injury of unknown origin was reported to the state agency. Document review of the form titled, Progress notes, dated 3/7/16, at 7:30 a.m. read, "Nurse was called to dining area this am, Resident was observed to be bleeding from an open area on right hand. [F-B] was contacted and informed about skin tear via phone. NP on site updated, nurse manager updated." Documentaion lacked evidence that the administrator was informed immediately regarding the injury of unknown origin and that the state agency was notified. When interviewed on 6/9/16, at 2:00 p.m. the administrator verified not being informed immediately of the injuries of unknown origin that occurred 3/7/16. Review of a Resident Concern Report indicated the administrator was notified 3/8/16 of R54's shoulder injury of unknown origin and the state agency was contacted 3/8/16, at 12:30 p.m., according to the form titled Confirmation of submitting a Incident report to MDH. Review of 54's progress notes also identified that on, "2/24/16, Observed a 10 cm (centimeter)

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TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA	). 0938-039 TE SURVEY MPLETED
		245326			04	6/10/2016
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD		
ROSE O	F SHARON MANOR			1000 LOVELL AVENUE ROSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 226	faded yellow bruise thigh-unknown etio (signs/symptoms) of turned on rounds. [ no evidence that the immediately called to the state agency On 3/14/16, at 11:3 interviewed and un investigation and s bruise to the upper etiology. Document review of Policy addressed, I and read, "Classify source" when both met. The source of by any person or the the source of the ir because of the ext of the injury or the one particular poin injuries over time." R81, 6/6/16 at 11:5 and reported an all that he had asked when he had chest concern that one e had chest pain, sel and asked a facility clinic for medical c informed later that clinic was not calle called the facility's an order for "Oxy,"	a upper inner Rt (right) logy- 0 (no) s/s of discomfort. A or 2- {sic} signed by RN-G]. There was e injury of unknown origin was to the administrator, reported and investigated thoroughly. 66 a.m. the adminisrator was able to provide an ubsequent report for this inner right thigh of unknown of the facility July 2015, Abuse injuries of Unknown Source as an "injury of unknown of the following conditions are the injury was not observed he resident could not explain njury. The injury is suspicious ent of the injury or the location number of injuries observed at t in time, or the incidence of i5 a.m., approached a surveyor egation of neglect, explaining the nurse to call the clinic t pain. R81 reported having a vening in recent months he f-medicated with nitro tablets, y nurse to call his after-hours are. R81 stated he was evening that his after-hours d, but a facility nurse had medical director and received and R81 refused that the he did not want to take	F 22	26		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/30/2016 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		E CONSTRUCTION		E SURVEY PLETED
		245326	B. WING			06/*	10/2016
NAME OF F	PROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE		
ROSE OF	SHARON MANOR				000 LOVELL AVENUE		
				R	OSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	Continued From pa	ge 22	F:	226			
		It his concerns for appropriate incident but has never been to his concerns.					
		on 6/8/16, at 2:10 p.m. the (DON) stated that this concern vestigated.					
		f R81's record showed no nvestigation of this incident.					
	was asked about th and R81 was prese there was document this incident and sh documentation of th because R81 had r incident or the staff that there had been incident that include medical director, and the medical director sa not recall the incident	6/9/16, at 11:21 a.m. the DON be investigation of this incident ent. The DON was asked if intation of the investigation of the stated that there was no ne investigation of this incident not been sure of the date of the involved. R81 then stated in a meeting regarding this ed himself, the DON and the nd R81 had been upset with r at this meeting because the id at that meeting that he did ent being investigated. The					
	a meeting regardin herself, R81, and the confirmed that the did not recall the da place in recent wee was true that he did involved in the incid names, but he had nursing that one of accent specific to a DON confirmed that of the nurses involved	the surveyor if there had been g this incident that included ne medical director and she meeting did take placeshe ate, but believed that it took eks. R81 then stated that it d not want to get the nurses dent into trouble by telling their previously told the director of the nurses involved had an a nurse at the facility. The at R81 had mentioned that one yed in the incident had a ccent and that a facility nurse					

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		AND HUMAN SERVICES				FORM	06/30/2016 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION		e survey IPleted
		245326	B. WING			06/	10/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ROSE OF	SHARON MANOR				000 LOVELL AVENUE ROSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 226	Continued From pa has that type of acc	•	F	226			
		rterly Minimum Data Set /15, revealed R5 was					
		on of verbal abuse and the ow their policy regarding an					
	Prevention and Re Mistreatment, Negl of Unknown Source Resident Property, written, or gestured disparaging and de or their families or	olicy dated July 2015 and titled porting: Resident ect, Abuse, Including Injuries e, and Misappropriation of revealed "Verbal abuse is oral, I language that includes erogatory terms to the resident within their hearing distance age, ability to comprehend or					
	"Mental/Emotional Includes, but is not harassment, and th deprivation."	Abuse limited to, humiliation, areats of punishment or					
	11:33 a.m. R5 expr with nursing assista "ball her out", tells should stay away f	sident interview on 6/7/16, at ressed a verbal abuse concern ant (NA)-B. R5 stated NA-B will R5 who to talk to and who R5 rom. RN-B will also tell R5 she cated she feels NA-B acts like ry demanding.					
	working today in th NA-B had not both she talks to the so	a.m. R5 stated NA-B was e east hallway and indicated ered her today. R5 indicated cial service director (SSD), but s much help and used to be					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/30/2016 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
		245326	B. WING	i		06/	10/2016
NAME OF F	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 1000 LOVELL AVENUE		
ROSE OF	SHARON MANOR				ROSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 226	Continued From pa more helpful.	ge 24	F	226	8		
	mostly complained	a.m. SSD stated R5 had about other residents, was not laints with nursing assistants.					
	came into her room told R38 she did no	a.m. R5 stated when R38 o offering pizza last night R5 ot want any. Then NA-B came 5 out and told R5 not to talk to					
	occurred with NA-E ago, R5 reported it director of nursing	a.m. R5 stated when incident approximately three months to the Administrator and (DON) and was informed they it right away, yet R5 felt					
	stated she recalled take her medication like NA-B makes he will state knows she further indicated NA	a.m. nursing assistant (NA)-E NA-B would remind R5 to ns. NA-E indicated R5 feels er take medications, but R5 e needs to take them. NA-E A-B tells R5 to eat and will blood sugar doesn't get too low.					
		2 a.m. DON stated she was sues between R5 and NA-B.					
	administrator state incident between R retract statements by R81. The admin	8 a.m. when interviewed, the d he was informed about an 5 and NA-B, but R5 wanted to because they were influenced istrator stated R5 had not problems with NA-B.					
		resident concern report dated R5 was uncomfortable with					

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TATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY
		245326	B. WING	06/	10/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 LOVELL AVENUE		
	-			ROSEVILLE, MN 55113		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 226	Resolution and disp	alk was intimidating. position indicated NA-B was have another staff member	F 22	6		
F 242 SS=D	3/20/16, indicated I approach and sugg residents for a peri satisfaction on daily QA. NA-B's assign possible in best into behaviors.	resident concern report dated NA-B was advised regarding jestion made to switch od of time and would monitor y rounds and caring partners ments were changed when erest of all parties and ETERMINATION - RIGHT TO	F 24	2		
	schedules, and hea her interests, asses interact with memb inside and outside	he right to choose activities, alth care consistent with his or assments, and plans of care; hers of the community both the facility; and make choices is or her life in the facility that e resident.		F242 R (32) preferences have been bathing, and care plan and nu assistant communication she updated.	ursing	
	by: Based on observa review, the facility f preferences was a bathing/shower for for choices in daily	1 of 3 resident (R32) reviewed		Residents will be reviewed fo preferences have been review Enrichment care plan and nur communication sheet has bee Residents will be reviewed fo upon admission by Life Enrich	ved and l rsing assis en update r preferer	ife stant ed. nces
	responded "no cho	ed on 6/6/16, at 7:09 p.m. and ice" regarding how many times wered during a week. R32		quarterly or with significant c status during care conference	hanges in	r

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 245326 B. WING 06/10/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1000 LOVELL AVENUE** ROSE OF SHARON MANOR ROSEVILLE, MN 55113 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) services. All residents will be offered F 242 Continued From page 26 F 242 added, "I did not have a shower for two weeks baths/ showers per preferences. now and I am supposed to have shower twice a week. No one comes to ask me and I did not ask Staff has received education regarding them either." offering cares according to resident rights, On 6/9/16 at 8:57 a.m. R32 was lying in bed, preferences, and choices. when approached by surveyor, R32 explained her preference was to take two showers per week as DON or designee will complete audit of staff told her and posted a noted on her bedside stand that reads, "Maxine's shower Thursdays completion of bathing 3 x weeks for 4 A.M. Sunday P.M." which was confirmed by weeks and then weekly ongoing. surveyor when R32 pointed to the note. Further indicated, staff gave her shower yesterday even though she does not normally take shower on Alleged date of compliance: July 20, 2016. Wednesday but she took it because, "I have not had a shower for two weeks". R32 further stated, "I will take another one today if they want to give me another one today. I will be glad if they ask me and give me shower at least two times a week." R32's diagnoses included multiple sclerosis, anxiety disorder, Diabetes mellitus II, major depression, and abnormalities of gait and mobility obtained from Admission Record dated 6/30/14. R32's Activities of Daily Living (ADL) CAA dated 10/1/15, indicated, "Has assist needs with bed mobility, transfers, dressing, toileting, hygiene and bathing secondary to weakness with dx (diagnosis) of MS (multiple sclerosis), seizures disorder, anemia ...". R32's 30 day Minimum Data Set (MDS) dated 3/27/16, indicated R32 had had intact cognition with Brief Interview for Mental Status (BIMS) score of 15. Nursing note dated 6/6/16, read, "Client

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

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						OND NO. 0800-03		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED	
		245326	B. WING			06/1	10/2016	
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
ROSE OF	SHARON MANOR				00 LOVELL AVENUE OSEVILLE, MN 55113			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 242	requesting okay for week Lacerations nursing notes lacke shower/bath in the (5/6/16-6/8/16). The treatment adm May 23, 2016 thru "Weekly skin asses (+) new area of ski	s. Sutured put in" however ed evidence that R32 refuses	F2	242				
F 282 SS=D	only once dated 5/3 5/26/16-6/7/16. On 6/9/16 at 11:26 (DON) explained the need to document showers and if a rest should be notified a board. DON further to chart about it and the refusal." 483.20(k)(3)(ii) SE PERSONS/PER C The services provi- must be provided b	a.m. the director of nursing nat the expectation is staff what they are doing regarding esident refuses, the nurse and written on the 24 hour er explained, "The nurses need d let me know and document RVICES BY QUALIFIED ARE PLAN ded or arranged by the facility by qualified persons in ach resident's written plan of	F	282				
	care. This REQUIREME by: Based on interview review the facility f	NT is not met as evidenced w, observation and document ailed to provide services in he resident's written plan of			F282 NA-A was provided education r following the residents plan of is no longer a resident at this fa	care. R(	-	

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TATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:	. ,		(X3) DATE	0938-039 SURVEY PLETED
		245326		·	06/1	10/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/	10/2010
	F SHARON MANOR			1000 LOVELL AVENUE ROSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETIC DATE
F 282	care for 1 of 3 resid who required assis toileting/incontinent hearing accommod Findings include: R105's plan of care "Incontinent" "Goal impairment r/t (rela Integrity Assessme Plan)." The undated form f and Assessment, o "Difficulty starting u dribbling" and "Void The plan of care do Skin Integrity Asses incontinence, keep Implement an indiv every 2 hours." The facility policy of Incontinence direct necessary care for of urine and to fold every two hours. During a continuou 7:15 a.m. R105 wa off, lying on the left brief and there was on the incontinence calling out with mo faint "Come and he assistant (NA-A) ca asked for a urinal.	dents (R105) in the sample tance with ce care, shaving, oral care and	F 282	Residents will be assessed for the shaving, oral care, and hearing accommodation needs upon accommodation needs upon accommunicated via resident care plans and nursing communication sheet. Resident shaving, oral care, and hearing accommodation needs have been revieupdated accordingly. Staff will communicate between shifts or repositioning and elimination of completion for continuity of cares the plan of care, including how concerns with hearing aides fur appropriately.	Imission gnifican the assistar ts' toilet een asse wed and f ares re. educate accordir to man	, t int ing, ssed d ed ng to age

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/30/2010 APPROVEI 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245326	B. WING	- <u></u>		06/	10/2016
NAME OF I	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ROSE O	SHARON MANOR			-	000 LOVELL AVENUE OSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	lying down. NA-A sa R105 told NA-A "My When interviewed of verified R105 did no prior to NA-A provid NA-A verified the 18 staining on the inco dried ring of urine. If urine stain and wou last offered cares. On 6/8/16, not sure produced a docume specified, which rea {sic} I found [R105] deflated. I plugged flated, and recheck report to [nurse] an not I had done care and [R105] was dry allegation-"[R105] of had removed [R105] there was no bm th During an interview 3:00 p.m. verified I sometime between NA-A provided care verified a dark dryin would indicate a lor checked and chang When interviewed of DON verified the fa check on R105 even	at R105 on the side of the bed. y bed is wet." on 6/8/16 at 8:30 a.m. NA-A ot have any morning cares ling the cares at this time. B inch brown/tan ring of ntinence pad looked like a _PN-A was informed of the Id find out when the night shift of the time, the DON ent dated 6/8/16, no time ad, "[R105] was dry at 4am with the bed cord out, bed the bed back in,m it rein {sic} ed [R105] 4-4:30am. I gave d informed her that [R105] did as with [R105] at 4 am rounds, ." Clarification to lid not have stool at 4 am. I b) brief to check [R105] and ere." with the DON on 6/8/16, at R105 was incontinent of urine 4:00 a.m. and 8:20 a.m. when as. Furthermore the DON ng brown/tan ring of urine ng period of time without being	Fź	282	DON or designee will complete audits to ensure cares are provi according to resident care plan for 4 weeks, and weekly x 4 wee will be brought to monthly qapi for identification of potential or of improvement and determine needs. IDT team will ensure all have been assessed and plan of communicated according to the schedule and with significant ch resident status during CCPR. Alleged date of compliance: July	ded 3 x a w eks. Res meetin oportur furthe residen care MDS nanges	eek sults ng nities r ts in

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 245326 06/10/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1000 LOVELL AVENUE ROSE OF SHARON MANOR** ROSEVILLE, MN 55113 PROVIDER'S PLAN OF CORRECTION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 282 Continued From page 30 F 282 Delivery Guide, directed staff R105 required assistance of one with grooming. Oral Care indicated an upper denture and assist of one for oral care. There was no further direction with shaving. A family (F-C) interview was conducted on 6/7/16, at 11:37 a.m. and F-C expressed concern had not been shaved since coming to the facility and was not receiving oral care. F-C expressed R105 was always clean shaven and would not like having all the facial hair that was currently present. During an observation on 6/7/16, at 3:00 p.m. another family member (F-D) was visiting and expressed concern to this surveyor that R105 had not been shaved of facial hair and partial plate was not in R105's mouth. During a continuous observation on 6/8/16, at 7:15 a.m. R105 was observed with bed covers off, laying on the left side. R105 was calling out with moans and every now and again a faint "Come and help me." At 8:05 a.m. nursing assistant (NA-A) came to the room using a a transfer belt, ambulated R105 to the bathroom (BR), R105 asked for a tooth brush to brush teeth. NA-A assisted R105 to the sink. There were no oral care supplies in the room and NA-A had to retrieve a basin, toothbrush, toothpaste and mouthwash from the storage room. Another NA-C came into the room and searched for oral care supplies and not finding any left the room. NA-A returned to the room and prepared a toothbrush with toothpaste. R105 asked NA-A, "Did you find my partial?" to which NA-A responded "The hair is long on your face." R105 repeated, "Did you find my partial?" NA-A explained being off for a week and did not have

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/30/2016 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245326	B. WING			06/1	10/2016
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	********	
ROSEO	SHARON MANOR				000 LOVELL AVENUE OSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	an assignment she R105 had teeth. On 6/8/16, during n 7:15 a.m.,NA-A pro R105's top bedside shave R105. NA-A heavy growth of fac gratitude for being better!" The plan of care da Communication Ca Hearing Aide, Intern as needed. There w regarding the heari During observation hearing aide in plac through 6/9/16, at 1 During an interview 11:00 a.m. verified shave facial hair ev a day and if a resid nurse and to reapp 483.25 PROVIDE 0	et for R105 so did not know horning cares which started at duced an electric shaver from drawer and proceeded to verified there was a very stal hair. R105 expressed shaved and stated, "That's ated 6/7/16, read, Sensory the Plan, Auditory Disturbance, vention Assist to place in ear was no further direction ng aide. s, R105 did not have the ce from 6/8/16, at 8:30 a.m. 10:30 a.m. with the DON on 6/10/16, at the facility expectation was to veryday Provide oral care twice ent refused care to inform the roach at another time. CARE/SERVICES FOR		282	F309 R (54) is no longer a resident at Residents have had their pain as with physician notification if ind	ssessed	,
SS=D	provide the necess or maintain the hig mental, and psycho	EING t receive and the facility must ary care and services to attain hest practicable physical, osocial well-being, in e comprehensive assessment			care plans reviewed and update accordingly. Residents will recei assessment and care plan review admission, quarterly and annua significant change. Residents ut medication will be reviewed for pain assessments and MD upda accordingly for appropriate mar	ive a pa wed up Ily or w ilizing P ongoin ted	on rith a PRN ng

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

### PRINTED: 06/30/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245326	B. WING			06/1	10/2016
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 LOVELL AVENUE ROSEVILLE, MN 55113				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETIO DATE
F 309	by: Based on docume facility failed to ass assessment which symptoms was cor (R54) reviewed for shoulder dislocatio The findings includ R54's medical reco document titled Ad indicated R54 was dementia with beha contracture unspec disorders, and uns substance or know was assessed as h impairment accord (MDS) assessmen Review of a Progre indicated registere late entry for 3/7/10 [nursing assistant do not both seem a shoulder to be off [NA-B] resident wa (nurse practitioner arrives. Nurse held fidgeting, was not shoulder as [R54] An additional docu Investigation State indicated registere documenting a late	NT is not met as evidenced ent review and interview, the sure that a comprehensive pain included non verbal signs and inducted for 1 of 1 resident pain control following an acute n.	F	309	Staff has been educated regard policy and procedure for pain management. IDT team will complete chart a quarterly to ensure care plans assessments are completed tim DNS or designee will audit pain management weekly utilizing t review audit x 4 weeks and the thereafter. Results of the audit reviewed at monthly QAPI for trending to identify further op for improvement. Alleged date of compliance: Ju	udit and nely. he syste month will be tracking portunit	nly and ies

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00126

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

PRINTED: 06/30/2016 FORM APPROVED OMB NO. 0938-0391

	101 UN MEDICARE					1	0000 0001
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245326	B, WING			06/	10/2016
	Provider or Supplier F SHARON MANOR	·	<b>.</b>		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 LOVELL AVENUE ROSEVILLE, MN 55113	<u></u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	shoulder. Upon ass different, but I wasr (certified nursing as scheduled to be se Nurse will ensure N shoulder. Expected was not here in AM R54's family memb 6/15/16 at 4:30 p.m at the facility on 3/7 she and F-B had be social services but stated when F-B ar p.m., R54's face ar looking. NA-B was door at the time an looked to be in pain Progress Notes da had been notified a R54's left shoulder right shoulder. The arrived at the faciliti ordered a left shoul indicated the X- ray but was unable to Documentation is u physician or NP we delay in getting the whether alternate i were required to as Review of docume Investigation State 11:00-11:30 a.m. ra "Res (resident) wa according to NA/R	sessment left shoulder seems n't sure why. Informed CNA ssistant) that [R54] was en by NP (nurse practitioner). NP is informed about resident's d NP in AM (morning) but [NP] I." oer (F)-A, was interviewed n F-A reported having been 7/16 at lunch time. F-A stated een scheduled to meet with F-B was running late. F-A rrived at the facility around 2:00 opeared red and clammy standing by R54's bedroom d F-B had told NA-B that R54		309	<b>&gt;</b>		

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Facility ID: 00126

If continuation sheet Page 34 of 53

		AND HUMAN SERVICES				FORM	APPROVED
r	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	O	OMB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	a. Build	ING		СОМ	PLETED
		245326	B. WING			06/*	10/2016
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ROSE OF	SHARON MANOR				000 LOVELL AVENUE ROSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	high temperature. It it was noted to be S On 3/7/16, at 2:15 p Physician Progress change in patient. [ temperature noted. right forearm today left shoulder deform dusky." On 3/8/16 at 11:58 to the facility. Licen reported to nurse p the X-ray that were 3/8/16, at 8:04 a.m view, left. Results: inferiorly dislocated There is no fracture coracoclavicular jo Anterior shoulder d pain cues, If notice A Witness Investig practical nurse (LP noted on Monday t morning the pt (pati in pain, at this time gave an order to se On 3/9/16, no time a progress note: "O usually a very good grimacing early in t (milligrams) PRN (	-	F	309			
	in pain, at this time gave an order to se On 3/9/16, no time a progress note: "O usually a very good grimacing early in t (milligrams) PRN ( the rest of the noc	the Doctor was updated and end pt to the hospital." specified, RN-I documented in Dnly taking sips tonight, is d drinker. Resident was the shift-given 680 [sic] mg as needed) Tylenol, slept well					

Facility ID: 00126

If continuation sheet Page 35 of 53

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/30/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245326	B. WING			06/	10/2016
NAME OF F	PROVIDER OR SUPPLIER	Leanna,			TREET ADDRESS, CITY, STATE, ZIP CODE		
ROSE OF	SHARON MANOR				000 LOVELL AVENUE ROSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	been given. On 3/9/16 at 10:15 progress notes incl crying out." On 3/9/16, at 10:30 ambulance to the h R54 at 10:15 a.m. a signs) 97-70-18-18 out-R (right) should to [hospital] ER (en (left) shoulder dislo will meet at [hospital documented vital s pressure for R54 w NP-C was interview the NP-C stated, "I anterior dislocation where there have b muscle fatigue, but dislocation is due to to the facility. Anoth have dislocated is forward." When interviewed verified witnessing lot of pain" when tr 3/9/16, and no PRI given prior to trans R54's current Phys had utilized Acetan	a.m. documentation in the uded: "resident up in chair a.m. R54 was transported by iospital after LPN-A observed and documented, "v/s (vital 0/68 resident up in chair crying der. NP called, per order send nergency room) for ortho L iocation, [guardian] called she al]." According to the igns, the typical blood ras 100/60 to 130/70. ved on 6/9/16, at 10:13 a.m. do not know enough about the on [R54]. I have seen cases been contractures due to a typically an anterior o trauma. [R54] did not return her way the shoulder could to have been stretched too far on 6/10/16, at 1:00 p.m. LPN-A R54 had been "crying out in a ansported to the hospital on N pain medication had been		309	11 - Hartone,		
	since 6/6/14 for pa	in, with directions not to 24 hours.					

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		AND HUMAN SERVICES				FORM	06/30/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245326	B. WING			06/	10/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ROSE OF	SHARON MANOR				000 LOVELL AVENUE OSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	Continued From pa	ige 36	F	309			
	Record (MAR) was R54 was to receive a.m., 12:30 p.m. ar documentation for signed off to indica given.	Medication Administration reviewed. The MAR indicated the acetaminophen at 6:30 nd 4:30 p.m The MAR 3/7/16, at 12:30 p.m. was not te the medication had been					
	Medication, docum control included: "I for you? If no, prov non-interviewable r pain scale." On 3/3 documentation was assessment had or Another section of record included: "P noted call provider, was not completed	ument titled March 2016 entation in a section for pain ls your pain program effective ide pain rating (For residents, utilize Wong-Baker 7/16 that section of s blank indicating no pain ccurred for the day shift. the March 2016 Medication Please monitor for pain cues. If "The 3/7/16 documentation to indicate whether pain cues nd/or what pain cues may have					
	had Standing Orde 325-650 mg (millig grain X q (every) 4	hysician orders verified R54 ers for "Acetaminophen ram) PO (orally) or Suppository hrs (hours) prn (whenever 100 or discomfort."					
	Management inclu not-verbal signs ar unrelieved by orde Report to Provider distress or pain un	lan of care for Pain ded: "Assess for verbal and nd symptoms of distress or pain red treatments/medications. signs and symptoms of relieved by ordered tions. Identify precipitating					

Facility ID: 00126

If continuation sheet Page 37 of 53

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 245326 B. WING 06/10/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1000 LOVELL AVENUE** ROSE OF SHARON MANOR ROSEVILLE, MN 55113 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F312 F 312 Continued From page 37 F 312 F 312 F 312 483.25(a)(3) ADL CARE PROVIDED FOR R (105) is no longer a resident at the DEPENDENT RESIDENTS SS=D facility. NA-A received education regarding providing cares according to the plan of A resident who is unable to carry out activities of daily living receives the necessary services to care. maintain good nutrition, grooming, and personal and oral hygiene. Resident oral cares and shaving needs will be assessed upon admission, quarterly, annually and with changes to resident This REQUIREMENT is not met as evidenced by: status and communicated via the nursing Based on observation, interview and document assistant communication sheet. Dependent review, the facility failed to provide personal hygiene care for 1 of 1 resident (R105) in the residents' shaving and oral care needs sample who required assist from staff for oral have been assessed and care plans care and shaving. reviewed and updated accordingly. Findings include: Staff has been educated to complete R105, during an observation on 6/6/16, at 5:00 p.m., was in bed positioned to the left side, personal hygiene cares according to the uncovered, fully clothed, with legs extending over plan of care. the edge of the mattress. There was a heavy accumulation of facial hair/whiskers.When an DON or designee to complete random interview was attempted, R105 stated, "let me sleep." audits of dependent resident ADL's to be completed weekly for 4 weeks. Results of A family (F)-C interview was conducted on 6/7/16, at 11:37 a.m. and F-C expressed concern about audits to be tracked and trended and R105 who had been mentally intact and living at reviewed at QAPI monthly for home two weeks ago. F-C expressed concern that R105 had not been shaved since coming to identification of areas of opportunities and the facility, was not getting out of bed, was not frequency of audits to be determined as eating, was not receiving oral care, and the family did not understand what services the facility was indicated. providing for R105. Furthermore, F-C expressed Alleged date of compliance: July 20, 2016. R105 was always clean shaven and would not like having all the facial hair that was currently

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/30/2016

FORM APPROVED

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 06/30/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		PLE CONSTRUCTION G		E SURVEY IPLETED
		245326	B. WING	÷		06/	10/2016
NAME OF F	PROVIDER OR SUPPLIER	un	-		STREET ADDRESS, CITY, STATE, ZIP CODE		
ROSE OI	F SHARON MANOR				1000 LOVELL AVENUE ROSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	'IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 312	Continued From pa present.	ige 38	F	312	2		
	another family men expressed concern was in the bed fully	ion on 6/7/16, at 3:00 p.m. hber (F-D) was visiting and to this surveyor that R105 dressed, trying to get out of een shaved of facial hair and ot in R105's mouth.			·		
	7:15 a.m. R105 wa off, laying on the le with moans and ev "Come and help m assistant (NA-A) ca transfer belt, ambu (BR). R105 asked teeth. NA-A assiste were no oral care s had to retrieve a ba and mouthwash fro NA-C came into the care supplies and in NA-A returned to the toothbrush with too "Did you find my pa responded "The have repeated, "Did you explained being off	s observation on 6/8/16, at s observed with bed covers ft side. R105 was calling out ery now and again a faint e." At 8:05 a.m. nursing ame to the room using a a lated R105 to the bathroom for a tooth brush to brush ed R105 to the sink. There supplies in the room and NA-A asin, toothbrush, toothpaste om the storage room. Another e room and searched for oral not finding any left the room. he room and prepared a othpaste. R105 asked NA-A, artial?" to which NA-A air is long on your face." R105 find my partial?" NA-A for a week and did not have set for R105 so did not know					
	nightstand (in a cu complained of mou R105 stuck out tor	partial upper plate from the p without water). R105 uth/tongue being sore. When igue, it was observed to be red, uple areas that appeared					

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING B. WING 245326 06/10/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1000 LOVELL AVENUE ROSE OF SHARON MANOR** ROSEVILLE, MN 55113 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 312 Continued From page 39 F 312 NA-A produced an electric shaver from R105's top bedside drawer and proceeded to shave R105, NA-A verified there was a very heavy growth of facial hair. R105 expressed gratitude for being shaved and stated, "That's better!" On 6/8/16, at 10:00 a.m. the licensed practical nurse (LPN-A) was informed that R105 had complained of having trouble swallowing and having a sore mouth/tongue. LPN-A documented in the progress notes, "11:00 a.m. Tongue has red and white patches present. Mouth and lips dry." On 6/8/16, at 12:00 p.m. the director of nursing (DON) was informed that no oral care supplies were available in the bedside. On 6/9/16, at 10:07 a.m. the hospice aide (HA) was providing cares. When interviewed regarding oral care provided on 6/7/16, HA stated, "I brought my own toothette's and provided the oral care with the toothette's because there was no toothbrush or toothpaste supplies in the room." During an interview on 6/8/16, at 10:00 a.m. regarding the facility expectation for oral care, LPN-A verified oral cares were to be provided twice a day and the hospice services were to be above and beyond the services of the facility. During an interview on 6/10/16 at 10:00 a.m. with RN-D explained that a mouth exam had not been completed on R105 because R105 was due 6/10/16, according to the minimum data set (MDS) schedule, and R105 was transferred to another facility, per family wishes, on 6/10/16 so the assessments were not completed.

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Facility ID: 00126

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#### **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING B. WING 245326 06/10/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1000 LOVELL AVENUE ROSE OF SHARON MANOR** ROSEVILLE, MN 55113 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 312 Continued From page 40 F 312 A facility policy regarding oral care and shaving of residents was requested but not received. During an interview with the DON on 6/10/16, at 11:00 a.m. verified the facility expectation was to shave facial hair everyday, provide oral care twice a day and if a resident refused care to inform the F313 nurse and to reapproach at another time. 483.25(b) TREATMENT/DEVICES TO MAINTAIN F 313 F 313 R(105) hearing aide was located and SS=D **HEARING/VISION** remained functional at the time of survey. To ensure that residents receive proper treatment No other concerns have been noted and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, regarding audiology services. assist the resident in making appointments, and by arranging for transportation to and from the Residents audiology needs will be assessed office of a practitioner specializing in the treatment of vision or hearing impairment or the upon admission, quarterly/ annually and office of a professional specializing in the with significant changes in resident status. provision of vision or hearing assistive devices. Changes in resident status will be communicated to the nurse for further This REQUIREMENT is not met as evidenced assessment and referral services obtained bv: Based on observation, interview and document if indicated. Residents have been reviewed review, the facility failed to ensure 1 of 1 resident to ensure all audiology needs have been (R105) in the sample who was identified as requiring a hearing aide, received the addressed and care plans reviewed and communication device. updated as indicated. Findings include: Staff has been provided education R105 was observed on 6/6/16, at 5:00 p.m. in regarding ensuring residents have the bed positioned to the left side and had a hearing aid in place. When an interview was attempted, ancillary services and communication R105 replied, "let me sleep." devices provided to allow the residents to On 6/8/16, at 8:30 a.m. R105's hearing aid was function to the highest level of abilities.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 06/30/2016

FORM APPROVED

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/30/2016 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245326	B. WING	;		06/	10/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ROSE OF	SHARON MANOR				000 LOVELL AVENUE OSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 313 F 315 SS=D	noted to be in place be having difficulty batteries were obse dresser drawer, NA LPN-A to assess an During an observat R105 did not have having difficulty und LPN-D assigned to about the hearing a was unable to find to medication cart. Th there was a hearing no one knew who it LPN-A was intervie inquire about the he given her to check someone giving he then found it on the belonged to. NA-C, overheard the conv specifically handing informing LPN-A th R105. The plan of care da Communication Ca Hearing Aide, Inter as needed. There was no furth hearing aide. A fac with hearing aides aide was broken w 483.25(d) NO CAT	e, however, R105 appeared to hearing. Although extra erved to be located in the top A-C brought the hearing aide to nd return to R105. ion on 6/9/16, at 10:31 a.m. the hearing aide and was derstanding the conversation. R105 did not know anything ide not being available and the hearing aide in the re health unit coordinator said g aide at the nurses station but t belonged to. wed on 6/9/16 at 10:40 a.m. to earing aide that NA-C had on 6/8/16. LPN-A recalled r a hearing aide yesterday but e floor and didn't know who it who was standing near by, versation and reported g LPN-A the hearing aide and e hearing aide belonged to ated 6/7/16, read, Sensory are Plan, Auditory Disturbance, vention Assist to place in ear er direction regarding the ility policy regarding working and what to do when a hearing as requested, but not received. HETER, PREVENT UTI,		313	DON or designee to complete ra audits weekly for 4 weeks, and monthly for 3 months. Results of be tracked and trended and rev QAPI monthly for identification opportunities and frequency of be determined as indicated. Alleged date of compliance: Jul	then of audit viewed a of area audits	at is of to

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CENTER	RS FOR MEDICARE	AND HUMAN SERVICES		TIDI		FORM. MB NO.	06/30/2016 APPROVED 0938-0391 E SURVEY
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					PLETED
		245326	B. WING		· · · · · · · · · · · · · · · · · · ·	06/	10/2016
NAME OF F	PROVIDER OR SUPPLIER	<b>k</b> a na <u>i 1014 na 8000 na 1</u>			TREET ADDRESS, CITY, STATE, ZIP CODE		
ROSE OF	F SHARON MANOR				000 LOVELL AVENUE OSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 315		-	F:	315	F315		
	assessment, the fa resident who enters indwelling catheter resident's clinical co catheterization was who is incontinent of treatment and serv infections and to re function as possible				NA-A was educated regarding p cares according to the resident care. Resident's bladder assessments reviewed and care plans and nu assistant communication sheet updated accordingly.	plan of s have b ursing	een
	by: Based on observa review, the facility f (R105) in the samp incontinent of urine and services to ma Findings include: R105 was admitted on 6/4/16, at 4:30 p care. According to dated 6/8/16, read, h/o (history of) left decreased oral inta of dysphagia. Due pursue hospice wh with diagnosis of C accident). Urology: retention, Pt was n infection) and was has been straight of During an observation	I from the hospital to the facility o.m. with an order for hospice the physician progress notes "Neurology: Pt with previous basal ganglia stroke and with ake and increase in symptoms to declining function agreed to ich [R105] is now signed up for VA (cerebral vascular Pt with h/o chronic urinary oted to have UTI (urinary tract placed on antibiotics. [R105] cathing twice a day at home."			Nursing department has been p education ensure residents wh identified as incontinent of urin the necessary care and services incontinence. DON or designee to complete r audits weekly to ensure depen residents toileting needs are co according to the plan of care for then monthly for 3 months. Re audits to be tracked and trender reviewed at QAPI monthly for identification of areas of opport frequency of audits to be deter indicated.	o are ne receiv s to mar random dent omplete or 4 wee esults of ed and rtunities rmined a	ve hage d eks, s and as
	Based on observa review, the facility f (R105) in the samp incontinent of urine and services to ma Findings include: R105 was admitted on 6/4/16, at 4:30 p care. According to dated 6/8/16, read, h/o (history of) left decreased oral inta of dysphagia. Due pursue hospice wh with diagnosis of C accident). Urology: retention, Pt was n infection) and was has been straight of During an observation	ailed to ensure 1 of 3 residents ole, who was identified as received the necessary care mage incontinence. If from the hospital to the facility o.m. with an order for hospice the physician progress notes "Neurology: Pt with previous basal ganglia stroke and with ake and increase in symptoms to declining function agreed to ich [R105] is now signed up for VA (cerebral vascular Pt with h/o chronic urinary oted to have UTI (urinary tract placed on antibiotics. [R105] cathing twice a day at home."			education ensure residents whildentified as incontinent of uring the necessary care and services incontinence. DON or designee to complete reaudits weekly to ensure dependents toileting needs are continent to the plan of care for then monthly for 3 months. Reaudits to be tracked and trendent reviewed at QAPI monthly for identification of areas of opport frequency of audits to be determined to b	o are ne receiv s to mar random dent omplete or 4 wee esults of ed and rtunities rmined a	ve nage d eks, s and as

Facility ID: 00126

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		AND HUMAN SERVICES				FORM	06/30/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
		245326	B. WING	i		06/	10/2016
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
ROSE OF	SHARON MANOR				1000 LOVELL AVENUE ROSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 315	uncovered, fully clo the edge of the mat A family (F-C) inter- at 11:37 a.m. and F R105 who had bee home two weeks ag that R105 was not g family did not under facility was providin During an observat another family men expressed concern dressed, trying to g on the call light for During a continuou 7:15 a.m. R105 wa off, lying on the left brief and there was on the incontinence calling out with mos faint "Come and he assistant (NA-A) ca asked for a urinal. I holding the urinal in asked to sit up bec lying down. NA-A s R105 told NA-A "M transfer belt and an bathroom (BR) and toilet. There was a	othed, with legs extending over ttress. F-C expressed concern about n mentally intact and living at go. F-C expressed concern getting out of bed and the rstand what services the ng for R105. tion on 6/7/16, at 3:00 p.m. nber (F-D) was visiting and that R105 was in the bed fully jet out of the bed and turned	F	315	5		
	R105 voided what the toilet. When interviewed	sounded like a small amount in on 6/8/16 at 8:30 a.m. NA-A ot have any morning cares					

Facility ID: 00126

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-03								
			(X2) MUL	TIP			E SURVEY	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD			COMI	PLETED	
		245326	B. WING			06/1	10/2016	
NAME OF F	PROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE			
ROSE OF	SHARON MANOR							
			15	1	ROSEVILLE, MN 55113 PROVIDER'S PLAN OF CORRECTION	1	(75)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
E 045					_			
F 315	Continued From pa	lge 44 ding the cares at this time.	F	315				
	NA-A verified the 18	8 inch brown/tan ring of						
		ontinence pad looked like a LPN-A was informed of the						
		Id find out when the night shift						
	last offered cares.							
	On 6/8/16, DON pr	roduced a document dated	- - -					
		cified, which read, "[R105]						
		c} I found [R105] with the bed ted. I plugged the bed back						
	in,m it rein {sic} flat	ed, and rechecked [R105]						
		eport to [nurse] and informed not I had done cares with						
	[R105] at 4 am rou	nds, and [R105] was dry."						
		gation-"[R105] did not have I removed [R105] brief to						
		here was no bm there."						
		with the DON on 6/8/16, at						
		R105 was incontinent of urine 4:00 a.m. and 8:20 a.m. when						
	NA-A provided care	es. Furthermore the DON						
		ng brown/tan ring of urine ng period of time without being						
	checked and chang							
	The undated form f	titled, Bladder Data Collection						
	and Assessment, ir	ndicated R105 had "Difficulty						
	starting urine stream Voiding small amo	m" "Post void dribbling" and ounts often "						
	The plan of care do	ocument dated 6/7/16, titled,						
		ssment,bladder incontinence, wrinkle free. Implement an						
		ng schedule of every 2 hours.						
	The facility policy d	ated July 2015, titled Urinary						
		ed staff to provide whenever residents who are incontinent						

Facility ID: 00126

If continuation sheet Page 45 of 53

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 245326 B. WING 06/10/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1000 LOVELL AVENUE** ROSE OF SHARON MANOR ROSEVILLE, MN 55113 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) F 315 | Continued From page 45 F 315 of urine and to follow the skin integrity guideline of every two hours. When interviewed on 6/10/16, at 11:00 a.m. the DON verified the facility expectation would be to check on R105 every two hours for incontinence. F 412 483,55(b) ROUTINE/EMERGENCY DENTAL F 412 SERVICES IN NFS SS=D The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and F412 must promptly refer residents with lost or damaged dentures to a dentist. R (29) has a dentist appointment scheduled for 06/21/2016 per resident This REQUIREMENT is not met as evidenced request. by: Based on observation, interview and document review, the facility failed to ensure 1 of 2 Medicaid Residents offered dental services upon residents (R29) reviewed for dental issues were admission, quarterly, and with change in provided dental services. status. Consents will be obtained and Findings include: ancillary services are offered to residents upon admit and reviewed quarterly and On 6/7/16, at 10:40 a.m. during conversation, R29 was observed with several teeth missing in the lower jaw and R29 stated, she had cancer of the jaw and most of her teeth were removed. Review of the physician order sheet dated 6/2/16, R29 was admitted to the facility on 9/27/2005 with diagnoses including oral cavity squamous cell

FORM CMS-2567(02-99) Previous Versions Obsolete

		AND HUMAN SERVICES & MEDICAID SERVICES					06/30/2 \PPRO\ 0938-0	<b>/</b> ED
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED	
		245326	B. WING			06/′	10/2016	;
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
ROSE OF	SHARON MANOR				000 LOVELL AVENUE OSEVILLE, MN 55113			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLET DATE	
	and depression. In review of R29's a (MDS) dated 3/5/16 blank of any dental not limited to broke denture, no natural abnormal mouth tis natural teeth, inflam or facial pain, disco chewing. The integrated care read, "MALIGNANT RETROMOLAR AF PEG- Mandibular re Declines further EN reducing proximal p NPO (nothing by m (drop) 1 qd (everyd hour as needed)." Apple Tree Coon R revealed, " review floss, prophy, cavitr varnish. Radiograp Treatment recomm plan will be sent to every 6 months, pro However R29 had no 8/12/15 as recomm Quarterly assessm "Difficulty swallowir Care plan with goa with TF (tube feedi	tube placement, dysphagia annual Minimum Data Set 5, the dental sections were left concerns which included but n or loosely fitting full or partial teeth or tooth fragments, isue, obvious cavity or loose ned or bleeding gums, mouth omfort or difficulty with a by Medica dated 4/5/16, T NEOPLASM OF REA w (with) dysphagia and esection revision in 2014 NT assessment. Stoma paste beg tube irritation. She remains iouth) and uses atropine gtt lay) and q4 hr prn (every four capids sheet dated 8/12/15, ved, toothbrush with peridex, ron, exam, placed a fluoride hs not indicated at this time. hendations; filling treatment rparty for approval. Exam ophy every 6 months." not been seen by dentist since hended. ent dated 6/6/16, point out,	F	412	<ul> <li>with change in status. Resident assessed for dental service requiservices scheduled accordingly.</li> <li>Staff have been provided education and education and control of ancillary services.</li> <li>IDT Team will complete audits a completion and follow up of an services upon admission, quart with change in resident status CCPR. Results of audits to be the trended and reviewed at QAPI identification of areas of opport frequency of audits to be determined.</li> <li>Alleged date of compliance: June 2012.</li> </ul>	uests ar ation schedul to ensu acillary during acked a monthl tunitie	nd ing re d and y for s and as	

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 06/30/2016 APPROVED . 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY MPLETED
		245326	B. WING	6		06,	/10/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ROSE OI	SHARON MANOR				000 LOVELL AVENUE ROSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Pref Tag	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 412	Continued From pa	ge 47	F	412			
	stated R29 had diag cancer, dysphagia RN-A confirmed R2 on 8/12/15 and indi the dental appointm concern had been h attention and provid On 6/8/16 at 9:03 a could not remember and added "I would please, I do not tak problems with swal On 6/8/16 at 9:57 a interview with Apple community care co specified, R29 was 8/12/15 and a treat husband on 8/14/19 responses and late was deceased. Fur fax was sent to the health unit coordina requested the infor it read, "Wednesda [R29] was sent to F have listed as the r consent. At this tim response. If someo representative now of Sharon Manor, 1 55113, please let m work will not be dow	.m. registered nurse (RN)-A gnosis of retro molar area and tube feeding. In addition, 9 was last seen by a dentist cated she had just scheduled nent on 6/14/16, after the brought to the facility staff ded the number to the clinic. .m., R29 mentioned, she er when last seen by dentist like to be seen by a dentist e anything by mouth and have lowing." .m. during a telephone e Tree Coon Rapids dental ordinator (CCC), the CCC last seen in the facility on ment plan was sent to R29's 5, 9/25/15 and 12/9/15 with no r learned that the husband thermore CCC mentioned, a facility 3/16/16 addressed to ator (HUC). Surveyor mation refax to the facility and by The treatment plan for R29's [husband], the person we epresentative, three times for e we have not received a one other than [husband] is or if their address is not Rose 000 Lovell Ave, Roseville, MN he know. This proposed dental he at this time and [R29] will be tatus and seen when due					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245326	B. WING			06/ <sup>,</sup>	10/2016
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ROSE OI	SHARON MANOR				1000 LOVELL AVENUE ROSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 412 F 441 SS=D	Interview on 6/8/16 indicated she had r Apple Tree Coon R surveyor request, A refaxed the informa showed the origina On 6/8/16 at 11:14 verified R29's medi dental visit or appoint stated, "My expecta from Apple Tree Co be writing on the re when is received an keeping track of tha On 6/8/16 at 3:11 p stated R29 is curre funding, that includ and transportation Policy and procedu REFERRAL TO, da The social services the assist and/or co not limited to, the for services. Emergent Appointments. Tran office. Prompt refer indicated, "1. Deter the contracted dent the center. 2. Ident routine services tha to: Inspection of or annual) Dental radi Fillings (new and re 483.65 INFECTION	at 10:03 a.m.,the HUC not received a fax from the apids dental on 3/16/16. On apple Tree Coon Rapids attion to the facility, which al fax was sent on 3/16/16. a.m. with director of nursing cal records lacked evidence of intment in last 6 months and ation is when we get referral bon Rapids dental, staff should ferral that someone noted it nd scheduled. We should be at." .m. social services director ntly receiving Medicaid es assistant with appointments arrangements. re title DENTAL SERVICES - ated July 2015, direct staff, " or such as, but not limited to, bordinate services such as, but collowing: Routine dental cy dental services. nsportation to and from the trals." The policy also mine/scheduled the dates for tal services to be available at ify those residents who need at include, but are not limited al cavity (new admission or ographs. Dental cleaning. epairs)" N CONTROL, PREVENT		441			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245326	B. WING			06/ <sup>,</sup>	10/2016
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
ROSE O	SHARON MANOR						
				R	OSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<b>(</b>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	The facility must es Infection Control Pr safe, sanitary and o to help prevent the of disease and infect (a) Infection Contro The facility must es Program under whit (1) Investigates, col- in the facility; (2) Decides what pr should be applied to (3) Maintains a reco actions related to in (b) Preventing Spre (1) When the Infect determines that a re- prevent the spread isolate the resident (2) The facility mus communicable dise from direct contact direct contact will tr (3) The facility mus hands after each di hand washing is inc professional practic (c) Linens	tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction. I Program tablish an Infection Control ch it - ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective ifections. and of Infection ion Control Program esident needs isolation to of infection, the facility must t prohibit employees with a tase or infected skin lesions with residents or their food, if ansmit the disease. t require staff to wash their rect resident contact for which dicated by accepted as.	F 4	41		l educationiques, includir g garding tion cor l glovin random rol wee for 3 tracked API reas of	ng ntrol g kly
		ndle, store, process and as to prevent the spread of			Alleged date of compliance: Ju	ly 20, 2	016.

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		AND HUMAN SERVICES				FORM	06/30/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245326	B. WING	i		06/	10/2016
NAME OF	PROVIDER OR SUPPLIER	• • • • • • • • • • • • • • • • • • •			STREET ADDRESS, CITY, STATE, ZIP CODE		
ROSE O	F SHARON MANOR				1000 LOVELL AVENUE ROSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 441	by: Based on observa review the facility fa to prevent the spre handwashing for 1 observed for handw Findings include: During observation 8:05 a.m., nursing room and without v sanitizing gel, donr nightstand, remove then went into the l urinal to assist R10 was incontinence pad in gloves and without the room. NA-A ret did not wash hands a pair of gloves an closets looking for R105's gripper stor bed, assisted R105 bed. NA-A placed t and walked R105 i and was positioned same gloves, NA-A water faucet and p back, underarms a gloves, disposed o obtained soap and seconds, and turne using a paper towe gloves from the be room to assist. NA	age 50 NT is not met as evidenced tion, interview and document ailed to implement procedures ad of infection during of 1 residents (R105) washing during cares. of morning cares on 6/8/16, at assistant (NA)-A came to the vashing hands or using ned a pair of gloves from the ed R105's incontinence brief, bathroom (BR) to obtain a 05 with using the urinal. R105 urine in the brief and on the n the bed. NA-A removed the washing/sanitizing hands left urned to the room at 8:20 a.m., s or use sanitizing gel, donned d proceeded to go through morning clothing. NA-A put on ckings, raised the head of the 5 to sit up on the side of the the transfer belt around R105 nto the BR without difficulty d on the toilet. Wearing the A wet the wash cloth under the roceeded to wash R105's and groin areas. NA-A removed f in the trash receptacle, washed hands for ten ed off the water faucet without el. NA-A donned a pair of dside stand. NA-C came to the -C did not wash/sanitize hands of gloves. NA-C obtained a		441			

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245326	B. WING			06/ <sup>,</sup>	10/2016
NAME OF	PROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
				1	000 LOVELL AVENUE		
KUSE U	F SHARON MANOR			F	ROSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	while sitting on the of water. There was removed gloves, wa did not use a paper off, and left the root incontinence brief w room to get the righ returned with the br proceeded to provid R105. NA-C adjuste pants for R105. The putting around R10 the same gloves us cleansing. NA-C re hands for thirteen s and washed hands turned the faucet of Initially R105 starte tired and NA-A took NA-A removed the seconds and retriev the bedside. NA-A partial with toothpa: NA-A removed the hands, put away the R105 out to the din On 6/8/16, at 9:29 a NA-A putting R105 donned gloves with to assist R105 into both nursing assists the room without w When interviewed on NA-C and NA-D we	er and assisted to dress R105 toilet. R105 asked for a drink is none in the room so NA-A ashed hands for six seconds, towel to turn the water on or in to get a cup and straw. The vas too big so NA-A left the nt size brief. At 8:27 a.m. NA-A rief and donned gloves. NA-C de perineal cleansing for ed the brief and pulled up the en taking the transfer belt and 5 for transfer while wearing sed to perform perineal moved gloves and washed seconds. NA-A removed gloves for eleven seconds and ff without using paper towels. d to shave self but became c over. After finishing shaving, gloves, washed hands for ten ved the partial denture from donned gloves, brushed the ste and put into R105's mouth. gloves and did not wash e supplies and transported	F 4	41			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245326       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) D         NAME OF PROVIDER OR SUPPLIER ROSE OF SHARON MANOR       245326       B. WING       0         NAME OF PROVIDER OR SUPPLIER ROSE OF SHARON MANOR       STREET ADDRESS, CITY, STATE, ZIP CODE 1000 LOVELL AVENUE ROSEVILLE, MN 55113       0         (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)         F 441       Continued From page 52 three acknowledged the faucet was to be turned off using a clean paper towel after handwashing. The NA's verified they did not use sanitizing gel when assisting with R105's cares earlier.       F 441       F 441         Document review the facility policy dated, July 2015, titled, Hand Hygiene-Plain Soap and Water       F 441       F 441			AND HUMAN SERVICES				FORM	06/30/2016 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         1000 LOVELL AVENUE         ROSE OF SHARON MANOR         (X4) ID         PREFIX       SUMMARY STATEMENT OF DEFICIENCIES         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES         (EACH DEFICIENCY MUST BE PRECEDED BY FULL       ID         REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX         TAG       Continued From page 52         three acknowledged the faucet was to be turned off using a clean paper towel after handwashing. The NA's verified they did not use sanitizing gel when assisting with R105's cares earlier.         Document review the facility policy dated, July 2015, titled, Hand Hygiene-Plain Soap and Water	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         ROSE OF SHARON MANOR       1000 LOVELL AVENUE         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL         TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL         REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX         F 441       Continued From page 52       F 441         three acknowledged the faucet was to be turned off using a clean paper towel after handwashing. The NA's verified they did not use sanitizing gel when assisting with R105's cares earlier.       F 441         Document review the facility policy dated, July 2015, titled, Hand Hygiene-Plain Soap and Water       July			245326	B. WING	)		06/	10/2016
ROSE OF SHARON MANOR(X4) ID PREFIX TAGSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)ID PREFIX PREFIX TAGPROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE 	NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	,	
PREFIX TAG(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAG(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)F 441Continued From page 52 three acknowledged the faucet was to be turned off using a clean paper towel after handwashing. The NA's verified they did not use sanitizing gel when assisting with R105's cares earlier.F 441Document review the facility policy dated, July 2015, titled, Hand Hygiene-Plain Soap and WaterDocument review the facility policy dated, July 2015, titled, Hand Hygiene-Plain Soap and WaterF 441	ROSE OF	F SHARON MANOR						
three acknowledged the faucet was to be turned off using a clean paper towel after handwashing. The NA's verified they did not use sanitizing gel when assisting with R105's cares earlier. Document review the facility policy dated, July 2015, titled, Hand Hygiene-Plain Soap and Water	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	) BE	(X5) COMPLETION DATE
Handwashing, directed to thoroughly distribute the scap over the entire area of the wrists, work suds between fingers, rub fingertips in palm of opposite hand and to rub hands together vigorously for 15-20 seconds generating friction on all surfaces of the hands and fingers. Rinse hands thoroughly, dry hands with paper towel and turn faucets off with the paper towel.	F 441	three acknowledge off using a clean pa The NA's verified th when assisting with Document review th 2015, titled, Hand H Handwashing, direc the soap over the e suds between finge opposite hand and vigorously for 15-20 on all surfaces of th hands thoroughly, o	d the faucet was to be turned aper towel after handwashing. hey did not use sanitizing gel a R105's cares earlier. he facility policy dated, July Hygiene-Plain Soap and Water cted to thoroughly distribute entire area of the wrists, work ers, rub fingertips in palm of to rub hands together 0 seconds generating friction he hands and fingers. Rinse dry hands with paper towel and h the paper towel.	F	441			

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

T5326024

PRINTED: 07/18/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG 01 - MAIN BUILDING 0102		E SURVEY PLETED
		245326	B. WING		06/	07/2016
	PROVIDER OR SUPPLIER F SHARON MANOR			STREET ADDRESS, CITY, STATE, ZIP COD 1000 LOVELL AVENUE ROSEVILLE, MN 55113	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	TS	K 00	00		
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM USED AS VERIFIC UPON RECEIPT C ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CC REGULATIONS H/ ACCORDANCE W A Life Safety Code Minnesota Departm time of this survey, found not in substa requirements for pa Medicare/Medicaid 483.70(a), Life Saf edition of National (NFPA) Standard 1 Chapter 19 Existing HEALTHCARE FIF STATE FIRE MAR 445 MINNESOTA ST. PAUL, MN 551	MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION. Survey was conducted by the nent of Public Safety. At the Rose of Sharon Manor was antial compliance with the articipation in at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 101, Life Safety Code (LSC), g Health Care. RE INSPECTIONS SHAL DIVISION STREET, SUITE 145 101-5145		EPC	C	
	Marian.Whitney@s Angela.Kappenma				]	
ABORATOR		DER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE	TITLE		(X6) DATE

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

OLIVILI	TO FUR MEDICARE	& MEDICAID SERVICES			1	0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	ECONSTRUCTION 1 - MAIN BUILDING 0102		E SURVEY PLETED
		245326	B. WING		06/	07/2016
NAME OF I	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
ROSE O	F SHARON MANOR			00 LOVELL AVENUE DSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
K 000	Continued From pa DEFICIENCY MUS FOLLOWING INF	T INCLUDE ALL OF THE	K 000			
	to correct the defic			20		
	3. The name and/or responsible for corprevent a reoccurr Rose of Sharon Mano basement. The different times. The constructed in 196 Type II(222) constr was constructed to determined to be or Because the origin are of the same typ was surveyed as o The building is fully has a fire alarm sy the corridors and s	/ fire sprinklered. The facility stem with smoke detection in paces open to the corridors			52	
K 018 SS=E	notification. The fa and had a census The requirement a NOT MET as evide NFPA 101 LIFE SA Doors protecting c required enclosure hazardous areas s as those construct core wood, or capa	or automatic fire department cility has a capacity of 63 beds of 53 at the time of the survey. t 42 CFR, Subpart 483.70(a) is enced by: AFETY CODE STANDARD orridor openings in other than is of vertical openings, exits, or hall be substantial doors, such ed of 13/4 inch solid-bonded able of resisting fire for at least ance between bottom of door	K 018	5		7/20/16

Event ID: LCV721

Facility ID: 00126

If continuation sheet Page 2 of 12

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

A. BOILDING OF FINALIN DOLEDING OF 2       245326     B. WING     O6/07/2016       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       ROSE OF SHARON MANOR     1000 LOVELL AVENUE       ROSEVILLE, MN 55113     ROSEVILLE, MN 55113		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
NAME OF PROVIDER OR SUPPLIE         STREET ADDRESS, CITY. STATE, ZIP CODE         ODITION           ROSE OF SHARON MANOR         STREET ADDRESS, CITY. STATE, ZIP CODE         1000 LOVELL AVENUE         Control         1000 LOVELL AVENUE         10000 LOVELLAVENUE AVENUE AVENUE AVENUE AVENUE AVENUE AVENUE AVENUE A		CONNECTION	BERTH IS THOM HOWDER.	A. BUILDING 01 - MAIN BUILDING 0102			
ROSE OF SHARON MANOR       1000 LOVELL AVENUE ROSE/LF AVENUE ROSE/LE, MN 55113         PHE/EX REGULATORY OF LSC IDENTIFYING INFORMATION)       Image: Construct of the second should be cross-references of the second performance of the second should be cross-references of the second performance second should be provided with a means suitable for keeping the door closed Dutch doors shall be provided with a means suitable for keeping the door closed. Dutch doors medial pi3.63.63 ere permitted. Door frames shall be labeled and made of steel or other materialia in compliance with 6.2.3.2.1. Roller latches are prohibited by CrMS regulations in all health care facilities. 19.3.6.3       K018 Rooms S8, E1 and E7 have been adjusted for positive latch. Director of maintenance will audit document all unit doors quarterly for positive latch. Director of section 19.3.6.3, they did not fit tight in the frame or latch. This deficient practice could affect the safety of approximately 45 of 63 residents and an undetermined number of staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable.       K018 Rooms S8, E1 and E7 have been replaced to comply with code requirements.         Findings include: On the facility tour between 0830 and 1330 on S0/7/2016 observations revealed that the following room doors did not positive latch and replaced to comply with code areas do not meet code of corridor doors. The deficient practice was observed by the Maintenance Supervisor (TB).       K020       G/30/16			245326	B. WING			07/2016
Might Too       Teach DEPRICENCY MUST BE PRECEDED BY FULL REQUERTORY OR LSC IDENTIFYING INFORMATION)       PREFIX Too       Cach Connection Content Action MHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEPICENCY)       COMMENTS DEPICENCY)         K 018       Continued From page 2 and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Door shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door fames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3       K018 Rooms S8, E1 and E7 have been adjusted for positive latch. Director of Maintenance has reviewed all other doors on units for positive latch. Director of Maintenance has reviewed all other doors on units for positive latch. Director of Maintenance will add tocument all unit doors quartery for positive latch. Director of Maintenance will add to comment all unit doors quartery for positive latch and report to the safety committee. Closet doors at the end of the corridor have been requirements.         Findings include: On the facility tour between 0830 and 1330 on 5/07/2016 observations revealed that the following room doors atd not positively latch: Room S8, E1, and E7.       K 020       K 020         K 020       NFPA 101 LIFE SAFETY CODE STANDARD       K 020       6/30/16					1000 LOVELL AVENUE	E	
and floor covering is not exceeding 1 inch. Doors in fully septinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3 & are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on the observation and staff interview, the facility had several corridor doors that did not meet the requirements of NFPA 101 LSC (00) Section 19.3.6.3. they did not fit tight in the frame or latch. This deficient practice could affect the safety of approximately 45 of 63 residents and an undetermined number of staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On the facility tour between 0830 and 1330 on 5/07/2016 observations revealed that the following room doors did not positive latch: Room S8, E1, and E7. Closet doors at ends of the halls in the shower areas do not meet code of corridor doors. The deficient practice was observed by the Maintenance Supervisor (TB). K 020 NFPA 101 LIFE SAFETY CODE STANDARD K 020	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP	OULD BE	COMPLETIO
K 020 NFPA 101 LIFE SAFETY CODE STANDARD K 020 6/30/16 SS=D	K 018	and floor covering i in fully sprinklered required to resist the no impediment to to open devices that re- pushed or pulled all provided with a med door closed. Dutch permitted. Door fra- made of steel or ot with 8.2.3.2.1. Rolf CMS regulations in 19.3.6.3 This STANDARD is Based on the obset facility had several meet the requirem Section 19.3.6.3, the or latch. This defice safety of approxim- undetermined num- smoke from a fire va- access corridors me Findings include: On the facility tour 5/07/2016 observa- following room door Room S8, E1, and Closet doors at en- areas do not meet The deficient pract	s not exceeding 1 inch. Doors smoke compartments are only ne passage of smoke. There is he closing of the doors. Hold release when the door is re permitted. Doors shall be ans suitable for keeping the doors meeting 19.3.6.3.6 are mes shall be labeled and her materials in compliance er latches are prohibited by all health care facilities. is not met as evidenced by: ervation and staff interview, the corridor doors that did not ents of NFPA 101 LSC (00) ney did not fit tight in the frame tient practice could affect the ately 45 of 63 residents and an ber of staff and visitors, if were allowed to enter the exit taking it untenable. between 0830 and 1330 on tions revealed that the ors did not positively latch: E7. ds of the halls in the shower code of corridor doors. ice was observed by the	K O	K018 Rooms S8, E1 and E7 adjusted for positive latch. Di Maintenance has reviewed all on units for positive latch. Dir Maintenance will audit docum doors quarterly for positive lat report to the safety committee doors at the end of the corridor replaced to comply with code	rector of other doors ector of ent all unit ch and c. Closet	
		NFPA 101 LIFE SA	FETY CODE STANDARD	КO	20		6/30/16

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LCV721

Facility ID: 00126

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - MAIN BUILDING 0102 245326 B. WING 06/07/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1000 LOVELL AVENUE ROSE OF SHARON MANOR** ROSEVILLE, MN 55113 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION)** CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 020 Continued From page 3 K 020 shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5, 8.2.5.6, 19.3.1.1 This STANDARD is not met as evidenced by: K020 The penetration in the elevator Observations revealed that pipes penetrating the room has been properly sealed to meet ceiling floor assembly were not sealed in accordance with NFPA 101 "The Life Safety requirements. Director of Maintenance will review all contrator work to ensure any Code" 2000 edition section 19.3.1.1. This and all penetrations created are properly deficient practice could allow the products of sealed upon completion of any work. combustion to travel vertically throughout the building, which will negatively impact all the residents, visitors and staff of the facility. Findings Include: During the facility tour on 06/07/2016, between 0830 and 1330 it was observed that a pipe penetration through the ceiling/floor assembly are located in the elevator equipment room were sealed with spray foam. . This was verified by Maintenance Supervisor (TB) during the facility tour and at the exit conference. K 025 NFPA 101 LIFE SAFETY CODE STANDARD 6/30/16 K 025 SS=F Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the K025 Penetrations above the smoke bariiers ceilings in South and West hall facility failed to maintain smoke barrier walls in has been properly sealed on both sides of accordance with the following requirements of the smoke barrier. The penetration above 2000 NFPA 101, Section 19.3.7.3, and 8.3.4.1. ceiling leading to therapy wing has been The deficient practice could affect 45 of the 63

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PRINTED: 07/18/2016

TATEMENT	OF DEFICIENCIES	KEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:			X3) DATE	
	I CONNECTION		A BUILDING	01 - MAIN BUILDING 0102		
		245326	B. WING		06/0	7/2016
	PROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 000 LOVELL AVENUE ROSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
K 025	Continued From pa	age 4	K 025			
	patients and an un and visitors.	determined amount of staff		properly sealed. Director of Main will review all contrator work to er and all penetrations created are p	nsure any	
	Findings include:			sealed upon completion of any w	ork.	
	6/07/2016 observa	between 0830 and 1330 on tions revealed that smoke rations at the following				
	Above ceiling at the	e smoke doors in South Hall e smoke doors in West Hall n the wall leading to Therapy				
	The penetrations w both sides of the si	vill all need to be sealed on moke barrier.				
	Director of Environ	ice was observed by the mental Services (EA).				
K 034 SS=E	Stairways and smo exits are in accord 18.2.2.4, 19.2.2.3,	AFETY CODE STANDARD okeproof enclosures used as ance with 7.2. 18.2.2.3, 19.2.2.4 is not met as evidenced by:	K 034			6/30/16
	Based on observa facility has failed to unobstructed exit s NFPA 101 Life Saf This deficient prac- use of the exit stain delay needed staff	itions and staff interview, the omaintain a clear and stairway in accordance with ety Code (2000) section 7.2.2. tice could negatively affect the rway used by staff that would assistance to residents and t of an emergency.		K034 All equipment stored in bot of the exit stairwell has been rem Director of Maintenance and Environmental Services Director weekly rounds will ensure no equ stored in either level of the stairw	oved. during ipment is	
	Findings include:	······································				

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Event ID: LCV721

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 0102 245326 B. WING 06/07/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1000 LOVELL AVENUE** ROSE OF SHARON MANOR ROSEVILLE, MN 55113 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION)** CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 034 Continued From page 5 K 034 06/07/2016, It was observed, that there were several carts, floor scrubbing machines, batteries and battery chargers, and other equipment being stored in both levels of the exit stairwell. This deficient practice is restricting the exit capacity and the capability for this stairwell as a required egress. This deficient practice was verified by the Maintenance Supervisor (TB). 6/30/16 K 046 NFPA 101 LIFE SAFETY CODE STANDARD K 046 SS=E Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. This STANDARD is not met as evidenced by: K046 Emergency backup exit lighting has Based on observations and an interview with been tested and documented. Director of staff, the facility has failed to ensure that Maintenance shall test and document all emergency lighting has been tested in battery backup emergency lights monthly accordance with NFPA LSC (00) Section 7.9.3, and report monthly to safety Committee. and 19.2.9.1. This deficient practice could effect all residents, staff and visitors in the event of an emergency evacuation during a power outage. Findings include: On facility tour between 0830 to 1330 on 06/07/2016, during the review of available emergency battery back up exit lighting maintenance documentation and interview with the Maintenance Supervisor (TB) revealed that the facility could not provide any documentation verifying that the battery backup emergency lights had been tested monthly or annually. This deficient practices were confirmed by the Maintenance Supervisor (TB) at the time of discovery.

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#### PRINTED: 07/18/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BUILDING 0102 B. WING 245326 06/07/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1000 LOVELL AVENUE ROSE OF SHARON MANOR** ROSEVILLE, MN 55113 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE **REGULATORY OR LSC IDENTIFYING INFORMATION)** TAG TAG DEFICIENCY) 6/30/16 K 050 NFPA 101 LIFE SAFETY CODE STANDARD K 050 SS=F Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: K050 Fire drills shall be varied during all Based on review of reports, records and shifts. Director of Maintenance will interview., it was determined that the facility failed ensure compliance and report to the to conduct fire drills in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice Safety Committee monthly. could affect how staff react in the event of a fire. Findings include: On facility tour between 0830 and 1330 on 06/07/2016, based on review of available documentation it was revealed that fire drills were not varied throughout the shift during the Morning shift. All drills on the first shift for the 1st guarter of 2016 and 2nd and 3rd guarters of 2016 were conducted between 1300 and 1315. This deficient practice was confirmed by the facility Maintenance Supervisor (TB) at the time of discovery. 6/30/16 K 052 K 052 NFPA 101 LIFE SAFETY CODE STANDARD SS=F A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily

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		& MEDICAID SERVICES	r			. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	IPLE CONSTRUCTION NG <b>01 - MAIN BUILDING 0102</b>		TE SURVEY MPLETED
		245326	B. WING		06	/07/2016
NAME OF 1	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	F SHARON MANOR			1000 LOVELL AVENUE ROSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC	OULD BE	(X5) COMPLETIO DATE
	maintenance and to applicable requiren 9.6.1.4, 9.6.1.7, This STANDARD i Based on observa failed to maintain th accordance with NI Section 9.6 and Ch and NFPA 72 (1999 7-5.2.2 and, Table could adversely aff FINDINGS INCLUE On 06/07/2016 bet performing the reco documentation it w was not being teste This finding was co Supervisor (TB). NFPA 101 LIFE SA Where required by facilities shall be pr approved, supervis in accordance with systems are equip switches which are the building fire ala construction, altern shall be permitted to protection in specifi regulations prohibit NPFA 13	em shall have an approved esting program complying with hent of NFPA 70 and 72. s not met as evidenced by: tion and interview, the facility he building fire alarm system in FPA 101 (00) Chapter 9, hapter 19, Section 19.3.4.1, e edition) Sections 7-3.2 and 7-3.1. This deficient practice ect 105 of 105 residents. DE: ween 0830 and 1330, while ord review of available as observed that the DACT ed Monthly. onfirmed with the Maintenance AFETY CODE STANDARD section 19.1.6, Health care rotected throughout by an section 9.7. Required sprinkler bed with water flow and tamper e electrically interconnected to rm. In Type I and II native protection measures to be substituted for sprinkler fic areas where State or local t sprinklers. 19.3.5, 19.3.5.1,	К 0	52 K052 The DACT is tested and documented monthly. The Dire Maintenance will test and docu report monthly to The Safety C	ment and	7/8/16
	This STANDARD Where required by Life Safety code He	is not met as evidenced by: / section 19.1.6 of the 2000 ealth care faclities shall be out by an approved, supervised		k056 The Director of Maintena been able to confirm the eleva pits is properly sprinkled. Direc	or shaft	

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	OF DEFICIENCIES	& MEDICAID SERVICES		PLE CONSTRUCTION		0938-039 E SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:		G 01 - MAIN BUILDING 0102		PLETED
		245326	B. WING		06/	07/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
ROSE O	F SHARON MANOR			1000 LOVELL AVENUE ROSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 056	Continued From pa	age 8	K 056	3		
	automatic sprinkler section 9.7	system in accordance with		Maintenance shall maintain documentation to verify compli- dumoster storage area has be		
	06/07/2016 the fac	acility was unable to verify that t/pit was properly sprinklered.				
	The dumpster is be with a ceiling that i	eing stored in an outdoor area s not sprinklered.				
K 062	Maintenance Supe	ice was observed by the rvisor (TB) . \FETY CODE STANDARD	K 062	2	2	7/6/16
SS=C	Required automati continuously maint condition and are i	c sprinkler systems are ained in reliable operating nspected and tested 7.6, 4.6.12, NFPA 13, NFPA 25,				
	Based on observa complete automati being maintained i	is not met as evidenced by: tion and interview, the c fire sprinkler system is not n accordance with NFPA .7. This deficient practice could		K062 The escutcheon plates on sprinkler heads outside the kitche leading to the service area next t cupboard space has been install sidewall type pendants have bee	chen door (t to the alled. Two	
	06/07/2016, obser sprinkler head esc	ween 0830 and 1330 on vation revealed that the utcheon plates on sprinkler ig in the following areas:		Director of Maintenance will re report monthly to the Safety C	view and	
	area next to the cu	n door leading to the service pboard space. e smoke barrier doors.		31		
	Also, the spare spi sidewall type pend	inkler heads box is missing 2 ants.	n 11 1			
	This deficient prac	tice was verified by the				

#### PRINTED: 07/18/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BUILDING 0102 245326 B. WING 06/07/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1000 LOVELL AVENUE** ROSE OF SHARON MANOR ROSEVILLE, MN 55113 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 062 Continued From page 9 K 062 Maintenance Supervisor (TB). 6/30/16 K 064 NFPA 101 LIFE SAFETY CODE STANDARD K 064 SS=B Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 This STANDARD is not met as evidenced by: k064 The fire extinguisher located at the Based on observation and staff interview, it was nurses station is no longer blocked. determined that the facility failed to maintain Director of Maintenance will audit and portable fire extinguisher in accordance with document during daily rounds. Findings NFPA 101-2000 edition, Section 9.7.4.1 and NFPA 10. This deficient practice could affect 30 will be reported monthly to the Safety Committee. out of 63 residents. Findings include: On facility tour between 0830 and 1330 on 06/07/2016, observation revealed that the fire extinguisher located at the nurses station was being blocked by a cart. This deficient practice was confirmed by the Maintenance Supervisor (TB). K 076 6/30/16 K 076 NFPA 101 LIFE SAFETY CODE STANDARD SS=D Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4

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ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	l ` '	E CONSTRUCTION		SURVEY
ID PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01 - MAIN BUILDING 0102		
		245326	B. WING		06/0	7/2016
IAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
	F SHARON MANOR			000 LOVELL AVENUE ROSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
K 076	Continued From pa	ane 10	K 076			
11 07 0		is not met as evidenced by:	1010			
	Based on observa	tion and staff interview, the		K076 The second floor oxygen ro		
		medical gas cylinders in a formance with NFPA 99 (1999	ł.	longer houses intermingled empty oxygen containers. Director of	and full	
		-3.5.2.2 (2) and 8-3.1.11.2.		Maintenance will audit compliance	e once a	
	This deficient prac	tice could effect 40 out of 63		week and document. Findings wi reported monthly to the Safety	ll be	
	residents			Committee.		
	FINDINGS INCLU	DE:				
		ween 0830 and 1330 on				
		vation revealed that the 2nd ge room found numerous				
		cylinders intermingled.				
	This deficient prac	tice was confirmed by the				
		ervisor (TB) at the time of this				
K 144	discovery.	FETY CODE STANDARD	K 144			6/30/16
SS=C	1		1			
		ted weekly and exercised ninutes per month and shall be				
		NFPA 99 and NFPA 110.				
	1	NFPA 99), Chapter 6 (NFPA				
	110) This STANDARD	is not met as evidenced by:				
		of records and interview, the		K144 Documentation for the min		
		intain the emergency generator		minute cool down period for the g		
		the requirements of NFPA 110 NFPA 99 - 1999 edition,		is being maintained. The Directo Maintenance will maintain docum		
		This deficient practice could		and report monthly to the Safety		
	affect the safety of	all patients, staff and visitors.		Committee.		
	Findings include:					
	On facility tour bet	ween 0830 and 1330 on				
	06/07/2016, based	l on review of available				
	documentation it w documentation for	as revealed that there was no				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LCV721

Facility ID: 00126

If continuation sheet Page 11 of 12

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG <b>01 - MAIN BUILDING 0102</b>	(X3) DATE SURVEY COMPLETED
		245326	B. WING		06/07/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 LOVELL AVENUE ROSEVILLE, MN 55113	·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE COMPLETION
	when testing the ge This deficient pract Maintenance Super	minute cool down period enerator. ice was verified by the rvisor (TB).	K 1		0/00/40
K 147 SS=D	Electrical wiring and accordance with Na (NFPA 99) 18.9.1, This STANDARD i Based on observat facility failed to mai accordance with NI Code this deficient affect the safety of Findings include: On the facility tour 06/07/2016 observa a grounding plug bi Executive Director	s not met as evidenced by: tion and staff interview the ntain electrical devices in FPA 70 (99), National Electrical practice could negatively staff and visitors. between 0830 and 1330 on ations revealed that there was roken off in an outlet in the s office.	K 1	47 K147 The outlet in the Executive Direcor's office has been repaired Broken electrical outlets will be re immediately upon identification b Director of Maintenance.	d. epaired
	The deficient practi Maintenance Supe	ice was observed by the rvisor (TB).			

FORM CMS-2567(02-99) Previous Versions Obsolete

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNIFE AND NEE	AH "A" FORM
FOR SNFs AND NFs       245326       B. WING	E SURVEY
245326     B. WING	MPLETE:
ID       1000 LOVELLAVENUE         ROSE OF SHARON MANOR       1000 LOVELLAVENUE         ID       PREFIX         TAG       SUMMARY STATEMENT OF DEFICIENCIES         K 038       NFPA 101 LIFE SAFETY CODE STANDARD         Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1.         19.2.1       This STANDARD is not met as evidenced by:         Based on observation and interview, the facility failed to provide and maintain the vertical opening protection required by NFPA 101 - 2000 edition, Sections 19.3.1.1, 8.2.5. This deficient practice could affect 4 of the 63 residents.         Findings include:       On facility tour between 0830 and 1330 on 06/07/2016, it was observed that:         There was a barrel lock on a bathroom door of room W6. This deficiency was fixed during the remainder of the inspection.	/2016
ROSE OF SHARON MANOR       ROSEVILLE, MN         ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES         K 038       NFPA 101 LIFE SAFETY CODE STANDARD         Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1         This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide and maintain the vertical opening protection required by NFPA 101 - 2000 edition, Sections 19.3.1.1, 8.2.5 .This deficient practice could affect 4 of the 63 residents.         Findings include:       On facility tour between 0830 and 1330 on 06/07/2016, it was observed that:         There was a barrel lock on a bathroom door of room W6. This deficiency was fixed during the remainder of the inspection.	
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<ul> <li>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1.</li> <li>19.2.1</li> <li>This STANDARD is not met as evidenced by:</li> <li>Based on observation and interview, the facility failed to provide and maintain the vertical opening protection required by NFPA 101 - 2000 edition, Sections 19.3.1.1, 8.2.5. This deficient practice could affect 4 of the 63 residents.</li> <li>Findings include:</li> <li>On facility tour between 0830 and 1330 on 06/07/2016, it was observed that:</li> <li>There was a barrel lock on a bathroom door of room W6. This deficiency was fixed during the remainder of the inspection.</li> </ul>	
<ul> <li>19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide and maintain the vertical opening protection required by NFPA 101 - 2000 edition, Sections 19.3.1.1, 8.2.5. This deficient practice could affect 4 of the 63 residents.</li> <li>Findings include: On facility tour between 0830 and 1330 on 06/07/2016, it was observed that: There was a barrel lock on a bathroom door of room W6. This deficiency was fixed during the remainder of the inspection.</li> </ul>	
On facility tour between 0830 and 1330 on 06/07/2016, it was observed that: There was a barrel lock on a bathroom door of room W6. This deficiency was fixed during the remainder of the inspection.	
the inspection.	
These deficiencies were observed by the Maintenance Supervisor (TB).	

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



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 6160 June 30, 2016

Mr. Dennis Decosta, Administrator Rose of Sharon Manor 1000 Lovell Avenue Roseville, Minnesota 55113

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5326025 & Complaints Numbered H5326055, H5326057, H5326058, H5326060, H5326061, H5326063, H5326064, & H5326065

Dear Mr. Decosta:

The above facility was surveyed on June 6, 2016 through June 10, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaints numbered H5326055, H5326057, H5326058, H5326060, H5326061, H5326063, H5326064, & H5326065. 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 <u>only a suggestion</u> 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 deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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

Rose of Sharon Manor June 30, 2016 Page 2

"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 after the statement, "This Rule 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.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, P.O. Box 64900, St Paul MN, 55164-0900. 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 Susanne Reuss, Unit Supervisor at (651) 201-3793.

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,

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s) cc: Original - Facility Licensing and Certification File Rose of Sharon Manor June 30, 2016 Page 3

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED
	<u> </u>	00126	B. WING		06/10/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S		00/10/2010
ROSE OF	F SHARON MANOR		ELL AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETE E DATE
2 000	Initial Comments		2 000		
	*****ATTEN	VTION***			
	NH LICENSING (	CORRECTION ORDER			x
	144A.10, this correct pursuant to a survey found that the defici- herein are not corre- not corrected shall to with a schedule of fi- the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Rul When a rule contain comply with any of the lack of compliance. re-inspection with ar result in the assess that was violated dual corrected.	ether a violation has been ompliance with all rule provided at the tag e number indicated below. s several items, failure to ne items will be considered Lack of compliance upon by item of multi-part rule will nent of a fine even if the item ring the initial inspection was			
1	that may result from orders provided that the Department with	earing on any assessments non-compliance with these a written request is made to in 15 days of receipt of a it for non-compliance.			
t c r	Department's staff vi the following correct corrections are comp make a copy of thes	0, 2016, surveyors of this sited the above provider and on orders are issued. When bleted, please sign and date, e orders and mail or email to:		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal softwar Tag numbers have been assigned to Minnesota state statutes/rules for Nursi Homes.	
	Susanne Reuss, Uni	t Supervisor			

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E SURVEY	
		00126	B. WING	06	06/10/2016	
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROSE OF	SHARON MANOR		ELL AVENU			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE	
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this corre pursuant to a surve found that the defic herein are not corre not corrected shall	Minnesota Statute, section ction order has been issued ey. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance fines promulgated by rule of artment of Health.				
	corrected requires requirements of the number and MN Ru When a rule contai comply with any of lack of compliance re-inspection with a result in the assess	hether a violation has been compliance with all a rule provided at the tag ule number indicated below. ns several items, failure to the items will be considered . Lack of compliance upon any item of multi-part rule will sment of a fine even if the item uring the initial inspection was				
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	Department's staff the following correct corrections are con	TS: 10, 2016, surveyors of this visited the above provider and ction orders are issued. When npleted, please sign and date, se orders and mail or email to:		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.		
	Susanne Reuss, U	nit Supervisor				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

6899

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00126	B. WING		06/1	0/2016
	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE JE		0/2010
ROSE OF	SHARON MANOR		LLE, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLE DATE
2 000	Continued From pa	age 1	2 000			
2 565	following complaint H5326055 was fou Rule 4658.0525 Su H5326057 was fou Rule 4658.0520 Su H5326058 was fou St. Statute 626.557 626.557 subd. 4a H5326060 was fou St. Statute 144.651 626.557 subd. 3 an subd. 4a H5326061 was fou St. Statute 144.651 626.557 subd. 3 an subd. 4a H5326064 was fou Rule 4658.0520 Su subd. 3 and MN St H5326065 was fou St. Statute 626.557 626.557 subd. 4a MN Rule 4658.040 Plan of Care; Use Subp. 3. Use. A c	ification Program Division nent of Health ota 55164-0900 urvey, investigations of the s were completed: nd to be substantiated at MN ibp. A. B nd to be substantiated at MN ibp. 1 nd to be substantiated at MN ' subd. 3 and MN St. Statute nd to be substantiated at MN subd. 20; MN St. Statute id MN St. Statute 626.557 nd not to be substantiated at MN subd. 20; MN St. Statute id MN St. Statute 626.557 nd to be substantiated at MN subd. 20; MN St. Statute id MN St. Statute 626.557 nd to be substantiated at MN subd. 20; MN St. Statute id MN St. Statute 626.557 . Statute 626.557 subd. 4a nd to be substantiated at MN ' subd. 3 and MN St. Statute 5 Subp. 3 Comprehensive	2 565	The assigned tag number a far left column entitled "ID The state statute/rule out o listed in the "Summary Stat Deficiencies" column and r Comply" portion of the corr This column also includes ' which are in violation of the after the statement, "This F as evidence by." Following findings are the Suggested Correction and Time period PLEASE DISREGARD THI THE FOURTH COLUMN V STATES, "PROVIDER'S PI CORRECTION." THIS AP FEDERAL DEFICIENCIES WILL APPEAR ON EACH THERE IS NO REQUIREM SUBMIT A PLAN OF CORI VIOLATIONS OF MINNES STATUTES/RULES.	Prefix Tag." f compliance is tement of eplaces the "To ection order. the findings e state statute Rule is not met the surveyors Method of d for Correction. E HEADING OF VHICH LAN OF PLIES TO ONLY. THIS PAGE. IENT TO RECTION FOR	

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COM	PLETED
		00126	B. WING	06/10/2		10/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
ROSE OI	F SHARON MANOR		LE, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 2	2 565			
	by: Based on interview review the facility fa accordance with the care for 1 of 3 reside who required assiss toileting/incontinent hearing accommod	ce care, shaving, oral care and				
	Findings include:					
	"Incontinent" "Goal impairment r/t (rela Integrity Assessme Plan)." The undated form t and Assessment, d "Difficulty starting u dribbling" and "Voic The plan of care do Skin Integrity Asses incontinence, keep Implement an indiv every 2 hours."	e dated 6/7/16, read, : Will be free of skin ted to) incontinence (See Skin nt Prevention and Treatment titled, Bladder Data Collection lirected staff R105 had urine stream" "Post void ding small amounts often." bocument dated 6/7/16, titled, ssment, read, "bladder linen dry and wrinkle free. idualized turning schedule of				
	Incontinence direct necessary care for	ated July 2015, titled Urinary ed staff to provide whenever residents who are incontinent w the skin integrity guideline o	f			
	7:15 a.m. R105 wa off, lying on the left	s observation on 6/8/16, at s observed with bed covers side, wearing an incontinence a brown/tan ring of staining				

	ota Department of He	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		E SURVEY
	I OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
		00126	B. WING		<b>06</b> /	10/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
ROSE O	F SHARON MANOR		ELL AVENUE LE, MN 55113			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE
2 565	on the incontinence calling out with moa faint "Come and he assistant (NA-A) ca asked for a urinal. N holding the urinal in asked to sit up beca lying down. NA-A sa R105 told NA-A "My When interviewed of verified R105 did no prior to NA-A provid NA-A verified the 18 staining on the inco dried ring of urine. I urine stain and wou last offered cares. On 6/8/16, not sure produced a docume specified, which rea {sic} I found [R105] deflated. I plugged flated, and recheck report to [nurse] and not I had done care and [R105] was dry allegation-"[R105] of had removed [R105] there was no bm th During an interview 3:00 p.m. verified F sometime between NA-A provided care verified a dark dryin	a pad in the bed. R105 was ans and every now and again a lp me." At 8:05 a.m. nursing me to the room and R105 NA-A assisted R105 with place. At 8:20 a.m. R105 ause R105 could not urinate at R105 on the side of the bed. y bed is wet." on 6/8/16 at 8:30 a.m. NA-A ot have any morning cares ling the cares at this time. B inch brown/tan ring of ntinence pad looked like a _PN-A was informed of the ld find out when the night shift of the time, the DON ent dated 6/8/16, no time ad, "[R105] was dry at 4am with the bed cord out, bed the bed back in,m it rein {sic} ed [R105] 4-4:30am. I gave d informed her that [R105] did s with [R105] at 4 am rounds, ." Clarification to lid not have stool at 4 am. I 5] brief to check [R105] and ere." with the DON on 6/8/16, at R105 was incontinent of urine 4:00 a.m. and 8:20 a.m. when s. Furthermore the DON ng brown/tan ring of urine ag period of time without being		DEFICIENCY		

STATEMEN	DIA Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00126	B. WING		06/	10/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
ROSE O	F SHARON MANOR		LE, MN 5511			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG	i i	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 565	Continued From pa	ige 4	2 565			
	DON verified the fa	on 6/10/16, at 11:00 a.m. the cility expectation would be to ery two hours for incontinence.				
	Delivery Guide, dire assistance of one v indicated an upper	are dated, 6/4/16, titled, Care ected staff R105 required vith grooming. Oral Care denture and assist of one for as no further direction with				
	at 11:37 a.m. and F been shaved since not receiving oral c always clean shave	view was conducted on 6/7/16, F-C expressed concern had not coming to the facility and was are. F-C expressed R105 was en and would not like having all was currently present.	t			
	another family men expressed concern	ion on 6/7/16, at 3:00 p.m. hber (F-D) was visiting and to this surveyor that R105 hac facial hair and partial plate nouth.	4			
	7:15 a.m. R105 wa off, laying on the lei with moans and eve "Come and help me assistant (NA-A) ca transfer belt, ambu (BR). R105 asked f teeth. NA-A assiste	s observation on 6/8/16, at s observed with bed covers ft side. R105 was calling out ery now and again a faint e." At 8:05 a.m. nursing ame to the room using a a lated R105 to the bathroom for a tooth brush to brush d R105 to the sink. There upplies in the room and NA-A				
	and mouthwash fro NA-C came into the care supplies and r	isin, toothbrush, toothpaste om the storage room. Another e room and searched for oral not finding any left the room. ne room and prepared a				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00126	B. WING		06/	06/10/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
ROSE O	F SHARON MANOR		VELL AVENUE				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 565	Continued From pa	age 5	2 565				
	"Did you find my pa responded "The ha repeated, "Did you explained being off an assignment she R105 had teeth. On 6/8/16, during n 7:15 a.m.,NA-A pro R105's top bedside shave R105. NA-A heavy growth of fac	thpaste. R105 asked NA-A, artial?" to which NA-A ir is long on your face." R105 find my partial?" NA-A for a week and did not have et for R105 so did not know norning cares which started at iduced an electric shaver from e drawer and proceeded to verified there was a very cial hair. R105 expressed shaved and stated, "That's					
	The plan of care da Communication Ca Hearing Aide, Inter	ated 6/7/16, read, Sensory are Plan, Auditory Disturbance, vention Assist to place in ear was no further direction ng aide.					
		s, R105 did not have the ce from 6/8/16, at 8:30 a.m. 10:30 a.m.					
	11:00 a.m. verified shave facial hair ev a day and if a resid	with the DON on 6/10/16, at the facility expectation was to veryday Provide oral care twice ent refused care to inform the roach at another time.					
	The director of nurs review and revise p to ensuring the care resident is followed	THOD OF CORRECTION: sing (DON) or designee could policies and procedures related e plan for each individual I. The director of nursing or velop a system to educate staf					

	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00126	B. WING	B. WING		10/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
ROSE O	F SHARON MANOR		VELL AVENUE LLE, MN 55113			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 565	Continued From pa	ge 6	2 565			
		itoring system to ensure staff as directed by the written plan				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Car	0 Subp. 1 Adequate and re; General	2 830			
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be our possible unless there is a he attending physician that the in in bed or the resident bed.				
	by: Based on documen facility failed to assi 1 of 1 resident (R54 following an acute s occured to R54 whe					
	The findings include	9:				
	According to R54's	Admission Record onset date				

STATEMEN	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
		00100	B. WING			00/40/0040	
		00126			06/	10/2016	
	PROVIDER OR SUPPLIER		DRESS, CITY, ST /ELL AVENUE				
ROSE O	F SHARON MANOR		LE, MN 5511				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	ge 7	2 830				
	dementia with beha contracture unspec disorders, and unsp substance or known quarterly minimum dated 2/20/16 indic as having severe co Document review o 3/8/16, Registered entry for 3/7/16, "ca [NA-B] seen [R54] s alike. Observed [R5 right shoulder. Infor scheduled to be ser when [NP] arrives. resident was fidgetif fidgeted due to sho of the time."	liagnosed with unspecified avioral disturbances, ified hand, delusional becified psychosis not due to a in physiological condition. A data set (MDS) assessment ated R54 had been assessed ognitive impairment. f Progress Notes dated Nurse (RN)-G wrote a late alled to residents room as shoulders do not both seem 54] left shoulder to be off from rmed [NA-B] resident was en by NP would inform NP Nurse held left arm up, ng, was not clear if resident ulder as [R54] fidgeted most					
	dated 3/8/16, identi for 3/7/16, "called to (morning) to see re assessment left sho wasn't sure why. In assistant) that [R54 NP (nurse practition informed about rest in AM (morning) bu	ess Investigation Statement, fied RN-G wrote a late entry o resident's room in AM sident's shoulder. Upon oulder seems different, but I formed CNA (certified nursing -] was scheduled to be seen by her). Nurse will ensure NP is ident's shoulder. Expected NP t [NP] was not here in AM." -A, interviewed 6/15/16, at	,				
	4:30 p.m., reported at lunch time. F-A e had been schedule but F-B was running F-B returned to the R54's face appeared	being at the facility on 3/7/16, explained that F-A and F-B d to meet with social services g late. F-A reported that when facility around 2:00 p.m., ed red and clammy looking. by R54's bedroom door at the					

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		00126	B. WING		06/10/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ROSE O	F SHARON MANOR		VELL AVENUE LE, MN 5511:			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	ige 8	2 830			
	time and F-B told NA-B that R54 looked to be in pain.					
	practitioner (NP) wa regarding R54's left different from the ri around 2:15 p.m. to shoulder X ray. The however, unable to The physician and/ the X-ray delay to d	tted 3/7/16, identified the nurse as notified at 1:15 p.m. t shoulder that looked very ght shoulder. NP arrived o the facility and ordered a left e X ray company was notifed, perform the X-ray until 3/8/16. or NP were not informed of letermine if alternative difications were required to for R54.				
	Investigation Stater 11:00-11:30 a.m. re (NA)-B included: "F uncomfortably acco assistant registered R54's family memb R54 "looks uncomf R54 had a high tem	ntation from a report, Witness ment, from 3/7/16, at eported by nursing assistant Res (resident) was moving ording to NA/R (nursing d)." On 3/7/16, after lunch er expressed concern that ortable" and suggested maybe operature. NA-B took the was noted to be 95.5 degrees				
	(NP)-C documente Note, "Today staff r is diaphoretic, with sustained a skin tea cause unknown. Th	o.m. the nurse practitioner d on a Physician Progress note a change in patient. [R54] out temperature noted. [R54] ar to right forearm today, ney note a left shoulder shaking, skin is dusky."				
	to the facility. Licen reported to nurse p the X-ray that were	a.m., X-ray results were faxed sed practical nurse (LPN-A) ractitioner (NP) the results of electronically signed on . Report identified, "Shoulder 1				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
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AME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
OSE OI	SHARON MANOR		VELL AVENUE LLE, MN 55113				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	age 9	2 830				
	inferiorly dislocated There is no fracture coracoclavicular jo Anterior shoulder of pain cues, If notice A Witness Investig from licensed prace "Resident was note Wednesday mornin be moaning in pain	The humerus is anteriorly and d with respect to the glenoid. e. Acromioclavicular and ints are normal. Conclusion: lislocation. Please monitor for d, report to provider." ation Statement for 3/7/16, tical nurse (LPN)-B included: ed on Monday to be in pain. Or ng the pt (patient) was noted to an order to send pt to the					
	a progress note: "C usually a very good grimacing early in t PRN Tylenol. slept (night)." Review of	specified, RN-I documented in Only taking sips tonight, is I drinker. Resident was the shift-given 680 mg {sic} well the rest of the noc the MAR lacked t the PRN medication had					
		a.m. documentation in the luded: "resident up in chair					
	ambulance to the h R54 at 10:15 a.m. a signs) 97-70-18-18 out-R. shoulder. NI [hospital] ER (eme shoulder dislocatio meet at [hospital]."	a.m. R54 was transported by hospital after LPN-A observed and documented, "v/s (vital 0/68 resident up in chair crying called per order send to rgency room) for ortho L n, [guardian] called she will According to the documented cal blood pressure for R54 was	3				
	NP-C was interview	ved on 6/9/16, at 10:13 a.m.					

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NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, ST	TATE, ZIP CODE		10/2010
ROSE O	F SHARON MANOR		ELL AVENUE LE, MN 5511			
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2 830	Continued From pa	age 10	2 830			
	anterior dislocation where there have to muscle fatigue, but dislocation is due t to the facility. Anoth have dislocated is forward." When interviewed verified witnessing lot of pain." when to 3/9/16, and that no been given prior to R54's current Phys had utilized Acetan (milligrams) caplets since 6/6/14 for pa exceed 4000 mg /2 R54's March 2016 Record (MAR) was R54 was to receive a.m., 12:30 p.m. and documentation for	sician Orders, indicated R54 ninophen (Tylenol) 500 mg s 2 by mouth three times daily in, with directions not to				
	Medication, docum control included: " for you? If no, prov non-interviewable i pain scale." On 3/ documentation was	ument titled March 2016 ientation in a section for pain Is your pain program effective ride pain rating (For residents, utilize Wong-Baker 7/16 that section of s blank indicating no pain				
	Another section of record included: "P	ccurred for the day shift. the March 2016 Medication Please monitor for pain cues. If ." The 3/7/16 documentation				

	It OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ROSEO	F SHARON MANOR		VELL AVENUE LE, MN 5511			
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2 830	Continued From pa	age 11	2 830			
		to indicate whether pain cues nd/or what pain cues may have				
	had Standing Orde 325-650 mg (millig	nysician orders verified R54 rs for "Acetaminophen ram) PO (orally) or Suppository hrs (hours) prn (whenever 100 or discomfort."	/			
	not-verbal signs an unrelieved by order Report to Provider distress or pain un	ded: "Assess for verbal and of symptoms of distress or pair red treatments/medications. signs and symptoms of	ו			
	The director of nurs the assessment pro- experience pain. A ensure the proper a have been implement The results of the a	THOD OF CORRECTION: sing could in-service staff on ocess for residents who an audit could be developed to assessment and interventions ented after each resident pain. audit could be reported to the committee during the quarterly				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
2 840	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 2 B Adequate and re; Clean skin	2 840			

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
	F SHARON MANOR	1000 LO	VELL AVENUE			
		ROSEVIL	LE, MN 5511:	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 840	Continued From pa	ige 12	2 840			
	proper care. The criteria for determining adequate and proper care include:					
	odors. A bathing pl resident's plan of ca condition requires t must be given a co other day and more incontinent resident every two hours, ar following each epis [ 144A.04 Subd. 11 Notwithstanding Mi 4658.0520, an inco checked according written in the resider attending physician interval longer than if competent, or a fa appointed conserva agent of a resident in writing to waive p determining this interval	and freedom from offensive lan must be part of each are. A resident whose hat the resident remain in bed mplete bath at least every e often as indicated. An t must be checked at least ad must receive perineal care ode of incontinence. I. Incontinent residents. nnesota Rules, part ntinent resident must be to a specific time interval ent's care plan. The resident's must authorize in writing any two hours unless the resident amily member or legally ator, guardian, or health care who is not competent, agrees obysician involvement in erval, and this waiver is resident's care plan. ]				
	promptly each time Perineal care includ the perineal area. It to keep the bed dry comfort. Special at skin to prevent irrita types of protectors completely covered contact with the res	hing must be provided the bed or clothing is soiled. des the washing and drying of Pads or diapers must be used and for the resident's ttention must be given to the ation. Rubber, plastic, or other must be kept clean, be I, and not come in direct sident. Soiled linen and moved immediately from revent odors.				

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NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
ROSE OI	F SHARON MANOR		VELL AVENUE LE, MN 55113			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 840	Continued From pa	ge 13	2 840			
	by: Based on observative review, the facility for hygiene care for 1 of sample who required care and shaving. Findings include: R105, during an ob p.m., was in bed por uncovered, fully clo the edge of the mate accumulation of fact interview was attemption	ent is not met as evidenced ion, interview and document ailed to provide personal of 1 resident (R105) in the ed assist from staff for oral servation on 6/6/16, at 5:00 ositioned to the left side, thed, with legs extending over ttress. There was a heavy cial hair/whiskers.When an npted, R105 stated, "let me				
	at 11:37 a.m. and F R105 who had been home two weeks as that R105 had not b the facility, was not eating, was not reco did not understand providing for R105. R105 was always c	view was conducted on 6/7/16, F-C expressed concern about in mentally intact and living at go. F-C expressed concern been shaved since coming to getting out of bed, was not eiving oral care, and the family what services the facility was Furthermore, F-C expressed lean shaven and would not acial hair that was currently				
	another family men expressed concern was in the bed fully	ion on 6/7/16, at 3:00 p.m. nber (F-D) was visiting and to this surveyor that R105 dressed, trying to get out of en shaved of facial hair and ot in R105's mouth.				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		00126	B. WING		06/10/2016	
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, STATE, ZIP CODE			10/2010
ROSE O	F SHARON MANOR		/ELL AVENUE LE, MN 5511:			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 840	Continued From pa	age 14	2 840			
	<ul> <li>7:15 a.m. R105 wa off, laying on the lewith moans and ev "Come and help massistant (NA-A) catransfer belt, ambut (BR). R105 asked teeth. NA-A assister were no oral care shad to retrieve a baand mouthwash from NA-C came into the care supplies and rowith toothbrush with too "Did you find my paresponded "The har repeated, "Did you explained being off an assignment she R105 had teeth.</li> <li>NA-A retrieved the nightstand (in a cup complained of mou R105 stuck out ton cratered, with a com white/red sores.</li> <li>NA-A produced an top bedside drawer R105. NA-A verified growth of facial hai for being shaved at On 6/8/16, at 10:00 nurse (LPN-A) was</li> </ul>	s observation on 6/8/16, at s observed with bed covers ft side. R105 was calling out ery now and again a faint e." At 8:05 a.m. nursing ame to the room using a a lated R105 to the bathroom for a tooth brush to brush ed R105 to the sink. There supplies in the room and NA-A asin, toothbrush, toothpaste om the storage room. Another e room and searched for oral not finding any left the room. he room and prepared a thpaste. R105 asked NA-A, artial?" to which NA-A tir is long on your face." R105 find my partial?" NA-A for a week and did not have bet for R105 so did not know partial upper plate from the p without water). R105 th/tongue being sore. When gue, it was observed to be red, uple areas that appeared electric shaver from R105's r and proceeded to shave d there was a very heavy r. R105 expressed gratitude nd stated, "That's better!"				

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NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
	F SHARON MANOR	1000 LOV	ELL AVENUE				
	F SHANON MANON	ROSEVIL	LE, MN 55113	3			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 840	Continued From pa	ge 15	2 840				
	having a sore mouth/tongue. LPN-A documented in the progress notes, "11:00 a.m. Tongue has red and white patches present. Mouth and lips dry." On 6/8/16, at 12:00 p.m. the director of nursing (DON) was informed that no oral care supplies were available in the bedside.						
	was providing cares oral care provided of brought my own too care with the toothe	a.m. the hospice aide (HA) s. When interviewed regarding on 6/7/16, HA stated, "I othette's and provided the oral ette's because there was no paste supplies in the room."					
	regarding the facilit LPN-A verified oral twice a day and the	on 6/8/16, at 10:00 a.m. y expectation for oral care, cares were to be provided hospice services were to be the services of the facility.					
	RN-D explained that completed on R105 6/10/16, according (MDS) schedule, ar	on 6/10/16 at 10:00 a.m. with at a mouth exam had not been because R105 was due to the minimum data set and R105 was transferred to family wishes, on 6/10/16 so ere not completed.					
		arding oral care and shaving of ested but not received.					
	11:00 a.m. verified shave facial hair ev a day and if a resid	with the DON on 6/10/16, at the facility expectation was to eryday, provide oral care twice ent refused care to inform the roach at another time.					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
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IAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
ROSE O	F SHARON MANOR		LE, MN 5511			
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2 840	Continued From pa	age 16	2 840			
	The director of nur- and/or revise facilit related to the provi activities of daily liv Responsible perso these policies and provision of ADL se for the individual(s) with supporting door residents could be provision of ADL se could be developed results shared with Assessment & Ass on-going compliant	THOD OF CORRECTION: sing or designee, could review y policies and procedures sion of assistance with ving (ADLs) such as oral care. nnel could be re-educated on procedures. Appropriate ervices could be re-assessed ) identified in the deficiency, cumentation maintained. Othe evaluated for appropriate ervices. An auditing system d and implemented, with the facility's Quality surance committee, to ensure ce. R CORRECTION: Twenty One				
2 910	Incontinence Subp. 5. Incontine have a continuous management to req unnecessary use of comprehensive res home must ensure A. a resident w without an indwellin unless the resident that catheterization B. a resident w receives appropriat prevent urinary trace	5 Subp. 5 A.B Rehab - nce. A nursing home must program of bowel and bladder duce incontinence and the of catheters. Based on the sident assessment, a nursing that: who enters a nursing home ng catheter is not catheterized t's clinical condition indicates was necessary; and ho is incontinent of bladder te treatment and services to ct infections and to restore as der function as possible.	2 910			

	ta Department of He T OF DEFICIENCIES					
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00126		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00100	B. WING			
				06/	10/2016	
	ROVIDER OR SUPPLIER		DRESS, CITY, S <sup>-</sup> /ELL AVENUE			
ROSE OF	SHARON MANOR		LE, MN 5511			
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2 910	Continued From pa	age 17	2 910			
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R105) in the sample, who was identified as incontinent of urine received the necessary care and services to manage incontinence.		5			
	Findings include: R105 was admitted from the hospital to the facility		,			
	care. According to dated 6/8/16, read, h/o (history of) left decreased oral inta of dysphagia. Due pursue hospice wh with diagnosis of C accident). Urology: retention, Pt was no infection) and was has been straight c	b.m. with an order for hospice the physician progress notes "Neurology: Pt with previous basal ganglia stroke and with ake and increase in symptoms to declining function agreed to ich [R105] is now signed up for VA (cerebral vascular Pt with h/o chronic urinary oted to have UTI (urinary tract placed on antibiotics. [R105] cathing twice a day at home."				
	R105 was in bed p	tion on 6/6/16, at 5:00 p.m. ositioned to the left side, othed, with legs extending over ttress.				
	at 11:37 a.m. and F R105 who had bee home two weeks a that R105 was not	view was conducted on 6/7/16, F-C expressed concern about n mentally intact and living at go. F-C expressed concern getting out of bed and the rstand what services the ng for R105.				
nesota D	During an observat	tion on 6/7/16, at 3:00 p.m.				
ATE FORM			<sup>6899</sup> LO	CV711	If continuati	on sheet 18 c

			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED	
		00126	B. WING		06/	06/10/2016
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	•	
ROSE O	F SHARON MANOR		VELL AVENUE LE, MN 55113			
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2 910	Continued From pa	-	2 910			
	expressed concern dressed, trying to g	another family member (F-D) was visiting and expressed concern that R105 was in the bed fully dressed, trying to get out of the bed and turned on the call light for assistance.				
	During a continuous observation on 6/8/16, at 7:15 a.m. R105 was observed with bed covers off, lying on the left side, wearing an incontinence brief and there was a brown/tan ring of staining on the incontinence pad in the bed. R105 was calling out with moans and every now and again a faint "Come and help me." At 8:05 a.m. nursing assistant (NA-A) came to the room and R105					
	asked for a urinal. I holding the urinal ir asked to sit up beck lying down. NA-A si R105 told NA-A "My transfer belt and an bathroom (BR) and toilet. There was a moisture on the inc	NA-A assisted R105 with place. At 8:20 a.m. R105 ause R105 could not urinate at R105 on the side of the bed y bed is wet." NA-A used a nbulated R105 to the l assisted R105 to sit on the 18 inch ring of dark brown/tan ontinence pad in the bed. sounded like a small amount in				
	verified R105 did no prior to NA-A provid NA-A verified the 18 staining on the inco dried ring of urine.	on 6/8/16 at 8:30 a.m. NA-A ot have any morning cares ding the cares at this time. 8 inch brown/tan ring of ontinence pad looked like a LPN-A was informed of the Ild find out when the night shift				
	6/8/16, no time spe was dry at 4am {sic cord out, bed deflat in,m it rein {sic} flat	roduced a document dated cified, which read, "[R105] c} I found [R105] with the bed ted. I plugged the bed back ed, and rechecked [R105] eport to [nurse] and informed				

STATEMENT	a Department of He	(X1) Provider/Supplier/Clia	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00126		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		B. WING		06/10/2016		
NAME OF PF	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
ROSE OF	SHARON MANOR		VELL AVENUE LE, MN 5511:			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETI DATE
	her that [R105] did not I had done cares with [R105] at 4 am rounds, and [R105] was dry." Clarification to allegation-"[R105] did not have stool at 4 am. I had removed [R105] brief to check [R105] and there was no bm there." During an interview with the DON on 6/8/16, at 3:00 p.m. verified R105 was incontinent of urine sometime between 4:00 a.m. and 8:20 a.m. when NA-A provided cares. Furthermore the DON verified a dark drying brown/tan ring of urine would indicate a long period of time without being checked and changed for R105.					
	and Assessment, ir starting urine strea "Voiding small amo The plan of care do Skin Integrity Asses keep linen dry and	titled, Bladder Data Collection ndicated R105 had "Difficulty m" "Post void dribbling" and punts often." ocument dated 6/7/16, titled, ssment,bladder incontinence, wrinkle free. Implement an ng schedule of every 2 hours.				
	Incontinence direct necessary care for	ated July 2015, titled Urinary ed staff to provide whenever residents who are incontinent ow the skin integrity guideline or	f			
1	DON verified the fa	on 6/10/16, at 11:00 a.m. the acility expectation would be to ery two hours for incontinence.				
-     	The facility could re review their policies to include individua incontinence scheo	THOD OF CORRECTION: eview the state requirements, s/procedures and revise them lized toileting/urinary dules/plan/program, the facility				
nesota Dep ATE FORM	partment of Health		6899 LO	CV711	If continuati	on sheet 20 c

	ota Department of He	aith (X1) provider/supplier/clia	(X2) MULTIPLE	E CONSTRUCTION		SUBVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00126			A. BUILDING:		(X3) DATE SURVEY COMPLETED 06/10/2016	
		B. WING				
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ROSE O	F SHARON MANOR		ELL AVENUE LE, MN 5511			
(X4) ID			ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLET DATE
2 910	Continued From pa	ge 20	2 910			
	educate staff on ho maintain an individu incontinence plan fo could then develop system as part of th maintain compliance	assessments and tools and w to assess, implement, and ualized toileting/urinary or all residents. The facility and implement an auditing ne quality assure process to e. R CORRECTION: Twenty-one				
2 920	MN Rule 4658.0525	5 Subp. 6 B Rehab - ADLs	2 920			
	comprehensive res home must ensure B. a resident who activities of daily live	is unable to carry out ing receives the necessary n good nutrition, grooming,				
	by: Based on observati review, the facility fa hygiene care for 1 c	ent is not met as evidenced on, interview and document ailed to provide personal of 1 resident (R105) in the ed assist from staff for oral				
	Findings include:					
	p.m., was in bed po uncovered, fully clo the edge of the mat accumulation of fac	servation on 6/6/16, at 5:00 sitioned to the left side, thed, with legs extending over tress. There was a heavy ial hair/whiskers.When an upted, R105 stated, "let me				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00126	B. WING			10/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ROSE O	F SHARON MANOR		VELL AVENUE			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 920	Continued From pa	age 21	2 920			
	at 11:37 a.m. and F R105 who had bee home two weeks as that R105 had not b the facility, was not eating, was not rec did not understand providing for R105. R105 was always of like having all the fa present. During an observat another family men expressed concern was in the bed fully the bed, had not be partial plate was not During a continuou	s observation on 6/8/16, at				
	7:15 a.m. R105 wa off, laying on the le with moans and ev "Come and help me assistant (NA-A) ca transfer belt, ambu (BR). R105 asked to teeth. NA-A assisted	s observed with bed covers ft side. R105 was calling out ery now and again a faint e." At 8:05 a.m. nursing ame to the room using a a lated R105 to the bathroom for a tooth brush to brush ed R105 to the sink. There				
	had to retrieve a ba and mouthwash fro NA-C came into the care supplies and r NA-A returned to th	supplies in the room and NA-A asin, toothbrush, toothpaste om the storage room. Another e room and searched for oral not finding any left the room. he room and prepared a thpaste. R105 asked NA-A,				
nnesota D	"Did you find my pa responded "The ha	artial?" to which NA-A artial?" to which NA-A ir is long on your face." R105 find my partial?" NA-A				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00126				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		B. WING		06/10/2016		
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ROSE O	F SHARON MANOR		VELL AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	ige 22	2 920			
		for a week and did not have et for R105 so did not know				
	nightstand (in a cup complained of mou R105 stuck out ton	partial upper plate from the o without water). R105 th/tongue being sore. When gue, it was observed to be red uple areas that appeared	,			
	top bedside drawer R105. NA-A verified growth of facial hai	electric shaver from R105's and proceeded to shave d there was a very heavy r. R105 expressed gratitude nd stated, "That's better!"				
	nurse (LPN-A) was complained of havi having a sore mout in the progress not	a.m. the licensed practical informed that R105 had ng trouble swallowing and h/tongue. LPN-A documented es, "11:00 a.m. Tongue has nes present. Mouth and lips	ł			
		p.m. the director of nursing d that no oral care supplies e bedside.				
	was providing care oral care provided brought my own too care with the toothe	a.m. the hospice aide (HA) s. When interviewed regarding on 6/7/16, HA stated, "I othette's and provided the oral ette's because there was no paste supplies in the room."				
	regarding the facilit LPN-A verified oral	on 6/8/16, at 10:00 a.m. y expectation for oral care, cares were to be provided hospice services were to be				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00126	B. WING		06/	06/10/2016	
	PROVIDER OR SUPPLIER	00126	DDRESS, CITY, ST		06/	06/10/2016	
			VELL AVENUE				
RUSE U	F SHARON MANOR	ROSEVII	LLE, MN 55113	3			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 920	Continued From pa	ige 23	2 920				
	above and beyond	the services of the facility.					
	RN-D explained that completed on R105 6/10/16, according (MDS) schedule, at	on 6/10/16 at 10:00 a.m. with at a mouth exam had not been because R105 was due to the minimum data set nd R105 was transferred to family wishes, on 6/10/16 so vere not completed.					
		arding oral care and shaving of ested but not received.	f				
	11:00 a.m. verified shave facial hair ev a day and if a resid	with the DON on 6/10/16, at the facility expectation was to reryday, provide oral care twice ent refused care to inform the roach at another time.	9				
	The director of nurs and revise the polic dental services car provide education t system could be de	THOD OF CORRECTION: sing or designee would review by and procedures related to es and treatment plan and o staff members. A monitoring eveloped to ensure staff are directed and report the results ance committee.	9				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one					
21390	MN Rule 4658.080	0 Subp. 4 A-I Infection Control	21390				
	control program mu procedures which p A. surveillance	and procedures. The infection ust include policies and provide for the following: based on systematic data y nosocomial infections in					

STATEMEN	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00126	B. WING		06/10/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ROSE OI	F SHARON MANOR		VELL AVENUE LE, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21390	control of outbreak C. isolation and reduce risk of trans D. in-service e prevention and com E. a resident h immunization progra defined in part 465 procedures of resid the prevention and F. the develop employee health por practices, including defined in part 465 G. a system for H. a system for products which affe disinfectants, antise incontinence produ I. methods for	r detection, investigation, and s of infectious diseases; d precautions systems to smission of infectious agents; ducation in infection atrol; ealth program including an ram, a tuberculosis program as 58.0810, and policies and dent care practices to assist in treatment of infections; ment and implementation of policies and infection control g a tuberculosis program as 8.0815; or reviewing antibiotic use; r review and evaluation of ect infection control, such as eptics, gloves, and	21390			
	by: Based on observat review the facility fa to prevent the spre handwashing for 1 observed for handw	ent is not met as evidenced ion, interview and document ailed to implement procedures ad of infection during of 1 residents (R105) washing during cares.				
	8:05 a.m., nursing room and without v sanitizing gel, donr	of morning cares on 6/8/16, a assistant (NA)-A came to the vashing hands or using ned a pair of gloves from the ed R105's incontinence brief,	t			

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00126	_	B. WING		06/10/2016	
					06/	10/2010	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, ST /ELL AVENUE				
ROSE O	F SHARON MANOR		LE, MN 5511				
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (		(X5)	
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE	
21390	Continued From pa	ge 25	21390				
		pathroom (BR) to obtain a					
		5 with using the urinal. R105					
		urine in the brief and on the the bed. NA-A removed the					
		washing/sanitizing hands left					
	the room. NA-A returned to the room at 8:20 a.m.,		,				
	did not wash hands or use sanitizing gel, donned						
		d proceeded to go through					
		morning clothing. NA-A put on kings, raised the head of the					
		to sit up on the side of the					
		he transfer belt around R105					
		nto the BR without difficulty					
		on the toilet. Wearing the					
		wet the wash cloth under the					
		oceeded to wash R105's nd groin areas. NA-A removed					
		in the trash receptacle,					
		washed hands for ten					
		d off the water faucet without					
	using a paper towe	I. NA-A donned a pair of					
	0	dside stand. NA-C came to the					
		C did not wash/sanitize hands					
		of gloves. NA-C obtained a er and assisted to dress R105					
		toilet. R105 asked for a drink					
	0	s none in the room so NA-A					
		ashed hands for six seconds,					
	did not use a paper	towel to turn the water on or					
	-	m to get a cup and straw. The					
		vas too big so NA-A left the					
		nt size brief. At 8:27 a.m. NA-A rief and donned gloves. NA-C					
		de perineal cleansing for					
		ed the brief and pulled up the					
		en taking the transfer belt and					
		5 for transfer while wearing					
		sed to perform perineal					
		moved gloves and washed					
	hands for thirteen s	econds. NA-A removed gloves	;				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED	
		00126	B. WING	B. WING		06/10/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	•		
ROSE O	F SHARON MANOR		VELL AVENUE LE, MN 55113				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
21390	Continued From pa	age 26	21390				
		for eleven seconds and ff without using paper towels.					
	tired and NA-A took NA-A removed the seconds and retriev the bedside. NA-A partial with toothpa NA-A removed the	ed to shave self but became k over. After finishing shaving, gloves, washed hands for ten ved the partial denture from donned gloves, brushed the ste and put into R105's mouth. gloves and did not wash e supplies and transported ing room.					
	NA-A putting R105 donned gloves with to assist R105 into both nursing assist	a.m. NA-D came to assist back to bed. Both NA's nout washing/sanitizing hands bed. After transferring R105, ants removed gloves and left rashing/sanitizing hands.					
	NA-C and NA-D we seconds hand was three acknowledge off using a clean pa The NA's verified th	on 6/8/16 at 1:30 p.m. NA-A, ere not sure how many hing was to take place. All d the faucet was to be turned aper towel after handwashing. hey did not use sanitizing gel n R105's cares earlier.					
	2015, titled, Hand H Handwashing, direct the soap over the e suds between finge opposite hand and vigorously for 15-20 on all surfaces of th	he facility policy dated, July Hygiene-Plain Soap and Water cted to thoroughly distribute entire area of the wrists, work ers, rub fingertips in palm of to rub hands together 0 seconds generating friction he hands and fingers. Rinse dry hands with paper towel and h the paper towel.					

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BOILDING.		06/10/2016	
		00126	B. WING			
IAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
ROSE O	F SHARON MANOR		LE, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21390	Continued From pa	ige 27	21390			
	policy and procedur directions for staff t control practices, s providing cares to r spread of infection. designee could ass monitored, supervis assure good infecti					
	(21) days.	R CORRECTION: Twenty-one				
21426	MN St. Statute 144 Prevention And Co	A.04 Subd. 3 Tuberculosis ntrol	21426			
	maintain a compreh infection control pro- current tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding implement	e provider must establish and hensive tuberculosis ogram according to the most s infection control guidelines d States Centers for Disease htion (CDC), Division of hation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis an that covers all paid and contractors, students, inteers. The Department of e technical assistance intation of the guidelines.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00126	B. WING	B. WING		06/10/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
ROSE OI	F SHARON MANOR		VELL AVENUE LE, MN 55113				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE	
21426	Continued From pa	age 28	21426				
	by: Based on documer facility failed to upd assessment plan, f baseline TB scree registered nurse (F (R105 and R000) r recommendations Control (CDC). 1 o X Ray without com interpreted for TB. 1 of 1 R105 did not 3 days after admiss potential to affect a the facility.	ent is not met as evidenced Int review and interview, the late the tuberculosis (TB) risk failed to complete accurate nings for 1 of 5 employees RN-A) and for 2 of 5 residents eviewed according to the from the Centers for Disease f 1 employee (E1) had a chest plete Medical evaluation t receive the TB Mantoux until sion. This practice had the all 53 residents who resided in					
	Facility Tuberculos dated 2015, with da facility was identifie exposure and the h complete the risk a During an interview (DON) on 6/10/16, facility risk assess in 2015 by the form not known. Further completing the risk	of the facility policy titled, is (TB) Risk Assessment Plan ata used in 2014, indicated the ed at medium risk for TB nealth care settings were to assessment annually. with the director of nursing at 11:00 a.m. verified the ment was completed sometime her DON and the exact date is more, the DON verified assessment now for June he facility is to complete a risk.					
	screening policy da Regulations for Tub Health Care Setting	of the facility symptom ated July 2013, and titled, berculosis Control in Minnesota gs, indicated all employees and nave a symptom screening					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00126	B. WING		06/	06/10/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
ROSE OI	F SHARON MANOR		VELL AVENUE LE, MN 55113				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21426	Continued From pa	ige 29	21426				
	completed upon ad	mission and upon hire.					
	Symptom Screenin interviewed on 6/10	26/16, and did not have a g in the employee file. When )/16 at 9:30 a.m. RN-A verified ing was not completed upon					
	since admission of documents since a Symptom Screenin interviewed on 6/10 coordinator (HUC)	of R000 admission documents 5/31/16, and R105, admission dmission of 6/4/16, a g could not be located. When D/16, at with the health unit verified a symptom screening d for R000 or R105.					
	identified as a newl requiring a chest X form was complete Chiropractics) and "Negative chest stu	E1 was hired 5/17/16, and y-identified positive TST Ray completed 1/26/16. The d by a DC (Doctor of the Impression read, idy. No evidence of acute or skeletal abnormality."					
	evaluation is to rule TB disease in other	blicy dated July 2013, Medical e out a diagnosis of infectious r organs of the body. E1 did cal evaluation to rule out a bus TB disease					
	was not offered the 6/8/16, at which tim there was no docur to the refusal. Furth	I to the facility on 6/4/16, and first step Mantoux until the the resident refused but mentation of any training due hermore there was not a t to administer the Mantoux.					
	(DON) on 6/10/16,	with the director of nursing at 10:00 a.m. regarding the s and procedures, the DON					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00126	B. WING	B. WING		06/10/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
ROSE O	F SHARON MANOR		VELL AVENUE LLE, MN 55113				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21426	Continued From pa	ge 30	21426				
	verified the follow u	p needed to be enhanced.					
	The DON or design screening audits, in ensure residents ar disease. The DON staff were educated Ray without comple- interpreted, indurati tuberculin skin testi could randomly aud ensure adequate de	HOD OF CORRECTION: the could conduct resident terventions and monitoring to the free from communicable or designee could ensure the d on the importance of chest X ete Medical evaluation ion and interpretation of ng. The DON or designee dit resident's documents to occumentation for induration.					
21830	(21) days MN St. Statute 144 Residents of HC Fa	.651 Subd. 10 Patients &	21830				
		pation in planning treatment;					
	in the planning of the includes the opport alternatives with inco- opportunity to reque- care conferences, a family member or of both. In the event the present, a family member or of both. In the event the present, a family member or of conferences. (b) If a resident we unconscious or con- communicate, the fit	Il have the right to participate heir health care. This right unity to discuss treatment and dividual caregivers, the est and participate in formal and the right to include a ther chosen representative or hat the resident cannot be ember or other representative lent may be included in such who enters a facility is natose or is unable to acility shall make reasonable under paragraph (c) to notify					

	ta Department of He					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00126	B. WING		06/	10/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
ROSE OI	F SHARON MANOR		VELL AVENUE			
(X4) ID	SUMMARY STA		ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETE
21830	Continued From pa	ige 31	21830			
	either a family merr	ber or a person designated in				
		ent as the person to contact in				
	an emergency that	the resident has been				
		lity. The facility shall allow the				
		articipate in treatment				
		e facility knows or has reason ent has an effective advance				
		trary or knows the resident has				
		that they do not want a family				
		n treatment planning. After				
		ember but prior to allowing a				
		articipate in treatment				
		/ must make reasonable				
		vith reasonable medical				
	•	ne if the resident has				
		ce directive relative to the				
		re decisions. For purposes of asonable efforts" include:				
		e personal effects of the				
	resident:					
	,	e medical records of the				
		session of the facility;				
		ny emergency contact or				
		tacted under this section				
		nt has executed an advance				
		er the resident has a the resident normally goes for				
	care; and	the resident normally goes for				
		e physician to whom the				
		oes for care, if known,				
		nt has executed an advance				
		y notifies a family member or				
		ncy contact or allows a family				
		ate in treatment planning in				
		is paragraph, the facility is not				
		r damages on the grounds tha ne family member or	L			
		or the participation of the				
		s improper or violated the				
	ianing mornoor was					1

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00126	B. WING		06/	10/2016
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
OSE OF	SHARON MANOR		ELL AVENUE	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE
21830	family member or of the facility shall atter members or a desi examining the pers and the medical re- possession of the f to notify a family m emergency contact admission, the faci social service agen agency that the res the facility has been member or designat county social service enforcement agence identifying and notif designated emerges service agency or la that assists a facilit subdivision is not li damages on the gr the family member	hts. asonable efforts to notify a designated emergency contact, empt to identify family gnated emergency contact by ional effects of the resident cords of the resident in the acility. If the facility is unable ember or designated twithin 24 hours after the lity shall notify the county ney or local law enforcement ident has been admitted and n unable to notify a family ated emergency contact. The ce agency and local law cy shall assist the facility in fying a family member or ency contact. A county social ocal law enforcement agency y in implementing this able to the resident for ounds that the notification of or emergency contact or the family member was improper	21830			
	by: Based on observat review, the facility f preferences was ac	1 of 3 resident (R32) reviewed				
	Findings include:					
	R32 was interviewe	ed on 6/6/16, at 7:09 p.m. and				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00126	B. WING		06/	06/10/2016	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, STATE, ZIP CODE				
ROSE OI	F SHARON MANOR		ELL AVENUE				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21830	Continued From pa	ge 33	21830				
	she bathed or show added, "I did not ha now and I am supp week. No one come them either." On 6/9/16 at 8:57 a when approached b preference was to t staff told her and po stand that reads, "M A.M. Sunday P.M." surveyor when R32 indicated, staff gave though she does no Wednesday but she had a shower for tw "I will take another me another one too	ice" regarding how many times vered during a week. R32 tive a shower for two weeks osed to have shower twice a es to ask me and I did not ask .m. R32 was lying in bed, by surveyor, R32 explained her ake two showers per week as osted a noted on her bedside Maxine's shower Thursdays which was confirmed by pointed to the note. Further e her shower yesterday even of normally take shower on e took it because, "I have not vo weeks". R32 further stated, one today if they want to give lay. I will be glad if they ask ower at least two times a					
	anxiety disorder, Di depression, and ab	cluded multiple sclerosis, abetes mellitus II, major normalities of gait and mobility ission Record dated 6/30/14.					
	10/1/15, indicated, mobility, transfers, and bathing second	Daily Living (ADL) CAA dated "Has assist needs with bed dressing, toileting, hygiene dary to weakness with dx multiple sclerosis), seizures ".					
	3/27/16, indicated F	num Data Set (MDS) dated R32 had had intact cognition for Mental Status (BIMS)					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00126	B. WING	B. WING		10/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ROSE O	F SHARON MANOR		VELL AVENUE LLE, MN 5511:			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
21830	Continued From pa	age 34	21830			
	requesting okay for week Lacerations nursing notes lacked shower/bath in the (5/6/16-6/8/16). The treatment adm May 23, 2016 thru a "Weekly skin asses (+) new area of skin area of skin". Howe	inistration record (TAR) dated June 8, 2016, indicated, ssment: Complete on bath day n impairment (-) no new ever it was left blank.				
		ted that resident showered 31/16 between the dates of				
	(DON) explained the need to document to showers and if a re should be notified a board. DON furthe	a.m. the director of nursing hat the expectation is staff what they are doing regarding isident refuses, the nurse and written on the 24 hour ir explained, "The nurses need d let me know and document				
	The director of nurs review and revise p ensure residents w bathing. The social in-service all emplo	THOD OF CORRECTION: sing and social worker could policies and procedures to ere offered choices for worker or administrator could oyees to offer residents or of nursing could monitor				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00126	B. WING		06/10/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, ST	ATE, ZIP CODE		
			VELL AVENUE			
ROSEO	F SHARON MANOR	ROSEVIL	LE, MN 55113	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21880	Continued From pa	ge 35	21880			
21880	MN St. Statute 144 Residents of HC Fa	.651 Subd. 20 Patients & ac.Bill of Rights	21880			
	shall be encourage their stay in a facilit to understand and o patients, residents, residents may voice changes in policies and others of their o interference, coerci including threat of o grievance procedur well as addresses a Office of Health Fa nursing home ombo	nces. Patients and residents d and assisted, throughout y or their course of treatment, exercise their rights as and citizens. Patients and e grievances and recommend and services to facility staff choice, free from restraint, on, discrimination, or reprisal, discharge. Notice of the e of the facility or program, as and telephone numbers for the ucility Complaints and the area udsman pursuant to the Older tion 307(a)(12) shall be uous place.				
	residential program 253C.01, every nor facility employing m provides outpatient have a written inter at a minimum, sets followed; specifies limits for facility res or resident to have advocate; requires grievances; and pro an impartial decisio otherwise resolved. residential program 253C.01 which are treatment programs	inpatient facility, every n as defined in section hacute care facility, and every fore than two people that mental health services shall rnal grievance procedure that, forth the process to be time limits, including time ponse; provides for the patient the assistance of an a written response to written ovides for a timely decision by n maker if the grievance is not Compliance by hospitals, ns as defined in section hospital-based primary s, and outpatient surgery n 144.691 and compliance by				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00126	B. WING		06/10/2016		
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	ADDRESS, CITY, STATE, ZIP CODE				
ROSE O	F SHARON MANOR		/ELL AVENUE .LE, MN 5511:				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21880	Continued From pa	age 36	21880				
		to be compliance with the vritten internal grievance					
	by: Based on interview facility failed to ens made by the facility voice grievances w	ent is not met as evidenced and document review, the ure that prompt efforts were to ensure resident rights to ithout reprisal affecting 2 of 3 ) in the sample who filed a					
	Findings include:						
	R3 filed 3 concerns treatment.	s with the facility of improper					
		as cognitively intact according ta set (MDS) quarterly review					
	reported grave con (NA-B) who was "a ago. R3 expressed NA-B and that the f seriously. R3 furth after [NA-B] did wh not feeling confider department becaus follow up. R3 confid	d on 6/7/16, at 10:33 a.m. and cern about nursing assistant busive" to R3 several months "fear and retaliation" from facility did not take the concern er stated, "My heart ached at [NA-B] did." R3 expressed at to go to the social service se does not trust there will be ded seeing other residents in ed and that the residents are					
nocot- D		n., interview with R3's garding help from the nursing					
ATE FOR	-		<sup>6899</sup> LO	CV711	If continuati	on sheet 37	

STATEMEN	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00126	B. WING		06/	06/10/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE	•		
ROSE O	F SHARON MANOR		LE, MN 5511				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21880	Continued From pa	age 37	21880				
	games with us." R [NA-B] but that the	ported that "[NA-B] plays mind 78 verified having issues with re is no one to listen to what m management in this facility.					
	Report, from R3 re retaliation from car to flirt while working [NA-B] took me in t the toilet and said, my life is my life. I h did not take me to someone else took	of a 4/6/16, Resident Concern ad, "I have had 2 incidents of e recently. 1. I told [NA-L] not g. In response, the next day the bathroom, left me naked or '[NA-L] life is [NA-L] life and have a life at home.' 2. [NA-B] lunch after that so by the time me my lunch was cold. [NA-B] complaints are made."					
	that the roommate interviewed, there v information regardi Administration char assignment so that R3, however, there education and/or le member, there was obtained from the c	nged the staff members NA-B would not take care of was no documented earning report for the staff s no documented statement care givers NA-B or NA-L and t filed with the State Agency	n				
	the Resident Conce at this time, filed a	p.m. administration reviewed ern Report from 3/15/16, and report to the State Agency. led pending investigation.					
	Concern Report, w 3/13[16] I asked [N (because) my legs was too close to lu	of the 3/15/16, Resident ritten by R3 read, "On Sunday A-A] to put me in bed bc/ hurt. [NA-A] said "No" bc/ it nchtime. I said I needed to lie vere bothering me a lot. [NA-A]					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00126	B. WING		06/10/2016	
NAME OF PR	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
ROSE OF	SHARON MANOR		/ELL AVENUE .LE, MN 55113			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
	but never did. My t come get me for lu Eventually I started was wet, I needed R81 completed a F corroborate R3's c coming in from the screaming with [R3 me. As I was comi help, [licensed prac phone and called f from somewhere in came up the back that wing. [R3] said Although the Resic Disposition read, "S between peers who the unit. Staff educ allow coverage/Re documentation of t administrator wrote during daily rounds being met." There support this interve R81 completed and on 3/15/15, which i especially, it takes lights. I am entirely bathroom needs, g	age 38 come back to get me for lunch ablemate [R5] asked [NA-F]to inch but [NA-F] refused. d to yell for help bc/ my bed to be changed. I was hungry." Resident Concern Report to oncern and wrote, "I was e outside and [R3] was 3] call light on help me, help ng up the hallway to get [R3] ctical nurse (LPN-A)] got on the or east aides. [NA-A] came in the west wing and [NA-B] stairs. There were no aides on d this went on for 20 minutes." dent Concern Report under Staff educated to communicate en going on break or leaving eated to coordinate breaks to sident cares." there was no this education. The e, "Writer will check on resident is to interview regarding needs was no documentation to ention by the administrator. other Resident Concern Report read, "During the day shifts far too long to answer the call of depending for help w/ my getting up, and dressed. I of wheelchair by myself."		DEFICIENC	7)	
	being met." There support this interve R81 completed and on 3/15/15, which i especially, it takes lights. I am entirely bathroom needs, g	was no documentation to ention by the administrator. other Resident Concern Report read, "During the day shifts far too long to answer the call depending for help w/ my getting up, and dressed. I				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00126		B. WING		06/10/2016	
NAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
ROSE O	F SHARON MANOR		LE, MN 5511				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE <sup>-</sup> DATE	
21880	•	-	21880				
	p.m. verified there	Idministrator on 6/9/16, at 3:00 was no documentation to ntions occurred as no s implemented.					
	which read, " When aide on my hall [NA- [NA-B] working her residents? I feel as [NA-B] have not be example, when [NA- toilet." The investig administrator read, assignments on the agreed with the cha worked with that re allegations 4/6/16 f resident per policy and also resident a assignments. Write	e a Resident Concern Report n [NA-B] is assigned as the A-B] refuses to help me. Why is re if [NA-B] can refuse to help if my past complaints about een taken seriously, for A-B] left me naked on the lation report completed by the "Administrator changed e hall. Resident requested and ange on 4/6/16. [NA-B] has not isident since 4/6/16. Previous followed up with. Employee and protocol. Unsubstantiated agreed with change in caregiver er assigned BOM BH to ell being 4/17/16 thru n reported."					
	titled, Concern-Res center provides res members with an u concern procedure each and every res right to express the directly to the center verbally or in writing	lity policy dated, July 2015, sident/Family, read, "The sidents and their family uninhibited resident/family . The procedure is such that sident and/or family has the sir grievance or concerns er's administration either g. Assure the resident and/or n voice their concern without on or reprisal."					
	6/9/16, at 3:00 p.m documentation to s	v with the administrator on . verified there was no support the interventions cumentation was implemented.					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00126	B. WING		06/10/2016	
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			10/2010
			VELL AVENUE			
ROSE O	F SHARON MANOR		LLE, MN 5511			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN(	THE APPROPRIATE	COMPLET DATE
21880	Continued From pa	age 40	21880			
	approached a surve her. R81 stated the evening in recent n self-medicated with facility nurse to call medical care. R81 that evening that hi called, but a facility medical director an and R81 refused th not want to take op facility administration appropriate care refinever been told of R81 did not rememing the names of the state	on 6/6/16 at 11:55 a.m., R81 eyor and asked to speak with at he had a concern that one nonths he had chest pain, n nitro tablets, and asked a his after-hours clinic for stated he was informed later s after-hours clinic was not nurse had called the facility's d received an order for "Oxy," hat medication because he did iates. R81 stated that he told on about his concerns for lated to this incident but has a resolution to his concerns. ber the date of the incident or taff involved.				
	director of nursing of R81 had been in	(DON) stated that this concern				
	During interview on was asked about th and R81 was prese there was document this incident and sh documentation of th because R81 had n incident or the staff that there had been incident that include medical director, an	hvestigation of this incident. a 6/9/16, at 11:21 a.m. the DON the investigation of this incident ent. The DON was asked if thatation of the investigation of the stated that there was no the investigation of this incident not been sure of the date of the involved. R81 then stated the a meeting regarding this ed himself, the DON and the the R81 had been upset with r at this meeting because the	t			

STATEMEN	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00126	B. WING		06/10/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
ROSE OI	F SHARON MANOR		ELL AVENUE LE, MN 55113			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC <sup>1</sup>	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21880	not recall the incide DON was asked by a meeting regarding herself, R81, and the confirmed that the did not recall the da place in recent wee was true that he did involved in the incide names, but he had nursing that one of accent specific to a	age 41 id at that meeting that he did ent being investigated. The y the surveyor if there had been g this incident that included ne medical director and she meeting did take placeshe ate, but believed that it took eks. R81 then stated that it d not want to get the nurses dent into trouble by telling their previously told the director of the nurses involved had an a nurse at the facility. The at R81 had mentioned that one	21880			
	particular type of ac has that type of acc SUGGESTED MET The director of nurs the requirement to and make a good for grievances. Then do ensure ongoing cor	red in the incident had a ccent and that a facility nurse cent. THOD OF CORRECTION: sing could in-service staff on address resident concerns aith attempt to resolve the levelop monitoring systems to mpliance and report the lity Assurance Committee.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21980	Maltreatment of Vu Subd. 3. Timing of reporter who has re vulnerable adult is or who has knowled	.557 Subd. 3 Reporting - Inerable Adults of report. (a) A mandated eason to believe that a being or has been maltreated, dge that a vulnerable adult ysical injury which is not	21980			

6899

	ota Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
		00126	B. WING		06/	10/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
		1000 LOV	ELL AVENUE	1		
RUSE U	F SHARON MANOR	ROSEVIL	LE, MN 5511	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
21980	Continued From pa	ge 42	21980			
21980	reasonably explained information to the co- individual is a vulner the individual is a dri reporter is not requi- maltreatment of the to admission, unless (1) the individual wa another facility and believe the vulneral previous facility; or (2) the reporter k that the individual is in section 626.5572 (b) A person not provisions of this s as described above (c) Nothing in this known or suspected knows or has reason been made to the co- (d) Nothing in this reporter from also r agency. (e) A mandated r reason to believe th 626.5572, subdivisi (5), occurred must subdivision. If the r time believes that a agency will determit the reported error w the criteria under se 17, paragraph (c), o	ed shall immediately report the common entry point. If an erable adult solely because mitted to a facility, a mandated ired to report suspected a individual that occurred prior is: as admitted to the facility from the reporter has reason to ble adult was maltreated in the snows or has reason to believe a vulnerable adult as defined 2, subdivision 21, clause (4). required to report under the ection may voluntarily report as section requires a report of d maltreatment, if the reporter on to know that a report has common entry point. s section shall preclude a reporting to a law enforcement reporter who knows or has nat an error under section fon 17, paragraph (c), clause make a report under this reporter or a facility, at any in investigation by a lead ne or should determine that vas not neglect according to ection 626.5572, subdivision clause (5), the reporter or	21980			
<u>_</u>	the reported error w the criteria under se 17, paragraph (c), c facility may provide directly to the lead a how the event mee	vas not neglect according to ection 626.5572, subdivision				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00126	B. WING		06/10/2016	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		10/2010
ROSE OI	SHARON MANOR		LE, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC <sup>Y</sup>	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21980	Continued From pa	age 43	21980			
		ncy shall consider this naking an initial disposition of Ibdivision 9c.				
	by: Based on documen facility failed to ensi- involving injuries of violations of mistre were reported to the reported immediate thoroughly investig	tent is not met as evidenced int review and interview, the sure that all alleged violations if unknown origin, or alleged atment neglect and abuse be administrator immediately, ely to the state agency and ated for 4 of 5 residents (R3, ewed for incidents.				
	Findings include:					
	R3 filed 3 concerns treatment.	s with the facility of improper				
		as cognitively intact according ta set (MDS) quarterly review				
	6/7/16, at 10:33 a.r about nursing assis to R3 several mont and retaliation" from not take the concer "My heart ached af did." R3 doesn't fee service department will be follow up. R	sident (R3) interview on m. reported grave concern stant (NA-B) who was abusive ths ago. R3 expressed "fear m NA-B and that the facility did rn seriously. R3 further stated, fter [NA-B] did what [NA-B] el confident to go to the social t because does not trust there 3 confided seeing other cility mistreated and that the aken seriously.				
		roomate (R78) 6/7/16 at 10:45 hat "[NA-B] plays mind				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00126	B. WING		06/	06/10/2016	
IAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE			
ROSE OF	F SHARON MANOR						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ROSEVIL ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
21980	Continued From pa	age 44	21980				
	[NA-B] but that the	78 verified having issues with re is no one to listen to what m management in this facility.					
	Report, from R3 re retaliation from car to flirt while working [NA-B] took me in t the toilet and said, my life is my life. I h did not take me to b someone else took	of a 4/6/16, Resident Concern ad, "I have had 2 incidents of e recently. 1. I told [NA-L] not g. In response, the next day he bathroom, left me naked or '[NA-L] life is [NA-L] life and have a life at home.' 2. [NA-B] lunch after that so by the time me my lunch was cold. [NA-B] complaints are made."					
	immediately notifed a thorough investig administration wrot that roomate and n documentation lack findings. The repor assignments were not take care of R3 documented educa member, there was obtained from the c	ence the administrator was d, the State agency notified or lation completed. Although e on the investigation report eighbors were interviewed, ked evidence of the interview t idenfied that staff members changed so that NA-B would b, however, there was no tion and learning for the staff s no documented statement care givers NA-B or NA-L and t filed with the state agency on.					
	reviewed the Resid 3/15/16, and at this	p.m. administration again lent Concern Report from time, filed a report to the state suspended pending					
	3/7/16, between 6:3	njury of unknown origin on 30 a.m. and 7:00 a.m., ar of unknown origin on 3/7/16,	,				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00126	B. WING		06/10/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, ST	TATE, ZIP CODE		
ROSE O	F SHARON MANOR		/ELL AVENUE .LE, MN 55113			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21980	Continued From pa	ige 45	21980			
	2/24/16 a 10 cm br right inner thigh of t	. and 11:30 a.m. and on uise was discovered on R54's unknown origin that lacked a istrator, state agency and an				
	Record, onset date with unspecified de disturbances, contr delusional disorder	ument titled, Admission , 10/1/15, R54 was diagnosed mentia with behavioral acture unspecified hand, s, and unspecified psychosis nce or known physiological				
	impairment accordi	as severe cognitive ing to the minimum data set completed 2/20/16.				
	Investigation Stater on 3/7/16, between	of a form titled, Witness ment, an incident that occurred 6:30 a.m. and 7:00 a.m. a left shoulder that looked very ght shoulder.				
	Investigation Stater (NA-B) read, "On th a.m. I went to [R54] breakfast. After sha left shoulder looked	of a form titled, Witness ment, from nursing assistant ne 7th of March, around 6:30 ] room to get [R54} dressed for aving [R54], I realize that [R54] d different, so I called the nurse RN-G) to pls (please) come to k [R54] out."				
	Investigation Stater (NA-A) read, "I didr co-worker that [NA- for [R54's] morning shoulder wasn't rigl	of a form titled, Witness ment, from nursing assistant n't see it but I was told by my -B] went to dress the resident meal and notice that resident ht so [NA-B] immediately e nurse to come and accessed				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00126	B. WING		06/	06/10/2016	
	PROVIDER OR SUPPLIER		DRESS, CITY, ST		0/	10/2016	
	F SHARON MANOR	1000 LOV	/ELL AVENUE				
(X4) ID		ROSEVIL ATEMENT OF DEFICIENCIES	.LE, MN 55113	PROVIDER'S PLAN OF	COBBECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	COMPLE DATE	
21980	Continued From pa	age 46	21980				
	the shoulder."						
	Investigation State 3/8/16, from an inc read, "Nurse called see residents should shoulder seem diffe There was no docu administrator was in documented evider origin was reported Document review of notes, dated 3/7/16 was called to dining observed to be blear right hand. [family nand informed about site updated, nurse Documentaion lack administrator was in	of a form titled, Witness ment, from RN-G, dated ident that occurred 3/7/16 d to residents room in AM to alder. Upon assessment left erent, but I wasn't sure why." umented evidence that the informed immediately and no nce that the injury of unknown d to the state agency. of the form titled, Progress 6, at 7:30 a.m. read, "Nurse g area this am, Resident was eding from an open area on member F-B] was contacted it skin tear via phone. NP on e manager updated." ked evidence that the informed immediately y of unknown origin and that ias notified.					
	administrator verifi- immediately of the occurred 3/7/16. Re Report indicated th 3/8/16 of R54's sho and the state agen 12:30 p.m., accord	on 6/9/16, at 2:00 p.m. the ed not being informed injuries of unknown origin that eview of a Resident Concern the administrator was notified bulder injury of unknown origin cy was contacted 3/8/16, at ing to the form titled bmitting an Incident report to					
	on, "2/24/16, Obse	ogress notes also identified that rved a 10 cm (centimeter) e upper inner Rt (right) ology- 0 (no) s/s					

STATEMEN	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00126	B. WING	B. WING		10/2016
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		10/2010
ROSE OI	F SHARON MANOR		VELL AVENUE			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLET
21980	Continued From pa	age 47	21980			
	turned on rounds. [ no evidence that th immediately called to the state agency On 3/14/16, at 11:3 interviewed and un investigation and s	of discomfort. A or 2- {sic} signed by RN-G]. There was the injury of unknown origin was to the administrator, reported and investigated thoroughly. 66 a.m. the adminisrator was able to provide an ubsequent report for this inner right thigh of unknown				
	Policy addressed, I and read, "Classify source" when both met. The source of by any person or th the source of the in because of the exte of the injury or the	of the facility July 2015, Abuse Injuries of Unknown Source as an "injury of unknown of the following conditions are the injury was not observed he resident could not explain hjury. The injury is suspicious ent of the injury or the location number of injuries observed at t in time, or the incidence of				
	surveyor and repor regarding a concer months he had che nitro tablets, and as after-hours clinic fo was informed later after-hours clinic w nurse had called th received an order f medication becaus	1:55 a.m., approached a ted an allegation of neglect n that one evening in recent est pain, self-medicated with sked a facility nurse to call his or medical care. R81 stated he that evening that his as not called, but a facility he facility's medical director and or "Oxy," and R81 refused that e he did not want to take d that he told facility	ł			
	administration about care related to this	to that he told facility ut his concerns for appropriate incident but has never been to the concerns. R81 did not				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00126	B. WING	B. WING		10/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
		1000 LOV	/ELL AVENUE			
RUSEO	F SHARON MANOR	ROSEVIL	LE, MN 55113	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21980	Continued From pa	ge 48	21980			
	remember the date of the incident or the names of the staff involved.					
		on 6/8/16, at 2:10 p.m. the DON) stated that this concern vestigated.				
		f R81's record showed no vestigation of this incident.				
	and R81 was prese there was document this incident and sh documentation of th because R81 had n incident or the staff that there had been incident that include medical director, and the medical director sai not recall the incide DON was asked by a meeting regarding herself, R81, and th confirmed that the n did not recall the da place in recent wee was true that he did involved in the incide names, but he had nursing that one of accent specific to a DON confirmed that	e investigation of this incident nt. The DON was asked if intation of the investigation of e stated that there was no ne investigation of this incident not been sure of the date of the involved. R81 then stated a meeting regarding this ed himself, the DON and the nd R81 had been upset with r at this meeting because the d at that meeting that he did nt being investigated. The the surveyor if there had been g this incident that included ne medical director and she neeting did take placeshe ite, but believed that it took ks. R81 then stated that it I not want to get the nurses lent into trouble by telling their previously told the director of the nurses involved had an nurse at the facility. The t R81 had mentioned that one ed in the incident had a				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		E SURVEY PLETED
		00126	B. WING			10/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ROSE O	F SHARON MANOR		VELL AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21980	Continued From pa	ige 49	21980			
	R5's quarterly Minimum Data Set (MDS) dated 12/31/15, revealed R5 was cognitively intact.					
	R5 had an allegation of verbal abuse and the facility failed to follow their policy regarding the allegation of abuse.					
	11:33 a.m. R5 expr with nursing assista "ball her out", tells F should stay away fr	sident interview on 6/7/16, at essed a verbal abuse concern ant (NA)-B. R5 stated NA-B wi R5 who to talk to and who R5 om. RN-B will also tell R5 she cated she feels NA-B acts like y demanding.				
	working today in the NA-B had not bothe she talks to the soc	a.m. R5 stated NA-B was e east hallway and indicated ered her today. R5 indicated sial service director (SSD), but much help and used to be				
	mostly complained	a.m. SSD stated R5 had about other residents, was no laints with nursing assistants.	t			
	came into her room told R38 she did no	a.m. R5 stated when R38 n offering pizza last night R5 nt want any. Then NA-B came 5 out and told R5 not to talk to				
	occurred with NA-B ago, R5 reported it director of nursing (	a.m. R5 stated when incident approximately three months to the Administrator and (DON) and was informed they it right away, yet R5 felt				

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	00126	B. WING	B. WING		10/2016
AME OF PROVIDER OR SUPPLI	ER STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
OSE OF SHARON MANO		VELL AVENUE LE, MN 55113			
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
stated she recall take her medica like NA-B makes will state knows further indicated remind R5 so her On 6/10/16, at 1 not aware of any On 6/10/16, at 1 administrator statincident betweer retract statemen by R81. The adr reported any oth Review of facility 11/6/15, indicate NA-B around an Resolution and o "advised to alwa present when int Review of facility 3/20/16, indicate approach and su residents for a p satisfaction on d QA. NA-B's assi possible in best behaviors. Review of facility Prevention and d	page 50 44 a.m. nursing assistant (NA)-E ed NA-B would remind R5 to tions. NA-E indicated R5 feels a her take medications, but R5 she needs to take them. NA-E NA-B tells R5 to eat and will r blood sugar doesn't get too low 1:02 a.m. DON stated she was r issues between R5 and NA-B. 1:08 a.m. when interviewed, the tted he was informed about an n R5 and NA-B, but R5 wanted to ts because they were influenced ninistrator stated R5 had not er problems with NA-B. r's resident concern report dated d R5 was uncomfortable with d talk was intimidating. lisposition indicated NA-B was ys have another staff member eracting with R5." r's resident concern report dated d NA-B was advised regarding tiggestion made to switch eriod of time and would monitor aily rounds and caring partners gnments were changed when interest of all parties and policy dated July 2015 and titled Reporting: Resident eglect, Abuse, Including Injuries				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00126	B. WING		06/	10/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ROSE O	F SHARON MANOR		VELL AVENUE LLE, MN 55113			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21980	disparaging and de or their families or v regardless of their a disability." "Mental/Emotional / Includes, but is not harassment, and th deprivation." SUGGESTED MET The director of nurs and/or revise facility related to abuse pro personnel could be and procedures. R injuries of unknown compliance with the	rogatory terms to the resident within their hearing distance age, ability to comprehend or				
21995	results shared with Assessment & Assion-going compliant TIME PERIOD FOF (14) days. MN St. Statute 626 Maltreatment of Vu Subd. 4a. Interna (a) Each facility sh ongoing written pro applicable licensing of suspected maltrefacility has an intern	R CORRECTION: Fourteen .557 Subd. 4a Reporting - Inerable Adults I reporting of maltreatment. all establish and enforce an ocedure in compliance with grules to ensure that all cases eatment are reported. If a nal reporting procedure, a may meet the reporting	21995			

STATEMEN	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00126	B. WING		06/10/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
ROSE O	F SHARON MANOR		/ELL AVENUE .LE, MN 55113			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21995	Continued From pa	ige 52	21995			
		r, the facility remains pplying with the immediate ents of this section.				
	This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to ensure that all alleged violations involving injuries of unknown origin, or alleged violations of mistreatment, neglect and abuse were reported to the administrator immediately, reported to the state agency and thoroughly investigated for 4 of 5 residents (R3, R54, R81, R5) reviewed for incidents.					
	Findings include:					
	2015, and titled Pre Resident Mistreatm injuries of Unknown of Resident Propert centers to report th Executive Director immediately. "Imme possible but not to discovery of incider state time frame re Prevention 1. Ensu prevention techniqu not limited to: Ongo and staff. Observation Observation and re burnout. Observation	ediately" means as soon as exceed 24 hours after nt, in the absence of a shorter quirements. re implementation of ues in the center including, but bing supervision of residents ion of care delivery. cognition of signs of staff on and recognition of signs of and/or resideent -to-staff				
	titled, Investigation	f the policy dated July 2015, Protocol, in Summary directed ne complaining party. Interview				

STATEMEN	<u>ota Department of He</u> NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00126	6 B. WING			10/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
ROSE O	F SHARON MANOR		VELL AVENUE			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
21995	Continued From pa	ge 53	21995			
	accused employee employee. Listen ca Who, What, When, needed to establish all of the interviews Complete an invest recommendations. complaining party a agencies. Document review of Policy addresses, I and read, "Classify source" when both met. The source of by any person or th the source of the in because of the exte of the injury or the rest	In the investigation. Review is file.Interview the accused arefully and take notes on the Where, Why and How in facts of the situation. Review and supporting information. tigation summary and make Follow up with the and if necessary any reporting of the facility July 2015, Abuse njuries of Unknown Source as an "injury of unknown of the following conditions are the injury was not observed e resident could not explain jury. The injury is suspicious ent of the injury or the location number of injuries observed at in time, or the incidence of				
		with the facility of improper				
		as cognitively intact according a set (MDS) quarterly review				
	6/7/16, at 10:33 a.n about nursing assis to R3 several mont and retaliation" from not take the concer "My heart ached aff did." R3 doesn't fee	sident (R3) interview on n. revealed grave concern stant (NA-B) who was abusive hs ago. R3 expressed "fear n NA-B and that the facility did in seriously. R3 further stated, ter [NA-B] did what [NA-B] el confident to go to the social is because does not trust there				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00126	B. WING		06/	10/2016	
NAME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
ROSE OF	SHARON MANOR		LE, MN 5511				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21995	Continued From pa	ige 54	21995				
	residents in the facility mistreated and that the residents are not taken seriously.						
	10:45 a.m., and rep games with us." R [NA-B] but that ther they are saying from Document review of Report, from R3 rea retaliation from care to flirt while working [NA-B] took me in t the toilet and said," my life is my life. I h did not take me to l	) was interviewed 6/7/16 at borted that "[NA-B] plays mind 78 verified having issues with re is no one to listen to what m management in this facility. of a 4/6/16, Resident Concern ad, "I have had 2 incidents of e recently. 1. I told [NA-L] not g. In response, the next day he bathroom, left me naked or "[NA-L] life is [NA-L] life and nave a life at home.' 2. [NA-B] unch after that so by the time					
	always retaliates if Although administra roomate and neight information lacked findings. Although a	me my lunch was cold. [NA-B complaints are made." ation wrote on the investigation bors were interviewed, the evidence of the interview administration changed the					
	not take care of R3 education and learn there was no docur from the care gives no evidence that th	gnment so that NA-B would , there was no documented hing for the staff member, mented statement obtained s NA-B or NA-L. There was e administrator was informed red to the State agency and estigation occurred.					
	reviewed the Resid 3/15/16, and at this	o.m. administration again ent Concern Report from time, filed a report to the 3 was suspended pending					
necoto D	R54 sustained an ir	njury of unknown origin on					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00126	B. WING		06/	06/10/2016	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	•		
ROSE OI	F SHARON MANOR		VELL AVENUE				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21995	Continued From pa	age 55	21995				
	sustained a skin te between 11:00 a.m 2/24/16 a 10 cm br right inner thigh of immediate notificat	30 a.m. and 7:00 a.m., ar of unknown origin on 3/7/16 a. and 11:30 a.m. and on ruise was discovered on R54's unknown origin that lacked tion to the administrator, a agency and a thorough	,				
	Record, onset date with unspecified de disturbances, contr delusional disorder	ument titled, Admission e, 10/1/15, R54 was diagnosed ementia with behavioral racture unspecified hand, rs, and unspecified psychosis ance or known physiological					
	impairment accord	l as severe cognitive ing to the minimum data set t completed 2/20/16.					
	Investigation Stater a.m. and 7:00 a.m.	of form titled, Witness ment, on 3/7/16, between 6:30 R54 had a left shoulder that nt from the right shoulder.					
	Investigation Stater (NA-B) read, "On th a.m. I went to [R54 breakfast. After sha left shoulder looked	of a form titled, Witness ment, from nursing assistant he 7th of March, around 6:30 ] room to get [R54} dressed fo aving [R54}, I realize that [R54] d different, so I called the nurse RN-G) to pls (please) come to ck [R54] out."	]				
	Investigation Stater (NA-A) read, "I didr coworker that [NA-	of a form titled, Witness ment, from nursing assistant n't see it but I was told by my B] went to dress the resident g meal and notice that resident					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00126	B. WING		06/	10/2016
IAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
ROSE O	F SHARON MANOR		ELL AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21995	Continued From pa	ige 56	21995			
		ht so [NA-B] immediately e nurse to come and accessed				
	Investigation Stater called to residents of shoulder. Upon ass different, but I wasn documented evider informed immediate	of a form titled, Witness ment, from RN-G read, "Nurse room in AM to see residents sessment left shoulder seem n't sure why." There was no nce that the administrator was ely and no documented njury of unknown origin was e agency.				
	notes, dated 3/7/16 was called to dining observed to be blee right hand. [F-B] wa about skin tear via nurse manager upo evidence that the a immediately regard	of the form titled, Progress b, at 7:30 a.m. read, "Nurse g area this am, Resident was eding from an open area on as contacted and informed phone. NP on site updated, dated." Documentaion lacked dministrator was informed ling the injury of unknown state agency was notified.				
	administrator verifie immediately of the occurred 3/7/16. Re Report indicated the 3/8/16 of R54's sho and the state agend 12:30 p.m., accordi	on 6/9/16, at 2:00 p.m. the ed not being informed injuries of unknown origin that eview of a Resident Concern e administrator was notified oulder injury of unknown origin cy was contacted 3/8/16, at ing to the form titled omitting a Incident report to				
	on, "2/24/16, Obser	gress notes also identified that rved a 10 cm (centimeter) upper inner Rt (right) logy- 0 (no) s/s				

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00126	B. WING		06/10/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
	F SHARON MANOR	1000 LO\	/ELL AVENUE			
	F SHARON MANOR	ROSEVIL	LE, MN 55113	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21995	Continued From pa	ige 57	21995			
	turned on rounds. [ no evidence that th immediately called to the state agency On 3/14/16, at 11:3 interviewed and un- investigation and su bruise to the upper etiology. Document review of Policy addressed, I and read, "Classify source" when both met. The source of by any person or th the source of the in because of the exter of the injury or the t	of discomfort. A or 2- {sic} signed by RN-G]. There was e injury of unknown origin was to the administrator, reported and investigated thoroughly. 6 a.m. the adminisrator was able to provide an ubsequent report for this inner right thigh of unknown of the facility July 2015, Abuse njuries of Unknown Source as an "injury of unknown of the following conditions are the injury was not observed e resident could not explain jury. The injury is suspicious ent of the injury or the location number of injuries observed at in time, or the incidence of				
	and reported an alle that he had asked to when he had chest concern that one ev had chest pain, self and asked a facility clinic for medical ca informed later that clinic was not called called the facility's r an order for "Oxy," medication because opiates. R81 states administration about	5 a.m., approached a surveyor egation of neglect, explaining the nurse to call the clinic pain. R81 reported having a vening in recent months he f-medicated with nitro tablets, r nurse to call his after-hours are. R81 stated he was evening that his after-hours d, but a facility nurse had medical director and received and R81 refused that e he did not want to take d that he told facility ut his concerns for appropriate incident but has never been				

STATEMENT OF DEFICIENCIES () AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED
		00126	B. WING		06/10/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
ROSE O	F SHARON MANOR		LE, MN 5511			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
21995	Continued From pa	ge 58	21995			
	told of a resolution to his concerns.					
	When interviewed on 6/8/16, at 2:10 p.m. the director of nursing (DON) stated that this concern of R81 had been investigated.					
	Document review of R81's record showed no documentation of investigation of this incident.					
	was asked about th and R81 was prese there was document this incident and sh documentation of th because R81 had r incident or the staff that there had been incident that include medical director, ar the medical director sa not recall the incide DON was asked by a meeting regarding herself, R81, and th confirmed that the r did not recall the da place in recent wee was true that he did involved in the incide	6/9/16, at 11:21 a.m. the DON the investigation of this incident ant. The DON was asked if intation of the investigation of the stated that there was no the investigation of this incident not been sure of the date of the involved. R81 then stated in a meeting regarding this and himself, the DON and the the R81 had been upset with in a this meeting because the id at that meeting that he did and the surveyor if there had been g this incident that included the medical director and she meeting did take placeshe ate, but believed that it took is. R81 then stated that it anot want to get the nurses lent into trouble by telling their previously told the director of				
	accent specific to a DON confirmed tha of the nurses involv	the nurses involved had an nurse at the facility. The at R81 had mentioned that one red in the incident had a ccent and that a facility nurse cent.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00126	B. WING		06/10/2016		
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
ROSE OF	SHARON MANOR		VELL AVENUE				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21995	Continued From page 59		21995				
	Review of R5's quarterly Minimum Data Set (MDS) dated 12/31/15, revealed R5 was cognitively intact.						
	R5 had an allegation of verbal abuse and the facility failed to follow their policy regarding an allegation of abuse.						
	Review of facility policy dated July 2015 and titled Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property, revealed "Verbal abuse is oral, written, or gestured language that includes disparaging and derogatory terms to the resident or their families or within their hearing distance regardless of their age, ability to comprehend or disability."		3				
	"Mental/Emotional Abuse Includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation."						
	11:33 a.m. R5 expr with nursing assista "ball her out", tells F should stay away fr	sident interview on 6/7/16, at essed a verbal abuse concern ant (NA)-B. R5 stated NA-B wil R5 who to talk to and who R5 om. RN-B will also tell R5 she cated she feels NA-B acts like y demanding.					
	working today in the NA-B had not bothe she talks to the soc	a.m. R5 stated NA-B was e east hallway and indicated ered her today. R5 indicated ial service director (SSD), but much help and used to be					
	On 6/8/16, at 11:36	a.m. SSD stated R5 had					

Minnesota Department of Health         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1)         PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         00126		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED 06/10/2016		
		B. WING					
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STATE, ZIP CODE				
ROSE O	F SHARON MANOR		ELL AVENUE				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21995	Continued From pa	age 60	21995				
	mostly complained about other residents, was not aware of any complaints with nursing assistants.						
	On 6/10/16, at 9:20 a.m. R5 stated when R38 came into her room offering pizza last night R5 told R38 she did not want any. Then NA-B came into room balling R5 out and told R5 not to talk to R38.						
	occurred with NA-E ago, R5 reported it director of nursing	2 a.m. R5 stated when incident 3 approximately three months to the Administrator and (DON) and was informed they it right away, yet R5 felt					
	stated she recalled take her medication like NA-B makes he will state knows she further indicated NA	A a.m. nursing assistant (NA)-E NA-B would remind R5 to ns. NA-E indicated R5 feels er take medications, but R5 e needs to take them. NA-E A-B tells R5 to eat and will blood sugar doesn't get too low.					
		2 a.m. DON stated she was sues between R5 and NA-B.					
	administrator stated incident between R retract statements by R81. The admin	8 a.m. when interviewed, the d he was informed about an 5 and NA-B, but R5 wanted to because they were influenced istrator stated R5 had not problems with NA-B.					
	11/6/15, indicated F NA-B around and ta Resolution and disp	resident concern report dated R5 was uncomfortable with alk was intimidating. position indicated NA-B was have another staff member acting with R5."					

Minnesota Department of Health         STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         00126         NAME OF PROVIDER OR SUPPLIER       STREET AD			(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING			(X3) DATE SURVEY COMPLETED	
		00126			06/10/2016		
		DDRESS, CITY, ST			00/10/2010		
OSE OF	SHARON MANOR		VELL AVENUE LE, MN 55113				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21995	Continued From page 61		21995				
	Review of facility's resident concern report dated 3/20/16, indicated NA-B was advised regarding approach and suggestion made to switch residents for a period of time and would monitor satisfaction on daily rounds and caring partners QA. NA-B's assignments were changed when possible in best interest of all parties and behaviors.						
	The facility could a potential abuse are immediately report residents are prote while an investigati Administrator, direc could assure policie	THOD OF CORRECTION: ssure that all allegations of thoroughly investigated and ed to the state agency and that incted from potential retaliation ion is pending. The ctor of nursing and/or designee es are reviewed, up to date, hat staff training has been					
	TIME PERIOD FO (14) days.	R CORRECTION: Fourteen					