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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PXFS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00497

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245105**

2.STATE VENDOR OR MEDICAID NO.
(L2) **264638200**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE ESTATES AT ROSEVILLE LLC**
(L4) **2727 NORTH VICTORIA**
(L5) **ROSEVILLE, MN** (L6) **55113**

4. TYPE OF ACTION: 7 (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **03/01/2017**

6. DATE OF SURVEY **12/13/2017** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **175** (L18)
13.Total Certified Beds **175** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: A (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	175			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Michelle Torrance, HFE NE II 01/04/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing - Health Program Rep 01/04/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1969
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
01111
(L31)

30. REMARKS
Posted 01/10//2018 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/27/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245105

January 4, 2018

Mr. Ryan Onstad, Administrator
The Estates At Roseville LLC
2727 North Victoria
Roseville, MN 55113

Dear Mr. Onstad:

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 November 24, 2017 the above facility is certified for:

175 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 175 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 4, 2018

Mr. Ryan Onstad, Administrator
The Estates At Roseville LLC
2727 North Victoria
Roseville, MN 55113

RE: Project Number S5105029

Dear Mr. Onstad:

On October 30, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 19, 2017. 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 December 13, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 15, 2017 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 October 19, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 24, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 19, 2017, effective November 24, 2017 and therefore remedies outlined in our letter to you dated October 30, 2017, 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.

Sincerely,

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PXFS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00497

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(L1) **245105**

2.STATE VENDOR OR MEDICAID NO.
(L2) **264638200**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE ESTATES AT ROSEVILLE LLC**
(L4) **2727 NORTH VICTORIA**
(L5) **ROSEVILLE, MN** (L6) **55113**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **03/01/2017**

6. DATE OF SURVEY **10/19/2017** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

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To (b) :

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

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	175			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Sue Miller - HFE - Nursing Evaluator II 11/13/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing - Health Program Rep 12/27/2017 (L20)

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

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

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
08/01/1969
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
01111
(L31)

30. REMARKS
Posted 12/27/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/27/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 30, 2017

Mr. Ryan Onstad, Administrator
The Estates At Roseville LLC
2727 North Victoria
Roseville, MN 55113

RE: Project Number S5105029

Dear Mr. Onstad:

On October 19, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Metro A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793

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 November 28, 2017, 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 November 28, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- 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 ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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 ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 January 19, 2018 (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 April 19, 2018 (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 an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. 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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT ROSEVILLE LLC	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On October 16, 2017 through October 19, 2017, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH) to determine compliance with requirements at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility's electronic Plan of Correction (ePoC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePoC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the PoC will be used as verification of compliance.	F 000		
F 176 SS=D	483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the safe practice of self-administration of medications (SAM) for 1 of 1 resident (R93) who was observed during random observations to self-administer a nebulizer treatment. Findings include: R93 was observed during a random observation on 10/16/17 at 8:01 a.m., to self-administer a nebulizer treatment. The resident was observed	F 176	Preparation, submission, and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. F176	11/24/17

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

Electronically Signed | 11/09/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT ROSEVILLE LLC	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 176	Continued From page 1 to be awake with a nebulizer facemask in place, with the nebulizer machine running. Registered nurse (RN)-C was observed to enter R93's room at 8:08 a.m., turn the nebulizer off, remove the facemask, and rinse the mask and chamber. On 10/16/17 at 8:15 a.m., RN-C confirmed, R93 was self-administering Budesonide suspension 0.5 mg (milligram)/2ML (milliliter) nebulizer treatment without nursing staff supervision. RN-C stated she had not been the nurse who placed the nebulizer treatment. RN-C mentioned, nursing assistant (NA)-B informed her R93's nebulizer was running without nursing staff supervision. In addition, RN-C explained, the expectation was for nurses to stay with a resident until the resident took all medications unless there was a SAM in place and R93 did not have SAM in place due to cognitive impairment and R93 unable to self-administer medication. On 10/16/17 8:23 a.m., licensed practical nurse (LPN)-B verified R93 was self-administering Budesonide suspension 0.5 mg/2ML nebulizer treatment without nursing staff supervision. LPN-B acknowledged R93 should not have been left to self-administer the medication because R93 does not have SAM in place. LPN-B stated the nebulizer normally runs for 15 minutes and that LPN-B needed to check a blood sugar for another resident before breakfast. On 10/17/17 at 6:15 p.m. (RN)-C verified the medical record lacked an assessment, an order and the care plan lacked identification of R93's ability to SAM. R93's current physician order, dated 10/8/17, directed staff to administer Budesonide	F 176	A self-administration of medications assessment for nebulizer treatment was completed for R93 on 10/16/17 and resident was deemed unable to self-administer a nebulizer. On 10/16/17 LPN-B was re-educated that licensed nurses must remain with residents for the duration of a nebulizer treatment if those residents do not have SAMs in place that assess and authorize to self-administer. All current residents who have nebulizer treatments will be assessed for the ability to self-administer a nebulizer treatment via the Self-Administration of Medication Assessment. All licensed nurses will be re-educated on the Oral Inhalation Administration Policy and Procedure which includes remaining with residents receiving nebulizer treatments if deemed unable to self-administer the nebulizer treatment via the SAM assessment. Policy and Procedure for Oral Inhalation Administration was reviewed and remains current. DON or designee(s) will conduct weekly observations of residents identified as unable to self-administer nebulizer treatments for 4 weeks, and randomly thereafter. The QAPI committee will review the compliance of each audit to determine the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT ROSEVILLE LLC	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 176	Continued From page 2 suspension 0.5 mg/2ML 0.5 mg inhale orally two times a day for asthma prevention. The medical record lacked approval for R93 to self-administer medication prior to 10/16/17 at 8:01 a.m., when self-administration of Budesonide suspension was observed. Interventions on R93's care plan dated 11/21/13 included, "Administer medications as ordered. Observe labs, response to medication and treatments". The quarterly Minimum Data Set (MDS) dated 7/25/17, indicated the R93 had a diagnosis of Asthma, shortness of breath, Alzheimer's disease, and that R93 had severely impaired cognition. Policy and procedure titled ORAL INHALATION ADMINISTRATION, dated 06/15, directed staff, "k. Instruct the resident to take a deep breath, pause briefly and then exhale normally. Repeat pattern throughout treatment. L. Remain with the resident for the treatment unless the resident has been assessed and authorized to self-administer."	F 176	need for continuation or adjustment of this plan of correction.	
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.	F 242		11/24/17

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F 242	Continued From page 3 (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to assess and provide bathing preferences for 1 of 2 residents (R138) reviewed. Findings include: Review of the quarterly MDS dated 8/1/17, revealed R138 was cognitively intact and required one person physical assist for bathing. On 10/16/17, at 1:33 p.m., R138 stated being provided only one shower each week and would prefer more than one. R138 indicated the facility had never asked how many showers R138 wanted per week. On 10/18/17, at 9:32 a.m. licensed practical nurse (LPN)-F identifed that R138 received one shower per week. On 10/18/17, at 10:06 a.m. registered nurse (RN)-F confirmed R138's shower was scheduled once per week. Review of the undated group sheet did not identify the number of showers R138 was provided per week. R138's interdisciplinary care conference and quarterly reviews dated 5/16/17, and 8/8/17, revealed R138 was asked bathing and time preference, however, there was no indication R138 had been asked how many times R138 preferred to bathe each week.	F 242	Preparation, submission, and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. F242 R138 was assessed for bathing preferences. The care plan and resident information sheet was immediately updated to reflect R138's preference. All residents will be assessed for bathing preferences. Care plans and resident information sheets will be updated to reflect changes in preference. Bathing/showering preferences assessment regarding number per week will be added to the admission assessment and reviewed quarterly during care conferences and as needed based on a change in condition. Director of Nursing or designee(s) will audit 10 current residents per week. The resident's admission assessments, care conference documentation, care plans	

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F 242	Continued From page 4 On 10/19/17, at 1:13 p.m., RN-F explained that each room on the unit had one weekly bath scheduled. RN-F acknowledged that prior to March 2017, residents were never asked at admission or during their stay, how often they wanted to be bathed. RN-F further identified that he was informed yesterday R138 wanted two showers per week and the care plan had been updated to include R138's bathing frequency preferences.	F 242	and resident information sheets will be audited to ensure that resident preferences are being assessed and preferences are reflected appropriately. The QAPI committee will review the compliance of each audit and will dictate the need for continuation or adjustment of this plan of correction based on the compliance noted.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures.	F 272		11/24/17

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F 272	Continued From page 5 (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure oral assessments for 2 of 3 residents (R24, R223); and a bladder incontinence assessment for 1 of 3 residents (R81) were comprehensive and accurate reflection of each resident's status. Findings include: R24, on 10/17/17, at 1:54 p.m., was observed to have missing teeth on the lower gum line and no upper teeth. On 10/18/17, at 3:12 p.m. licensed practical nurse (LPN)-D verified R24 did not have any upper teeth, but did have some teeth on the lower gum. Record review revealed R42 had a significant change Minimum Data Set (MDS) completed on 5/8/17, which noted R24 had teeth	F 272	Preparation, submission, and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. F272 The oral assessments for R24 and R223 were reviewed and updated to ensure that the residents' oral status was accurate and comprehensive. The bladder incontinence assessment for R81 was	

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F 272	Continued From page 6 fragments. However, a dental assessment dated 5/5/17, incorrectly identified R24 as not having any teeth; and as having upper and lower dentures, which R24 did not wear. There were no other oral/dental assessments found in the medical record which addressed R24's dentition. R223, on 10/16/17 at 11:08 a.m., was observed to have missing upper and lower teeth, with no partials in place. R223's oral status was not accurately and comprehensively assessed. Record review revealed R223 was admitted to the facility on 10/10/17. A 10/10/17, document titled Admit/Initial Data Collection indicated R223 had tooth fragments, as well as broken or loose full or partial dentures. The admission MDS dated 10/16/17, indicated R223 had tooth fragments, as well as broken or loose full or partial dentures. However, a more detailed and comprehensive 10/10/17, document titled MHM Oral/Dental Evaluation did not address R223's tooth fragments/missing teeth, and instead indicated R223 was edentulous. R81 was originally admitted to the facility on 3/13/17. From admission to completion of a quarterly MDS on 9/5/17, the medical record lack documentation of a comprehensive bladder assessment to address whether R81 was or was not occasionally incontinent of urine. A five (5) day MDS dated 3/20/17; and a 14-day MDS dated 3/27/17, indicated R81 was occasionally incontinent of urine. However, a urinary incontinence assessment dated 3/21/17, identified R81 was continent of urine. A quarterly MDS completed on 6/13/17, indicated R81 was incontinent of urine.	F 272	reviewed and updated to ensure that the resident's incontinence status was accurate and comprehensive. All resident oral assessments and bladder incontinence assessments will be audited for comprehensiveness and accuracy. The IDT completing oral and bladder incontinence assessments will be re-educated on importance of accuracy and comprehensiveness through exhaustive review of resident documentation, interview and observation. Director of Nursing or designee(s) will conduct weekly audits of 10 residents' oral assessments and 10 residents' bladder incontinence assessments to ensure that assessments are accurate and comprehensive. Audits will occur weekly for four weeks and then be reviewed at the monthly QAPI committee meeting. The QAPI committee will review the compliance of each audit and will dictate the need for continuation or adjustment of this plan of correction based on the compliance noted.	

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R81 was admitted to the hospital on 6/14/17, and readmitted on 6/16/17. A 5-day admission MDS dated 6/23/17, and bladder assessment dated 6/25/17, identified R81 was continent of urine. However, at the time of the quarterly assessment, dated 9/5/17, R81 was identified as being occasionally incontinent of urine. A bladder assessment dated 9/15/17, identified R81 was continent of urine.

On 10/18/17, at 9:42 a.m. registered nurse (RN)-D stated R81 always knew when needing to use the bedpan, did not use any incontinent products; and had not had any incontinent episodes that she was aware of.

On 10/18/17, at 10:45 a.m. R81, who received dialysis, stated not having incontinent episodes. Per review of a quarterly MDS completed on 9/5/17, R81's BIMS score was 15/15, indicating an intact and accurate cognitive status.

On 10/18/17, at 10:13 a.m. RN-E acknowledged R81's care plan did not address urinary incontinence. At 11:19 a.m. RN-E stated R81 had several hospitalizations that may have impacted urinary continence at the time each MDS was completed. RN-E obtained nursing assistant documentation from the computer, which identified the following dates of urinary incontinence for R81: two episodes on 9/2; and no urinary incontinent episodes from 9/3 to 9/25/17. RN-E stated she was not able to access information further back than 9/2/17.

A copy of the facility's policy and procedure regarding completion of assessments was requested. On 10/19/17, at 10:00 a.m. the administrator stated the facility did not have a

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F 272	Continued From page 8 policy regarding care plan development and used the Resident Assessment Instructions (RAI) manual to develop the care plan after completion of assessments. The manual, dated 10/17, indicated the assessment information was used to develop, review, and revise the plan of care that was to be used to provide services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.	F 272		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or	F 278		11/24/17

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F 278	Continued From page 9 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to complete an accurate Minimum Data Set (MDS) for 1 of 1 resident (R42) identified on the MDS as wandering about the facility. Findings include: R42 was admitted to the facility on 5/9/17, and an admission MDS completed on 5/16/17, indicated R42 exhibited wandering behaviors. The behavior care area assessment (CAA) dated 5/17/17, identified R42 had wandered, however, a review of R42's progress notes, dated 5/9/17 to when discharged on 6/14/17, did not reveal R42 exhibited wandering behaviors. A progress note dated 5/17/17, revealed R42 had agreed to move to a secure unit because spouse had behaviors of wandering/elopement, not because of any wandering/elopement behaviors on R42's part. Review of R42's care plan, dated 6/9/17, did not address wandering behaviors. On 10/19/17, at 1:35 p.m., during interview, licensed practical nurse (LPN)-E stated R42 and spouse had moved to a secure unit because R42's spouse would attempt to elope and take R42, who was wheelchair dependent, along. LPN-E stated that once they were both on the secure unit, R42's spouse would wheel R42	F 278	Preparation, submission, and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. F278 R42 is no longer a resident of the facility. MDS Coordinator or designee will review the MDS for current residents identified with elopement/wandering behaviors to ensure accuracy of MDS coding. IDT members who complete Section E of the MDS will be provided re-education to thoroughly review all available documentation and data such as progress notes, assessments, interviews and observations to ensure accuracy of coding in the MDS. Social Services Director or designee(s) will conduct weekly audits of section E of the MDS prior to submission to ensure	

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F 278	Continued From page 10 around on the unit and attempt to elope. On10/19/17, at 1:45 p.m. registered nurse (RN)-E stated R42's spouse needed more supervision than R42. At 2:49 p.m. RN-E, who was also the MDS coordinator, explained that R42's spouse would push R42 about the facility and then leave R42 alone in the hallway. RN-E stated R42 would then wheel self back to room. RN-E verified there was no documentation in R42's record which indicated R42 wandered. RN-E explained that R42 purposefully would go back to room and acknowledged the MDS was coded inaccurately for wandering behavior.	F 278	accuracy of MDS coding. Audits will occur weekly for four weeks and then be reviewed at the monthly QAPI committee meeting. The QAPI committee will review the compliance of each audit and will dictate the need for continuation or adjustment of this plan of correction based on the compliance noted.	
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the	F 280		11/24/17

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F 280	Continued From page 11 right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 280		

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F 280	Continued From page 12 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise an individualized care plan for 1 of 1 resident (R170) to include the need for extensive assistance with toileting. Findings include: On 10/17/17, from 1:17 p.m. to approximately 2:30 p.m., R170 was observed to sit at a table, walk on the unit and go into R1770's room independently. R107 was wearing brown slacks with a belt and a tan shirt. At 1:17 p.m. a wet, darkened area was noted on the zipper/fly area of R170's slacks. During this time, R170 walked around the unit, went into room, leave the room and walk into the hallway again. At approximately 2:30 p.m., the darkened area on the front of R170's pants appeared lighter and drier. During this random observation no staff intervention was noted. On 10/18/17 at 8:29 a.m., R170 was	F 280	Preparation, submission, and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. F280 The care plan for R170 was reviewed and revised appropriately for toileting needs on 10/18/17. Toileting care plans for current residents will be reviewed; care plans will be revised to reflect any identified changes in resident toileting needs.	

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F 280	Continued From page 13 sitting at a table eating breakfast with other residents and dressed in clean clothes. R170 remained at the table until 9:11 a.m. and then went to his room. At 9:26 a.m., R170 was in the bathroom in room independently, was standing by the toilet, however facing away from the toilet. The toilet had just been flushed and at 9:37 a.m. R170 remained in the bathroom alone, with the door closed. At 10/18/17, at 9:41 a.m. nursing assistant (NA)-B went into the room and assisted R170 with washing hands and then walked R170 walked out of the room. On 10/18/17, at approximately 9:45 a.m., NA-B acknowledged helping R170 wash hands, however explained not being assigned to R170 that shift. At 9:50 trained medication assistant (TMA)-A brought R170 back into room and assisted with shaving. On 10/18/17 at 9:53 a.m.,TMA-A reported R170 required more help with cares due to dementia and increased difficulty with the sequence process of getting dressed, etc. TMA-A indicated she would take R170 to the bathroom before lunch, but explained that R170 often took self. On 10/19/17, at 10:52 a.m., NA-G reported R170 sometimes stayed dry and other times R170 was unable to locate the bathroom and would urinate on the floor. NA-G explained frequently asking R170 if he needed to use the bathroom and also reported R170 would take self to the toilet. On 10/18/17, at 2:34 p.m. registered nurse (RN)-C was asked how staff knew how to care for R170. RN-C explained R170 would take self, however, staff would take R170 every two hours to use the toilet. When the kardex assignment sheet and the care plan were reviewed, RN-C	F 280	All nursing staff will be re-educated on the importance of reporting changes in a resident's toileting needs to licensed nurse supervisors in a timely manner. IDT members responsible for care plan documentation will be re-educated on the importance of revising a care plan to reflect the current status of a resident's toileting needs. The Director of Nursing or designee(s) will audit 10 resident care plans to ensure that the care plan reflects the current status of a resident's toileting needs. Audits will occur weekly for four weeks and then be reviewed at the monthly QAPI committee meeting. The QAPI committee will review the compliance of each audit and will dictate the need for continuation or adjustment of this plan of correction based on the compliance noted.	

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F 280	Continued From page 14	F 280		

acknowledged the care plan did not specify interventions for toileting for R170 and indicated another bladder assessment may be needed.

R170 had a change from the quarterly Minimum Data Set (MDS) dated 6/6/17, from limited assistance to extensive assistance with toileting on the annual MDS dated 8/19/17. The Care Area Assessment (CAA) dated 8/29/17, indicated R170 was frequently incontinent of urine, wore disposable briefs and required extensive assistance for physically managing clothes, at times, and verbal cues to use the bathroom. The care plan had not been updated to reflect R170's increase in staff assistance with toileting.

The electronic care plan reviewed indentified R170 was incontinent of urine due to diuretic use and cognitive impairment. Interventions included: discussed medications with medical doctor, monitor and report changes in ability to toilet or continence, monitor for signs and symptoms of a urinary tract infection etc. use of briefs, pads for incontinence protection. R170's toileting plan was to monitor and report changes: in ability to toilet, in continent status, and to monitor/report signs and symptoms of urinary tract infections (UTI) and use of brief/pads for incontinence protections. The care plan also indicated R170 had a physical functional deficit related to mobility, impairment, self care impairment and needed toileting assistance of one staff for cueing and physical needs, as needed.

On 10/19/17, at 11:43 a.m. the director of nurses (DON) stated the facility did not have a policy regarding care plan revision; and used the Resident Assessment Instructions (RAI) manual to revise the care plan. The manual dated 10/17,

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F 280	Continued From page 15 indicated assessment information was used to develop, review, and revise the plan of care that was to be used to provide services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.	F 280		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan to ensure 1 of 5 residents (R24) received the appropriate care following a urinary incontinence episode; failed to follow the care plan to ensure 1 of 3 residents (R223) was well groomed/dressed and and failed to ensure 1 of 1 resident (R208) was toileted according to the care plan. Findings include: R24's care plan dated 1/11/17, identified R24 was incontinent of urine, wore incontinent briefs and was to be checked and changed upon rising, before/after meals, at bedtime and as needed. The most recent bladder assessment dated 5/5/17, indicated R24 was to be checked and changed every two hours because of functional urinary incontinence. However, based on observation, R24 did not receive complete urinary	F 282	Preparation, submission, and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. F282 Proper peri care was provided to R24 on 10/17/17. R223 was shaven and dressed in clean clothing on 10/19/17. R223's belonging were transferred from his old room to his new room on 10/19/17. R208's care plan was reviewed and updated.	11/24/17

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F 282	Continued From page 16 incontinence care after a urinary incontinence episode. On 10/17/17, at 6:23 p.m. R24 was observed being transferred via a mechanical lift from the wheelchair to bed, by nursing assistants (NA) I and C. Once in bed at 6:30 p.m., R24's urinary incontinence pad was removed and noted to be wet. NA-I verified at this time the pad was wet. R24 was then turned to the right side and NA-C began cleansing the buttocks and rectal /urethral areas. After cleansing and drying, a protective skin cream barrier was applied to the buttock area. R24 was then turned onto the back, and with a disposable wipe the resident's abdominal fold area was cleansed, dried and a protective skin cream barrier applied. At 6:39 p.m. NA-C began pulling the incontinent product up between R24's legs when NA-C was asked why the front of the pubic area had not been cleansed . NA-C stated, "You are right" and then proceeded to provide the proper pericare. NA-C stated some residents became upset if urinary incontinence care was done too vigorously, such as when a resident also had a bowel movement. R223 was admitted to the facility on 10/10/17, and the initial care plan dated 10/10/17, indicated R24 had diagnoses which included dementia. The initial care plan identified R24 was to be clean and well groomed every day, and required extensive assistance of one (1) staff for dressing and grooming. On 10/16/17, at 10:51 a.m. R223 was observed to have beard stubble and the front of his pants were noted to be wet, but no odor detected. A	F 282	All residents incontinence care plans will be reviewed and updated as needed by 11/24/17. Incontinence/Peri Care training was completed with NA-C on 10/17/17 to ensure proper incontinent care is performed. Incontinence/Peri Care training will be completed with all certified nursing assistants by 11/20. The IDT completing resident care plans and MDS assessments were educated on the importance of continuity of care as reflected in care plans and assessments. The Director of Nursing or Designee(s) will conduct audits of incontinence/peri care to ensure it is completed per protocol. Audits will occur weekly for four weeks and then be reviewed at the monthly QAPI committee meeting. The QAPI committee will review the compliance of each audit and will determine the need for continuation or adjustment of this plan of correction based on the compliance noted.	

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nursing assistant was observed to change R223's pants and dress R223 in a pair of plaid pajama bottoms, as the nursing assistant stated R223 did not have any other pants in the closet.

On 10/18/17, at 11:29 a.m. R223 was observed laying down in bed and was still noted to have beard stubble. At 4:27 p.m. R223 was still observed to be unshaven, the front of R223's black sweatshirt was noted to be soiled, and R223 was wearing the same plaid pajama bottoms as observed on 10/16/17.

On 10/19/17, at 9:08 a.m. R223 was still unshaven and was wearing the same soiled black sweatshirt as observed on 10/18/17. R223 was also wearing the same plaid pajama bottoms he had been observed wearing on 10/16/17.

On 10/19/17, at 9:09 a.m. a nursing assistant student, who had been assigned to R223 for the day was interviewed. The student stated R223 did not have any other clothes in the closet than what R223 was wearing at this time and did not have any other clothes to wear.

On 10/19/17, at 9:21 a.m. registered nurse (RN)-G stated she did not know R223 had not been shaven and did not have other clothes. RN-G stated R223 had been transferred from another unit on 10/13/17, and RN-G would check to ensure all R223's belongings had been transferred, and would also check with social services regarding additional clothing. At 9:33 a.m. RN-G stated R223's clothes had not been moved to the new room when R223 was moved on 10/13/17.

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On 10/19/17 at 8:32 a.m. R208 was sitting on a chair in the dining room with beverages and breakfast placed on the table. R208 remained in the dining room until approximately 9:00 a.m. when R208 got up and began walking up and down the hall. At 9:14 a.m. R208 sat down in a day room, where R208 remained until 9:23 a.m. when an activity staff person asked R208 if she wanted to participate in an activity. R208 remained in the day room until 11:30 a.m. when a staff person assisted R208 to the dining room, where R208 received medications, a nutritional beverage and coffee to drink. No offer to use the bathroom was observed from 8:32 to 11:30 a.m. a total of 2 hours and 58 minutes.

The current care plan reviewed identified the resident needed extensive assist with activities of daily living and directed staff to assist R208 to the toilet every 2 hours and as needed.

On 10/19/17 at approximately 11:50 am, nursing assistant (NA)-G was asked if she was responsible for R208. NA-G reported another NA-H was R208's nursing assist. When asked, NA-H reported not being the assigned nursing assistant for R208. At that point NA-G retrieved the working assistant worksheets and verified she was responsible, however the NA/TMA (TMA)-A had gotten R208 up earlier in the morning. NA-C indicated R208 was taken to the bathroom about 9:15 am before the nursing assistant went on break. At 12:00 p.m. the registered nurse (RN)-C took R208 into the bathroom. R208 was wearing a dry urinary incontinent pad and voided on the toilet.

On 10/19/17 at 12:15 p.m., RN-C verified the care plan identified R208 should be toileted every 2

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F 282	Continued From page 19 hours, and stated staff reported taking R208 to the toilet after breakfast, however, observations of R208 well exceeded 2 hours and 45 minutes of not being toileted. RN-C explained R208 frequently took self to the bathroom, and did not understand why the care plan indentified every two hours. RN-C acknowledged the need to review the care plan and assessment. The care plan, updated on 10/19/17, identified R208 "requires cueing and assist of 1 with routine toileting and prn, will toilet self independently at times. On 10/19/17 at 3:40 p.m. the RN-C acknowledged care plan had been revised, however, no further assessments had been conducted.	F 282		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the appropriate incontinence care was provided to 1 of 5 residents (R24) dependent on staff for incontinence care: failed to ensure 1 of 3 residents (R223) was well groomed and dressed; and failed to ensure 1 of 3 residents (R170) was provided with assistance with toileting per the care plan. Findings include: On 10/17/17, at 6:23 p.m. R24 was observed	F 312	Preparation, submission, and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. F312 Proper peri care was provided to R24 on	11/24/17

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F 312	Continued From page 20 being transferred via a mechanical lift from the wheelchair to bed, by nursing assistants (NA) I and C. Once in bed at 6:30 p.m., R24's urinary incontinence pad was removed and noted to be wet. NA-I verified at this time the pad was wet. R24 was then turned to the right side and NA-C began cleansing the buttocks and rectal /urethral areas. After cleansing and drying, a protective skin cream barrier was applied to the buttock area. R24 was then turned onto the back, and with a disposable wipe the resident's abdominal fold area was cleansed, dried and a protective skin cream barrier applied. At 6:39 p.m. NA-C began pulling the incontinent product up between R24's legs. NA-C was asked why the front of the pubic area had not been cleansed . NA-C stated "You are right" and then proceeded to provide the proper pericare. NA-C stated some residents became upset if urinary incontinence care was done too vigorously, such as when a resident also had a bowel movement. The facility's 2012 policy titled Perineal Care indicated for female residents complete pericare was to be provided in the following manner: raise the upper leg or position on back raising knees; wash perineal area with wash cloth, warm water and soap moving from front to back, separating labia; rinse soap from genital area, moving from front to back; position on side; wash and rinse area around annus from front to back using a clean area of the wash cloth for each stroke; and dry area thoroughly, moving towel from front to back. R223 was observed to have been unshaven since 10/16/17; was observed wearing the same pajama bottoms since 10/16; and was observed	F 312	10/17/17. R223 was shaven and dressed in clean clothing on 10/19/17. R223's belonging were transferred from his old room to his new room on 10/19/17. R170's care plan was reviewed and updated regarding the assistance with toileting on 10/18/17. R170 received assistance with toileting thereafter. All residents that require appropriate incontinence care will be identified and facility will ensure the appropriate incontinence care is given according to their care plan. All residents will be observed to ensure that they are receiving proper grooming and clean clothing according to their care plans. All residents will be observed to ensure that they are receiving assistance with toileting needs according to their care plans. Re-education will be provided to all nursing staff on: 1. The policy and procedure of proper incontinence care and nursing assistance will give a return demonstration of proper incontinence care; 2. The policy and procedure of resident grooming and hygiene 3. Identifying, reporting and giving increased need for toileting assistance The Director of Nursing or designee(s) will conduct an audit of 10 residents identified as requiring incontinence care to ensure proper incontinence care is being given. The Director of Nursing or designee(s) will conduct an audit of 10 residents to ensure they are receiving grooming and good	

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F 312	Continued From page 21 wearing the same black soiled sweatshirt for two days. R223 was admitted to the facility on 10/10/17, and the initial care plan dated 10/10/17, indicated R24 had diagnoses which included dementia. The initial care plan identified R24 was to be clean and well groomed every day, and required extensive assistance of one (1) staff for dressing and grooming. On 10/16/17, at 10:51 a.m. R223 was observed to have beard stubble and the front of his pants were noted to be wet, but no odor was detected. A nursing assistant was observed to change R223's pants and dress R223 in a pair of plaid pajama bottoms, as the nursing assistant stated R223 did not have any other pants in the closet. On 10/18/17, at 11:29 a.m. R223 was observed laying down in bed and was still noted to have beard stubble. At 4:27 p.m. R223 was still observed to be unshaven, the front of R223's black sweatshirt was noted to be soiled, and R223 was wearing the same plaid pajama bottoms as observed on 10/16/17. On 10/19/17, at 9:08 a.m. R223 was still unshaven and was wearing the same soiled black sweatshirt as observed on 10/18/17. R223 was also wearing the same plaid pajama bottoms he had been observed wearing on 10/16/17. On 10/19/17, at 9:09 a.m. a nursing assistant student, who had been assigned to R223 for the day was interviewed. The student stated R223 did not have any other clothes in the closet than what R223 was wearing at this time and did not have any other clothes to wear.	F 312	hygiene. The Director of Nursing or designee(s) will conduct an audit of 10 residents identified of needing assistance toileting to ensure they are receiving the assistance according to the care plan. These audits will occur weekly for four weeks and then be reviewed at the monthly QAPI committee meeting. The QAPI committee will review the compliance of each audit and will dictate the need for continuation or adjustment of this plan of correction based on the compliance noted.	

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F 312	Continued From page 22 On 10/19/17, at 9:21 a.m. registered nurse (RN)-G stated she did not know R223 had not been shaven and did not have other clothes. RN-G stated R223 had been transferred from another unit on 10/13/17, and RN-G would check to ensure all R223's belongings had been transferred, and would also check with social services regarding additional clothing. At 9:33 a.m. RN-G stated R223's clothes had not been moved to the new room when R223 was moved on 10/13/17. On 10/17/17, from 1:17 p.m. to approximately 2:30 p.m. , R170 was sitting at a table, walking on the unit and went to his room independently. R107 was wearing brown slacks with a belt and a tan shirt; and at 1:17 p.m. a wet, darkened area was noted on the zipper/fly area of R170's slacks. During this time, R170 walked around the unit, go into his room, leave and walk the hallway again, At approximately 2:30 p.m. the darkened area on R170's front pants, appeared lighter and drier. During this random observation no staff intervention was noted. On 10/18/17 at 8:29 a.m. R170 was sitting at a table eating breakfast with other residents and dressed in clean clothes. R170 remained at the table until 9:11 a.m. when R170 went to his room. At 9:26 a.m. R170 was in the bathroom in room independently, standing by the toilet, however, facing away from the toilet. The toilet had just been flushed and at 9:37 a.m., R170 remained in the bathroom alone, with the door closed. At 10/18/17, at 9:41 a.m. nursing assistant (NA)-B went into the room and assisted R170 with washing hands and then walked R170 out of the room. R170 had a change from the quarterly Minimum	F 312		

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F 312	Continued From page 23 Data Set (MDS), dated 6/6/17, from limited assistance to extensive assistance with toileting on the annual MDS dated 8/19/17. The Care Area Assessment (CAA) dated 8/29/17, identified R170 was frequently incontinent of urine, wore disposable briefs and required extensive assistance for physically managing clothes at times, and verbal cues to use the bathroom. R170's annual MDS dated 8/29/17, indicated R170 had impaired cognition with a BIMS score of 2. R170 needed extensive assist with toileting and with personal hygiene. R170 did not have a toileting program, and was frequently incontinent of bowel and bladder. R170 was able to ambulate around the unit with supervision. The electronic care plan reviewed indicated the R170 was incontinent of urine due to diuretic use and cognitive impairment. Interventions included: discussed medications with medical doctor, monitor and report changes in ability to toilet or continence, monitor signs and symptoms of a urinary tract infection etc. use of briefs, pads for incontinence protection. Resident toileting plan is to monitor and report change in ability to toilet on continent status and monitor and report signs and symptoms of urinary tract infections (UTI) and use of brief/pads for incontinence protections. The care plan also identified R170 had a physical functional deficit related to mobility, impairment, self care impairment and needed toileting assistance of one staff for cueing and physical needs as needed. . On 10/18/17, at approximately 9:45 a.m., NA-B explained she had just helped R170 wash hands and that she was not assigned to R170 that shift. At 9:50 TMA-A brought R170 back into room and assisted with shaving. On 10/18/17 at 9:53 a.m.	F 312		

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F 312	Continued From page 24 trained medication assistant (TMA)-A reported R170 needs more help with cares due to dementia and increase difficulty with the sequence process of getting dressed etc. TMA-A indicated she would take him to the bathroom before lunch, but that he often took himself. On 10/19/17, at 10:52 a.m. NA-G reported R170 sometimes stayed dry and then other times R170 was unable to locate the bathroom and would urinate on the floor. NA-G indicated frequently asking R170 if he needed to use the bathroom and also reported R170 would take elf to the toilet. On 10/18/17, at 2:34 p.m. registered nurse (RN-C) was asked how staff knew how to care for R170. RN-C explained R170 would take elf, however, staff would take R170 every two hours to use the toilet. When the kardex assignment sheet and the care plan were reviewed, RN-C confirmed the care plan did not specify interventions for toileting for R170 and indicated another bladder assessment may be needed.	F 312		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-	F 315		11/24/17

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F 315	Continued From page 25 (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess and identify the necessary care and services for 1 of 3 residents (R208) reviewed for urinary incontinence. Findings include: R208's annual minimum data set (MDS) dated 7/13/17, indicated R208 was severely cognitively impaired, required extensive assistance for toileting and was occasionally incontinent of bladder. The quarterly MDS dated 10/3/17, indicated R208 needed extensive assist with	F 315	Preparation, submission, and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. F315 The bladder assessment for R208 was	

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	245105	A. BUILDING _____ B. WING _____	10/19/2017

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F 315	Continued From page 26 toileting and was frequently incontinent. The current care plan reviewed indicated the resident needed extensive assist with activities of daily living and directed staff to assist R208 to the toilet every 2 hours and as needed. On 10/19/17 at 8:32 a.m. R208 was sitting on a chair in the dining room with beverages and breakfast placed on the table. R208 remained in the dining room until approximately 9:00 a.m. and then got up and began walking up and down the hall. At 9:14 a.m. R208 sat down in a day room, where R208 remained until 9:23 a.m., when an activity person asked if R208 wanted to attend an activity. At approximately 11:50 am, nursing assistant (NA)-G was asked if she was responsible for R208. NA-G reported NA-H was R208's nursing assistant. When asked, NA-H reported not being the assigned nursing assistant for R208. At that point NA-G retrieved the working assistant worksheets and verified she was responsible, however the NA/TMA (TMA-A) had gotten R208 up earlier in the morning. NA-C reported that R208 was taken to the bathroom after breakfast and that R208 was wearing a dry urinary incontinent pad and voided on the toilet. On 10/19/17 at 12:15 p.m., RN-C verified the care plan identified the resident should be toileted every 2 hours, and stated staff reported taking R208 to the toilet after breakfast. However, the time well exceeded 2 hours and 45 minutes of not being toileted. RN-C explained R208 frequently took self to the bathroom, and did not understand why the care plan indentified every two hours. RN-C said that the care plan and assessment needed to be reviewed. The care plan, updated on 10/19/17, identified,	F 315	reviewed on 10/19/17 and the care plan for R208 was updated on 10/19/17 to reflect the change in care. All current residents' bladder assessments will be reviewed to ensure the care plan reflected the most current bladder assessment. All residents will receive a bladder assessment at least annually or as needed based on a change in condition. The IDT team members completing resident care plans and MDS assessments will be educated on the importance of continuity of care as reflected in care plans and assessments. The Director of Nursing or designee(s) will audit 10 residents' bladder assessments and care plans to ensure the bladder assessment and care plan are accurate. The audits will occur weekly for four weeks and then be reviewed at the monthly QAPI committee meeting. The QAPI committee will review the compliance of each audit and will dictate the need for continuation or adjustment of this plan of correction based on the compliance noted.	

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F 315	Continued From page 27 "requires cueing and assist of 1 with routine toileting and prn , will toilet self independently at times." On 10/19/17 at 3:40 p.m. the RN-C verified the care plan had been revised, however, no further assessments had been completed.	F 315		

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K 000	INITIAL COMMENTS 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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (The Estates of Roseville) was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and	K 000	EPOC	

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

Electronically Signed — 11/09/2017

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

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K 000	Continued From page 1 Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Golden Living Center Lake Ridge was built in 1965 as a 2-story building without a basement and was determined to be Type II (222) construction. In 1973 a 1-story addition was constructed to the west of the existing building and was determined to be Type II (222) construction. In 1983 a 2 story addition (Woodhill) was constructed to the south of the original building and was determined to be Type II (222) construction. In 1995 a dining room addition was constructed to the south wing of the 1973 addition and was determined to be Type II (222) construction. The entire building is fully fire sprinkler protected. The facility has a fire alarm system with smoke detectors at all smoke barrier doors that are held open and with detection in areas open to the corridor. The facility has 30-foot on center corridor smoke detection in the 1983 addition (Woodhill) that is on the fire alarm system. Hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code.	K 000		

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K 000	Continued From page 2 The building is divided into 9 smoke zones with 1/2 hour fire rated barriers. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as one building. The facility has a capacity of 175 beds and had a census of 137 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 351 SS=D	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is not met as evidenced by: Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by	K 351	K351 The wooden shelve located in closet 235	11/24/17

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K 351	Continued From page 3 construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Findings Include: On facility tour between 09:00 AM and 01:00 PM on 10/18/2017, based on observation and interview revealed that the following include: Found a wooden shelve blocking the fire sprinkler head coverage in closet 235. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 351	was removed on 11/1/2017 All closet and storage areas were audited on 11/3/17 to ensure nothing is blocking the fire sprinkler heads All closet and storage areas will be added to the quarterly preventative maintenance schedule which will include checking the sprinkler heads to ensure they have adequate clearance. The preventative maintenance schedule will be audited by the Executive Director or designee each quarter to ensure the sprinkler heads located in closets and storage areas have adequate clearance The QAPI committee will review the results of audits and determine the need for continuation or adjustment of this plan of correction	
K 372 SS=F	**NFPA 101 Subdivision of Building Spaces - Smoke Barrie** Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour	K 372		11/24/17

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K 372	Continued From page 4 fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 10/18/2017, based on observation and interview revealed that the following include: Found penetrations above ceiling in smoke barriers located in the memory care unit around duct work and next to room 414, a 4" hole in wall. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment.	K 372	K372 The penetrations above the ceiling in the memory care unit and next to room 414 will be sealed with a fire block foam sealant by 11/15/17. All smoke barriers were audited on 10/26/17 for penetrations above the ceiling. All penetrations identified in the additional smoke barriers will be sealed by 11/24/17. All smoke barriers will be audited for penetrations on an annual basis. This annual check will be added to the annual preventative maintenance schedule. Executive Director will audit the smoke barriers to ensure penetrations are sealed by 11/24/17. Executive Director will audit the annual preventative maintenance schedule and add it into the QAPI process to review annually. The QAPI committee will review the	

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K 372	Continued From page 5 This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 372	results of audits and determine the need for continuation or adjustment of this plan of correction	