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: SVLD

Facility ID: 00126

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245326**

2.STATE VENDOR OR MEDICAID NO.
(L2) **106542400**

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

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **7/8/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **63** (L18)

13.Total Certified Beds **63** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	63			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Susanne Reuss, Supervisor 07/11/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 07/11/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00450
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/30/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5326

July 11, 2014

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

Dear Ms. Camuel:

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

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

Effective July 10, 2014 the above facility is certified for for:

63 - Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Protecting, Maintaining and Improving the Health of Minnesotans

July 11, 2014

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

RE: Project Number S5326023

Dear Ms. Camuel:

On June 3, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 21, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On July 8, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 26, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 21, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 10, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 21, 2014, effective July 10, 2014 and therefore remedies outlined in our letter to you dated June 3, 2014, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245326	A. Building B. Wing	7/8/2014

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(b** LSC	Correction Completed **06/30/2014**	ID Prefix **F0166** Reg. # **483.10(f)(2)** LSC	Correction Completed **06/30/2014**	ID Prefix **F0276** Reg. # **483.20(c)** LSC	Correction Completed **06/30/2014**
ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **06/30/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **06/30/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **06/30/2014**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **06/30/2014**	ID Prefix **F0466** Reg. # **483.70(h)(1)** LSC	Correction Completed **06/30/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SR/AK	07/11/2014	16022	07/08/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 5/21/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245326	01 - MAIN BUILDING 0102	6/26/2014

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0029	Correction Completed 06/01/2014	ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 06/01/2014	ID Prefix Reg. # NFPA 101 LSC K0147	Correction Completed 06/01/2014
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** PS/AK	**Date:** 07/11/2014	**Signature of Surveyor:** 12424	**Date:** 06/26/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 5/20/2014		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

July 11, 2014

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

Re: Enclosed Reinspection Results - Project Number S5326023

Dear Ms. Camuel:

On July 8, 2014 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 8, 2014. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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

Please feel free to call me with any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: SVLD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00126

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245326**

2.STATE VENDOR OR MEDICAID NO.
(L2) **106542400**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/21/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **63** (L18)

13.Total Certified Beds **63** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	63			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Mary Beth Lacina, HFE NE II 06/19/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 06/26/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00450
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5326

At the time of the standard survey completed 05/21/14, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D) whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit (PCR) to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 5095

June 3, 2014

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

RE: Project Number S5326023

Dear Ms. Camuel:

On May 22, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 30, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

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

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

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

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

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

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 21, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 21, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245326	A. BUILDING _____ B. WING _____	05/21/2014

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

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	This plan of correction is not an admission of guilt on behalf of the provider. This plan of correction is being submitted because it is required by law.	6/30/14
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 156	F156 Resident #105 has been provided notice regarding resident's rights. All residents are provided notice regarding resident rights on admission. Staff have been re-educated regarding providing resident's notice of resident rights. NHA/Designee will audit up to 3 admissions per week to ensure that notification of residents rights have been provided upon admission. Results of audits to be reviewed at QPI	

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

Steve Connell Administrator 6-12-2014

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

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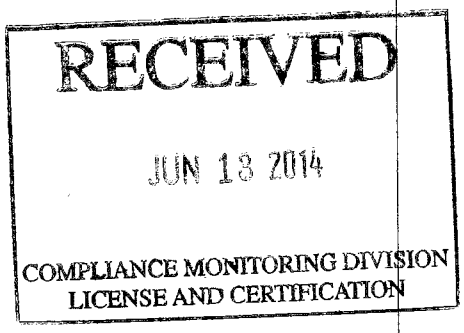
F 156	Continued From page 1 inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the	F 156		

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F 156	Continued From page 2 facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to give notice of resident's rights within 24 hours of admission for 1 of 3 residents (R105), whose family was interviewed. Findings include: Interview with R105's family member (F1) on 5/19/14, at 11:45 a.m., F1 indicated no one had talked to him/her about residents's rights, financial information, or asked him/her to sign any facility forms. F1 indicated R105 admitted on 5/15/14 in the early evening. F1 questioned R105 and R105 denied receiving any information about resident rights. Interview with the Licensed Social Worker (LSW)-1 on 5/19/14 at 12:30 p.m., he/she indicated the business office personnel was responsible for the admission packet. Interview	F 156		

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F 156	Continued From page 3 with business office assistant (BOA)-1 on 5/19/14 at 12:45 p.m., BOA-1 indicated F1 had left already, and she would try to catch him/her tomorrow. Interview with BOA-1 on 5/20/14 at 2:40 p.m., indicated F1 was coming in after 4:00 p.m., and would try to catch her. Interview with BOA-1 on 5/21/14 at 2:40 p.m., BOA-1 indicated F1 signed the admission paperwork on 5/20/14. BOA-1 indicated if a resident is admitted on the weekend, or late on a Friday, the admission paperwork is done on Monday. Review of the facility's Admission Packet policy dated 7/1/09 stated the following: " It is the Center's policy to have a complete and accurate admission packet for all residents and that all packet documents (with the exception of the Admission Packet Checklist) are completed prior to or at the time of admission. The admission agreement must be signed within 24 hours of admission." The admission packet contained the Bill of Resident's Rights.	F 156		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that prompt efforts were made by the facility to resolve resident grievances for 2 of 2 residents (R10, R30) reviewed who expressed a grievance to	F 166	F166 Resident grievances for resident R10 and R30 have been resolved with residents being informed of the results of the center's investigation and actions taken. All Residents with grievances and allegations of misappropriation are having their concerns/allegations investigated per policy with follow up noted on concern report or investigation summary and care plan where appropriate.	6/30/14

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F 166	Continued From page 4 facility staff. Findings include: The facility did not follow their own established Policy and Procedure for properly identifying, investigating, and following up on resident concerns according to the Resident Concern and the Misappropriation of Property procedures. During observation and when interviewed on 5/19/14, at 9:56 a.m. R10 expressed missing $50.00 from the lock box in her bedside cabinet when she was hospitalized in January 2014. R10 was observed to be upset and said she was very "angry" about missing the money because it was in the lock box and some one "Used a knife or something sharp to force the box open". R10 felt the facility was responsible since the procedure was followed to lock up her valuables but someone broke into it while she was in the hospital in January. R10 strongly stated, "I told everyone about the missing money including the administrator and no one has told me if I will be reimbursed for the missing money." R10 did not know if staff were looking for the missing money or what the outcome to the missing money was. R10 did not feel the issue had been resolved appropriately. R10 stated, "I got angry, $50.00 is a lot of money to me on a fixed income and they took it as, oh well, and never settled it with me." R10 could not recall if she had a roommate at the time of the theft in January and stated, "You would need a knife to get all the screws from the bottom which were all taken out." Currently R10 did not have a lock on the bedside cabinet drawer and carried her money on her person at all times. R10 verified she remains very upset about the missing $50.00 bill and feels she never got a	F 166	Staff have been re-educated regarding follow up with grievance/concerns and allegations of misappropriation. NHA/Designee to audit up to 3 concerns/allegations per week. Results of audits to be reviewed in QPI.	

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F 166	Continued From page 5 report about the missing money and never got an answer if the facility would replace her money. R10's diagnosis from the document titled, "Face Sheet" lists, but is not limited to, hypothyroidism, anxiety state, depressive disorder and acute respiratory failure. The form titled, "Brief Interview for Mental Status (BIMS) dated 3/27/14, indicated a summary score of 15 out of a possible 15 for cognitive patterns indicating "Cognitively Intact." When interviewed on 5/20/14, at 8:35 a.m., the administrator verified any complaints of theft are to be "Verbally" reported to her immediately. No form is completed because the administrator stated, "I don't want to have pieces of paper that may get misplaced, I want to handle it all myself through the common entry point." When asked to review the investigation for R10's missing money the administrator had the common entry point document, however, there were no documented statements from employees or residents regarding the missing money. There was a piece of paper dated Thursday 1/16, and day, pm and night staff names were written on the paper. Document review of the policy titled, "Resident Concern Report" and dated January 2009, directed staff to "Initiate the Resident Concern Report for any and all concerns and to "Provide the administrator with Resident Concern report once initiated." The procedure directed "Follow up with resident/family about the concern to ascertain satisfaction with the resolution of the reported concern. Note: In the event satisfaction is not obtained, the Administrator will be responsible for documenting this fact on the	F 166		

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F 166	Continued From page 6 Resident Concern Report and documenting any additional follow-up needed." On 5/18/14 at 11:00 a.m., R30 told nursing assistant (NA)-D about $10.00 that was missing from her panda bear wallet. R30 stated, "I told the nurse about it yesterday (5/17/14) but I forgot which nurse I told." When interviewed, NA-D was not sure how to proceed with the report of the missing money but was going on break and then would let the administrator know. R30's diagnosis from the document titled, "Diagnosis Listing Form" lists, but is not limited to, Diabetes, End Stage Renal Disease, Peripheral Vascular Disease, and Depressive Disorder. The form titled, "Brief Interview for Mental Status (BIMS) dated 3/5/14, indicated a summary score of 15 out of a possible 15 for cognitive patterns indicating "Cognitively Intact." When interviewed on 5/20/14 at 8:30 a.m. the administrator verified she was not aware of R30 reporting missing money and stated, "This is very upsetting to me that I was not told right away." The administrator further offered, "The nursing assistant is new and did not know the procedure." A procedure directing staff to verbally tell the administrator of all thefts in the building was not available, according to the administrator.	F 166		
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than	F 276	F276 Resident 74 has had the quarterly assessment completed. All residents in house have been reviewed for quarterly assessments. MDS staff have been re-educated regarding quarterly assessments. CRC/Designee will audit up to 5 MDS per week to ensure quarterly assessments are completed; results of audits will be reviewed at QPI.	6/30/14

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F 276	Continued From page 7 once every 3 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to complete a federally mandated minimum data set (MDS) for 1 of 5 residents (R74) reviewed for a quarterly MDS. Findings include: R74 did not have a quarterly MDS completed in March. Review of the medical record identified R74 was admitted for rehabilitation following a hospitalization on 12/3/13. The medical record reveled that an admission MDS was completed on 12/10/13, and a 30 day MDS was completed on 12/29/13. A quarterly MDS was to be completed in March 2014. No record of a quarterly MDS could be located. When interviewed on 5/20/14, at 2:00 p.m. the MDS registered nurse (RN)-D confirmed the MDS for March was missed. She was unsure as to why it had not been completed.	F 276		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by:	F 311	F311 Resident 74 has had her quarterly assessment completed to determine her mobility status. Care plan interventions have been implemented based upon the assessment to ensure appropriate treatment and	6/30/14

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F 311	Continued From page 8 Based on observation, interview and record review the facility did not ensure 1 of 3 residents (R74) received the necessary care and services to maintain or improve functional ability in mobility. Findings include: R74 did not have a quarterly minimum data set (MDS) completed along with assessments to determine if R74 had maintained, increased or decreased in her ability to be mobile. R74 was admitted 12/3/13, for rehabilitation. R74 was started on physical therapy 12/3/13, with a diagnosis of difficulty in walking and dementia. At the start, the gait task was for the resident to progress to gait training with straight cane for 300 feet and supervision. At the start, the goal for ambulation was, R74 required, without assistive device and stand by assistance, (SBA) safe ambulation of 175 feet. At the end of the goal status on 1/3/14, R74 required front wheeled walker and supervision (verbal cuing but no physical assist) for safe ambulation of 250 ft. Goal of 300 ft and cane was not reached. The transfer ability was for the resident to transfer from sitting to standing and vice versa with no physical assist and no assistive devices. At the start the resident was able to safely transition from sit to stand and vice versa requiring only SBA and verbal cues. At the end of therapy on 1/3/14, the goal had already been met on 1/16/14, as the resident was able to safely transition from sit to stand and vice versa independently with no SBA required. On 12/18/14, therapy sent an In-Service Training Record to nursing, detailing the restorative	F 311	services to maintain or improve her abilities. All residents are having quarterly assessments completed and care plan interventions initiated to maintain or improve mobility as appropriate. MDS staff have been re-educated regarding quarterly assessments and initiating intervention to maintain or improve mobility. DON/Designee will audit up to 5 resident assessments and interventions weekly to ensure the development and provision of appropriate interventions for maintaining or improving mobility are in place. Results of audits will be reviewed at QPI.	

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F 311	Continued From page 9 program for nursing to complete for [R74]. The program indicated, "Pt [patient] is to walk to and from meals and BID [twice a day] in halls with FWW [front wheeled walker], gait belt and SBA, up to 260 ft." Added instructions for staff included; for meals, walk with FWW to table and follow with her wheelchair. Sit in wheel chair for meals. The resident was observed on 5/18/14, 5/19/14, 5/20/14, and 5/21/14 on various shifts and at various times, including four meal times. She was not observed ambulating or transferring, during the observation times. The admission MDS assessment completed 5/10/14, indicated the resident needed supervision with transferring and ambulation. The 30 day MDS completed 12/29/13, indicated the resident needed extensive assistance with transferring and the resident was not walking. The current care plan for ADL/Mobility dated 12/3/13, did not comprehensively address mobility and interventions for mobility, however, the written Restorative Resident Summary Report, did address the goal and the interventions. The current undated nursing assistant work sheet, which was provided, indicated under the section for mobility, assist of one with transfers, not ambulating at this time. The "other information" section indicated, walk to meals and BID in halls with a gait belt and SBA assist 260 ft. The top of the nursing assistant work sheet indicated, report all refusals of cares to the nurse. The Restorative Detail Report and the Restorative Resident Summary report from 1/1/14 through 5/20/14 was reviewed. The	F 311		

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F 311	Continued From page 10 restorative report identified in January the resident refused the mobility program 25 times and walked at least 260 ft 2 times. Many times the resident would only walk 5-10 feet. In February the resident refused the mobility program 31 times and one time was able to walk 300 feet. Most of the time she ambulated 5-15 feet. In March the resident refused the mobility program 27 times and was able to ambulate more than 260 feet 5 times. Most of the other times she walked about 25-50 feet. In April the resident refused the mobility program 22 times and was able to ambulate 260 feet 3 times. Most days she would walk 15-20 feet. From May 1st to May 20th the resident refused the mobility program 14 times. On 2 occasions she walked more than 260 feet. Most of the other times she was walking 10-50 feet. Interview with physical therapist aide (PTA)-A on 5/21/14, at 10:50 a.m. revealed R74 was walking on her own with a walker when discharged on 1/3/14. She was capable of getting in and out of bed without assistance and capable of getting in and out of a chair without assistance. The walking program was started 12/18/13, to ambulate the resident to and from all meals. The nursing assistants were educated. PTA-A indicated physical therapy had not been notified that resident was refusing the ambulation program so he had not seen her to assess whether or not she had declined. On 5/21/14, at 11:30 a.m. the MDS registered nurse (RN)-D revealed the quarterly MDS had been missed which would have triggered assessments to determine if the resident had declined in mobility.	F 311		

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F 311	Continued From page 11 Interview with R74 on 5/21/14, at 11:45 a.m., when asked about transferring and walking, R74 indicated, she could do it by herself but staff does offer to help. When asked, R74 did not indicate that she refused to ambulate or transfer. When interviewed about the mobility program on 5/21/14, at 11:55 a.m. (RN)-A indicated resident does refuse. At 1:35 (RN)-A indicated mobility should be on the care plan and if she is refusing that should also be on the care plan and it is not. Interview on 5/21/14 at 1:40 p.m. with nursing assistant (NA)-B revealed that sometimes the resident refuses to walk but most days she is offered and will accept. He also indicated the nurse is notified when the resident refuses. A policy and procedure for restorative nursing was requested. When interviewed on 5/21/14, at 1:45 p.m. the DON indicated there was no actual restorative policy and procedure, however physical therapy (PT) develops the restorative program and gives it to nursing, Nursing inputs the program with goals and interventions into the computer, and staff completes the program. If the resident refuses the program she would expect the staff to notify nursing who would notify therapy. The RN corporate nursing consultant indicated if the MDS was missed in March, as it apparently was, we would have missed the entire mobility program, as the MDS drives the programs, progress, and the needed revisions.	F 311		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323	F323 Resident 65 room has had electrical wiring completed as needed. All resident rooms have been inspected to ensure sufficient outlets without the use of piggybacking power strips. All staff have been re-educated regarding the use of power strips.	6/30/14

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F 323	Continued From page 12 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain an environment free from a potentially hazardous situation in regards to the electrical outlets and the electrical cords connected to surge protectors which were connected to the outlets in 1 of 4 rooms serviced by the same circuit breaker. This had the potential to affect 4 of 55 residents (R65, R78, R27, R9) serviced by the circuit breaker. Findings include: Surge protectors were piggybacked into one another causing a potential hazardous electrical situation. On 5/18/14, at 6:06 p.m. R65's room was observed to have several electrical cords going into a surge protector on the floor behind and to the right of the bed. R65 had a tracheotomy with humidified air, plugged into the surge protector, a feeding tube machine, a special bed, a special air mattress, a suction machine, a nebulizer machine (currently unplugged) and the TV. Behind the large oxygen tank was another surge protector and the first surge protector was piggy backed into that one. On 5/20/14, at 12:20 p.m. the state fire marshal was alerted and told maintenance (M)-A piggy backing could not be done. M-A agreed there	F 323	Maintenance/Designee will audit 5 rooms per week to ensure no use of piggybacking power strips. Results of audits will be reviewed at QPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245326	A. BUILDING _____ B. WING _____	05/21/2014

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

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F 323	Continued From page 13 would be no more piggy backing of electrical cords and indicated the room would have to be looked at by an electrician. 5/21/14 at 2:00 p.m. the administrator called and indicated the electrician had placed more outlets into the room. She indicated the residents on the same circuit breaker as R65 were R78, R27, R9. At the time, none of these residents had any medical equipment that was pulling a lot of amperage. Accidents and incidents were reviewed for R65 for the past year. There had been no issues related to the electrical outlets.	F 323		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors.	F 356	F356 Facility name, current date and total hours worked at the center are being posted on the wall by the nursing station. Staff have been re-educated regarding the correct format when posting daily hours worked. NHA/Designee will audit up to 3 times per week to ensure compliance. Result of audit to be reviewed at QPI.	6/30/14

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F 356	Continued From page 14 The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to post the required nurse staffing information to include the actual hours worked by licensed and unlicensed staff for 5 of 5 days reviewed, and did not include the daily census on 2 days reviewed. This practice had the potential to affect family, staff, visitors and all 56 residents residing at the facility. Findings include: Review of the Staffing forms, dated 5/17/14 and 5/18/14, lacked documentation of total daily census. The posted staffing form dated 5/17/14 through 5/21/14, lacked documentation of the actual hours worked by licensed and unlicensed staff at the facility. During the initial facility tour on 5/18/14, approximately 12:00 p.m. the facility staffing posting dated 5/17/14 and 5/18/14, was observed posted on the bulletin board in the lobby wall by the nursing station across from the main dining room. The form identified the charge nurse, number of licensed and unlicensed staff, "hours worked - 6:30-3:00 PM", number of FTEs (full	F 356		

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F 356	Continued From page 15 time equivalents) and identified the shift as Morning, Afternoon and Night. The posting lacked documentation of the total daily census and the actual hours worked in the facility by licensed and unlicensed nursing staff that provided direct cares to the residents. During the random observations of the nursing staff posting forms posted on the bulletin board in the lobby wall by the nursing station on 5/19/14, 5/20/14 and 5/21/14, it was noted the daily shift hours for the licensed and unlicensed staff was lacking, how many hours on each shift the staff had worked on the units. During an interview with staffing coordinator, on 5/21/14, at 8:42 a.m., the staffing coordinator verified the actual hours worked by nursing staff at the facility and daily census for two days was lacking and stated this would be corrected moving forward. Staffing coordinator further indicated, "This has been brought up many times, but I will correct it now." During an interview with the administrator on 5/21/14, at 8:58 a.m., the administrator verified the actual hours worked by nursing staff at the facility daily census for two days was lacking and stated, "This is a learning opportunity and we are going to fix it right away." The policy and procedure revised date July 2008, reads, and "2. Post the following information on a daily basis at the beginning of each shift: c. Resident census."	F 356		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431	F431 Resident 9 & 78 are receiving medications that are not expired. All residents are receiving medications within storage parameters. All licensed staff have been re-educated regarding medication storage. DON/Designee will audit 3 med carts per week for expired medications. Results of audit will be reviewed at QPI.	6/30/14

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F 431	Continued From page 16 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to discard expired house stock medication, which could potentially affect	F 431		

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F 431	Continued From page 17 an unspecified number of residents and failed to dispose of expired medications for 2 of 10 residents (R9, R78) who received insulin. Findings include: During medication storage review on 5/18/14, at 11:55 a.m., on the South hallway medication cart, a bottle of 325 mg aspirin,which was used as a stock medication, had an expiration date on 3/14. Registered Nurse (RN) C verified the expiration date and removed the bottle from the medication cart. This could potentially affect an unspecified number of residents, as the South hallway was for short term residents, and the number of residents receiving aspirin changed frequently. The facility did not discard expired medications per facility policy for 2 of 10 residents (R9 and R78) who received insulin. Review of the medication cart for the East hallway, on 5/18/14, at 12:30 p.m., the following was discovered: an open bottle of Lantus insulin for R78, with an opened on date of 4/8/14,(40 days prior) and a sticker from the pharmacy to discard the medication 28 days after opened. an open bottle of Novolog insulin for R78 with an opened on date of 4/8/14,(40 days prior) and a sticker from the pharmacy to discard the medication 28 days after opened. an open bottle of Novolog insulin for R 9 with an opened on date of 4/16/14 (32 days prior) and a sticker from the pharmacy to discard the medication 28 days after opened. Licensed Practical Nurse (LPN) B verified the medications were expired and should not have	F 431		

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F 431	Continued From page 18 been used . Review of R 78's record included diagnosis of chronic kidney disease, and diabetes, and indicated a physician order for Lantus insulin SQ (subcutaneous) 10 units QD (every day), and Novolog Insulin SQ 3 units TID (three times a day) with meals. Review of R 9's record included diagnosis of end stage renal disease, Diabetes, and High blood pressure, and indicated a physician's order for Insul-Novolog (Aspart) 100 units/1 ml, Inject 10 units sub Q three times daily with meals and Insul-Novolg (Aspart) inject three times daily with meals per sliding scale. Review of the Facility's Pharmacy Services and procedure Manual, dated 2010, section 5.3 titled Storage and Expiration Dating of Medications, Biological's, Syringes and Needles, directs the following: 4. Facility should ensure that medications and biological that (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the supplier. 16. Facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biologicals in accordance with Pharmacy return/destruction guidelines.	F 431		
F 466 SS=C	483.70(h)(1) PROCEDURES TO ENSURE WATER AVAILABILITY The facility must establish procedures to ensure	F 466		

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F 466	Continued From page 19 that water is available to essential areas when there is a loss of normal water supply. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure potable and non-potable water needs for the facility were estimated and planned for, should loss of normal water supply occur. This had the potential to affect all 55 residents residing in the facility. Findings include: The facility's emergency water supply contract dated 1/1/2010, was reviewed. The contract identified 20 gallon jugs of water should be on hand at the facility. The contract lacked a method for storage, distribution of the water or calculations for estimating the gallons of water required daily to meet the needs of the residents and staff should there be loss of the water supply in an emergency. During an interview with the administrator on 5/18/14, at 2 p.m. the administrator verified the facility had not analyzed normal water consumption for the facility to determine possible water needs for the facility. The administrator confirmed a calculation had not been used to determine the amount of water needed for the various facility water needs, and further identified no plan for distribution or storage of water was available. The administrator verified the facility did not have 20 available gallon jugs of water according to the water contract	F 466	F466 The NHA has executed provisions and estimates of potable and non-potable water needs for the facility should loss of normal water supply occur. All residents will have availability of potable and non-potable water needs should loss of water supply occur. Center staff have been re-educated regarding the need for potable and non-potable water. The vendor agreement for water supply will be reviewed annually to ensure availability of water.	6/30/14

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F 466	Continued From page 20 recommendations. Furthermore, the administrator confirmed the current facility's emergency water policy did not contain specifications of how water would be distributed throughout the facility nor were there calculations regarding how much total potable and non potable water would be needed in the event of a water emergency. The policy for emergency water supply was not received as requested. The administrator indicated the policy had been thrown out and was not able to locate another copy.	F 466		

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	245326	A. BUILDING 01 - MAIN BUILDING 0102 B. WING _____	05/20/2014

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Rose of Sharon Manor was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH	K 000	RECEIVED JUN 13 COMPLIANCE MONITORING LICENSE AND CERTIFICATION POC ok 6-24-14 RECEIVED JUN 23 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 6-30-14

EXIT: 5-21-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cherie Cornell	administrator	6-12-2014

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
	245326	A. BUILDING **01 - MAIN BUILDING 0102** B. WING _____	**05/20/2014**

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K 000	Continued From page 1 DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Rose of Sharon Manor is a 2-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1968 and was determined to be of Type II(222) construction. In 1992, an addition was constructed to the North side that was determined to be of Type II(222) construction. Because the original building and the 1 addition are of the same type of construction, the facility was surveyed as one building. The building is fully fire sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 63 beds and had a census of 57 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		~~6/30/14~~
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When	K 029	K 029 1. Director of Maintenance adjusted the 2 self closing doors and they are now in compliance. 2. Completion date June 1, 2014. 3. Director of Maintenance is responsible for monitoring to prevent reoccurrence the deficiency. 4. Monitoring will be reviewed in QPI.	

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

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	245326	A. BUILDING 01 - MAIN BUILDING 0102 B. WING _____	05/20/2014

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K 029	Continued From page 2 the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain hazardous areas in accordance with the requirements of NFPA 101 - 2000 edition, sections 19.3.2.1 and 8.4.1. The deficient practice affected approximately 20 of the 63 residents. Findings include: On facility tour between 09:00 AM and 01:00 PM on 05/20/2014, it was observed that 2 self closing doors from the kitchen to the corridor did not latch when tested. This deficient practices was confirmed by the facility Administrator (CC) at the time of discovery.	K 029		
K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible	K 050	K 050 1. Fire Drills are being varied throughout the evening shift. 2. Compliance date 6/1/14. 3. Director of Maintenance is responsible for monitoring to prevent reoccurrence of the deficiency. 4. Monitoring will be reviewed in QPI.	~~6/30/14~~

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K 050	Continued From page 3 alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and interview,, it was determined that the facility failed to conduct fire drills in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Findings include: On facility tour between 09:00 AM and 01:00 PM on 05/20/2014, based on review of available documentation it was reveled that fire drills were not varied throughout the shift during the evening shift. All drills on the evening shift for the 1st quarter of 2014 and 3rd and 4th quarters of 2013 were conducted between 3 PM and 5 PM. This deficient practices was confirmed by the facility Administrator (CC) at the time of discovery.	K 050		~~6/30/14~~
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Electrical installations are not in accordance with NFPA 70 "The National Electrical Code 1999 edition. section 9.1.2. This deficiency could negatively effect the 10 of 63 residents. Findings include: On facility tour between 09:00 AM and 01:00 PM	K 147	K 147 1. NAC installed additional outlets in room E1 to accommodate all medical equipment. 2. Completion date 6/1/14. 3. Director of Maintenance is responsible for monitoring to prevent reoccurrence the deficiency. 4. Monitoring will be reviewed in QPI.	

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K 147	Continued From page 4 on 05/20/2014, it was observed that in resident room 1E, 2 multi plug extension cords were piggybacked together with medical equipment plugged into extension cords. This deficient practices was confirmed by the facility Administrator (CC) at the time of discovery.	K 147		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 5095

June 3, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5326023

Dear Ms. Camuel:

The above facility was surveyed on May 8, 2014 through May 22, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is 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 deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

When all orders are corrected, the order form should be signed and returned to:

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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 me.

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

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

Please feel free to call me with any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure(s)
cc: Original - Facility
Licensing and Certification File