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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: RE2L

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: **2** (L8)

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

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

6. DATE OF SURVEY **09/27/2021** (L34)

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	

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

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)

12. Total Facility Beds **150** (L18)

13. Total Certified Beds **150** (L17)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	150			
(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: Sarah Grebenc, Unit Supervisor Date: 10/11/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL: Melissa Poepping, Enforcement Specialist Date: 10/11/2021 (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

DETERMINATION APPROVAL

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **10/04/2021** (L33)

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
October 11, 2021

CMS Certification Number (CCN): 245105

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

Dear Administrator:

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

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

Effective September 17, 2021 the above facility is certified for:

150 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 150 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 11, 2021

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

RE: CCN: 245105
Cycle Start Date: August 5, 2021

Dear Administrator:

On August 26, 2021, we notified you a remedy was imposed. On September 27, 2021 the Minnesota Department of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 17, 2021.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective October 10, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 26, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 10, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on September 17, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: RE2L
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: **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 **08/05/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12. Total Facility Beds **150** (L18)

13. Total Certified Beds **150** (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___ 1. Acceptable POC
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
	150			
(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
Lisa Prokosch, HFE NE II
Date : 09/20/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL
Melissa Poepping, Enforcement Specialist
Date: 10/01/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **08/01/1969** (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

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
August 26, 2021

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

RE: CCN: 245105
Cycle Start Date: August 5, 2021

Dear Administrator:

On August 5, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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 electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 10, 2021.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 10, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 10, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO

only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by October 10, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Estates At Roseville Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 10, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Sarah Grebenc, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792 Mobile (651)238-8786

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 5, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING ______ B. WING ______	C 08/05/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments From 8/2/21 through 8/5/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 8/2/21 to 8/5/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5105202C (MN69378), however NO deficiencies were cited due to actions implemented by the facility prior to survey: The following complaints were found to be UNSUBSTANTIATED: H5105196C (MN67350), H5105197C (MN67829), H5105198C (MN68058), H5105199C (MN69233), H5105200C (MN69258), H5105201C (MN69287), H5105203C (MN72552), H5105204C (MN73205), H5105205C (MN73233, H5105206C (MN74976), and H5105207C (MN75032). The facility's plan of correction (POC) will serve as your allegation of compliance upon the	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/02/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING ______ B. WING ______	C 08/05/2021

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	Continued From page 1 Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to assess self-administration of oxygen (O2) for 1 of 1 resident (R27) reviewed for respiratory care. Findings include: R27's quarterly Minimum Data Set (MDS) dated 5/3/21, indicated R27 was cognitively intact, required minimal to no assistance with activities of daily living (ADLs) and required oxygen therapy. R27's diagnoses included lung cancer and chronic obstructive pulmonary disease (COPD). R27's leave of absence (LOA) care plan dated 11/20/20, indicated, for extended timeframe's, please obtain orders from physician to provide medications on LOA. Educate resident or	F 554	R27 had completed assessment for self administration of oxygen for respiratory care. Residents who utilize oxygen were asked if they would like to self administer oxygen and self administration assessments were completed. Re-education provided to staff regarding self administration of oxygen for respiratory care. DNS/or Designee to audit 3 residents per week X 4 weeks to ensure proper assessments were completed with residents who request self administering oxygen.	9/17/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING ______ B. WING ______	C 08/05/2021

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 554	Continued From page 2 responsible party on administration of medications/O2. R27's care plan further indicated, administer oxygen as ordered. R27's physician order dated 11/4/20, check O2 liquid and portable tanks for oxygen amount. Record percentage (%) in tank client is using. Fill if needed. R27's physician order dated 11/29/20, indicated, O2 via nasal cannula 2-4 liters (L)/minute. R27's physician order dated 11/18/20, indicated, Ok to self administer nebulizer [neb] treatments after setup by nurse - use mask as needed. R27's self administration of medication evaluation dated 11/18/20, indicated the resident was capable of self-administering inhalation medication. R27 was ok to self-administer neb treatments after setup by nurse - use mask as needed. During observation on 8/2/21, at 2:00 p.m. R27 was in bed and the oxygen ran at 3 liters per minute via nasal cannula attached to an oxygen concentrator. R27's room also contained a large liquid oxygen container, 2 portable oxygen containers, 1 oxygen canister (green) and a portable concentrator. When interviewed on 8/2/21, at 3:13 p.m. R27 stated it was normal to have all the tanks in his room, but license practical nurse (LPN)-C had just come to remove the green tank and said it was not supposed to be in here and did not want the state to see it. When interviewed on 8/3/21, at 1:19 p.m. R27	F 554	Results of the audit findings will be reviewed at QAPI monthly and to be adjusted based on the audit results.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING ______ B. WING ______	C 08/05/2021

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 554	Continued From page 3 stated he was out of the facility for 8 hours yesterday (8/2/21) but returned once during that time because his oxygen was low. R27 stated he refilled the portable tank and used the large liquid tank in his room. R27 further stated that if he ran out of oxygen prior to his return to the facility, he would increase the flow rate on the concentrator upon return. When interviewed on 8/3/21, at 2:20 p.m. LPN-B stated only staff were supposed to change a resident's oxygen from a concentrator or liquid tank to a portable tank. LPN-B further stated staff were supposed to check the level of the portable tank and only staff would fill it. LPN-B stated portable oxygen tanks were only filled in the oxygen room and never in the resident room. When interviewed on 8/3/21, at 2:28 p.m. nursing assistant (NA)-A stated when a resident, who was on oxygen, went out, staff were supposed to check the portable tank and if it was not full, staff would fill the portable tank in the oxygen room and should never fill it from a tank in the resident's room. When interviewed on 8/4/21, at 11:37 a.m. registered nurse (RN)-C stated R27 was independent and often signed himself out of the facility. RN-C further stated R27 would check his own portable tanks to make sure they were full and that he had enough until he returned to the facility. RN-C stated, "I have never helped him with the tanks, not sure who has." When interviewed on 8/4/21, at 12:39 p.m. NA-B stated R27 typically refused all cares in the morning and that he filled his own portable oxygen tank. NA-B stated, I have walked in and	F 554		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING ______ B. WING ______	C 08/05/2021

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 554	Continued From page 4	F 554		

observed him doing it and I asked him if he wanted help and he told me to get out.

When interviewed on 8/4/21, at 1:54 p.m. director of nursing (DON) stated the portable oxygen tanks were checked by the NA's and that it was the NA's responsibility to fill them when they were low or empty. DON further stated that the tanks were only refilled in the oxygen room and never in the resident rooms. DON stated residents should not fill their own tanks and was not aware that R27 filled his own. DON would expect staff to intervene and report if they ever witnessed a resident filling their own tank.

When interviewed on 8/4/21, at 2:27 p.m. R27 stated, he went out that morning (8/4/21) and that he filled the portable tank before he left and again when he returned in preparation for going out again that afternoon. R27 lifted the portable tank to show the fill level indicator was all the way to the green (full) side. R27 stated when the indicator was just above the red but still in the green, it was time to fill it. R27 stated that prior to admission he did not have to fill any portable tanks for himself, but he used to fill some for a friend. R27 further stated no one ever taught him how to fill or verify the level of the portable oxygen tanks.

When interviewed on 8/4/21, at 2:34 p.m. NA-C stated working with R27 on occasion and that R27 would leave the facility regularly. NA-C further stated, I have seen him fill his own portable tanks. I check them but they are often already full because he does it himself.

When interviewed on 8/4/21, at 2:58 p.m. the administrator stated staff removed the liquid tank

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING _____ B. WING _____	C 08/05/2021

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 554	Continued From page 5 from R27's room and educated R27 on having only staff fill his portable tank. When interviewed on 8/5/21, at 10:03 a.m. DON stated R27 did not receive an oxygen self-administration assessment or education because they were not aware he filled the tank himself. DON stated the liquid tank was in R27's room for back-up only and was not supposed to be used to refill the portable tanks. When interviewed on 8/5/21, at 12:36 p.m. LPN-B stated oxygen was considered a medication as it was listed on the medication administration record (MAR) for nurses to check the flow rate every shift. When interviewed on 8/5/21, at 1:15 p.m. DON stated oxygen was considered a medication. The facility checklist titled Filling a Portable Oxygen Tank used to evaluate staff competency included 11 items in a step-by-step procedure. The undated facility policy Oxygen General Guidelines indicated a self administration of oxygen per resident request required a Self-Administration of Medication Assessment. If determined that the resident is safe to self-administration oxygen, the physician shall authorize that the resident is mentally and physically capable of administering oxygen without the assistance of a licensed nurse ...continued ability to self-administer oxygen will be reviewed at patient care conferences.	F 554		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)	F 655		9/17/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING ______ B. WING ______	C 08/05/2021

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 655	Continued From page 6	F 655		

§483.21 Comprehensive Person-Centered Care Planning
§483.21(a) Baseline Care Plans
§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING ______ B. WING ______	C 08/05/2021

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 655	Continued From page 7 administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to offer/provide a summary of the baseline care plan to the resident and/or resident representative for 1 of 1 residents (R222) reviewed who were newly admitted. Findings include: R222's was admitted to the facility on 7/27/21, with diagnoses included unspecified fracture of right calcaneus (heel bone) with subsequent encounter for fracture with routine healing, pain and obesity obtained from the Admission Record dated 8/5/21. R222's Monarch Health Management (MHM) Brief Interview for Mental Status (3.0 BIMS) dated 8/3/21, indicated resident had intact cognition. R222's care plan dated 7/30/21, identified resident had a self care deficit related to impaired mobility related to surgery. The care plan directed staff to provide assist of one staff with bathing, dressing, and personal hygiene. In addition, the care plan indicated for bathing R222 preferred a shower. During interview on 8/2/21, at 3:10 p.m. R222 stated she was admitted to the facility on 7/27/21, and since admit no one at the facility had told her how often to get a shower, bed bath, or sponge bath despite asking multiple staff for the plan of care including the social worker (SW). R222	F 655	R222 was offered a summary of the baseline careplan and offered to sign. All new admission residents could be affected. New admissions were reviewed and ensured they were offered a summary of the baseline careplan to the resident and family and offered to sign. Re-education provided to Social Services regarding offering of the baseline careplan summary and signature to the resident and family. Administrator/or Designee to audit 3 new admissions per week X 4 weeks to ensure the baseline careplan summary and signature was offered to resident and family. Results of the audit findings will be reviewed at QAPI monthly and to be adjusted based on the audit results.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING ______ B. WING ______	C 08/05/2021

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 655	Continued From page 8	F 655		

stated she had asked to see the plan so she can see what was included in the package for the short stay at the facility. R222 also stated she had worn the same gown for 3 days and had not been offered a bed bath and her hair was was not clean and she felt not clean because she had not washed up. During the interview R222's hair was noted to be greasily, uncombed and she wore a blue gown. R222 was also observed with a soft cast on the right leg up to the knee and had ice packs around the ankle wrapped in a black wrapping. R222 stated she recently had surgery and was non weight bearing on the right leg and thus the staff were supposed to assist her with most of the ADL's due to the restrictions.

During interview on 8/3/21, at 2:05 p.m. registered nurse (RN)-A reviewed the MHM-48 Hour Baseline Care plan completed 7/27/21, and locked 7/30/21, by her and verified the care plan had not been reviewed by the resident. RN-A verified the care plan was not signed by R222 and the social worker. RN-A stated the SW was supposed to review it with the resident.

During interview on 8/3/21, at 1:30 p.m. SW stated the initial care conference was supposed to be completed within 24 to 48 hours after admission to the facility. SW stated at the time of the conference she would review the initial baseline care plan and would find out the resident preferences and things that should be in the care plan. The SW stated after the conference she would usually document in the progress notes. The SW acknowledged she had not completed the initial care conference with R222 and "there is no excuse for it."

The facility Care Planning policy revised 6/2019,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING ______ B. WING ______	C 08/05/2021

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 655	Continued From page 9 indicated a baseline plan of care will be developed within 48 hours of admission to ensure that the resident's immediate basic needs are met and maintained. The interdisciplinary team will review the healthcare practitioner's orders and implement a baseline care plan within 48 hours of admission to meet the resident's immediate basic care needs, including such things as; initial goals of the resident, physician orders, nursing orders, dietary orders, therapy services, and social services as needed. In addition, the resident and/or the resident representative will be provided with an opportunity to review and sign the baseline care plan.	F 655		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure bathing was completed for 1 of 5 residents (R222) who was dependent of staff for assistance reviewed with activities of daily living (ADL's). Findings include: R222's was admitted to the facility on 7/27/21, with diagnoses included unspecified fracture of right calcaneus (heel bone) with subsequent encounter for fracture with routine healing, pain and obesity obtained from the Admission Record dated 8/5/21.	F 677	R222 was offered bathing assistance and completed. All residents who need assistance with bathing have the potential to be affected. Re-education provided to nursing staff regarding obtaining preferences for bathing, and offering assistance completing bathing. DNS/or Designee to audit 3 residents per week X 4 weeks to ensure bathing assistance is being offered and provided.	9/17/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING ______ B. WING ______	C 08/05/2021

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 677	Continued From page 10 R222's Monarch Health Management (MHM) Brief Interview for Mental Status (3.0 BIMS) dated 8/3/21, indicated resident had intact cognition. R222's care plan dated 7/30/21, identified resident had a self care deficit related to impaired mobility related to surgery. The care plan directed staff to provide assist of one staff with bathing, dressing, and personal hygiene. In addition, the care plan indicated for bathing R222 preferred a shower. During interview on 8/2/21, at 3:10 p.m. R222 stated she was admitted to the facility on 7/27/21, and since admit no one at the facility had told her how often to get a shower, bed bath, or sponge bath despite asking multiple staff for the plan of care including the social worker (SW). R222 stated she had asked to see the plan so she can see what was included in the package for the short stay at the facility. R222 also stated she had worn the same gown for 3 days and had not been offered a bed bath and her hair was was not clean and she felt not clean because she had not washed up. During the interview R222's hair was noted to be greasily, uncombed and she worn a blue gown. R222 was also observed with a soft cast on the right leg up to the knee and had ice packs around the ankle wrapped in a black wrapping. R222 stated she recently had surgery and was non weight bearing on the right leg and thus the staff were supposed to assist her with most of the ADL's due to the restrictions. During a review of the Plan of Care (POC) response history charting completed by nursing assistants (NA's) it was revealed NA-A had documented he had provided one person physical assistance on 7/31/21, for "full body	F 677	Results of audit findings will be reviewed at QAPI monthly and to be adjusted based on the audit results.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING ______ B. WING ______	C 08/05/2021

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 677	Continued From page 11 bath/shower, sponge bath and transfers in/out of tub/shower." During interview on 8/3/21, at 2:03 p.m. registered nurse (RN)-A stated according to the POC documentation by NA-A R222 had received a shower on 7/31/21. As RN-A reviewed the documentation, NA-A approached surveyor and RN-A and stated he had not given a shower to R222 on 7/31/21. NA-A stated he had given a shower to a different resident with a similar first name and documented a mistake in R222's POC. During interview on 8/4/21, at 3:00 p.m. the director of nursing (DON) stated the staff were supposed to look at the shower/bath list in the units and give the shower/baths according to the list. The DON further stated she would expect the staff to have offered even a bed bath. The facility Activities of Daily Living (ADL's), Supporting policy revised March 2018 indicated "Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, personal and oral hygiene..."	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of	F 688		9/17/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING ______ B. WING ______	C 08/05/2021

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 688	Continued From page 12 motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R8) received range of motion (ROM) according to the plan of care reviewed for limited range motion. Findings include: R8's diagnoses included paraplegia, quadriplegia, and muscle weakness obtained from the annual Minimum Data Set (MDS) dated 4/20/21. In addition, the MDS indicated R8 had intact cognition, had functional limitation in ROM of both upper and lower extremities, required extensive to total physical assistance of two staff with all activities of daily living (ADL's) except eating and did not refuse cares during the assessment period. R8's care plan dated 9/30/18, indicated resident had a self care deficit related to needing assistance with ADL's due to diagnosis of paraplegia and left hand contracture. The care plan directed staff to do left upper extremity ROM before splint placed on at night and off in morning as needed per resident request. In addition, the care plan directed staff to complete passive ROM to lower extremities: ankle flexion and extension,	F 688	R8 is receiving range of motion according to the plan of care reviewed for limited range of motion. Residents with ROM orders were audited to ensure ROM is being completed and documented appropriately. Re-education provided to nursing staff regarding ROM according to the plan of care and documenting completed or refused. DNS/or Designee to audit 3 residents with ROM orders per week X 4 weeks to ensure ROM is being completed and documented appropriately. Results of audit findings will be reviewed at QAPI monthly and to be adjusted based on audit results.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING ______ B. WING ______	C 08/05/2021

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 688		F 688		

Continued From page 13
ankle rotation, toe flexion, hip and knee flexion and hip Abduction.

During interview 8/03/21, at 8:30 a.m. R8 stated the staff was supposed assist with range of motion but did not do it because there was not enough staff and the staff was over worked she thought.

During a continuous observation on 8/4/21, at 7:17 a.m. to 10:14 a.m. several staff were observed assist R8 with cares that included grooming, toileting, getting dressed and wound care however, during the cares no ROM was provided and offered to R8. During the cares registered nurse (RN)-E, RN-F, nursing assistant (NA)-A and NA-D were in the room and none of the staff offered the ROM during the observation.

During a follow up interview on 8/5/21, at 8:33 a.m. R8 stated verified no staff on 8/4/21, after morning cares and the evening shift had offered the ROM that day. R8 stated the staff was busy.

During review of the the Plan of Care (POC) Follow Up Question Report from 6/5/21, through 8/3/21, it was revealed R8 had received ROM 17 times out of 60 days and 5 times R8 had refused however the medical record lacked documentation of staff re-approaching R8.

During interview on 8/5/21, at 8:22 a.m. RN-E reviewed the NA's plan of care (POC) charting and verified that R8 did not receive the passive range of motion as directed and the NA's had documented "Not Applicable."

During a follow up interview on 8/5/21, at 9:06 a.m. RN-E stated the staff were supposed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING ______ B. WING ______	C 08/05/2021

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 688	Continued From page 14 document appropriately and if a resident refused they were to make sure to let the nurse know so to attempt. During interview on 8/5/21, at 12:16 p.m. NA-E stated R8 was supposed to get ROM daily and when R8 refused the staff were supposed to let the nurse know so the nurse could attempt to see if R8 will allow it to be completed. NA-E further stated "when documenting the computer would allow us only to put 9 minutes but I do more. They are to document the time or refuse and not applicable is not a choice I think it's a communication thing." During interview on 8/5/21, at 12:10 p.m. the director of nursing (DON) stated she would expect the staff to complete the ROM if they are to complete it on the POC charting and if they have questions they are to go to their nurse to ask for example how many minutes or repetitions to be completed. The facility Resident Mobility and Range of Motion policy revised July 2017 indicated residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility. In addition, the policy directed staff to document resident's progress towards the established goals and objectives.	F 688		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F 757		9/17/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING ______ B. WING ______	C 08/05/2021

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 757 Continued From page 15 F 757

§483.45(d)(1) In excessive dose (including duplicate drug therapy); or

§483.45(d)(2) For excessive duration; or

§483.45(d)(3) Without adequate monitoring; or

§483.45(d)(4) Without adequate indications for its use; or

§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure international normalized ratio (INR-a laboratory result indicating anti-clotting medication levels) was checked per physician orders and further failed to administer an anti-clotting medication for 1 of 1 resident (R326) reviewed for missed INR and Coumadin (medication that prevents blood clots) administration.

Findings include:

R326's Face Sheet dated 7/29/21, indicated R326 diagnoses included atrial fibrillation (an irregular and often rapid heart rate), myocardial infarction (heart attack), hypertension, and unspecified systolic congestive heart failure (when the heart is not pumping fully).

F635 was administered medication for anti-clotting for INR and Coumadin administration.

Like residents were audited for those receiving anti-clotting medications to ensure INR policy and procedures were being followed and administered medication for anti-clotting for INR and Coumadin administration.

Re-education provided to nursing staff regarding INR policy and procedures to ensure medication for anti-clotting for INR and Coumadin administration.

DNS/or Designee to audit 3 residents per week X 4 weeks to ensure administration of medication for anti-clotting for INR and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING ______ B. WING ______	C 08/05/2021

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 757	Continued From page 16 R326's care plan dated 8/2/21, indicated monitor labs as ordered. R326's Physician Order Summary Report from admission was requested but not provided. Only updated INR orders were indicated. R326's Hospital Discharge Summary dated 7/29/21, indicated INR daily for warfarin (generic name for Coumadin, a blood thinner medication) adjustment for four days. R326's INR-Protime Flow sheet undated indicated diagnoses atrial fibrillation with goal of 2.0-3.0. INR results were as follows: - 7/30/21, there were no indication of INR check on 7/30/21. -7/31/21, INR (3.0), give 4 milligrams (mg) on Saturday and Sunday and recheck INR on 8/2/21. - 8/2/21, INR (3.0), give 3 mg Tuesday and Wednesday recheck on 8/4/21. - 8/5/21, INR (2.3) 2 mg tonight and 5 mg on all other days recheck INR 8/9/21. R326's Medication Administration Record (MAR) indicated on 7/29/21, an order for Coumadin 5 mg was signed by staff. On 7/30/21, an order for Coumadin 4 mg was indicated with an "X" noted on that day and without staff signatures for Coumadin 4 mg indicating medication was not scheduled. On 7/30/21, an order for Coumadin 5 mg with an "X" indicated without staff signatures noted. Coumadin 4 mg was administered on 7/31/21, and 8/1/21, and Coumadin 3 mg was administered on 8/2/21, 8/3/21, and 8/4/21. There were no indication Coumadin was administered to R326 on 7/30/21.	F 757	Coumadin administration. Results of audit findings will be reviewed at QAPI monthly and to be adjusted based on audit results.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING ______ B. WING ______	C 08/05/2021

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 757	Continued From page 17 During observation and interview on 8/02/21, at 4:51 p.m. R326 laid in bed awake and alert and communicative. R326 stated, was scheduled for INR blood draws and took Coumadin. During interview on 8/5/21, at 2:30 p.m. registered nurse (RN)- B stated on 7/30/21, INR was not collected for R326 and Coumadin was not given to R326. RN-B further stated she was unaware Coumadin was due for R326 on 7/30/21, explaining that although she was R326's admitting nurse on 7/29/21, and had verified all orders after the health unit coordinator entered orders into the electronic health record (EHR), she had assumed R326's Coumadin was not scheduled on 7/30/21. RN-B also stated she did not check to see if INR's had been completed that day for R326 even though there was an order on the MAR for daily INR's because it was a busy shift. During interview on 8/05/21, at 3:11 p.m. director of nursing (DON) stated the expectation of the facility was that staff followed physician orders. DON further stated the nurses were expected to follow up on INR's and Coumadin orders to ensure adequate dosing. DON verified this was a medication error. The facility Anticoagulation-Clinical Protocol undated indicated, the nurses were to assess and document/report the following: current anticoagulation therapy, including drug and current dosage, recent labs, including therapeutic dose monitoring.	F 757		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2)	F 804		9/17/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING ______ B. WING ______	C 08/05/2021

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 804	Continued From page 18 §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide meals at a palatable temperature. This had the potential to affect 127 residents in the facility who ate meals from the dining room. Findings include: On 8/2/21, at 5:48 p.m., R30 indicated the food was cold and is often cold. On 8/2/21, at 5:50 p.m., R29 stated the food was cold most of the time. When questioned about asking to heat the food, R29 responded that once the food was served cold, it was too late, and he would not eat it. On 8/2/21, at 7:09 p.m., R 51 stated breakfast was good, but the lunch and supper are usually cold. Stated "No one has ever offered to warm it up for me." On 8/4/21, at 11:30 a.m., culinary cook (CC) A stated that the steam tables in the dining rooms were not being used, and hadn't been in the last 7 months. On 8/4/21 at 11:45 a.m., the food was temped in	F 804	All residents receive meals at a palatable temperature. All residents have the potential to be affected by palatable temperatures. Facility has ordered plate covers for all plates to keep quality temperatures of foods. Re-education provided to all staff regarding ensuring palatable temperatures of food outgoing to residents receiving. Administrator/or Designee to audit 3 meals per week X 4 weeks to ensure palatable temperatures of food. Results of the audit findings will be reviewed at QAPI monthly and to be adjusted based on audit results.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING ______ B. WING ______	C 08/05/2021

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 804	Continued From page 19	F 804		

the kitchen, by CC-A , the stroganoff was 154 degrees Fahrenheit (F), and the steamed vegetables (broccoli, cauliflower and carrots) were 191 degrees F. Acceptable temperatures for the stroganoff would be 130 degrees F and 140 degrees F for the vegetables.

On 8/4/21 at 11:57 a.m., the food cart to the 200 wing was taken to the nursing floor. At 12:20 p.m., after the last room tray was served, a test tray was reviewed. The stroganoff was 118 degrees F and the vegetables were 113.4 degrees F. The temperatures were confirmed by Licensed Practical Nurse (LPN)-A.

At 12:24 p.m. a cart with room trays for the 300 and 500 wings were taken to the nursing floor. At 12:45 p.m. after the last room tray was served and 21 minutes since the food left the kitchen, a test tray was reviewed. The stroganoff was 116.9 degrees F, and the vegetables were 112.3 degrees F. The temperature were confirmed by RN-A.

Interview with Assistant Culinary Director (ACD) on 8/4/21 at 1:00 p.m., she indicated an acceptable temperature for the stroganoff was 130 degrees F., and 140 degrees F. for the vegetables. The ACD indicated there were steam tables in the dining rooms, but they weren't being used at this time. She also indicated that there were not enough plate covers for the whole building and that is why some of the plates were covered by tin foil.
R119 during on 8/2/21, at 1:30 p.m. when asked if food tasted good, looked good and was food served at the right temperatures (cold or hot) R119 stated "food is horrible here and I have made it my job to take pictures of it. I think it's not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING ______ B. WING ______	C 08/05/2021

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 804	Continued From page 20	F 804		

the people cooking it, it's what the cooperate office says they have to get. The food is so bad that I go shopping and get Hormel meals and I put them in the microwave. I went grocery shopping today." During the interview 4 re-usable bags were observed on the bed with groceries which included frozen meals, fruits and snacks. R119 then opened the fridge door and brought out a Ziploc bag which had a piece of chicken and resident used both hands to bend it back and forth and stated she had saved the piece of chicken from the previous evening meal to show someone how tough it was served for the residents. R119 then stated "When I tell them about the food they just blow me off." R119 stated she had brought the food concerns to the regional ombudsman's attention and this had been brought up during the most recent resident council meeting however nothing had resolved. R119 further stated several residents at the facility had concerns about the food and the facility was aware.

R8 during interview on 8/3/21, at 8:25 a.m. when asked if food tasted good, looked good and was food served at the right temperatures (cold or hot) R8 stated "not very good."

On 8/4/21, at 9:32 a.m. after breakfast R8 stated all food was always cold and was not very good diet for her being diabetic she thought. R8 also stated the vegetables were always over cooked.

R104 during interview on 8/3/21, at 9:01 a.m. when asked if food tasted good, looked good and was food served at the right temperatures (cold or hot) stated "it varies it's not good. Yesterday I ate a dish my son brought."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING ______ B. WING ______	C 08/05/2021

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 804	Continued From page 21 On 8/4/21, at 12:58 p.m. when asked about the lunch meal R104 stated "I was not a fan. It was cold and you can do so much to the carrots before they are wrong with broccoli." During the interview R104's roommate R49 who was among the last room trays delivered during the lunch meal prior to the test tray stated "It was cold and strange. I ate it to get something in my body" when asked if food tasted good, looked good and was food served at the right temperatures (cold or hot). During interview on 8/2/21, at 2:31 p.m. R324 stated the food at the facility tasted terrible and it was usually cold. During interview on 8/2/21, at 4:47 p.m. R326 stated the facility food was cold when delivered to his room during meals. R326 stated he was planning to order food delivery because of the cold food. During meal observation on 8/2/21, at 5:25 p.m. to 5:35 p.m. the dining food cart was observed on the 800 hall. The food on the food cart was covered with aluminum foil while on the cart and staff lifted up the large aluminum foil covering to remove several plated food on varied shelves on the cart. The food cart was left opened as plated food was removed. Food was taken into the rooms on the 800 hall uncovered as staff ambulated from the food cart to deliver uncovered plated food to rooms. During interview on 8/2/21, at 6:30 p.m. R327 stated his food was often cold when it was delivered to his room during meal times. R327 further stated a few days earlier, he had to eat his ice cream sandwich first, before eating his regular meal because the ice cream sandwich was	F 804		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING ______ B. WING ______	C 08/05/2021

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 804	Continued From page 22 melted when delivered to his room. During interview on 8/5/21, at 2:00 p.m. R327 stated his lunch was served cold. R327 also stated, "they are just not sending me warm food." During interview on 8/5/21, at 2:15 p.m. R324 stated his lunch was delivered to his room cold and he did not eat it, and had only kept the juices. R324 also stated he had asked his family to bring him Subway, since he was unable to eat his lunch which was cold. During observation on 8/5/21, at 2:45 p.m. R326 food was observed on his bed side table uncovered. R326 was in his bed asleep.	F 804		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880		9/17/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING ______ B. WING ______	C 08/05/2021

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 880	Continued From page 23	F 880		

arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING ______ B. WING ______	C 08/05/2021

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 880	Continued From page 24 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure multi-use vital signs machines (blood pressure cuff, thermometer, pulse oximeter (used to check oxygen level and pulse) were disinfected between resident use for 5 of 5 residents (R8, R225, R223, R224, R76) observed to have vital signs checked. Findings include: During a random observation on 8/4/21, at 7:37 a.m. registered nurse (RN)-F was observed carrying a small lime tote with a automatic blood pressure cuff machine, thermometer and pulse oximeter all together inside the tote and went into R8's room and shut the door. -At 7:42 a.m. RN-F came out of R8's room shut the door, went across the room and cleansed her hands with form as she headed down the long hallway and entered R225's room. RN-F then was observed check R225's vital signs (VS) then came out out of the room and was never observed clean the VS machines before and after use on R225. RN-F then came out of R225's room came to the hallway. -At 7:46 a.m. RN-F then went across the hallway from R225's room to R223's room and was observed to set the lime tote on top of the bedside table with no barrier. RN-F then obtained the VS machines then thanked R223 and put all	F 880	R8, R225, R223, R224 and R76 had all vital sign machines disinfected between resident use. All residents have the potential to be affected by proper infection prevention and control while utilizing vital sign machines. Facility purchased blood pressure cuffs that have cleanable surface. All shared vital sign equipment will be disinfected utilizing available disinfectant after use on a resident. Disinfectant will be used per manufacture's recommendation. Re-education provided to nursing staff regarding proper disinfecting of vital sign machines (blood pressure cuff, thermometer, pulse oximeter) between resident use. DPOC Completed items 1-5 Director of Nursing or Designee completed audits for three shifts per day times seven days with 100% compliance. Director of Nursing or Designee may decrease the frequency based upon compliance to auditing 1 shift per day for 5 days.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING ______ B. WING ______	C 08/05/2021

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 880	Continued From page 25 of them back into the tote and came out of the room. RN-F was never observed again clean the machines before and after use. RN-F then came out of the room spoke briefly to trained medication aide (TMA)-A about R223's medications then was observed go into R224's room after she cleansed her hands with form outside the room. -At 7:47 a.m. RN-F approached R224 who was in the first bed, set the tote on the bedside stable without barrier obtained the VS, put the machines into the tote, did not clean before and after went into R76's side of the room. -At 7:49 a.m. RN-F was observed to approach R76 and set the tote on the bedside table and obtained the VS and then put all the machines into the tote and came out of the room but was never observed clean the machines. During interview on 8/4/21, at 7:55 a.m. RN-F acknowledged she was supposed to sanitize the VS machines between the residents each time and then she stated she was going to clean them. She then had TMA-A open the medication cart to find the disinfecting wipes however upon opening the cart, there was no wipes to use. RN-F then stated she was going to a different cart to find the wipes to clean the machines before the next use. During interview on 8/04/21, at 3:04 p.m. the director of nursing stated all resident re-usable devices which included VS machines were supposed to be cleaned between resident use and the staff was supposed to use disinfecting wipes to clean them between the residents. She stated the thermometer was touch free so she would not not have expected it to be cleaned however it was mixed with the other machines after multiple resident use.	F 880	The Director of Nursing or Designee will review the results of audits and monitoring with the QAPI program and adjust auditing frequency based on results.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING ______ B. WING ______	C 08/05/2021

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 880	Continued From page 26 On 8/5/21, at 11:38 a.m. RN-D infection control nurse stated all machines were supposed to be cleaned between and after each resident use and if the staff did not see the cleaning being completed, they were to clean the machine to be on the safe side before each use. The facility Cleaning and Disinfection of Resident -Care Items and Equipment policy revised October 2018, directed staff for reusable items they were to be cleaned and disinfected or sterilized between residents.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and	F 883		9/17/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING ______ B. WING ______	C 08/05/2021

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 883	Continued From page 27 (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the appropriate pneumonia vaccine Pneumococcal polysaccharide vaccine (PPSV23) or Pneumococcal conjugate vaccine (PCV13) was offered and provided for 1 of 5 residents (R99) reviewed for immunizations.	F 883	F99 was offered pneumococcal vaccine and declined as discharged from facility. All residents have the potential to be affected by this. Residents were audited within the facility to ensure the appropriate Pneumococcal vaccine was offered.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING ______ B. WING ______	C 08/05/2021

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 883	Continued From page 28	F 883		

Continued From page 28

Findings include:

The CDC recommends "Adults 65 years of age or older who have not previously received pneumococcal conjugate vaccine (PCV13 or Prevnar 13) and who have previously received one or more doses of Pneumococcal Polysaccharide 23 (PPSV23 or Pneumovax a vaccine to reduce risk infection from 23 forms of pneumococcal bacteria) should receive a dose of pneumococcal 13-valent Conjugate Vaccine (PCV13). The dose of PCV13 should be administered at least one year after the most recent PPSV23 dose. In addition, CDC recommends PCV13 for use in infants and young children and adults 65 years or older. Older children and adults younger than 65 years old who are at increased risk for getting pneumococcal disease may also need a dose of PCV13."

R99's Admission Record dated 8/5/21, indicated R99 was admitted to the facility on 6/23/21, and was 80 years old. During a review of the medical record, it was revealed R99 had not been offered either the PPSV-23 or PCV13 nor had he been given the risk and benefits for the immunizations by the facility. In addition, the medical record lacked documentation of staff obtaining an order from the physician to administer the immunization.

R99's diagnoses included atrial fibrillation, atherosclerotic heart disease of native coronary artery, chronic diastolic (congestive) heart failure and hypertension obtained from the Admission Record dated 8/5/21.

Re-education provided to Infection Control Preventionist and Care Coordinators regarding ensuring residents are offered appropriate pneumococcal vaccine.

DNS/or Designee to audit 3 new admissions per week X 4 weeks to ensure residents are offered appropriate pneumococcal vaccine.

Results of the audit findings will be reviewed at QAPI monthly and to be adjusted based on audit results.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING ______ B. WING ______	C 08/05/2021

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 883	Continued From page 29 On 8/5/12, at 1:00 p.m. the infection control registered nurse verified the missing immunizations stated he would follow up and would provide it. RN-D stated all resident immunizations were reviewed at admission. On 8/5/21, at 3:21 p.m. the facility administrator stated the Minnesota Immunization Information Connection (MIIC) form provided was all the information the facility had with R99's immunization records. The administrator stated the facility was going to reach out to R99's assisted living facility to check if they had any records on Pneumovax immunizations. The facility Pneumococcal Policy revised 11/2017, directed the following: "1. Upon admission to the facility (within 5 days), all residents will be assessed for current immunization status and eligibility to receive the pneumococcal vaccine, and within 30 days of admission, will be offered the vaccine, when indicated, unless the resident has already been vaccinated or the vaccine is medically contraindicated. 2. If resident's immunization status is unknown, facility staff will contact resident's physician to determine record of immunization status from resident's permanent clinic record..."	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/04/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/04/2021. At the time of this survey, The Estates of Roseville was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/02/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/04/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Estates of Roseville was built in 1965 as a 2-story building without a basement and was determined to be Type II (222) construction. In 1973 a 1-story addition was constructed to the west of the existing building and was determined to be Type II (222) construction. In 1983 a 2 story addition (Woodhill) was constructed to the south of the original building and was determined to be Type II (222) construction. In 1995 a dining room addition was constructed to the south wing of the 1973 addition and was determined to be Type II	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING **01 - MAIN BUILDING 01** B. WING ____________	**08/04/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 (222) construction. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 175 beds and had a census of 130 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills as per NFPA 101 (2012 edition), Life Safety Code, section 19.7.1.6. This deficient condition could have a widespread impact on the residents within the facility. Findings include:	K 712	Fire Drills are completed monthly at expected and unexpected times under varying conditions at least quarterly on each shift with staff and residents. All resident have potential to be affected by fire drills. A fire drill calendar and reminders set for completing fire drills with	9/17/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/04/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 712	Continued From page 3 On 08/04/2021 between 09:00 AM to 3:00 PM, it was revealed that the facility did not conduct fire drills during the 4th quarter of the calendar year for 1st and 3rd shifts. This deficient condition was verified by the Maintenance Director.	K 712	varying time and shifts to reflect quarterly drills on each shift. Re-education provided to Maintenance Department regarding ensuring fire drills are completed at least quarterly on each shift with staff and residents. Administrator to audit monthly fire drills X 3 months to ensure these are being completed monthly meeting requirements of shifts and times. Results of the audit findings will be reviewed at QAPI monthly and to be adjusted based on audit results.	
K 930 SS=D	Gas Equipment - Liguid Oxygen Equipment CFR(s): NFPA 101 Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to safely store liquid oxygen per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.7.4. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 08/04/2021 between 09:00 AM to 3:00 PM, it was revealed that there were two liquid oxygen	K 930	One of the two liquid oxygen tanks were removed from a residents room and placed in oxygen storage room. Residents who utilize oxygen had their rooms assess for two liquid oxygen tanks and removed any excess oxygen tanks and placed in oxygen storage room. Re-education provided to Nursing and Maintenance Department regarding only	9/17/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING **01 - MAIN BUILDING 01** B. WING ___________	**08/04/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 930	Continued From page 4 tanks, one in use and one in storage, located in Room 420. This deficient condition was verified by the Maintenance Director.	K 930	having one liquid oxygen tank per resident per room. DNS/or Designee to audit 3 resident rooms with oxygen per week X 4 weeks to ensure remain in compliance with requirement. Results of the audit findings will be reviewed at QAPI monthly and to be adjusted based on audit results.	

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
August 26, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: RE2L11

Dear Administrator:

The above facility was surveyed on August 2, 2021 through August 5, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Sarah Grebenc, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792 Mobile (651)238-8786

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: ______ B. WING ______	C 08/05/2021

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: On 8/2/21 through 8/5/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: ______ B. WING ______	C 08/05/2021

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) COMPLETE DATE
2 000	Continued From page 1 these orders, and identify the date when they will be completed. The following complaints were found to be SUBSTANTIATED: H5105202C (MN69378), however NO licensing orders issued. The following complaints were found to be UNSUBSTANTIATED: H5105196C (MN67350), H5105197C (MN67829), H5105198C (MN68058), H5105199C (MN69233), H5105200C (MN69258), H5105201C (MN69287), H5105203C (MN72552), H5105204C (MN73205), H5105205C (MN73233, H5105206C (MN74976), and H5105207C (MN75032).	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which 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.	
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:	2 895		9/17/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: ____ B. WING ____	C 08/05/2021

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) COMPLETE DATE
2 895	Continued From page 2 B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R8) received range of motion (ROM) according to the plan of care reviewed for limited range motion. Findings include: R8's diagnoses included paraplegia, quadriplegia, and muscle weakness obtained from the annual Minimum Data Set (MDS) dated 4/20/21. In addition, the MDS indicated R8 had intact cognition, had functional limitation in ROM of both upper and lower extremities, required extensive to total physical assistance of two staff with all activities of daily living (ADL's) except eating and did not refuse cares during the assessment period. R8's care plan dated 9/30/18, indicated resident had a self care deficit related to needing assistance with ADL's due to diagnosis of paraplegia and left hand contracture. The care plan directed staff to do left upper extremity ROM before splint placed on at night and off in morning as needed per resident request. In addition, the care plan directed staff to complete passive ROM to lower extremities: ankle flexion and extension, ankle rotation, toe flexion, hip and knee flexion and hip Abduction. During interview 8/03/21, at 8:30 a.m. R8 stated the staff was supposed assist with range of motion but did not do it because there was not enough staff and the staff was over worked she	2 895	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: ____ B. WING ____	C 08/05/2021

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) COMPLETE DATE
2 895	Continued From page 3 thought. During a continuous observation on 8/4/21, at 7:17 a.m. to 10:14 a.m. several staff were observed assist R8 with cares that included grooming, toileting, getting dressed and wound care however, during the cares no ROM was provided and offered to R8. During the cares registered nurse (RN)-E, RN-F, nursing assistant (NA)-A and NA-D were in the room and none of the staff offered the ROM during the observation. During a follow up interview on 8/5/21, at 8:33 a.m. R8 stated verified no staff on 8/4/21, after morning cares and the evening shift had offered the ROM that day. R8 stated the staff was busy. During review of the the Plan of Care (POC) Follow Up Question Report from 6/5/21, through 8/3/21, it was revealed R8 had received ROM 17 times out of 60 days and 5 times R8 had refused however the medical record lacked documentation of staff re-approaching R8. During interview on 8/5/21, at 8:22 a.m. RN-E reviewed the NA's plan of care (POC) charting and verified that R8 did not receive the passive range of motion as directed and the NA's had documented "Not Applicable." During a follow up interview on 8/5/21, at 9:06 a.m. RN-E stated the staff were supposed to document appropriately and if a resident refused they were to make sure to let the nurse know so to attempt. During interview on 8/5/21, at 12:16 p.m. NA-E stated R8 was supposed to get ROM daily and when R8 refused the staff were supposed to let the nurse know so the nurse could attempt to see if R8 will allow it to be completed. NA-E further stated "when documenting the computer would allow us only to put 9 minutes but I do more. They are to document the time or refuse and not applicable is not a choice I think it's a communication thing."	2 895		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: ___ B. WING ___	C 08/05/2021

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) COMPLETE DATE
2 895	Continued From page 4 During interview on 8/5/21, at 12:10 p.m. the director of nursing (DON) stated she would expect the staff to complete the ROM if they are to complete it on the POC charting and if they have questions they are to go to their nurse to ask for example how many minutes or repetitions to be completed. The facility Resident Mobility and Range of Motion policy revised July 2017 indicated residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility. In addition, the policy directed staff to document resident's progress towards the established goals and objectives. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee could review/revise facility policies to ensure they contain all components range of motion therapy to include evaluation, initiation, performance, and documentation. Then the DON or designee could educate staff and perform audits to ensure the policies are being followed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. 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 MN Requirement is not met as evidenced	2 920		9/17/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: ______ B. WING ______	C 08/05/2021

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) COMPLETE DATE
2 920	Continued From page 5 by: Based on observation, interview, and document review, the facility failed to ensure bathing was completed for 1 of 5 residents (R222) who was dependent of staff for assistance reviewed with activities of daily living (ADL's). Findings include: R222's was admitted to the facility on 7/27/21, with diagnoses included unspecified fracture of right calcaneus (heel bone) with subsequent encounter for fracture with routine healing, pain and obesity obtained from the Admission Record dated 8/5/21. R222's Monarch Health Management (MHM) Brief Interview for Mental Status (3.0 BIMS) dated 8/3/21, indicated resident had intact cognition. R222's care plan dated 7/30/21, identified resident had a self care deficit related to impaired mobility related to surgery. The care plan directed staff to provide assist of one staff with bathing, dressing, and personal hygiene. In addition, the care plan indicated for bathing R222 preferred a shower. During interview on 8/2/21, at 3:10 p.m. R222 stated she was admitted to the facility on 7/27/21, and since admit no one at the facility had told her how often to get a shower, bed bath, or sponge bath despite asking multiple staff for the plan of care including the social worker (SW). R222 stated she had asked to see the plan so she can see what was included in the package for the short stay at the facility. R222 also stated she had worn the same gown for 3 days and had not been offered a bed bath and her hair was was not clean and she felt not clean because she had not	2 920	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: ______ B. WING ______	C 08/05/2021

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) COMPLETE DATE
2 920		2 920		

Continued From page 6

washed up. During the interview R222's hair was noted to be greasily, uncombed and she worn a blue gown. R222 was also observed with a soft cast on the right leg up to the knee and had ice packs around the ankle wrapped in a black wrapping. R222 stated she recently had surgery and was non weight bearing on the right leg and thus the staff were supposed to assist her with most of the ADL's due to the restrictions.

During a review of the Plan of Care (POC) response history charting completed by nursing assistants (NA's) it was revealed NA-A had documented he had provided one person physical assistance on 7/31/21, for "full body bath/shower, sponge bath and transfers in/out of tub/shower."

During interview on 8/3/21, at 2:03 p.m. registered nurse (RN)-A stated according to the POC documentation by NA-A R222 had received a shower on 7/31/21. As RN-A reviewed the documentation, NA-A approached surveyor and RN-A and stated he had not given a shower to R222 on 7/31/21. NA-A stated he had given a shower to a different resident with a similar first name and documented a mistake in R222's POC.

During interview on 8/4/21, at 3:00 p.m. the director of nursing (DON) stated the staff were supposed to look at the shower/bath list in the units and give the shower/baths according to the list. The DON further stated she would expect the staff to have offered even a bed bath.

The facility Activities of Daily Living (ADL's), Supporting policy revised March 2018 indicated "Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: ______ B. WING ______	C 08/05/2021

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) COMPLETE DATE
2 920	Continued From page 7 grooming, personal and oral hygiene..." SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee could review/revise facility policies to ensure they contain all components activities of daily living to include evaluation, initiation, performance, and documentation. Then the DON or designee could educate staff and perform audits to ensure the policies are being followed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
2 960	MN Rule 4658.0600 Subp. 1 Dietary Service - Food Quality Subpart 1. Food quality. Food must have taste, aroma, and appearance that encourages resident consumption of food. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide meals at a palatable temperature. This had the potential to affect 127 residents in the facility who ate meals from the dining room. Findings include: On 8/2/21, at 5:48 p.m., R30 indicated the food was cold and is often cold. On 8/2/21, at 5:50 p.m., R29 stated the food was cold most of the time. When questioned about asking to heat the food, R29 responded that once the food was served cold, it was too late,	2 960	Corrected	9/17/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: ______ B. WING ______	C 08/05/2021

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) COMPLETE DATE
2 960		2 960		

Continued From page 8

and he would not eat it.

On 8/2/21, at 7:09 p.m., R 51 stated breakfast was good, but the lunch and supper are usually cold. Stated "No one has ever offered to warm it up for me."

On 8/4/21, at 11:30 a.m., culinary cook (CC) A stated that the steam tables in the dining rooms were not being used, and hadn't been in the last 7 months.

On 8/4/21 at 11:45 a.m., the food was temped in the kitchen, by CC-A , the stroganoff was 154 degrees Fahrenheit (F), and the steamed vegetables (broccoli, cauliflower and carrots) were 191 degrees F. Acceptable temperatures for the stroganoff would be 130 degrees F and 140 degrees F for the vegetables.

On 8/4/21 at 11:57 a.m., the food cart to the 200 wing was taken to the nursing floor. At 12:20 p.m., after the last room tray was served, a test tray was reviewed. The stroganoff was 118 degrees F and the vegetables were 113.4 degrees F. The temperatures were confirmed by Licensed Practical Nurse (LPN)-A.

At 12:24 p.m. a cart with room trays for the 300 and 500 wings were taken to the nursing floor. At 12:45 p.m. after the last room tray was served and 21 minutes since the food left the kitchen, a test tray was reviewed. The stroganoff was 116.9 degrees F, and the vegetables were 112.3 degrees F. The temperature were confirmed by RN-A.

Interview with Assistant Culinary Director (ACD) on 8/4/21 at 1:00 p.m., she indicated an acceptable temperature for the stroganoff was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: ______ B. WING ______	C 08/05/2021

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) COMPLETE DATE
2 960	Continued From page 9	2 960		

130 degrees F., and 140 degrees F. for the vegetables. The ACD indicated there were steam tables in the dining rooms, but they weren't being used at this time. She also indicated that there were not enough plate covers for the whole building and that is why some of the plates were covered by tin foil.

R119 during on 8/2/21, at 1:30 p.m. when asked if food tasted good, looked good and was food served at the right temperatures (cold or hot) R119 stated "food is horrible here and I have made it my job to take pictures of it. I think it's not the people cooking it, it's what the cooperate office says they have to get. The food is so bad that I go shopping and get Hormel meals and I put them in the microwave. I went grocery shopping today." During the interview 4 re-usable bags were observed on the bed with groceries which included frozen meals, fruits and snacks. R119 then opened the fridge door and brought out a Ziploc bag which had a piece of chicken and resident used both hands to bend it back and forth and stated she had saved the piece of chicken from the previous evening meal to show someone how tough it was served for the residents. R119 then stated "When I tell them about the food they just blow me off." R119 stated she had brought the food concerns to the regional ombudsman's attention and this had been brought up during the most recent resident council meeting however nothing had resolved. R119 further stated several residents at the facility had concerns about the food and the facility was aware.

R8 during interview on 8/3/21, at 8:25 a.m. when asked if food tasted good, looked good and was food served at the right temperatures (cold or hot) R8 stated "not very good."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: ______ B. WING ______	C 08/05/2021

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) COMPLETE DATE
2 960	Continued From page 10	2 960		

On 8/4/21, at 9:32 a.m. after breakfast R8 stated all food was always cold and was not very good diet for her being diabetic she thought. R8 also stated the vegetables were always over cooked.

R104 during interview on 8/3/21, at 9:01 a.m. when asked if food tasted good, looked good and was food served at the right temperatures (cold or hot) stated "it varies it's not good. Yesterday I ate a dish my son brought."

On 8/4/21, at 12:58 p.m. when asked about the lunch meal R104 stated "I was not a fan. It was cold and you can do so much to the carrots before they are wrong with broccoli." During the interview R104's roommate R49 who was among the last room trays delivered during the lunch meal prior to the test tray stated "It was cold and strange. I ate it to get something in my body" when asked if food tasted good, looked good and was food served at the right temperatures (cold or hot).

During interview on 8/2/21, at 2:31 p.m. R324 stated the food at the facility tasted terrible and it was usually cold.

During interview on 8/2/21, at 4:47 p.m. R326 stated the facility food was cold when delivered to his room during meals. R326 stated he was planning to order food delivery because of the cold food.

During meal observation on 8/2/21, at 5:25 p.m. to 5:35 p.m. the dining food cart was observed on the 800 hall. The food on the food cart was covered with aluminum foil while on the cart and staff lifted up the large aluminum foil covering to remove several plated food on varied shelves on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: ______ B. WING ______	C 08/05/2021

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) COMPLETE DATE
2 960	Continued From page 11	2 960		

the cart. The food cart was left opened as plated food was removed. Food was taken into the rooms on the 800 hall uncovered as staff ambulated from the food cart to deliver uncovered plated food to rooms.

During interview on 8/2/21, at 6:30 p.m. R327 stated his food was often cold when it was delivered to his room during meal times. R327 further stated a few days earlier, he had to eat his ice cream sandwich first, before eating his regular meal because the ice cream sandwich was melted when delivered to his room.

During interview on 8/5/21, at 2:00 p.m. R327 stated his lunch was served cold. R327 also stated, "they are just not sending me warm food."

During interview on 8/5/21, at 2:15 p.m. R324 stated his lunch was delivered to his room cold and he did not eat it, and had only kept the juices. R324 also stated he had asked his family to bring him Subway, since he was unable to eat his lunch which was cold.

During observation on 8/5/21, at 2:45 p.m. R326 food was observed on his bed side table uncovered. R326 was in his bed asleep.

SUGGESTED METHOD OF CORRECTION:
The administrator, director of nursing (DON), director of dining services or designee should ensure food is palatable and prepared and served at proper temperatures. The facility should review and/or update or create policies and procedures, and educate staff on specific requirements or interventions related to food preparation and service. The administrator, DON, director of food service, or designee should perform audits for a measurable amount of time as determined by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: ______ B. WING ______	C 08/05/2021

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) COMPLETE DATE
2 960	Continued From page 12 Quality Assurance Performance Improvement (QAPI) committee to ensure food items given, offered, or consumed by residents are palatable, and served at a safe and appropriate temperature. The facility should report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 960		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure multi-use vital signs machines (blood pressure cuff, thermometer, pulse oximeter (used to check oxygen level and pulse) were disinfected between resident use for 5 of 5 residents (R8, R225, R223, R224, R76) observed to have vital signs checked. Findings include: During a random observation on 8/4/21, at 7:37 a.m. registered nurse (RN)-F was observed carrying a small lime tote with a automatic blood pressure cuff machine, thermometer and pulse oximeter all together inside the tote and went into	21375	Corrected	9/17/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: ______ B. WING ______	C 08/05/2021

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) COMPLETE DATE
21375	Continued From page 13 R8's room and shut the door. -At 7:42 a.m. RN-F came out of R8's room shut the door, went across the room and cleansed her hands with form as she headed down the long hallway and entered R225's room. RN-F then was observed check R225's vital signs (VS) then came out out of the room and was never observed clean the VS machines before and after use on R225. RN-F then came out of R225's room came to the hallway. -At 7:46 a.m. RN-F then went across the hallway from R225's room to R223's room and was observed to set the lime tote on top of the bedside table with no barrier. RN-F then obtained the VS machines then thanked R223 and put all of them back into the tote and came out of the room. RN-F was never observed again clean the machines before and after use. RN-F then came out of the room spoke briefly to trained medication aide (TMA)-A about R223's medications then was observed go into R224's room after she cleansed her hands with form outside the room. -At 7:47 a.m. RN-F approached R224 who was in the first bed, set the tote on the bedside stable without barrier obtained the VS, put the machines into the tote, did not clean before and after went into R76's side of the room. -At 7:49 a.m. RN-F was observed to approach R76 and set the tote on the bedside table and obtained the VS and then put all the machines into the tote and came out of the room but was never observed clean the machines. During interview on 8/4/21, at 7:55 a.m. RN-F acknowledged she was supposed to sanitize the VS machines between the residents each time and then she stated she was going to clean them. She then had TMA-A open the medication cart to find the disinfecting wipes however upon opening	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: ______ B. WING ______	C 08/05/2021

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) COMPLETE DATE
21375	Continued From page 14	21375		

the cart, there was no wipes to use. RN-F then stated she was going to a different cart to find the wipes to clean the machines before the next use.

During interview on 8/04/21, at 3:04 p.m. the director of nursing stated all resident re-usable devices which included VS machines were supposed to be cleaned between resident use and the staff was supposed to use disinfecting wipes to clean them between the residents. She stated the thermometer was touch free so she would not not have expected it to be cleaned however it was mixed with the other machines after multiple resident use.

On 8/5/21, at 11:38 a.m. RN-D infection control nurse stated all machines were supposed to be cleaned between and after each resident use and if the staff did not see the cleaning being completed, they were to clean the machine to be on the safe side before each use.

The facility Cleaning and Disinfection of Resident -Care Items and Equipment policy revised October 2018, directed staff for reusable items they were to be cleaned and disinfected or sterilized between residents.

Suggested Method of Correction: The DON (Director of Nursing) or designee could review/revise facility policies to ensure they contain all components of an infection control program, including tracking/trending of all illnesses in the facility as well as an antibiotic stewardship program and that a facility assessment and plan are written for water borne pathogens. In addition, the DON or designee could review/revise policies on infection control regarding hand hygiene and equipment cleaning before/after each resident use. Then the DON or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: ______ B. WING ______	C 08/05/2021

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) COMPLETE DATE
21375	Continued From page 15 designee could educate staff and perform audits to ensure the policies are being followed. Time Period for Correction: Twenty-one (21) days.	21375		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure international normalized ratio (INR-a laboratory result indicating anti-clotting medication levels) was	21540	Corrected	9/17/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: ____ B. WING ____	C 08/05/2021

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) COMPLETE DATE
21540	Continued From page 16	21540		

checked per physician orders and further failed to administer an anti-clotting medication for 1 of 1 resident (R326) reviewed for missed INR and Coumadin (medication that prevents blood clots) administration.

Findings include:

R326's Face Sheet dated 7/29/21, indicated R326 diagnoses included atrial fibrillation (an irregular and often rapid heart rate), myocardial infarction (heart attack), hypertension, and unspecified systolic congestive heart failure (when the heart is not pumping fully).

R326's care plan dated 8/2/21, indicated monitor labs as ordered.

R326's Physician Order Summary Report from admission was requested but not provided. Only updated INR orders were indicated.

R326's Hospital Discharge Summary dated 7/29/21, indicated INR daily for warfarin (generic name for Coumadin, a blood thinner medication) adjustment for four days.

R326's INR-Protime Flow sheet undated indicated diagnoses atrial fibrillation with goal of 2.0-3.0. INR results were as follows:

- 7/30/21, there were no indication of INR check on 7/30/21.
-7/31/21, INR (3.0), give 4 milligrams (mg) on Saturday and Sunday and recheck INR on 8/2/21.
- 8/2/21, INR (3.0), give 3 mg Tuesday and Wednesday recheck on 8/4/21.
- 8/5/21, INR (2.3) 2 mg tonight and 5 mg on all other days recheck INR 8/9/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: ______ B. WING ______	C **08/05/2021**

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) COMPLETE DATE
21540	Continued From page 17	21540		

R326's Medication Administration Record (MAR) indicated on 7/29/21, an order for Coumadin 5 mg was signed by staff. On 7/30/21, an order for Coumadin 4 mg was indicated with an "X" noted on that day and without staff signatures for Coumadin 4 mg indicating medication was not scheduled. On 7/30/21, an order for Coumadin 5 mg with an "X" indicated without staff signatures noted. Coumadin 4 mg was administered on 7/31/21, and 8/1/21, and Coumadin 3 mg was administered on 8/2/21, 8/3/21, and 8/4/21. There were no indication Coumadin was administered to R326 on 7/30/21.

During observation and interview on 8/02/21, at 4:51 p.m. R326 laid in bed awake and alert and communicative. R326 stated, was scheduled for INR blood draws and took Coumadin.

During interview on 8/5/21, at 2:30 p.m. registered nurse (RN)- B stated on 7/30/21, INR was not collected for R326 and Coumadin was not given to R326. RN-B further stated she was unaware Coumadin was due for R326 on 7/30/21, explaining that although she was R326's admitting nurse on 7/29/21, and had verified all orders after the health unit coordinator entered orders into the electronic health record (EHR), she had assumed R326's Coumadin was not scheduled on 7/30/21. RN-B also stated she did not check to see if INR's had been completed that day for R326 even though there was an order on the MAR for daily INR's because it was a busy shift.

During interview on 8/05/21, at 3:11 p.m. director of nursing (DON) stated the expectation of the facility was that staff followed physician orders. DON further stated the nurses were expected to follow up on INR's and Coumadin orders to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: ______ B. WING ______	C 08/05/2021

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) COMPLETE DATE
21540	Continued From page 18 ensure adequate dosing. DON verified this was a medication error. The facility Anticoagulation-Clinical Protocol undated indicated, the nurses were to assess and document/report the following: current anticoagulation therapy, including drug and current dosage, recent labs, including therapeutic dose monitoring. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of laboratory results and medication administration and usage. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIMEFRAME FOR CORRECTION: Twenty-one (21) days.	21540		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to assess self-administration of oxygen (O2) for 1 of 1 resident (R27) reviewed for respiratory care.	21565	Corrected	9/17/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00497	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED C 08/05/2021

NAME OF PROVIDER OR SUPPLIER: **THE ESTATES AT ROSEVILLE LLC**

STREET ADDRESS, CITY, STATE, ZIP CODE: **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) COMPLETE DATE
21565	Continued From page 19	21565		

Findings include:

R27's quarterly Minimum Data Set (MDS) dated 5/3/21, indicated R27 was cognitively intact, required minimal to no assistance with activities of daily living (ADLs) and required oxygen therapy. R27's diagnoses included lung cancer and chronic obstructive pulmonary disease (COPD).

R27's leave of absence (LOA) care plan dated 11/20/20, indicated, for extended timeframe's, please obtain orders from physician to provide medications on LOA. Educate resident or responsible party on administration of medications/O2. R27's care plan further indicated, administer oxygen as ordered.

R27's physician order dated 11/4/20, check O2 liquid and portable tanks for oxygen amount. Record percentage (%) in tank client is using. Fill if needed.

R27's physician order dated 11/29/20, indicated, O2 via nasal cannula 2-4 liters (L)/minute.

R27's physician order dated 11/18/20, indicated, Ok to self administer nebulizer [neb] treatments after setup by nurse - use mask as needed.

R27's self administration of medication evaluation dated 11/18/20, indicated the resident was capable of self-administering inhalation medication. R27 was ok to self-administer neb treatments after setup by nurse - use mask as needed.

During observation on 8/2/21, at 2:00 p.m. R27 was in bed and the oxygen ran at 3 liters per minute via nasal cannula attached to an oxygen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: ______ B. WING ______	C 08/05/2021

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) COMPLETE DATE
21565	Continued From page 20	21565		

concentrator. R27's room also contained a large liquid oxygen container, 2 portable oxygen containers, 1 oxygen canister (green) and a portable concentrator.

When interviewed on 8/2/21, at 3:13 p.m. R27 stated it was normal to have all the tanks in his room, but license practical nurse (LPN)-C had just come to remove the green tank and said it was not supposed to be in here and did not want the state to see it.

When interviewed on 8/3/21, at 1:19 p.m. R27 stated he was out of the facility for 8 hours yesterday (8/2/21) but returned once during that time because his oxygen was low. R27 stated he refilled the portable tank and used the large liquid tank in his room. R27 further stated that if he ran out of oxygen prior to his return to the facility, he would increase the flow rate on the concentrator upon return.

When interviewed on 8/3/21, at 2:20 p.m. LPN-B stated only staff were supposed to change a resident's oxygen from a concentrator or liquid tank to a portable tank. LPN-B further stated staff were supposed to check the level of the portable tank and only staff would fill it. LPN-B stated portable oxygen tanks were only filled in the oxygen room and never in the resident room.

When interviewed on 8/3/21, at 2:28 p.m. nursing assistant (NA)-A stated when a resident, who was on oxygen, went out, staff were supposed to check the portable tank and if it was not full, staff would fill the portable tank in the oxygen room and should never fill it from a tank in the resident's room.

When interviewed on 8/4/21, at 11:37 a.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: ______ B. WING ______	C 08/05/2021

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) COMPLETE DATE
21565	Continued From page 21	21565		

registered nurse (RN)-C stated R27 was independent and often signed himself out of the facility. RN-C further stated R27 would check his own portable tanks to make sure they were full and that he had enough until he returned to the facility. RN-C stated, "I have never helped him with the tanks, not sure who has."

When interviewed on 8/4/21, at 12:39 p.m. NA-B stated R27 typically refused all cares in the morning and that he filled his own portable oxygen tank. NA-B stated, I have walked in and observed him doing it and I asked him if he wanted help and he told me to get out.

When interviewed on 8/4/21, at 1:54 p.m. director of nursing (DON) stated the portable oxygen tanks were checked by the NA's and that it was the NA's responsibility to fill them when they were low or empty. DON further stated that the tanks were only refilled in the oxygen room and never in the resident rooms. DON stated residents should not fill their own tanks and was not aware that R27 filled his own. DON would expect staff to intervene and report if they ever witnessed a resident filling their own tank.

When interviewed on 8/4/21, at 2:27 p.m. R27 stated, he went out that morning (8/4/21) and that he filled the portable tank before he left and again when he returned in preparation for going out again that afternoon. R27 lifted the portable tank to show the fill level indicator was all the way to the green (full) side. R27 stated when the indicator was just above the red but still in the green, it was time to fill it. R27 stated that prior to admission he did not have to fill any portable tanks for himself, but he used to fill some for a friend. R27 further stated no one ever taught him how to fill or verify the level of the portable oxygen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: ______ B. WING ______	C 08/05/2021

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) COMPLETE DATE
21565	Continued From page 22	21565		

tanks.

When interviewed on 8/4/21, at 2:34 p.m. NA-C stated working with R27 on occasion and that R27 would leave the facility regularly. NA-C further stated, I have seen him fill his own portable tanks. I check them but they are often already full because he does it himself.

When interviewed on 8/4/21, at 2:58 p.m. the administrator stated staff removed the liquid tank from R27's room and educated R27 on having only staff fill his portable tank.

When interviewed on 8/5/21, at 10:03 a.m. DON stated R27 did not receive an oxygen self-administration assessment or education because they were not aware he filled the tank himself. DON stated the liquid tank was in R27's room for back-up only and was not supposed to be used to refill the portable tanks.

When interviewed on 8/5/21, at 12:36 p.m. LPN-B stated oxygen was considered a medication as it was listed on the medication administration record (MAR) for nurses to check the flow rate every shift.

When interviewed on 8/5/21, at 1:15 p.m. DON stated oxygen was considered a medication.

The facility checklist titled Filling a Portable Oxygen Tank used to evaluate staff competency included 11 items in a step-by-step procedure.

The undated facility policy Oxygen General Guidelines indicated a self administration of oxygen per resident request required a Self-Administration of Medication Assessment. If determined that the resident is safe to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: ______ B. WING ______	C 08/05/2021

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) COMPLETE DATE
21565	Continued From page 23	21565		

self-administration oxygen, the physician shall authorize that the resident is mentally and physically capable of administering oxygen without the assistance of a licensed nurse ...continued ability to self-administer oxygen will be reviewed at patient care conferences.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could review applicable policies and procedures to ensure residents' are assessed timely with self administration of oxygen; then provide staff education. The quality assurance committee could monitor for compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.