#### CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTI	FICATION AND TRANSMITTAL
PART I - TO BE COMPLETED B	Y THE STATE SURVEY AGENCY

ID: LKWB Facility ID: 00497

MEDICARE/MEDICAID PROVIDER NO.     (L1) 245105  2.STATE VENDOR OR MEDICAID NO.     (L2) 264638200			.C (L6) 55113	4. TYPE OF ACTION: 7 (L8)  1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHI (L9) 03/01/2017	01 Hospital	PPLIER CATEGORY 05 HHA 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other  8. Full Survey After Complaint
6. DATE OF SURVEY 01/11/2019  8. ACCREDITATION STATUS: 0 Unaccredited	(L34) 02 SNF/NF/Dual (L10) 03 SNF/NF/Distinct 04 SNF	06 PRTF 10 NF 07 X-Ray 11 ICF/II 08 OPT/SP 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31
	X   A. In Complian   Program I   Complian	IS CERTIFIED AS: ance With Requirements ace Based On: Acceptable POC pliance with Program and/or Applied Waivers:	And/Or Approved Waivers Of The  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
14 LTC CERTIFIED DED DREAKDOWN	Requirements	and of Applied waivers.	* Code: A*  15. FACILITY MEETS	(LI2)
14. LTC CERTIFIED BED BREAKDOWN  18 SNF 18/19 SNF  175	19 SNF ICF	IID	1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39) (L42)	(L43)		
16. STATE SURVEY AGENCY REMARKS (IF A	PPLICABLE SHOW LTC CANCI	ELLATION DATE):		
17. SURVEYOR SIGNATURE	Date:		18. STATE SURVEY AGENCY A	APPROVAL Date:
Susanne Reuss, Unit Supe	ervisor	01/15/2018 (L19)	Kamala Fiske-Downing, Er	nforcement Specialist 01/15/2019 (L20)
PART II	- TO BE COMPLETED	BY HCFA REGIONA	AL OFFICE OR SINGLE STA	ATE AGENCY
DETERMINATION OF ELIGIBILITY      1. Facility is Eligible to Participate     2. Facility is not Eligible		MPLIANCE WITH CIVIL GHTS ACT:	<ul><li>21. 1. Statement of Finan</li><li>2. Ownership/Control</li><li>3. Both of the Above</li></ul>	Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE 23. LT	C AGREEMENT 2	24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION BI 08/01/1969	EGINNING DATE	ENDING DATE	VOLUNTARY 00 01-Merger, Closure	INVOLUNTARY  05-Fail to Meet Health/Safety
(L24) (L	41)	(L25)	02-Dissatisfaction W/ Reimbursemen	nt 06-Fail to Meet Agreement
	LTERNATIVE SANCTIONS Suspension of Admissions:	(1.44)	03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
(L27) B.	Rescind Suspension Date:	(L44) (L45)		00.144.0
28. TERMINATION DATE:	29. INTERMEDIARY/	CARRIER NO.	30. REMARKS	
	01111			
(L28		(L31)		
31. RO RECEIPT OF CMS-1539	32. DETERMINATION	OF APPROVAL DATE		
(L32	)	(L33)	DETERMINATION APPRO	OVAI



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 15, 2019

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

RE: Project Number S5105031

Dear Administrator:

On December 11, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for, a standard survey, completed on November 29, 2018. 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 January 11, 2019, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard standard survey, completed on November 29, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 4, 2019. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 29, 2018, effective January 4, 2019 and therefore remedies outlined in our letter to you dated December 11, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Licensing and Certification Program

Minnesota Department of Health

Kumalu Fiske Downing

P.O. Box 64900

St. Paul, MN 55164-0900

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245105

January 15, 2019

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 January 4, 2019 the above facility is certified for:

175 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Licensing and Certification Program Minnesota Department of Health

Kumalu Fiske Downing

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

				ON AND TRANSMITTAL STATE SURVEY AGENCY	ID: LKWB Facility ID: 00497
MEDICARE/MEDICAID PRO     (L1) 245105      2.STATE VENDOR OR MEDICA     (L2) 264638200	LID NO.	3. NAME AND ADD (L3) THE ESTATE (L4) 2727 NORTH (L5) ROSEVILLE,	S AT ROSEVILLE VICTORIA MN	(L6) <b>55113</b>	4. TYPE OF ACTION: 2 (L8)  1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE (L9) <b>03/01/2017</b>		7. PROVIDER/SUPP 01 Hospital	05 HHA 09 E		8. Full Survey After Complaint
	11/29/2018 (L34) — (L10) TJC Other	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 10 N 07 X-Ray 11 IC 08 OPT/SP 12 R	CF/IID 15 ASC	FISCAL YEAR ENDING DATE: (L35) 12/31
11LTC PERIOD OF CERTIFICATION (a):  To (b):	ATION	10.THE FACILITY IS  A. In Compliance  Program Rec Compliance	e With quirements	And/Or Approved Waivers Of T2. Technical Personnel3. 24 Hour RN	he Following Requirements:  6. Scope of Services Limit 7. Medical Director
12.Total Facility Beds 13.Total Certified Beds	175 (L18) 175 (L17)	X B. Not in Comp	ceptable POC diance with Program d/or Applied Waivers:	4. 7-Day RN (Rural SN 5. Life Safety Code * Code: <b>B</b> *	F) 8. Patient Room Size 9. Beds/Room (L12)
	AKDOWN 9 SNF 19 SNF 75	ICF	IID	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L37) (L37) (L37) (L37) (L37)	REMARKS (IF APPLICABL	(L42) E SHOW LTC CANCEL	(L43) LATION DATE):		
17. SURVEYOR SIGNATURE		Date:		18. STATE SURVEY AGENCY	APPROVAL Date:
Barbara White, H	IFE NE II	12	/31/2018 (L	Douglas Larson, En	forcement Specialist 01/14/2019 (L20
	PART II - TO BI	COMPLETED B	Y HCFA REGIO	NAL OFFICE OR SINGLE ST	ATE AGENCY
19. DETERMINATION OF ELIC  _X	ble to Participate		LIANCE WITH CIVIL ITS ACT:		ncial Solvency (HCFA-2572)  ol Interest Disclosure Stmt (HCFA-1513)  e:
22. ORIGINAL DATE	23. LTC AGREEM	ENT 24.	LTC AGREEMENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION <b>08/01/1969</b>	BEGINNING	DATE	ENDING DATE	VOLUNTARY 01-Merger, Closure	05-Fail to Meet Health/Safety
(L24) 25. LTC EXTENSION DATE:	(L41) 27. ALTERNATI A. Suspension	VE SANCTIONS a of Admissions:	(L25)	02-Dissatisfaction W/ Reimbursem 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	
(L2	B. Rescind Sus	pension Date:	(L44) (L45)		
28. TERMINATION DATE:	29	. INTERMEDIARY/CA	RRIER NO.	30. REMARKS	

(L31)

(L33)

DETERMINATION APPROVAL

01111

32. DETERMINATION OF APPROVAL DATE

(L28)

(L32)

31. RO RECEIPT OF CMS-1539



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 11, 2018

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

RE: Project Numbers S510503, H5105142

#### Dear Administrator:

On November 29, 2018, a standard survey was completed at your facility by the Minnesota Department(s) 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required. In addition, at the time of the November 29, 2018 standard survey, the Minnesota Department of Health completed an investigation of complaint number H5105142 that was found to be unsubstantiated.

#### OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is January 8, 2019.

#### ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10)** calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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.

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

The Estates At Roseville Llc December 11, 2018 Page 2

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.

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

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

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

#### **DEPARTMENT CONTACT**

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

Eva Loch, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: eva.loch@state.mn.us

Phone: (651) 201-3792 Fax: (651) 215-9697

#### 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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire

The Estates At Roseville Llc December 11, 2018 Page 3

Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by March 1, 2019 (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).

In addition, if substantial compliance with the regulations is not verified by May 29, 2019 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

#### 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

The Estates At Roseville Llc December 11, 2018 Page 4

deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc idr.cfm

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

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

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

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

Fax: (651) 215-0525

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

Feel free to contact me if you have questions.

Sincerely,

Towns Stapen

Douglas Larson, Enforcement Specialist

Minnesota Department of Health Licensing and Certification Program

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File

PRINTED: 12/31/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
							С
		245105	B. WING			11/:	29/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
THE EST	ATES AT ROSEVILLE	LLC			727 NORTH VICTORIA		
				F	ROSEVILLE, MN 55113		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		ΕC	000			
F 000	Emergency Prepare conducted on 11/26 recertification surve	iance with CMS Appendix Z edness Requirements, was 5/18 through 11/29/18, during a ey. The facility is in compliance Z Emergency Preparedness	FO	000			
	November 26 throu investigation was a	rvey was conducted gh 29, 2018 and a complaint lso completed at the time of y. The complaint #H5105142 I was found to be					
	as your allegation of Department's acceptoriolled in ePOC, year the bottom of the	f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.					
F 561 SS=D	on-site revisit of you validate that substate regulations has been your verification.	acceptable electronic POC, an ur facility may be conducted to untial compliance with the en attained in accordance with	F 5	561			1/4/19
L ABORATOR	promote and facilita through support of not limited to the rig (1) through (11) of t	e right to and the facility must ate resident self-determination resident choice, including but ghts specified in paragraphs (f)	IATLIBE		TITLE		(X6) DATE

Electronically Signed

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

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 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION  IG		COMPLETED		
		245105	B. WING _			C <b>29/2018</b>	
	PROVIDER OR SUPPLIER	LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2727 NORTH VICTORIA ROSEVILLE, MN 55113		23/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 561	activities, schedule waking times), hear care services considered assessments, and applicable provision §483.10(f)(2) The responsibility that are sign §483.10(f)(3) The responsibility that are sign §483.10(f)(3) The responsibility activities facility.  §483.10(f)(8) The responsibility activities facility.  §483.10(f)(8) The responsibility and community activities facility.  This REQUIREMED by:  Based on observative review, the facility frelated to morning residents (R42, R12).  Findings include:  R42's quarterly Min 9/25/18, indicated simpaired, required for bed mobility and never understood. 11/29/18, identified	esident has a right to choose s (including sleeping and ith care and providers of health stent with his or her interests, plan of care and other	F 56	• R42, R124 morning rising ro have been updated to reflect the preferences via the care plans a care sheet. R64 was on hospice since passed away. • All residents have the potent affected if they are not provided choices related to morning rising. • All residents rising preference reviewed and care plans and NA sheets updated to reflect their cheat and the completed at the facility CMM mand (which usually occur within 72 hospitalism occur within 7	ir nd NAR and has ial to be with routines. es will be R care loices. e eetings ours of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	COM	(X3) DATE SURVEY COMPLETED	
		245105	B. WING _			C <b>29/2018</b>	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2727 NORTH VICTORIA ROSEVILLE, MN 55113		23/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 561	she was severely corequired extensive and transfers. R124 11/29/18, identified directed staff to ass R64's quarterly MD was severely cognitextensive assist of for transfers.  During an observating R64 was up in her was appeared to be asleand R42 were where and seated in front had their eyes close At 9:06 a.m. R64, Fitheir breakfast food R124's shoulder an R124 replied "I am offer bites of food to closed and needed open her mouth. R6 closed and did not closed and did not closed and both with eyes close During an observating R64 was laying dreblanket. Nursing as assisted R64 to get then R64 told NA-Bassisted R64 back assisted R64 back assisted R64 back and both with eyes close then R64 told NA-Bassisted R64 back assisted R64 back and both with eyes close then R64 told NA-Bassisted R64 back assisted R64 back assisted R64 back and both with eyes close then R64 told NA-Bassisted R64 back assisted R64 back and both with eyes close then R64 told NA-Bassisted R64 back assisted R64 back and both with eyes close then R64 told NA-Bassisted R64 back assisted R64 back and both with eyes close then R64 told NA-Bassisted R64 back and both with eyes close then R64 told NA-Bassisted R64 back and both with eyes close then R64 told NA-Bassisted R64 back and both with eyes close then R64 told NA-Bassisted R64 back and both with eyes close the R64 back and both	OS dated 11/6/18, indicated orgitively impaired and assist of one for bed mobility It's care plan printed on alteration in mobility and sist with transfers.  S dated 10/9/18, indicated she tively impaired and required two for bed mobility and one for one of the table all three residents and appeared to be asleep; and drink; staff tapped and drink; staff tapped and drink; staff tapped at the staff as they stated her name. At R42 were in the dining room, at the dining room, and appearing to be asleep.  So tired." The staff began to the table all three residents are they stated her name. At R42 were in the dining room, and appearing to be asleep.  Son on 11/29/18, at 7:17 a.m. assed in her bed covered with a sistant (NA)-B stated she dressed around 6:30 a.m. she was tired so NA-B	F 56	contain resident's rising prefer These preferences will then be in the resident's care plan and resident's assignment sheets.  The facility will provide edu nursing staff, social services, a therapeutic recreation staff abe self-determination and the new forms.  Director of Nursing/Design responsible for conducting auc ensure that resident's preferen being collected and implement will be conducted on all new ac and 10 current residents per w weeks and reported to QAPI c for further review and recomm	e reflected on ucation to all and out resident preference ee will be lits to uces are ed. Audits dmissions eek x 3 ommittee		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		245105	B. WING		11	C / <b>29/2018</b>	
	PROVIDER OR SUPPLIER	ELLC		STREET ADDRESS, CITY, STATE, ZIP COD 2727 NORTH VICTORIA ROSEVILLE, MN 55113		, 20, 20 10	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 561	were seated in the closed and asleep stated R124 some wanted to stay in b R124 if she was re R42 was at times a and if she was slee extra time and ther NA-B explained R6 the morning they d bed to rest until brown bed to rest until brown number listed getting residents up indicated she would to get a resident up before. NA-A verificindicate resident's During an interview NA-C identified he listed on his care so to get ready and st breakfast." NA-C et alk could say no to scream so then you and those who don and get them ready During an interview registered nurse (F(SS)-A; RN-B states	confirmed R42, R124 and R64 sir wheelchairs with their eyes at the dining room table. NA-B times will inform staff she ed and indicated they ask ady to wake up. NA-B stated already awake in the morning eping then they allow her a little in get her ready for breakfast. At at time is "so sleepy" during ress her and assist her back to eakfast.  If on 11/29/18, at 8:43 a.m. e started with the first resident id on her care sheet when it is and ready for the day. NA-A id wait until closer to breakfast of if they were awake the night ed her care sheet did not preferred wake times.  If on 11/29/18, at 8:59 a.m. went in the order of residents when waking residents up ated "you need to get them to explained residents who could it waking up and some would up don't force them to wake up it refuse you wake them up	F 5	61			
	R124 would also sa up and further state	of want to wake up, SS-A stated ay she was not ready to wake ed R42's spouse wanted her RN-B identified the therapeutic					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245105	B. WING				C <b>29/2018</b>
	PROVIDER OR SUPPLIER			27	TREET ADDRESS, CITY, STATE, ZIP CODE 727 NORTH VICTORIA OSEVILLE, MN 55113	1 11/2	23/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE .	(X5) COMPLETION DATE
F 578 SS=D	personal preference During an interview therapeutic recreati they do ask about r they do not ask about A facility policy relative requested but not requested but not request/Refuse/Ds CFR(s): 483.10(c)(6) §483.10(c)(6) The rediscontinue treatment to participate in expformulate an advantion strued as the right provision of medical control of the provision of the provisio	ent completed an interview on es upon admission.  on 11/29/18, at 2:12 p.m. on assistant (TR)-A indicated esident preferences, however out preferred wake times.  ted to resident choices was eccived. scntnue Trmnt;FormIte Adv Dir 6)(8)(g)(12)(i)-(v)  right to request, refuse, and/or ent, to participate in or refuse perimental research, and to	F 5				1/4/19
	requirements speci subpart I (Advance (i) These requirement inform and provide residents concerning medical or surgical resident's option, for (ii) This includes a vertical facility's policies to and applicable Stat (iii) Facilities are perentities to furnish the	ents include provisions to written information to all adult ag the right to accept or refuse treatment and, at the rmulate an advance directive. Written description of the implement advance directives					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		245105	B. WING _			29/ <b>2018</b>
	PROVIDER OR SUPPLIER	LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2727 NORTH VICTORIA ROSEVILLE, MN 55113	11/2	13/2010
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F 578	requirements of this (iv) If an adult indivitime of admission a information or article has executed an admay give advance of individual's resident with State Law.  (v) The facility is not provide this information or she is able to receive Follow-up procedure the information to the information in information the information in information in information in information in information information information in	·	F 57	<ul> <li>R27's resuscitation order was reviewed and updated to match the resident's request for CPR via the form once it was found not to match 11/28/2018.</li> <li>All residents have the potential affected if their resuscitation statusted on the match their stated preferent advanced directives.</li> <li>All resident's resuscitation ordestated preferences were audited to residents preferences were reflect accurately. This was done immediduring the survey process on 11/2</li> <li>The facility has since reviewed process of documenting code stated POLST documentation and put in re-education with nursing personn.</li> <li>Director of Nursing/Designeer continue to review POLST orders match them to resident's preference upon admission, with scheduled Mareviews, significant changes, and</li> </ul>	POLST ch on all to be sorders ce for ers and censure ed ately 8/2018. If the us and to place el. will and ces IDS	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245105	B. WING			11/2	29/ <b>2018</b>
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F 578	Treatment (POLST "Cardiopulmonary F signed and dated the POLST was signed practitioner on 10/1 R27's Initial/Compre 8/16/18, indicated F Cardiopulmonary R R27's Order Summidentified and order however, the medic documentation who obtained to change hospitalization.  On 11/28/18, at 8:1 (LPN)-A assigned to the orders tab in Pousually listed the orders tab in Pousually listed the overified R27 current DNI/DNR.  On 11/28/18, at 9:0 wishes were R27 st CPR if they found how on the matching pertaining directive. RN-A stat to make sure it was had recently been a re-admitted to the fittime staff reviewed stated she would have a signed to the matching pertaining directive. RN-A stat to make sure it was had recently been a re-admitted to the fittime staff reviewed stated she would have signed to the staff reviewed stated she would have signed to the signed to the fittime staff reviewed stated she would have signed to the signed to the fittime staff reviewed stated she would have signed to the signed to the fitting staff reviewed stated she would have signed to the signed to	were reviewed and indicated Resuscitation" (CPR). R27 ne POLST on 10/11/18. The and dated by a nurse 1/18.  whensive care plan dated R27's current code status was esuscitation (CPR).  ary Report dated 11/28/18, for DNI/DNR dated 11/21/18, al record lacked wher a clarification had been R27 from a Full code prior to R27 stated if she needed to code status she would look at bint Click Care (PCC) which ode status on the top. LPN-A t listed code status was	F 5	578	needed.  • The QAPI committee will exam results of these reviews and will proredirection or change when necess ensure completion and/or continual monitoring process	ovide ary to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2727 NORTH VICTORIA ROSEVILLE, MN 55113	1 11/2	.5/2010
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F 578	were supposed to greviewed the hospit verified R27's code  On 11/28/18, at 2:1 nursing stated staff regarding assessing "when residents conurses to ask the reand we go by what was re-admitted fro DNI/DNR order I was to have clarified wit situation the ball was back. We will start of Free from Involunta CFR(s): 483.12(a)( §483.12  The resident has the neglect, misapprop and exploitation as includes but is not I corporal punishment any physical or chetreat the resident's  §483.12(a) The face §483.12(a)(1) Not uphysical abuse, corinvoluntary seclusion This REQUIREMENT by:  Based on observatoreview, the facility face	get a clarification. RN-A cal discharge orders and status was DNI/DNR.  3 p.m. the interim director of were to follow the policy get the code status and stated me to the facility we ask the esident their POLST wishes the resident wants. When he me the hospital with the bould have expected the nurse that he resident and in this as dropped when he came right away to audit."  Try Seclusion  1)  e right to be free from abuse, riation of resident property, defined in this subpart. This imited to freedom from ant, involuntary seclusion and mical restraint not required to medical symptoms.  illity must-  use verbal, mental, sexual, or poral punishment, or	F 60		Victoria view,	1/4/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED C		
		245105	B. WING			, 9/2018
	PROVIDER OR SUPPLIER  TATES AT ROSEVILLE	LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2727 NORTH VICTORIA ROSEVILLE, MN 55113		
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F 603	11/2/18, to the transdiagnoses that including without behavioral of Minimum Data Set R490 had a score of mental status (BIMS a resident was cognimedical record indictive Victoria secured On 11/28/18, at 8:3 surveyor on the Victoria secured On 11/28/18, at 8:3 surveyor on the Victoria secured On 11/28/18, at 9:0 surveyor on the Victoria secured to sit down and "state R490 was observed table with his back case that was up as case that was up as surveyor on the Victoria the felt like he was get past the doors. Tried to leave, he know to his home but "get would help. R490 of there was no one to residents on the unthe social worker was sisted living facility he was crazy and the unit a prison. R490 you can't leave? Healed around the	to the nursing home on sitional care unit (TCU), with uded unspecified dementia disturbances. The admission dated 11/22/18, identified of 14 on the brief interview for S), a score of 13-15 indicated nitively intact. Review of the cated R490 was transferred to d unit on 11/5/18.  4 a.m. R490 approached the toria secured unit and asked empted to re-direct R490 to d R490 said that he didn't want are at the wall". At 8:53 a.m. d in the dining room at his to the door and facing a book	F 603	discharged from the facility to an A 12/17/18.  All residents residing on the sememory care units have the potent be affected if a resident is placed of without proper assessment and qualifications.  All the residents that reside on secured units will be reviewed to e each resident is free from involuntated seclusion.  The facility will review each restresiding on a secure unit upon transadmission or at least quarterly or disgnificant changes to ensure each resident is free from involuntary set This review will be documented in progress note or on the care confectorm.  The facility will provide re-education and a secure units at the fact will be a secured in the secure units at the fact will be a secure unit upon transaction.	the nsure ary sident affer, luring a crence cation to a the acility at the acilit	

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F 603	Licensed practical interviewed on 11/2 said R490's signific LPN-C felt that R49 Woodhill secured of would be more resi LPN-C said R490 linever made any attrequire any redirect R490 was even on Registered nurse (I worker (SS)-A were 1:15 p.m. and ident on to the transitiona at night and went in rummaged through the residents on the R490.  SS-A said it was brinterdisciplinary teanot appropriate for SS-A said she and R490 and said he osecured Victoria unbeen on the secure gone into other residents on the residents on the residents of the secured victoria unbeen on the secured victoria	nurse (LPN)-C was 19/18, at 12:55 p.m. LPN-C ant other came in daily to visit. 20 would do better on the ementia unit because there dents to talk with on that unit. It ked to be in his room, he had empts to leave and did not ion. LPN-C was not sure why the Victoria secured unit.  RN)-B and licensed social interviewed on 11/29/18, at ified that R490 was admitted at care unit (TCU) and was up to other resident's rooms and other resident's rhings and interviewed on the TCU unit were frustrated with the mought up at the mought up a	F 60	03		

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F 603	Most of R490's day significant other and walk to the TCU un Both RN-B and SS-leave the secured \( \) and SS-A had any of seeking or leaving to the secured unit) who wever he current secure Victoria unit do better in a single were no single room care unit.  SS-A identified that other secure dement there were more all there were more all there that R490 country and R490 was see the room that we transferred to the VICR490 was not offer within the facility. Eaware that R490 did secured Victoria un RN-B and SS-A ide secured unit include seeking behaviors, and/or would benefit	d they watched television and it and sat in the front lobby. A said R490 had not tried to victoria unit and neither RN-B concerns about R490 exit he facility.  In g term care unit bed (not in bould be a better fit for R490 ly has a single room on the and SS-A felt that R490 would be room and currently there has available on the long term  R490 would be better on the intia unit (Woodhill) because extrand oriented residents ald converse with. SS-A said able rooms available on that not offered to tour that unit or vas available when he was ictoria secured unit.  R490 was definitely at a cialization compared to other ctoria secured unit and that ed any other room options both RN-B and SS-A were not donot want to be on the	Fe	603			

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F 603	11/29/18, at 1:57 p. criteria for placeme included a diagnosi and if a resident was they were at risk to placing someone of there should be a cand the resident, the tour the area and be move. The DON ice elopement risk assiprior to placement of DON said R490 was didn't feel that R490 dementia to be on the was unsure how R4.  RN-C was interview RN-C (who worked indicated that if a resident's rootlevel of dementia, the dementia unit. RN-and wandering into the was on the TCU was brought to and was made from the Victoria secured unhigher functioning resident's rootlevel of the was on the TCU was brought to and was made from the Victoria secured unhigher functioning resident wandering and rum.  Administrator was if 2:37 p.m. When as secured memory candicated a resident disorder, exhibit signed from additional programment.	m. The DON indicated the nt on a secure dementia unit s of dementia or Alzheimer's at at risk for wandering, and if themselves or others. When a secured dementia unit onversation with the family e family and resident should e involved with the decision to lentified there would be an essment done for all residents on the secured units. The s not an elopement risk and 0 was advanced enough in his the Victoria secure unit and 490 ended up on the unit.  Wed on 11/29/18, at 2:17 p.m. as an RN on the TCU) esident was rummaging, in ms and depending on their hey may be safer on a C said R490 was rummaging other resident's rooms while . RN-C said this information IDT meeting and a decision re to move R490 to the it. RN-C said the TCU had esidents and the memory unit ted for R490's needs due the	F	603		

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		245105	B. WING			C <b>11/29/2018</b>
	PROVIDER OR SUPPLIER	ELLC		STREET ADDRESS, CITY, STATE, ZIP CO 2727 NORTH VICTORIA ROSEVILLE, MN 55113		11/25/2510
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F 603	was noted to rummar closet in his room of TCU but made no mistakenly went introom and was eas nursing notes to iddregards to R490 be secured unit. R490 form and he signed from the TCU to the Progress note on 1 R490 was noted to and his closet. De behavioral issues, the lobby having a behaviors, easily remonitoring continual Progress note on 1 R490 exhibited was attempts of exit see enter another clien looking for his own  Progress note on 1 R490 was rummar from one bed to an seeking, pleasant with behaviors, frequenthru out shift.  Progress note on 1 R490 was adjusting No wandering/exit	age 12  s notes identified that R490 hage in his own drawers and on the TCU, wandered on the attempts to leave and to another TCU resident's fily re-directed. There were no entify a discussion was held in eing moved to the Victoria of was provided a room change of it himself to change rooms to evictoria secured unit.  1/4/18, at 1:35 a.m. identified rummage through his drawers nied any pain when asked, no pleasant with staff, sitting in snack, no exit seeking the edirected, frequent safety the esthru (sic) out the shift.  1/4/18, at 9:43 a.m. identified andering behaviors on unit, no eking or leaving unit. Client did to room; easily redirected.  1/5/18, at 1:58 a.m. identified ing around his room, going nother in his roomno exit with staff, no negative to safety monitoring continues  1/6/18, at 3:34 p.m. identified to his new environment well. seeing observed. There is no notify that R490 was transferred	F6	503		

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F 603	to a different unit or Progress note on 1 rounds R490 asked as other residents hand does not like it. wanted to go home Progress note on 1 stated to staff that hat he wished that An Elopement Risk 11/13/18, was revie 7 (0-14 was no risk R490 had not historfully ambulatory, ac disorientation but no noted, was on one a had a diagnosis of on the assessment what prevention me implemented and the Unit. The summary Resident is not a ris secure unit related admission to a secundated policy lister Have a major neuro sign and symptoms disorders. 2. Patie from increased, spea a controlled access Qualify for skilled not the second symptoms of the second symptoms disorders. 2. Patie from increased, spea a controlled access Qualify for skilled not second symptoms of the second sympto	1/10/18, at 9:23 p.m. during I staff why he was on this unit have wandered in the room. He further stated that he 1/18/18, at 9:44 p.m. R490 he felt like a caged animal and he could go home.  Evaluation assessment dated wed for R490. The score was accepting of the placement, had to wandering, no behaviors antipsychotic medication, and dementia. The last question read: If at risk for elopement, easures are being he response was Special Care of and interventions indicated: sk for elopement, placed on	F	603			
F 604	Right to be Free fro	m Physical Restraints	F6	604	L		1/4/19

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F 604 SS=D	CFR(s): 483.10(e)( §483.10(e) Respect The resident has a and dignity, including §483.10(e)(1) The physical or chemical	t and Dignity. right to be treated with respect ng: right to be free from any al restraints imposed for	F 6	04	
	required to treat the consistent with §48 §483.12 The resident has the neglect, misapproper and exploitation as includes but is not I corporal punishment any physical or che	re right to be free from abuse, riation of resident property, defined in this subpart. This imited to freedom from nt, involuntary seclusion and mical restraint not required to medical symptoms.			
	§483.12(a)(2) Ensure from physical or character purposes of disciplinare not required to symptoms. When the indicated, the facility alternative for the ledocument ongoing restraints.  This REQUIREMED by:  Based on observative review, the facility from the facility	are that the resident is free emical restraints imposed for ne or convenience and that treat the resident's medical he use of restraints is y must use the least restrictive east amount of time and re-evaluation of the need for NT is not met as evidenced tion, interview and document ailed to ensure 1 of 1 residents m the use of physical		<ul> <li>The pillows and cushion wer removed from under R43's bed immediately on 11/29/2018.</li> <li>R43's care plan was reviewed revised to ensure proper intervention.</li> </ul>	ed and

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F 604	9/25/18, indicated impaired and required and required to demention required the use of impulsive behavior in lowest position, as resident was known the floor while reduction to chair. The nursidentified R43 was the floor when in bout.  During an observate R43 was lying in bout.  R43 was lying in bout on Bed was noted to Nursing assistant morning cares. Repillows on R43's let tucked under the figetting R43 out of from under the material representation of the light of	Minimum Data Set (MDS) dated R43 was severely cognitively ired extensive assist with bed ers. R43's initial care plan ntified R43 was at risk for falls a with behavioral disturbances, f a wheelchair and had rs. Interventions included: bed mattress on floor next to bed nown to crawl out of bed around efusing to allow staff to assist ing assistant care guide, a high fall risk and mattress on red related to resident crawling tion on 11/29/18, at 7:11 a.m. ed. The bed was positioned nst the wall. R43's wheelchair de of R43's bed, there was no the floor beside R43's bed. be in the lowest position. (NA)-A assisted R43 with 43 was observed to have two off side. The pillows were itted sheet of the bed. Prior to bed NA-A took a cushion out attress. The cushion was feet long and one foot wide ight. The cushion was labeled	F6	604	falls and heel protection.  All residents have the potential affected if physical or chemical rest are used that do not treat the reside medical symptoms.  An audit of every resident will be completed to ensure no other reside were being restrained in a similar mathicident did appear to be an isclinicident.  Education on restraints will be provided to nursing staff to ensure the clear understanding on definition of restraints.  Director of Nursing/Designee was responsible for conducting audits. A will be conducted at 20 residents provided to QA committee for further review and recommendations.	raints ent's ee ents nanner. olated there is will be Audits er	

STATEMENT OF C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG		TE SURVEY MPLETED
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DN th was piun wsl Li al as Li ho ai fi oi sli no TR sa un sl th T1:	IA-A indicated that his unit and when some serviced the p.m. she assistance (TMA). illows under the fillows under the fillows under the fillows under the mattress when she had observed to the heel control to the heel control to the heel control to the heel management of the mattress the control to the heel management of the mattress the the mattress the control to the mattress that it is the control to the	on 11/29/18, at 7:45 a.m. ashe didn't normally work on she did work on the unit, she ift as a trained medication NA-A was not sure if the sted sheet and heel cushion were normally there however sed on the p.m. shift in the past shem.  Ewed on 11/29/18, at 7:51 a.m. as used to have a personal and that was removed. When sel management cushion, was used to off load R43's the floor mat was removed ushion was put on the floor so of bed she wouldn't land hard as stated that the heel cushion ander the mattress or the se fitted sheet if it would getting out of bed on her own.  EN)-B was interviewed on m. RN-B said when R43 was acility was using a fall mat and and a trial without the fall mat. The eventative measure. RN-B call to tuck the heel cushion or the pillows under the fitted not aware how staff were using	F 60			

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	Y
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		5	2727 NORTH VICTORIA	11/29/2016	<b>o</b>
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sheet and a heel m mattress it would be A facility policy titled was reviewed. The be documentation or restraint in the residuscussion of risks a physician's order ar form. R43's record discussion of risks a heel management of physician's order ar found.  Activities Meet Inter CFR(s): 483.24(c) (1)  §483.24(c) Activities §483.24(c)(1) The fithe comprehensive and the preferences program to support activities, both facili individual activities designed to meet the physical, mental, areach resident, encound interaction in the This REQUIREMENT by:  Based on observator review, the facility facil	anagement cushion under the econsidered a restraint. difference considered a restraint assessment and a "Restraint Assessment" was reviewed, there was no and benefits of the pillows or cushion that were used, no and no restraint assessment assessment assessment assessment and care plan as of each resident, an ongoing residents in their choice of ty-sponsored group and and independent activities, he interests of and support the and psychosocial well-being of buraging both independence be community. Not it is not met as evidenced alled to provide meaningful activity programs for 1 of 1 iewed for activities.		<ul> <li>An activity assessment was completed with R73 during the surve process and resident's activity care updated to reflect preferences, recommendations, and functioning equipment used for communication</li> <li>R73 was given a functional poot talker and will be asked if he wants</li> </ul>	plan of ket to see	
diagnoses including	g pain, depression, and		an audiologist for additional hearing		
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LEST EGULATORY OR LEST	ATES AT ROSEVILLE LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 17  sheet and a heel management cushion under the mattress it would be considered a restraint. A facility policy titled Restraints dated (undated) was reviewed. The policy indicated there would be documentation of consent for the use of a restraint in the resident's medical record with the discussion of risks and benefits along with a physician's order and a "Restraint Assessment" form. R43's record was reviewed, there was no discussion of risks and benefits of the pillows or heel management cushion that were used, no physician's order and no restraint assessment found.  Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.  This REQUIREMENT is not met as evidenced by:  Based on observation, interview and record review, the facility failed to provide meaningful and individualized activity programs for 1 of 1 residents (R73) reviewed for activities.	A BUILDING  245105  ROVIDER OR SUPPLIER  ATES AT ROSEVILLE LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 17  sheet and a heel management cushion under the mattress it would be considered a restraint. A facility policy titled Restraints dated (undated) was reviewed. The policy indicated there would be documentation of consent for the use of a restraint in the resident's medical record with the discussion of risks and benefits along with a physician's order and a "Restraint Assessment" form. R43's record was reviewed, there was no discussion of risks and benefits of the pillows or heel management cushion that were used, no physician's order and no restraint assessment found.  Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1)  \$483.24(c) Activities. \$483.24(c) Activities. \$483.24(c) Activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide meaningful and individualized activity programs for 1 of 1 residents (R73) reviewed for activities.  Findings include:  R73 face sheet dated 11/29/18 indicated	PROVIDER OR SUPPLIER  ATES AT ROSEVILLE LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES IN A DEFINITION OF DEFICIENCY OF DESTRUCTION OF CORRECTION O	ROVIDER OR SUPPLIER  245105  ROVIDER OR SUPPLIER  ATES AT ROSEVILLE LLC  SUMMARY STATEMENT OF DEFICIENCIES IEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 17  sheet and a heel management cushion under the mattress it would be considered a restraint. A facility policy titled Restraints dated (undated) was reviewed. The policy indicated there would be documentation of consent for the use of a restraint in the resident's medical record with the discussion of risks and benefits of the pillows or heel management cushion that were used, no physician's order and a "Restraint Assessment" form. R43's record was reviewed, there was no discussion of risks and benefits of the pillows or heel management cushion that were used, no physician's order and no restraint assessment found.  Atchitives Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by:  Based on observation, interview and record review, the facility programs for 1 of 1 residents (R73) reviewed for activities.  Findings include:  R73 face sheet dated 11/29/18 indicated

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	СОМ	E SURVEY PLETED
		245105	B. WING			C <b>29/2018</b>
	PROVIDER OR SUPPLIER	ELLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2727 NORTH VICTORIA ROSEVILLE, MN 55113		0,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 679	insomnia.  R73's significant ch (MDS) dated 10/11 moderate cognitive important to him to get outside, and do was no staff data e no activity assessm. There was no care for activities. The c indicated that R73 that a pocket talker supplies should be provided by activitie. An assessment dai indicated that the c quality of life and le consultation recom suggested as prima rumination on circuito engage in activities bringing activities bringing activities bringing activities to Review of the docuindicated 2 visits in October 2018, and During an interview a.m. he stated he cactivities because had been given a p device) a couple of headphones didn't he wished he could	nange minimum data set /18 indicated R73 had impairment, and it was very have books, know the news, his favorite activities. There ntered for activities. There was nent in the medical record.  area assessment completed are plan dated 11/7/18 only wanted to be in bed and and independent leisure provided. 1:1 visits to be ess.  ded 10/3/18 by a psychologist onsultation was to improve the evel of functioning for R73. The mended "distraction ary deterrent from anger and mstance. He'll need prompting and perhaps a start with the him in bed."  mentation of activities for R73 September 2018, 3 visits in 2 visits in November 2018.  with R73 on 11/27/18 at 8:55 shose not to go groups or ne couldn't hear. He stated he ocket talker (an amplification)	F 679	support.  All residents have the potent affected if meaningful and individe activity programs are not provide on resident's preferences.  All resident's activity assess be reviewed, and care plans upobased on resident's preferences recommendations.  The therapeutic Recreation Department will receive education regarding the requirement to provesident with an ongoing program support them in their choice of a based on their interested.  Social Services Director/Desconduct audits on all new admiss 10 residents per week x 3 weeks reported to QAPI committee for review and recommendations.	dualized ed based ments will dated and on ovide each m to ctivities signee will sions and s and	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		245105	B. WING			C / <b>29/2018</b>
	PROVIDER OR SUPPLIER TATES AT ROSEVILLE	LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2727 NORTH VICTORIA ROSEVILLE, MN 55113	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ULD BE	(X5) COMPLETION DATE
F 679	radio. There were r room. R73 was not room on any of the engaged in activitie On 11/29/18 at 10:0 services was interv recommendations t would be communic She stated that all t	on his back with no TV or no activity materials in the observed to be out of his days of the survey, or	F 6	79		
	at 8:30 a.m. and sta She stated R73 did only 1:1 visits from She verified that the assessment in the why R73 stayed in activity assessment each full MDS. She aware of the recompsychologist. She a	r was interviewed on 11/29/18 ated she was assigned to R73. I not attend groups and had her staff. 1-3 times a week ere was no activity record, and she didn't know bed. She verified that an t should be completed with e stated she had not been amendations from the also verified that R73 should be to use when visiting.				
F 689 SS=D	and checked the point work. R73 told headset that worke room. Free of Accident Ha CFR(s): 483.25(d)(  §483.25(d) Accider The facility must en	nts.	F 6	i89		1/4/19

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION		PLETED
		245105	B. WING		11/2	) 29/2018
	PROVIDER OR SUPPLIER	LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2727 NORTH VICTORIA ROSEVILLE, MN 55113		11/23/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPIDEFICIENCY)	) BE	(X5) COMPLETION DATE
F 689	as free of accident §483.25(d)(2)Each supervision and as accidents. This REQUIREMEI by: Based on observar review, the facility f interventions to red residents (R78) rev  Findings include:  R78 quarterly Minin 10/16/18, indicated impaired and requir all activities of daily required limited ass balance was only a assist. R78's care p R78 was at risk for extra chair out of re clutter free environ movements, encour and to wear gripper  A review of R78's F 10/15/18, indicated six months and to r pain and decreased incident reports ind falls on 10/2/18, 10 11/11/18 and 11/21.  During an observat R78 was walking in	hazards as is possible; and resident receives adequate sistance devices to prevent NT is not met as evidenced tion, interview and document ailed to implement uce the risk for fall for 1 of 5 iewed for falls.  num Data Set (MDS) dated she was severely cognitively red extensive assistance with a living. The MDS included R78 sistance for walking and ble to stabilize with human plan dated 10/26/18, identified falls and directed staff to keep residents room to maintain a ment, observe for unsafe rage use of walker, low bed, resocks at night.  Fall Review Evaluation dated she had two falls during past monitor for increased knee of mobility. A review of facility icated R78 had a history of /5/18, 10/21/18, 11/6/18, /18.  ion on 11/28/18, at 9:45 a.m. common area without	F 689	<ul> <li>R78's care plan was reviewed interventions and R78's care sheet updated to reflect those interventio</li> <li>All residents have the potential affected if the facility fails to implen interventions to reduce the risk of f</li> <li>All resident's care sheets will be reviewed and updated to reflect cufall interventions.</li> <li>The NAR care sheets will be a to include fall interventions for each resident, as applicable.</li> <li>Director of Nursing/Designee we responsible for conducting audits. Will be conducted at 20 residents pweek x 3 weeks and reported to Que committee for further review and recommendations.</li> </ul>	was ns. to be nent alls. e rrent djusted n vill be Audits er	
		er; nursing assistant (NA)-D nd stated let's go back to your				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245105		B. WING			C 11/29/2018	
NAME OF PROVIDER OR SUPPLIER  THE ESTATES AT ROSEVILLE LLC				S1 27	TREET ADDRESS, CITY, STATE, ZIP CODE 727 NORTH VICTORIA OSEVILLE, MN 55113	1172	29/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	OULD BE COMPLÉTION	
F 689	room held R78's left to her room. At 10:1 walking around her guided R78 to her be was able to go low supposed to be apphigher than the lowe ease of transfers. A R78 did not have he had been left in the reach since breakfar. During an observati at 10:46 a.m. NA-C bed and her bed was than the lowest pos reach near the bath extra chair in her rosupposed to be the During an interview registered nurse (R interventions includ position, encourage and no chairs should confirmed R78's fall on the NA care she During an interview interim director of nexpectation the NA current fall intervent The facility protocol Management Protoindicated "The purp	t hand and guided R78 back 10 a.m. R78 was observed room without walker; NA-D bed and verified R78's bed to the floor, however it was proximately two to three feet est position when occupied for at 10:30 a.m. NA-D confirmed er walker within reach and it dining room out of R78's ast.  Ion and interview on 11/29/18, confirmed R78 was lying in as approximately 3 feet higher ition, her walker was out of broom door and explained the om was for visitors and was re.  Ion 11/29/18, at 1:45 p.m.  N)-B stated R78's fall ed bed to be in lowest height a use of walker when walking and be left in R78's room. RN-B I interventions were not listed et.  In 11/29/18, at 2:43 p.m. the ursing (DON) stated it was her care sheet was updated with tions to match the care plan.  Falls Prevention and col revised date 7/2018, ose of this protocol is to risk for falls, implement fall	F 6	89			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245105	B. WING		C <b>11/29/2018</b>	
NAME OF PROVIDER OR SUPPLIER  THE ESTATES AT ROSEVILLE LLC			2	11/23/2310		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE	
F 697 F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Ma		F 697 F 697		1/4/19	
	consistent with prot the comprehensive and the residents' (	Its who require such services, fessional standards of practice, person-centered care plan, goals and preferences.  NT is not met as evidenced				
	Based on observa review the facility fa assess and implem	tion, interview, and document ailed to comprehensively nent interventions to reduce dents (R73) reviewed for pain.		<ul> <li>R73's pain assessment 10/11/18 v reviewed and MD notified of resident's concerns regarding pain management immediately during the survey process Another pain assessment was comple for R73 on 12/19/2018.</li> <li>R73's Pain medication has been</li> </ul>	3.	
	R73 face sheet dated 11/29/18 indicated diagnoses including unspecified pain, low back pain, and joint pain. A nurse practitioner note dated 8/6/18 indicated R73 had a left hip fracture from a recent fall.			<ul> <li>adjusted by the MD/NP and R73's care plan was revised to reflect pharmacological and non-pharmacological interventions.</li> <li>All residents have the potential to affected if the facility fails to</li> </ul>		
	(MDS) dated 10/11 moderate cognitive frequently, sometin non-pharmalogical pain. R73's care area as indicated R73 repo	nange minimum data set /18 indicated R73 had impairment, and had pain nes severe, and had no interventions identified for sessment dated 10/18/18 rted frequent, severe pain, cent fracture of the hip.		comprehensively assess and impleme interventions to reduce pain.  The MDS nurses or designees will report completed pain assessments to clinical IDT meetings to ensure effective pain management plans are implement for each resident.  The facility policy for Pain Management was reviewed and remain applicable.	I the ve nted	
	indicated frequent schedule pain med	n dated 10/11/18 also severe pain and noted no ication or non- pharmalogical mfort. The assessment noted ed dose of Tylenol.		Education will be completed with nursing staff regarding F697 and the facility Pain Management policy and the process for developing effective pain management plans and implementing		

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		245105	B. WING				C 29/2018
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THE ESTATES AT ROSEVILLE LLC					727 NORTH VICTORIA		
				R	ROSEVILLE, MN 55113		
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F 697	R73 had an alteral fractured hip and golan directed staff medication, rest, rindicated.  A hospital dischargindicated that R73 8/25/18 to 8/29/18 caused by an over Methadone is a natreat severe pain. indicated an interanew seizure medicated recommendation to narcotic medication Methadone.  The note from the 9/25/18 did not ad and change in pair R73 was interview and stated he does aid that since he only takes as need medications. He stem because the can't take narcotic	plan dated 10/26/18 indicated tion in comfort related to a gastrointestinal reflux. The care to assess pain and provide epositioning, or massage if  ge summary dated 8/29/18 had been hospitalized from for an altered mental status dose of Methadone. arcotic pain medication used to The discharge summary action with Methadone and a cation, and included a o consider a retrial of a nonin, or a lower dose of	Fé	697	non-pharmacological interventions pain.  • Director of Nursing/Designee we responsible for conducting audits for assessments and non-pharmacologintervention use. Audits will be conducted to the conduction of th	vill be or pain gical ducted s and	
	and stated his pair nurse because all that doesn't help. I	red on 11/29/18 at 9:30 a.m., is bad today, but didn't tell the they do is offer aspirin, and He stated getting up hurts so he ated he sometimes had					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245105			` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER  THE ESTATES AT ROSEVILLE LLC				STREET ADDRESS, CITY, STATE, ZIP C 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)			PROVIDER'S PLAN OF CORRECTIO  X (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)		(X5) COMPLETION DATE	
F 697	would be gone for to be lying in bed of independently roll to the room and assess would call the doctor orders.  During an interview 07:30 a.m. regarding She stated a signification due to decline and assessment was dinconsistent reports non pharmalogical assessed at this time of the change in michospitalization and prin medication for assessment did no occurred, she states	and sometimes the pain several days. He was observed n his back, and able to o each side. RN-A came into ssed R73 and agreed she	F 69	97			
	at 9:22 a.m., and s complained of pain bed with encourage tell the nurse if he l to take medication direct his care and choices.	O was interviewed on 11/29/18 tated that R73 sometimes in his legs, and will get out of ement. She stated she would had pain but R73 would refuse offered. she stated R73 would it was important to offer him ewed on 11/29/18 at 10:00					
	a.m. and stated R7 mediations, and his stated she asked dtell her. She stated	'3 sometimes will refuse s ain control is pretty good. She aily if he had pain and he will he got up only a couple of onth, and had no complaints					

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		245105	B. WING		C 11/29/2018		
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)			(EACH CORRECTIVE ACTION SHOUL	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 744 SS=D	Continued From page 25 of pain when up.  RN-A stated in an interview on 11/29/18 at 9:30 a.m., that ongoing pain assessment is done with R73 and the pain level varies, he often refuses medication.  The facility policy for pain management (undated) indicated that the interdisciplinary team should identify causes of pain, and evaluate for non pharmalogical interventions to address pain. Treatment/Service for Dementia CFR(s): 483.40(b)(3)  §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and document			F 744  • R487 transferred to the hospital		1/4/19	
	services were provand adjustment ne behavioral interver new resident that e of restlessness and residents.  Findings include:  R487's Admission date of 11/21/18, who be prestlessness and a was requested how	railed to ensure dementia ided for 1 of 5 (R12) residents, eds were identified and attions shared with staff for a exhibited signs and symptoms diagitation for 1 of 5 (R487)  Record identified an admission with diagnoses that included: avioral disturbances, gitation. An initial care plan wever was not provided. The are resident information sheet		<ul> <li>11/27/18 and family chose not to bed, so the resident was ultimatel discharged.</li> <li>R12 care plan was updated w resident's preferences and approphenavioral interventions.</li> <li>All residents with a diagnosis dementia have the potential to be affected.</li> <li>All residents with a diagnosis dementia will have their care plan reviewed to ensure behavioral interventions and preferences are date. NAR sheets will be reviewed reflect appropriate behavioral interventions.</li> </ul>	y ith oriate of of s up to		

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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 744	identified R487 had behaviors and directif refusing cares. T R487 would sit or last objects apart and of R487 was observed the dining room. Rand asked when he he ate three times upset because he independent and w Victoria unit without device.  R487 was observed afternoon and early Victoria unit and exon chairs by the nuthen would get bacand visitors when he could leave the unistaff attempted to r R487 was observed pacing throughout camera and asked R487 was observed attempted to leave attempted to leave.  Review of facility P following:  On 11/23/18, at 4:5 all shift with agitatic halls, in and out of to redirect. The not pain when asked at the staff attempted to leave at the shift with agitatic halls, in and out of the redirect. The not pain when asked at the shift with a	d multiple hallucinations and cted staff to re-approach R487 he care guide further indicated ay on the floor, and take carry them around.  d on 11/26/18, at 12:21 p.m. in t487 came up to the surveyor e could go home. R487 said already that day and he was needed his insulin. R487 was ralked through out the secured to the use of any assistive.  d on 11/26/18, throughout the vevening walking around the cit seek. R487 would sit down rsing station for a few minutes k up again. He asked staff he could go home and how he to the term of the could go home and how he to the appeared upset when e-direct him.  d on 11/27/18, after breakfast the unit. He looked for his staff if they knew where it was dat the exit doors and	F 744	<ul> <li>Education about F744 and Care will be provided to nursing service staff.</li> <li>Monthly dementia huddles a conducted on the dementia carprovide dementia-related training as well as solicit feedback from about effective behavioral interventions.</li> <li>Social Services Director/Debe responsible for conducting a care plans for appropriate beha interventions. Audits will be con 10 residents per week x 3 week reported to QAPI committee for review and recommendations.</li> </ul>	and social will be e units to g to staff staff ventions for esignee will udits of vioral ducted at as and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		045405	B. WING			С	
		245105	B. WING			11/2	29/2018
NAME OF PROVIDER OR SUPPLIER  THE ESTATES AT ROSEVILLE LLC				2	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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAGE CROSS-REFERENCED TO THE APPROVIDENCY)		BE	(X5) COMPLETION DATE
F 744	Agitation escalated swinging at staff. Rewhen writer heard swriter observed reswith no one else prohe was being puncliger and he would the R487 then sat on the "leave me alone"	with exit seeking and 487 was in the dining room screaming with loud banging, ident fighting and swinging esent, it almost appeared that ned in the face, his head would hrow himself against the wall, as few minutes later he unit going door to door. R487 ne doors and run down the sextremely agitated and was so staff. R487 then proceed to ursing desk on the long term as unsteady and he almost fell le was stating his blood sugar da blood sugar check. Due to ming himself or staff, 911 was e. When police arrived R487 and did allow a blood sugar with taking Olanzapine cation) PRN, the police k to the Victoria unit where ame agitated and was arguing 87 wanted to go to the hospital reluctant to send him. Around capine had been ineffective. In was notified of the situation for Seroquel (antipsychotic The police spend an hour	F	744			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245105	B. WING			C <b>11/29/2018</b>
	PROVIDER OR SUPPLIER  TATES AT ROSEVILLE	ELLC		STREET ADDRESS, CITY, STATE, ZIF 2727 NORTH VICTORIA ROSEVILLE, MN 55113	•	11/23/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 744	a dining room table dining room, barrica area. Staff were a R487 tried to push able to get R487 or hallway. After revie called for recomme physician. R487 w 11/23/18, related to hallucinations, exit aggressive behavior. On 11/23/18, at 8:0 facility.  On 11/24/18, at 11: 7:00 a.m., pacing in into other residents a stupid? Get my bag R487 was redirected environment was quantification given may be a stupid? The state of the afternoon.  On 11/24/18, at 9:2 pacing the unit all a Redirection given months and a sternoon.  On 11/27/18, at 12: had been agitated and afternoon, pour ummaging in and removing their below the sternoon and continum aging in and removing their below the sternoon are the sternoon and continum aging in and removing their below the sternoon are the sternoon and continum aging in and removing their below the sternoon are the sternoon and continum aging in and removing their below the sternoon are the sternoon and continum aging in and removing their below the sternoon are the sternoon and continum aging in and removing their below the sternoon are the sternoon are the sternoon and continum aging in and removing their below the sternoon are the sternoon and continum aging in and removing their below the sternoon are the sternoon ar	over in the doorway of the ading himself in the dining ble to flip the table back up but it back down again. Staff were ut of the dining area to the w of all reported incidents staff endation from the primary as sent to the hospital on danger to self and others, seeking, crying and yelling and ors toward staff.  Op.m. R487 returned to the 22 a.m. R487 was restless at a the hallway and wandering a rooms. R487 attempted to sit and stated "why are you so gs, I'm getting out of here." ed back to his room where uiet but came straight out of nued to pace the lifficult to redirect at times.	F 7	744		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		CONSTRUCTION	СОМ	E SURVEY PLETED
		245105	B. WING				C 29/2018
	PROVIDER OR SUPPLIER	ELLC		272	REET ADDRESS, CITY, STATE, ZIP CODE 27 NORTH VICTORIA DSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 744	throwing everything crawling under the to flip the tables ov kicking at the winds asked what he was camera. He then be (social services) shere, your using the can fix it." SS attente he grabbed the proexplained to her the lens covers and she covered up." R487 hallucinations and continued to enter beds trying to lift this going down stains the call lights out or remotes. Res. was which he believed wholding it up to his of people by hitting Staff were providing behavior and a risk.  A subsequent note indicated social send daughter regarding further progress not R487 going to the limit in the light	g out of them onto the floor, dining room tables and trying er as well as hitting and ows trying to get out. When a looking for R487 said his egan to feel the sleeve of SS hirt and stated, "My camera is e wrong lens give it to me so I apted to re-direct R487. Then ogram manager's hand and at her fingers were the different e needed to sit still to get it was distressed by his having delusional thoughts. He rooms and crawl under the em up with his back, stating he s. Res. then proceeded to pull f the wall and unplug the bed given a television remote was his camera and had been eye and trying to take pictures the buttons on the remote. If a 1:1 due to impulsive to himself and others.  dated 11/27/18, at 2:16 p.m. roices contacted R487's a bed hold. There were no otes in the record to identify hospital.  18, at 2:25 p.m. registered that R487 was still at the spital was looking for a place and the hospital did want to keep of his dementia was not	F7	744			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245105	B. WING				C <b>29/2018</b>
	PROVIDER OR SUPPLIER	ELLC		27	REET ADDRESS, CITY, STATE, ZIP CODE 27 NORTH VICTORIA OSEVILLE, MN 55113	1 11/2	23/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 744	on 11/29/18, at 8:40 R487's admission of to one monitoring a facility was told the wandering, not for SS-A was asked the re-admitted to the said that R487 was hospital was looking geriatric psychiatric was admitted to the R487 was on a bed.  Nursing assistant (11/29/18, at 10:00 a R487 and what into him when he was at that staff needed to re-approach later. upset and wanted that he lived at the needed to stay on the Licensed practical interviewed on 11/2 said the first time swhen he came bace 11/23/18 and states when he came bace 11/23/18 and states he noticed that he she would read his re-approach him if the unit on 11/27/18 hospital but stated had pushed over ta staff sending him to Family member (FI 11/29/18, at 12:21)	on a.m. SS-A said prior to on 11/21/18, R487 was on one at the hospital. SS-A said the one to one monitoring was for aggression or hallucinations. e status of R487 after he was nospital on 11/27/18. SS-A at the hospital and the g to possibly admit R487 to the cunit. SS-A thought that R487 hospital and indicated that d hold.  NA)-E was interviewed on a.m. NA-E was asked about erventions were identified for agitated or upset. NA-E said of leave him alone and NA-E said when R487 was on go home, she would tell him nursing home now and he the unit.  Inurse (LPN)-C was 29/18, at 10:14 a.m. LPN-C he worked with R487 was k from the hospital on d when she worked with R487 was irritated. LPN-C stated facial expression and would needed. LPN-C worked on 3, when R487 went to the she was unaware that R487 ables in the dining area prior to	F	744			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245105	B. WING		1	C <b>1/29/2018</b>
	PROVIDER OR SUPPLIER	ELLC		STREET ADDRESS, CITY, STATE, ZIP O 2727 NORTH VICTORIA ROSEVILLE, MN 55113		., ,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 744	FM-A stated she w slept and staff wou their shift and did r sent R487 to the he called and said, "Yare sending him to asked if the facility for R487 to help wi and said the facility ideas or suggestion restlessness or adj RN-B and SS-A we 10:23 a.m. and state one most of the tim nursing home. RN R487 was on a one thought that was for the facility, R487 w wandering, agitation R487 was difficult to When R487 was signed RN-B said that he for his camera. RN looking to find a came were interventions SS-A said they were the newspaper and approaches were used to look at the newspaper and approach	ould call and ask how R487 ld tell her that they just started not know. When the facility ospital, FM-A said the facility our dad is misbehaving and we the hospital". FM-A was asked her about interventions th his agitation or restlessness what never asked her any not be to help R487 with agitation, ustment to the facility.  The interviewed on 11/29/18, at the R487 had been on a one to the that he had been at the read to one at the hospital but or wandering. The indicated at as on one to one for n and exit seeking. RN-B said	F7	744		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245105	B. WING _			C <b>29/2018</b>	
	PROVIDER OR SUPPLIER	ELLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2727 NORTH VICTORIA ROSEVILLE, MN 55113	1 1/	23/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
F 744	what interventions with R487. SS-A si wife's phone numbrame and phone nadmission record semergency contact had been no directi interventions that makes and direction or information sheet for interventions to use SS-A acknowledge better job getting to approaches and interventions and interventions to use SS-A acknowledge better job getting to approaches and interventions and interventions to use SS-A acknowledge better job getting to approaches and interventions to use SS-A acknowledge better job getting to approaches and interventions to use SS-A acknowledge better job getting to approaches and interventions and interventions and interventions and interventions and interventions to getting to approaches and what he residents, and if the behaviors the facility DON stated typicall meeting was set up had the opportunity daughter. She state up and a resident we R487 had been, the call and talk to fam to set up a meeting R12's annual Minim 8/28/18, indicated fimpaired and require activities of daily living 1/12/18, identified final f	or approaches might work well tates she was not aware the er was listed for R487. (Wife's umber were listed on the heet as the second). SS-A further indicated there on given to staff on may be helpful with R487 ameras). SS-A verified there in the nursing assistant resident for staff to be aware of or ewith R487. Both RN-B and do they could have done a know resident and to identify the erventions and inform staff of and interventions.  Sing (DON) was interviewed on m., and indicated that family dimission about likes and and worked in the past for the eyer any triggers for the eyer and	F 74				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245105	B. WING	i	1.	C I/ <b>29/2018</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2727 NORTH VICTORIA ROSEVILLE, MN 55113	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 744	anticipate needs a participate to the further interaction. The cate behaviors regarding seeking and pacing to 1, redirect, reoritoffer snack or televation when he appeared on 11/28/18, at 7:2 enter room 926 so not come in here the unit nurse office (LPN)-C stated "the go that way." R12 sounded the door stated "hi buddy" a opposite direction. rearranged the dol stated "come let juice for you, let's go follow NA down the soiled utility room to the dining room the direction. At 7:41 aunit then turned ar upon entrance the do if I knew what he should and pointed R12 turned around NA yelled R12's na 10 feet away and F During an interview NA-E stated R12 varound the unit amout or move worked.	and encourage him to allest extent possible with each re plan further identified g wandering, rummaging, exit g and directed staff to provide 1 ent, speak in a calm voice, vision and take time to talk with ared not interested in things.  24 a.m. R12 was observed to meone in the room stated "do R12 then attempted to enter e; licensed practical nurse is is my office I am begging you attempted to exit the unit and alarm registered nurse (RN)-B and assisted R12 to turn the R12 entered room 934 and is a nursing assistant (NA) 's go this way;" R12 continued to e hall and the NA entered the while R12 continued to wards e NA went the oppositem. R12 attempted to exit the ound and entered room 924; resident asked "what does he e did" NA tapped R12 on with finger away from door and attempted to exit the unit time twice from approximately R12 turned around.  If you 11/28/18, at 1:26 p.m. valked from room to room didentified telling R12 to come	F7	744		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245105	B. WING				29/2018
	PROVIDER OR SUPPLIER	LLC		27	REET ADDRESS, CITY, STATE, ZIP CODE 27 NORTH VICTORIA DSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 744	door to the outside dining room where Activity assistant di On 11/29/18, at 7:0 unit; nurse walked attempted to enter go the other way. A 931; resident in 93 there's nothing here and opened door a resident in 931 furtl privacy and indicate he just tells him to I During an interview LPN-C indicated it the unit and walk in night. LPN-C stated get out of there. LP unsure if R12 had a further stated R12's television for his rowatch it.  During an interview RN-B identified R12 on the chair in his r for long periods of told movies. RN-B smovie preference was stated during windicated R12's preadded to his care scurrently listed.	then paced in and out of activity was in progress. d not invite R12 to activity.  9 a.m. R12 attempted to exit by and did not intervene then room 924 nurse stated no, no at 7:22 a.m. R12 entered room I stated "you don't belong here be for you now let's go this way" as R12 exited room. The ner stated R12 invaded his ed when R12 entered his room	F	744			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  DING	(X3	OMPLETED
		245105	B. WING			C
NAME OF F	PROVIDER OR SUPPLIER	240100		STREET ADDRESS, CITY, STATE, ZIP CC	DDE	11/29/2018
THE EST	ATES AT ROSEVILLE	LLC		2727 NORTH VICTORIA ROSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD BE	(X5) COMPLETION DATE
F 744	redirect a resident t would have offered as a diversion and t preferences should	that she would expect the staff food, fluids and/ or television further identified these be listed on the care sheet.	F 7	744		
F 758 SS=D	Free from Unnec PCFR(s): 483.45(c)(3 §483.45(e) Psychot	sychotropic Meds/PRN Use 3)(e)(1)-(5)		758		1/4/19
	affects brain activition processes and behavior	es associated with mental avior. These drugs include, o, drugs in the following				
		ehensive assessment of a must ensure that				
	psychotropic drugs unless the medicati	dents who have not used are not given these drugs ion is necessary to treat a s diagnosed and documented d;				
	drugs receive gradu behavioral intervent	dents who use psychotropic ual dose reductions, and tions, unless clinically an effort to discontinue these				
		dents do not receive pursuant to a PRN order				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG		E SURVEY MPLETED
		245105	B. WING _			C ( <b>29/2018</b>
	PROVIDER OR SUPPLIER	LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2727 NORTH VICTORIA ROSEVILLE, MN 55113	•	23/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (CEACH CORRECTIVE ACTION SHOUTH CORREST TO THE APPORT OF THE APPORT	OULD BE	(X5) COMPLETION DATE
F 758	unless that medical diagnosed specific in the clinical record §483.45(e)(4) PRN are limited to 14 da §483.45(e)(5), if the prescribing practitic appropriate for the beyond 14 days, he rationale in the resi indicate the duratio §483.45(e)(5) PRN drugs are limited to renewed unless the prescribing practitic the appropriateness. This REQUIREMED by:  Based on observative review, the facility for non-pharmacologic needed (PRN) antipadministration for 1 for unnecessary mediated 11/6/18, indicated 11/6/18, indicated 11/6/18, indicated 11/6/18, indicated R11 anti-depressant mediated reference perioduring an observat R112 was seated out "help me, I'm had seated 11 mediated 11 me	condition that is documented d; and  orders for psychotropic drugs ys. Except as provided in eattending physician or oner believes that it is PRN order to be extended or she should document their dent's medical record and for the PRN order.  orders for anti-psychotic 14 days and cannot be attending physician or oner evaluates the resident for sof that medication.  NT is not met as evidenced ation, interview, and document ailed to attempt al interventions prior to as osychotic medication of 5 resident (R112) reviewed edications.  Minimum Data Set (MDS) stated R112 had diagnoses mentia, depression and a dysfunction. In addition, the 2 received antipsychotic and edication for seven days during	F 7	<ul> <li>R112 PRN medication was immediately reviewed by nursir resident's physician and was discontinued. Non-pharmacolo interventions were added to R1 plan.</li> <li>All residents on a psychotr medication have the potential taffected.</li> <li>All residents on a psychotr medication will be reviewed for psychotropic medication use an non-pharmacological interventi prior to administration of PRN.</li> <li>Education about unnecess psychotropic medications will be to nursing and social service stregarding PRN medication use</li> </ul>	ng and the gical 12's care opic o be opic PRN nd on use ary se provided aff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245105	B. WING			11/2	29/ <b>2018</b>
NAME OF I	PROVIDER OR SUPPLIEF	 		ST	REET ADDRESS, CITY, STATE, ZIP CODE		0,2010
				27	27 NORTH VICTORIA		
THE EST	ATES AT ROSEVILL	E LLC			OSEVILLE, MN 55113		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE	
F 758	licensed practical had received the F 11/14/18, 11/16/18 documentation incinterventions. Reg there was no documentation being a 11/24/18, 11/25/18 medication being a 11/24/18, 11/25/18 medication was all the non-pharmacologimedication was all the non-pharmacologimedication. R112's physician of (antipsychotic medically and 7.5 mg between the total	etion.  W on 11/28/18, at 1:31 p.m.  nurse (LPN)-C confirmed R112  PRN Zyprexa on 11/11/18,  a and was unsure if there was  licating non-pharmacological  istered nurse (RN)-B verified	F 7	758	interventions.  • Monthly anti-psychotic meeting be implemented to review residents receiving anti-psychotic medication facility will continue to participate in CMPRP regarding Dementia Care Breakthrough Community through expensible for conducting audits of psychotropic medication use and non-pharmacological intervention use Audits will be conducted at 10 reside per week x 3 weeks and reported to committee for further review and recommendations.	s. The the CMS. vill be n PRN se. dents	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245105	B. WING			C <b>29/2018</b>	
	PROVIDER OR SUPPLIER	LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2727 NORTH VICTORIA ROSEVILLE, MN 55113		20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 761 SS=D	include this with his During an interview RN-B confirmed the communicated on tassistants. During an interview interim director of nexpectation for non to be attempted and medical record prio A facility policy relatinterventions prior tadministration was Label/Store Drugs a CFR(s): 483.45(g) (labeling Drugs and biological abeled in accordan professional princip appropriate access instructions, and the applicable.  §483.45(h) Storage §483.45(h)(1) In ac Federal laws, the fabiologicals in locked temperature contropersonnel to have a §483.45(h)(2) The fabiological formula for the Comprehensive Control Act of 1976	pharmacy recommendation. on 11/29/18, at 1:57 p.m. e care plan was not he care sheet to the nursing on 11/29/18, at 2:48 p.m. the ursing (DON) stated it was her -pharmacological interventions d documented in the electronic r to medication administration. ted to non-pharmacological o antipsychotic medication requested but not received. and Biologicals h)(1)(2) g of Drugs and Biologicals als used in the facility must be ace with currently accepted ales, and include the ory and cautionary e expiration date when  of Drugs and Biologicals cordance with State and acility must store all drugs and d compartments under proper lls, and permit only authorized	F 7			1/4/19	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245105	B. WING		11/2	; 9/2018
	PROVIDER OR SUPPLIER	ELLC		STREET ADDRESS, CITY, STATE, ZIP CODE  2727 NORTH VICTORIA  ROSEVILLE, MN 55113	,=	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761	quantity stored is more readily detected. This REQUIREMED by: Based on observation failed to ensure meremoved in medication carts.  Findings include: The medication storate unit (TC)U ware. Intravenous IV bulb of Meropenem 1 gr (NS), that had been 11/16/18 and expired antibiotic fights sevitation storated in addition, the medication care unit and it is sevitated in a continuous IV substitutes and it is sevitated in a continuous IV is sevitate	bution systems in which the hinimal and a missing dose can.  NT is not met as evidenced tion and interview, the facility dications and biologicals were ation storage areas when hedication rooms and 1 of 4  rage room on the transitional is reviewed 11/29/18, at 01:00 There were two mixed to containers in the refrigerator am (Gr)/100 ml normal saline in mixed by the pharmacy and on 11/20/18. Meropenem ere infections of the skin and dication room on TCU had 3 dapters of which one expired expired 4/17, and a third adapter additional expired supplies the expired on 11/13 and and linsyte Autoguard winged had PN-E confirmed the above	F 761	<ul> <li>All medication carts and medications were immediately audited for proper medications and supplies arranything expired was disposed of properly.</li> <li>Each medication room and medication cart have the potential to house expired medications.</li> <li>All medication carts and medications will continue to be audited for expired medications by both nursing pharmacy services per facility protoful to Education will be provided to nustaff regarding F761 Labeling and Sof Drugs and Biologicals.</li> <li>Director of Nursing/Designee were sponsible for conducting audits we wast weekly and then ongoing and repetit to QAPI committee for further review recommendations.</li> </ul>	o ation or g and ocol. ursing Storage rill be reekly ported	

Printed: 11/30/2018 **FORM APPROVED** 

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY A. BUILDING 01 - MAIN BUILDING 01 COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION 245105 B. WING 11/29/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER THE ESTATES AT ROSEVILLE LLC 2727 NORTH VICTORIA ROSEVILLE, MN 55113 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey. (The Estates of Roseville) was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. This 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 (222) construction. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with

census of 143 at the time of the survey.

full corridor smoke detection and spaces open to the corridors that are monitored for automatic fire

The facility has a capacity of 175 beds and had a

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

(X6) DATE

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

department notification.



Protecting, Maintaining and Improving the Health of All Minnes ot ans

Electronically delivered December 11, 2018

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

Re: State Nursing Home Licensing Orders - Project Numbers S5105031, H5105142

#### Dear Administrator:

The above facility was surveyed on November 26, 2018 through November 29, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number H5105142 that was found to be unsubstantiated. 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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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 <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. 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

The Estates At Roseville Llc December 11, 2018 Page 2

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:

Eva Loch, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: eva.loch@state.mn.us

Phone: (651) 201-3792 Fax: (651) 215-9697

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,

Douglas Larson, Enforcement Specialist Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

The Estates At Roseville Llc December 11, 2018 Page 3

Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File

PRINTED: 12/31/2018 **FORM APPROVED** Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_ C B. WING 00497 11/29/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2727 NORTH VICTORIA** THE ESTATES AT ROSEVILLE LLC ROSEVILLE, MN 55113 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 2 000 Initial Comments 2 000 \*\*\*\*\*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:** 

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 http://www.health.state.mn.us/divs/fpc/profinfo/inf obul.htm The State licensing orders are delineated on the attached Minnesota

Minnesota Department of Health

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

TITLE

(X6) DATE

**Electronically Signed** 

12/20/18 If continuation sheet 1 of 40

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

00497

(X3) DATE SURVEY COMPLETED

**IDENTIFICATION NUMBER:** 

B. WING \_\_\_\_\_

A. BUILDING: \_\_\_\_\_

C 11/29/2018

NAME OF PROVIDER OR SUPPLIER

AND PLAN OF CORRECTION

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, S	TATE, ZIP GODE	
THE ESTATES AT ROSEVILLE LLC	2727 NORTH VICTORI. ROSEVILLE, MN 5511		
(X4) ID SUMMARY STATEMENT OF DEFICIENC PREFIX (EACH DEFICIENCY MUST BE PRECEDED E REGULATORY OR LSC IDENTIFYING INFORMATION OF LSC IDENTIFYING INFORMATION	BY FULL PREFIX	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  Department of Health orders being sul you electronically. Although no plan o is necessary for State Statutes/Rules, enter the word "corrected" in the box a text. You must then indicate in the elec State licensure process, under the heac completion date, the date your orders corrected prior to electronically submit Minnesota Department of Health.  On November 26 through November 2 surveyors of this Department's staff, v above provider and the following correcteds are issued. Please indicate in electronic plan of correction that you hereviewed these orders, and identify the they will be completed.  Complaint #H5105162 was investigated not substantiated.  Minnesota Department of Health is do the State Licensing Correction Orders federal software. Tag numbers have be assigned to Minnesota state statutes/r Nursing Homes.  The assigned tag number appears in the column entitled "ID Prefix Tag." The statute/rule out of compliance is listed "Summary Statement of Deficiencies"	bmitted to f correction please available for ctronic ading will be ting to the ection your save e date when ed and was cumenting using een rules for the far left state in the column	CROSS-REFERENCED TO THE APPROPRIATE	COMPLETE
and replaces the "To Comply" portion of correction order. This column also inclined findings which are in violation of the stafter the statement, "This Rule is not revidence by." Following the surveyors are the Suggested Method of Correction.	ludes the ate statute net as findings		
PLEASE DISREGARD THE HEADING Minnesota Department of Health	G OF THE		

Minnesota Department of Health STATE FORM

M 6899 LKWB11 If continuation sheet 2 of 40

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			,
		00497	B. WING			9/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	ATES AT ROSEVILLE	· 1 1 C:	RTH VICTORI Le, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	.D BE	(X5) COMPLETE DATE
2 000 2 445	APPLIES TO FEDE THIS WILL APPEA THERE IS NO REC PLAN OF CORREC MINNESOTA STAT		2 000			1/4/19
	Punishment & Secl A resident must be and involuntary sec This MN Requirement by: Based on observation review, the facility for (R490) were free from Findings include: R490 was admitted 11/2/18, to the transchiagnoses that include without behavioral of Minimum Data Set R490 had a score of mental status (BIMS a resident was cognimedical record indication of the Victoria secured secured in the Victoria secured in	free from corporal punishment lusion.  ent is not met as evidenced on, interview and document ailed to ensure 1 of 1 residents om involuntary seclusion.  to the nursing home on sitional care unit (TCU), with uded unspecified dementia disturbances. The admission dated 11/22/18, identified of 14 on the brief interview for S), a score of 13-15 indicated nitively intact. Review of the cated R490 was transferred to d unit on 11/5/18.		Corrected		
	surveyor on the Vic for coffee. Staff att	4 a.m. R490 approached the toria secured unit and asked empted to re-direct R490 to d R490 said that he didn't want				

Minnesota Department of Health

STATE FORM 6899 LKWB11 If continuation sheet 3 of 40

Minnesota Department of Health

_ ` '	DER/SUPPLIER/CLIA FICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		A. BUILDING:			
0049	7	B. WING		11/2	9/2018
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE ESTATES AT ROSEVILLE LLC		RTH VICTORI LE, MN 5511			
(X4) ID SUMMARY STATEMENT OF E PREFIX (EACH DEFICIENCY MUST BE PR TAG REGULATORY OR LSC IDENTIFY)	DEFICIENCIES RECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
to sit down and "stare at the w R490 was observed in the din table with his back to the door case that was up against the w On 11/29/18, at 9:00 a.m. R44 surveyor on the Victoria secur that he felt like he was in prisc get past the doors. R490 said tried to leave, he knew that he to his home but "getting off the would help. R490 expressed there was no one to talk to be residents on the unit don't talk the social worker was assistin assisted living facility. R490 she was crazy and they didn't w unit a prison. R490 asked wh you can't leave? He told the swalked around the Victoria serif he sat in his room the "walls me".  Licensed practical nurse (LPN interviewed on 11/29/18, at 12 said R490's significant other of LPN-C felt that R490 would do Woodhill secured dementia ur would be more residents to tal LPN-C said R490 liked to be in never made any attempts to le require any redirection. LPN-R490 was even on the Victoria Registered nurse (RN)-B and worker (SS)-A were interviewed 1:15 p.m. and identified that R on to the transitional care unit at night and went into other re	ing room at his and facing a book wall.  90 approached the ed unit. R490 said on and that he can't defend that he had not ecould not go back the memory care unit" frustration because cause most of the and the staff thought want him to call the at would you call it if surveyor that he cured unit because would close in on  1)-C was the cause there are in daily to visit. The cure of the cure on the nit because there are lik with on that unit. In his room, he had eave and did not C was not sure why a secured unit.  Ilicensed social and of the cure of the cure of the nit because there are and did not the cure of the nit because there are and did not the cure of the nit because there are and did not the cure of the nit because there are and did not the cure of the nit because there are and did not the cure of the nit because there are and did not the cure of the nit because there are and did not the nit because there are a did not the nit because	2 445			

Minnesota Department of Health

STATE FORM 6899 LKWB11 If continuation sheet 4 of 40

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00497	B. WING		11/2	) 19/ <b>2018</b>
	PROVIDER OR SUPPLIER	2727 NOR	DRESS, CITY, S TH VICTORI LE, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 445	the residents on the R490.  SS-A said it was brown interdisciplinary tean of appropriate for SS-A said she and R490 and said he consecured Victoria unbeen on the secure gone into other resident through other resident re	e TCU unit were frustrated with bught up at the m (IDT) meeting that it was R490 to be on the TCU. RN-B went to TCU to review ould come with them to the it. SS-A said since R490 has d Victoria unit, R490 had not dent's rooms or rummaged ent's things.  Is a conversation at the IDT presented to RN-B and SS-A ger from TCU that R490 was the TCU.  Icated that R490 was fairly at SS-A was working on sted living facility to transfer to. Is were spent with his did they watched television and it and sat in the front lobby.  A said R490 had not tried to victoria unit and neither RN-B concerns about R490 exit	2 445			
		ntia unit (Woodhill) because				

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Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			,
		00497	B. WING		I	9/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	ATES AT ROSEVILLE	- 1 1 C	RTH VICTORI .LE, MN 5511			
(X4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	COMPLETE DATE
2 445	Continued From pa	ige 5	2 445			
	there were only dou unit and R490 was see the room that v	uld converse with. SS-A said uble rooms available on that not offered to tour that unit or was available when he was lictoria secured unit.				
	different level of so residents on the Vio R490 was not offer within the facility. E	t R490 was definitely at a cialization compared to other ctoria secured unit and that ed any other room options 30th RN-B and SS-A were not d not want to be on the nit.				
	secured unit include seeking behaviors,	entified the criteria for a ed; a resident exhibiting exit had a cognitive impairment fit from activity programs.				
	11/29/18, at 1:57 p. criteria for placeme included a diagnosi and if a resident was they were at risk to placing someone of there should be a condition and the resident, the tour the area and be move. The DON is elopement risk assignior to placement of DON said R490 was didn't feel that R490 dementia to be on the was unsure how R4	(DON) was interviewed on m. The DON indicated the ent on a secure dementia unit is of dementia or Alzheimer's as at risk for wandering, and if themselves or others. When n a secured dementia unit conversation with the family are family and resident should e involved with the decision to dentified there would be an essment done for all residents on the secured units. The as not an elopement risk and 0 was advanced enough in his the Victoria secure unit and 490 ended up on the unit.				
	RN-C (who worked	ved on 11/29/18, at 2:17 p.m. as an RN on the TCU) esident was rummaging, in				

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Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					c	;
		00497	B. WING		11/2	9/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	ATES AT ROSEVILLE	HIC	TH VICTOR LE, MN 551 <sup>-</sup>			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE
2 445	other resident's roo level of dementia, the dementia unit. RN-and wandering into he was on the TCU was brought to and was made from the Victoria secured un higher functioning resolution was made from the victoria secured un higher functioning resolution wandering and rum. Administrator was in 2:37 p.m. When as secured memory can indicated a resident disorder, exhibit significated the family decision process.  Review of progress was noted to rumm closet in his room of TCU but made no a mistakenly went interior and was easily nursing notes to ide regards to R490 be secured unit. R490 form and he signed from the TCU to the Progress note on 1 R490 was noted to and his closet. Der behavioral issues, puthe lobby having a sephaviors, easily resident in the troops of the lobby having a sephaviors, easily resident in the troops of the lobby having a sephaviors, easily resident in the troops of the lobby having a sephaviors, easily resident in the troops of the lobby having a sephaviors, easily resident in the troops of the lobby having a sephaviors, easily resident in the troops of the lobby having a sephaviors, easily resident in the troops of the lobby having a sephaviors, easily resident in the troops of the lobby having a sephaviors, easily resident in the troops of the lobby having a sephaviors, easily resident in the troops of the lobby having a sephaviors, easily resident in the troops of the lobby having a sephaviors, easily resident in the troops of the lobby having a sephaviors, easily resident in the troops of the lobby having a sephaviors, easily resident in the troops of the lobby having a sephaviors, easily resident in the troops of the lobby having a sephaviors, easily resident in the troops of the lobby having a sephaviors, easily resident in the troops of the lobby having a sephavior	ms and depending on their hey may be safer on a C said R490 was rummaging other resident's rooms while . RN-C said this information IDT meeting and a decision re to move R490 to the it. RN-C said the TCU had esidents and the memory unit ted for R490's needs due the	2 445			

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE	SURVEY LETED
			A. BUILDING:			
		00497	B. WING		11/2	; 9/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	ATES AT ROSEVILLE	. 1 1 ( '	TH VICTOR LE, MN 551 <sup>-</sup>			
(VA) ID	CHMMADV CTA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	ON.	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 445	Continued From pa	ge 7	2 445			
	R490 exhibited war attempts of exit see enter another client	1/4/18, at 9:43 a.m. identified ndering behaviors on unit, no eking or leaving unit. Client did room mistakenly while room; easily redirected.				
	R490 was rummag from one bed to an seeking, pleasant w	1/5/18, at 1:58 a.m. identified ing around his room, going other in his roomno exit with staff, no negative a safety monitoring continues				
	R490 was adjusting No wandering/exit s nursing note to ider	1/6/18, at 3:34 p.m. identified to his new environment well. seeing observed. There is no ntify that R490 was transferred why he was transferred.				
	rounds R490 asked as other residents h	1/10/18, at 9:23 p.m. during I staff why he was on this unit have wandered in the room . He further stated that he				
		1/18/18, at 9:44 p.m. R490 ne felt like a caged animal and he could go home.				
	11/13/18, was revie 7 (0-14 was no risk R490 had not historially ambulatory, ac disorientation but noted, was on one had a diagnosis of	Evaluation assessment dated wed for R490. The score was ). The assessment identified ry of elopement attempts, was accepting of the placement, had o wandering, no behaviors antipsychotic medication, and dementia. The last question read: If at risk for elopement, easures are being				

Minnesota Department of Health

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Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE	SURVEY LETED
712 . 21	o. oo2011011		A. BUILDING:			
		00497	B. WING		11/2	; 9/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	ATES AT ROSEVILLE	: 11 <i>C</i>	RTH VICTORI LE, MN 5511			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)		COMPLETE DATE
2 445	Continued From pa	ge 8	2 445			
	Unit. The summary	ne response was Special Care y and interventions indicated: sk for elopement, placed on to dementia.				
	admission to a secu undated policy lister Have a major neuro sign and symptoms disorders. 2. Patie from increased, spe a controlled access Qualify for skilled ne	sted for the criteria for cured unit. The untitled and d memory care criteria: 1. coognitive disorders or show of major neurocognitive ents would typically benefit ecialized programming and/or living environment. 3. cursing level of care or the all needs can be met.				
	The director of nurs all residents on a lo consent and indicat could conduct rand admitted to the lock	THOD OF CORRECTION: sing or designee, could review ocked unit for appropriate tion for admission. The facility om audits of the residents and unit.  R CORRECTION: Twenty-one				
2 510	MN Rule 4658.0300	O Subp. 2 Use of Restraints	2 510			1/4/19
	must be free from a restraints imposed	from restraints. Residents any physical or chemical for purposes of discipline or not required to treat the symptoms.				
	by:	ent is not met as evidenced on, interview and document		Corrected		

Minnesota Department of Health

STATE FORM 6899 LKWB11 If continuation sheet 9 of 40

С

11/29/2018

 Minnesota Department of Health

 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
 (X2) MULTIPLE CONSTRUCTION A. BUILDING:
 (X3) DATE SURVEY COMPLETED

00497 B. WING \_\_\_\_\_

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF I	PROVIDER OR SUPPLIER STREET	ADDRESS, CITY, S	TATE, ZIP CODE	
THE EST	ALES ALBOSEVILLE LLC:	ORTH VICTORIA ILLE, MN 5511		
(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
2 510	Continued From page 9 review, the facility failed to ensure 1 of 1 resident (R43) were free from the use of physical restraints.  Findings include:  R43's admission Minimum Data Set (MDS) date 9/25/18, indicated R43 was severely cognitively impaired and required extensive assist with bed mobility and transfers. R43's initial care plant dated 9/25/18, identified R43 was at risk for falls related to dementia with behavioral disturbances required the use of a wheelchair and had impulsive behaviors. Interventions included: begin lowest position, mattress on floor next to bed as resident was known to crawl out of bed around on the floor while refusing to allow staff to assist to chair. The nursing assistant care guide, identified R43 was a high fall risk and mattress of the floor when in bed related to resident crawling out.	d d d d		
	During an observation on 11/29/18, at 7:11 a.m. R43 was lying in bed. The bed was positioned with one side against the wall. R43's wheelchair was at the other side of R43's bed, there was no floor mat noted on the floor beside R43's bed. Bed was noted to be in the lowest position. Nursing assistant (NA)-A assisted R43 with morning cares. R43 was observed to have two pillows on R43's left side. The pillows were tucked under the fitted sheet of the bed. Prior to getting R43 out of bed NA-A took a cushion out from under the mattress. The cushion was approximately two feet long and one foot wide and 6 inches in height. The cushion was labeled "heel management".			

Minnesota Department of Health

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Minnesota Department of Health

	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00497	B. WING			) 29/ <b>2018</b>
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
THE ES	TATES AT ROSEVILLE	TIC	LE, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 510	had been seen cray on her behind on the During an interview NA-A indicated that this unit and when sworked the p.m. shassistance (TMA). pillows under the fit under the mattress when she had workshe had observed to LPN-C said that R4 alarm on her bed an asked about the helpn-C said that it wheels. LPN-C said and now the heel cuif R43 crawled out con the floor. LPN-C should not be put upillows put under the prevent R43 from good Registered nurse (F11/29/18, at 7:59 and first admitted, the fanow were conducting The heel managem R43's heels as a presaid it was not typic under the mattress sheet. RN-B was not the cushion or the part of the director of nurse of the director of nurse on the floor.	room. LPN-B indicated R43 wling out of bed and scooting e floor in her room.  on 11/29/18, at 7:45 a.m. she didn't normally work on she did work on the unit, she lift as a trained medication NA-A was not sure if the ted sheet and heel cushion were normally there however ed on the p.m. shift in the past hem.  wed on 11/29/18, at 7:51 a.m. 3 used to have a personal and that was removed. When el management cushion, was used to off load R43's the floor mat was removed ushion was put on the floor so of bed she wouldn't land hard content to the mattress or the efitted sheet if it would etting out of bed on her own.  RN)-B was interviewed on m. RN-B said when R43 was accility was using a fall mat and and a trial without the fall mat. eent cushion was used to float eventative measure. RN-B all to tuck the heel cushion or the pillows under the fitted ot aware how staff were using				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00497	B. WING		1	29/ <b>2018</b>
	PROVIDER OR SUPPLIER	2727 NOF	DRESS, CITY, S RTH VICTOR LE, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 510	resident was able to and had pillows und sheet and a heel m mattress it would be A facility policy titled was reviewed. The be documentation or restraint in the resid discussion of risks physician's order ar form. R43's record discussion of risks heel management of physician's order ar found.  SUGGESTED MET The director of nursuall residents with reconsent and indicat random audits of the	ge 11 or get out of bed on their own derneath the fitted mattress anagement cushion under the er considered a restraint. It Restraints dated (undated) a policy indicated there would of consent for the use of a dent's medical record with the and benefits along with a and a "Restraint Assessment" was reviewed, there was no and benefits of the pillows or cushion that were used, no and no restraint assessment.  THOD OF CORRECTION: sing or designee, could review straints for appropriate ion. The facility could conduct the residents restrained.	2 510			
2 835	Subp. 2. Criteria for proper care. The cadequate and proper Evidence of adequate	r determining adequate and criteria for determining er care include: ate care and kind and ent at all times. Privacy must	2 835			1/4/19
	by:	ent is not met as evidenced on, interview, and document		Corrected		

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(X3) DATE SURVEY

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ C B. WING 00497 11/29/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2727 NORTH VICTORIA** THE ESTATES AT ROSEVILLE LLC ROSEVILLE, MN 55113 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 2 835 Continued From page 12 2 8 3 5 review the facility failed to comprehensively assess and implement interventions to reduce pain for 1 of 5 residents (R73) reviewed for pain, failed to ensure dementia services were provided for 1 of 5 (R12) residents, and adjustment needs were identified and behavioral interventions shared with staff for a new resident that exhibited signs and symptoms of restlessness and agitation for 1 of 5 (R487) residents and failed to implement interventions to reduce the risk for fall for 1 of 5 residents (R78) reviewed for falls. Findings include: R73 face sheet dated 11/29/18 indicated diagnoses including unspecified pain, low back pain, and joint pain. A nurse practitioner note dated 8/6/18 indicated R73 had a left hip fracture from a recent fall. R73's significant change minimum data set (MDS) dated 10/11/18 indicated R73 had moderate cognitive impairment, and had pain frequently, sometimes severe, and had no non-pharmalogical interventions identified for pain. R73's care area assessment dated 10/18/18 indicated R73 reported frequent, severe pain, consideration of recent fracture of the hip. The Pain Evaluation dated 10/11/18 also indicated frequent severe pain and noted no schedule pain medication or non-pharmalogical interventions for comfort. The assessment noted R73 had 1 as needed dose of Tylenol. The current care plan dated 10/26/18 indicated R73 had an alteration in comfort related to a fractured hip and gastrointestinal reflux. The care plan directed staff to assess pain and provide

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00497	B. WING		11/2	9/ <b>2018</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	TATES AT ROSEVILLE	IIC	RTH VICTOR	<del></del>		
	OUR MAR DV OTA		LE, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 835	Continued From pa	ge 13	2 835			
	medication, rest, re indicated.	positioning, or massage if				
	indicated that R73 h 8/25/18 to 8/29/18 f caused by an overo Methadone is a nar treat severe pain. T indicated an interact new seizure medica	cotic pain medication used to the discharge summary stion with Methadone and a stion, and included a consider a retrial of a non				
		nurse practitioner dated ress the recent hospitalization medications.				
	and stated he does said that since he c only takes as neede medications. He sa them because they can't take narcotics	ed on 11/27/18 at 09:20 a.m., not get up due to pain, he ame back from the hospital he ed (prn) over the counter id he doesn't bother taking do nothing. R73 stated he . He was observed to be lying and moved legs and arms				
	and stated his pain nurse because all that doesn't help. H stays in bed, he sta problems sleeping, would be gone for sto be lying in bed or independently roll to	ed on 11/29/18 at 9:30 a.m., is bad today, but didn't tell the hey do is offer aspirin, and e stated getting up hurts so he ted he sometimes had and sometimes the pain several days. He was observed in his back, and able to be each side. RN-A came into essed R73 and agreed she or				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER:

Output

Description

(X2) MULTIPLE CONSTRUCTION

A. BUILDING:

C

B. WING

11/29/2018

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF I	PROVIDER OR SUPPLIER STREET A	DDRESS, CITY,	STATE, ZIP CODE		
THE EST	ATES AT BOSEVILLETTIC	RTH VICTORIA LLE, 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	
PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX TAG  2 835	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETE	
	choices.  LPN- D was interviewed on 11/29/18 at 10:00 a.m. and stated R73 sometimes will refuse mediations, and his ain control is pretty good. Sh stated she asked daily if he had pain and he will tell her. She stated he got up only a couple of times in the past month, and had no complaints of pain when up.  RN-A stated in an interview on 11/29/18 at 9:30 a.m., that ongoing pain assessment is done with R73 and the pain level varies, he often refuses medication.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00497	B. WING		11/2	9/ <b>2018</b>
	PROVIDER OR SUPPLIER	2727 NOR	DRESS, CITY, S TH VICTORI LE, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 835	835 Continued From page 15  The facility policy for pain management (undated) indicated that the interdisciplinary team should identify causes of pain, and evaluate for non pharmalogical interventions to address pain.					
	date of 11/21/18, will Dementia with beha restlessness and agwas requested how nursing assistant calidentified R487 had behaviors and directified refusing cares. The	ecord identified an admission th diagnoses that included: avioral disturbances, gitation. An initial care plan ever was not provided. The are resident information sheet multiple hallucinations and sted staff to re-approach R487 he care guide further indicated by on the floor, and take arry them around.				
	the dining room. Rand asked when he he ate three times a upset because he rindependent and was	d on 11/26/18, at 12:21 p.m. in 487 came up to the surveyor could go home. R487 said already that day and he was needed his insulin. R487 was alked through out the secured the use of any assistive				
	afternoon and early Victoria unit and ex on chairs by the nu- then would get back and visitors when h	d on 11/26/18, throughout the evening walking around the it seek. R487 would sit down rsing station for a few minutes up again. He asked staff e could go home and how he . He appeared upset when e-direct him.				
	pacing throughout t camera and asked	d on 11/27/18, after breakfast he unit. He looked for his staff if they knew where it was.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN OF CORRECTION IDENTIFICATION NOWIBER.		A. BUILDING:	<del></del>		
00497		B. WING		C 11/29/2018	
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
	2727 NOR	TH VICTORI	A		
THE ESTATES AT ROSEVILLE	11(:	_E, MN 5511			
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 835 Continued From pag	ge 16	2 835			
attempted to leave.					
Review of facility Profollowing:	ogress Notes identified the				
On 11/23/18, at 4:59 all shift with agitation halls, in and out of oto redirect. The note pain when asked an R487 refused PRN (Agitation escalated was winging at staff. R4 when writer heard so writer observed reside with no one else prehe was being punch jerk and he would the R487 then sat on the "leave me alone"	attempted to leave.  Review of facility Progress Notes identified the following:  On 11/23/18, at 4:59 a.m. indicated R487 was up all shift with agitation, pacing up and down the halls, in and out of other resident's rooms, unable to redirect. The note indicated R487 denied any pain when asked and accepted food and fluids. R487 refused PRN (as needed) medications. Agitation escalated with exit seeking and swinging at staff. R487 was in the dining room when writer heard screaming with loud banging, writer observed resident fighting and swinging with no one else present, it almost appeared that he was being punched in the face, his head would jerk and he would throw himself against the wall, R487 then sat on the floor, looked up and said, "leave me alone"a few minutes later he attempted to leave unit going door to door. R487 managed to open the doors and run down the 400 hallway. He was extremely agitated and was becoming abusive to staff. R487 then proceed to climb up onto the nursing desk on the long term care unit, his gait was unsteady and he almost fell numerous times. He was stating his blood sugar was low but refused a blood sugar check. Due to the potential for harming himself or staff, 911 was called for assistance. When police arrived R487 de-escalated some and did allow a blood sugar and was compliant with taking Olanzapine (antipsychotic medication) PRN, the police escorted R487 back to the Victoria unit where once again he became agitated and was arguing with the police. R487 wanted to go to the hospital				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
					C		
		00497	<u>I</u>		11/2	9/2018	
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  2727 NORTH VICTORIA						
THE EST	TATES AT ROSEVILLE	ELIC	LE, MN 5511				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
2 835	Continued From pa	ge 17	2 835				
	medication) 25 mg. with R487 until he v	The police spend an hour vent to sleep.					
	On 11/23/18, at 10:16 a.m. indicated R487 had behaviors of pacing in the hallway, anxiety, displayed delusional thoughts, hallucinations displayed by picking up things that were not there.  On 11/23/18, at 11:11 a.m. indicated R487 flipped a dining room table over in the doorway of the dining room, barricading himself in the dining area. Staff were able to flip the table back up but R487 tried to push it back down again. Staff were able to get R487 out of the dining area to the hallway. After review of all reported incidents staff called for recommendation from the primary physician. R487 was sent to the hospital on 11/23/18, related to danger to self and others, hallucinations, exit seeking, crying and yelling and aggressive behaviors toward staff.  On 11/23/18, at 8:00 p.m. R487 returned to the facility.						
	7:00 a.m., pacing ir into other resident's on other residents a stupid? Get my bag R487 was redirecte environment was q his room and contin	22 a.m. R487 was restless at the hallway and wandering s rooms. R487 attempted to sit and stated "why are you so us, I'm getting out of here." and back to his room where uiet but came straight out of nued to pace the ifficult to redirect at times.					
		0 p.m. R487 was restless and fternoon and into the evening. nultiple times					
	On 11/25/18, at 9:10 p.m. R487 continued to be						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE	ATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
						,
<u> </u>		00497	B. WING			9/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY. S	STATE, ZIP CODE		
		2727 NOR	TH VICTOR			
THE EST	TATES AT ROSEVILLE	ROSEVILL	_E, MN 5511	13		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 835	Continued From pa	ge 18	2 835			
	restless and agitated especially after family left in the afternoon.  On 11/27/18, at 12:50 p.m. note indicated R487 had been agitated and pacing the unit all morning and afternoon, pounding on the exit doors, rummaging in and out of other resident's rooms, removing their belongings and unable to re-direct. R487 was digging through the garbage cans and throwing everything out of them onto the floor, crawling under the dining room tables and trying to flip the tables over as well as hitting and kicking at the windows trying to get out. When asked what he was looking for R487 said his camera. He then began to feel the sleeve of SS (social services) shirt and stated, "My camera is					
	can fix it." SS attem he grabbed the pro- explained to her that lens covers and she	e wrong lens give it to me so I apted to re-direct R487. Then gram manager's hand and at her fingers were the different e needed to sit still to get it was distressed by his				
	hallucinations and h continued to enter r beds trying to lift the is going down stairs	naving delusional thoughts. He coms and crawl under the em up with his back, stating he can be then proceeded to pull				
	remotes. Res. was which he believed v holding it up to his e	the wall and unplug the bed given a television remote was his camera and had been eye and trying to take pictures				
	Staff were providing	the buttons on the remote. g a 1:1 due to impulsive to himself and others.				
	A subsequent note dated 11/27/18, at 2:16 p.m. indicated social services contacted R487's daughter regarding a bed hold. There were no further progress notes in the record to identify R487 going to the hospital.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  00497		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		B. WING			C 11/29/2018	
	PROVIDER OR SUPPLIER	2727 NOR	DRESS, CITY, S TH VICTORI LE, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 835	Interview on 11/28/nurse (RN)-B said thospital and the hose for him. RN-B state him and because of appropriate for psychiatric psychiatric was admitted to the said that R487 was hospital was looking geriatric psychiatric was admitted to the R487 was on a bed Nursing assistant (I 11/29/18, at 10:00 a R487 and what interviewed on 11/2 said the lived at the needed to stay on the Licensed practical responsible interviewed on 11/2 said the first time she would read his re-approach him if	18, at 2:25 p.m. registered that R487 was still at the spital was looking for a place d the hospital did want to keep f his dementia was not chiatric services.  rker (SS)-A was interviewed of a.m. SS-A said prior to on 11/21/18, R487 was on one to the hospital. SS-A said the one to one monitoring was for aggression or hallucinations. The estatus of R487 after he was anospital on 11/27/18. SS-A at the hospital and the group to possibly admit R487 to the funit. SS-A thought that R487 to hospital and indicated that I hold.  NA)-E was interviewed on a.m. NA-E was asked about erventions were identified for gitated or upset. NA-E said leave him alone and NA-E said when R487 was or go home, she would tell him nursing home now and he he unit.	2 835			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						,
		00497	B. WING		1	9/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TUE 501	AT DOOF\//\	2727 NOF	RTH VICTORI			
THE EST	TATES AT ROSEVILLE	ROSEVIL	LE, MN 5511	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 835	Continued From pa	ge 20	2 835			
2 835	hospital but stated a had pushed over ta staff sending him to Family member (FM 11/29/18, at 12:21 pdid not get a lot of it FM-A stated she was slept and staff woul their shift and did not sent R487 to the hocalled and said, "You are sending him to asked if the facility for R487 to help with and said the facility ideas or suggestion."	she was unaware that R487 bles in the dining area prior to	2 835			
	10:23 a.m. and state one most of the time nursing home. RN-R487 was on a one thought that was for the facility, R487 was wandering, agitation R487 was difficult to When R487 was seen RN-B said that he was for his camera. RN looking to find a care were interventions to SS-A said they were the newspaper and approaches were used to look at the newspande to find a came they asked family to	re interviewed on 11/29/18, at ed R487 had been on a one to e that he had been at the B and SS-A were aware that to one at the hospital but wandering. The indicated at as on one to one for and exit seeking. RN-B said ore-direct. Ent to the hospital on 11/27/18, was very agitated and looking B said activity staff was mera. When asked if there that may work with R487, a aware that R487 like to read liked cameras and stated sed with R487 to re-direct him paper but no attempts were era for him to use nor had bring one in. SS-A said her in the family was to call and ask				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00497	B. WING	·····	11/2	9/2018	
	PROVIDER OR SUPPLIER	2727 NOF	DRESS, CITY, S RTH VICTORI LE, MN 5511				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE	
2 835	the daughter if she when R487 went to when R487 returne 11/23/18, SS-A waw was gone for the wifurther conversation what interventions of with R487. SS-A st wife's phone number name and interventions to use SS-A acknowledged better job getting to approaches and interventions to use SS-A acknowledged better job getting to approaches and interventions to use SS-A acknowledged better job getting to approaches and interventions to use SS-A acknowledged better job getting to approaches and interventions to use SS-A acknowledged better job getting to approaches and interventions to use SS-A acknowledged better job getting to approaches and interventions to use SS-A acknowledged better job getting to approaches and interventions to use SS-A acknowledged better job getting to approaches and interventions to use SS-A acknowledged better job getting to approaches and interventions to use SS-A acknowledged better job getting to approaches and interventions to use SS-A acknowledged better job getting to approaches and interventions to use SS-A acknowledged better job getting to approaches and interventions to use SS-A acknowledged better job getting to approaches and interventions to use SS-A acknowledged better job getting to approaches and interventions to use SS-A acknowledged better job getting to approaches and interventions to use SS-A acknowledged better job getting to approaches and interventions to use SS-A acknowledged better job getting to approaches and interventions to use SS-A acknowledged better job getting to approaches and interventions to use SS-A acknowledged better job getting to approaches and interventions to use SS-A acknowledged bett	would like the bed to be held the hospital. SS-A stated do to the facility the evening of so not in the building and then eekend and had not had not swith the daughter as to or approaches might work well ates she was not aware the er was listed for R487. (Wife's umber were listed on the heet as the second). SS-A further indicated there on given to staff on may be helpful with R487 meras). SS-A verified there the nursing assistant resident or staff to be aware of or with R487. Both RN-B and do they could have done a know resident and to identify erventions and inform staff of and interventions.  Sing (DON) was interviewed on m., and indicated that family lmission about likes and ad worked in the past for ere were any triggers for y should be aware of. The ya 72 hour care management but she was not sure if SS-A to set that up with R487's ed if the meeting was not set was exhibiting behaviors as a DON would expect staff to ly about inventions and to try	2 835				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00497	B. WING		11/2	9/2018
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE ESTATES AT ROSEVILLE LLC			TH VICTOR			
0/A) ID	CLIMMADV CTA	TEMENT OF DEFICIENCIES	LE, MN 5511			(V5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDERICIENCY)	D BE	(X5) COMPLETE DATE
2 835	Continued From pa	ge 22	2 835			
2 833	8/28/18, indicated Fimpaired and required and required activities of daily liv 1/12/18, identified Fiperformance deficit anticipate needs are participate to the furinteraction. The care behaviors regarding seeking and pacing to 1, redirect, reoried offer snack or televial him when he appeared on 11/28/18, at 7:2 enter room 926 sornot come in here. The unit nurse office (LPN)-C stated "this go that way." R12 asounded the door a stated "hi buddy" are opposite direction. rearranged the doll stated "come let juice for you, let's go follow NA down the soiled utility room with the dining room the direction. At 7:41 activities are upon entrance the do if I knew what he should and pointed R12 turned around	R12 was severely cognitively red assistance with all ing. R12's care plan dated R12 had a self-care and directed staff to ind encourage him to illest extent possible with each re plan further identified g wandering, rummaging, exit g and directed staff to provide 1 ent, speak in a calm voice, ision and take time to talk with ared not interested in things.  4 a.m. R12 was observed to meone in the room stated "do R12 then attempted to enter e; licensed practical nurse is is my office I am begging you attempted to exit the unit and alarm registered nurse (RN)-B and assisted R12 to turn the R12 entered room 934 and is a nursing assistant (NA) is go this way I have some of this way;" R12 continued to hall and the NA entered the while R12 continued to wards a NA went the opposite in. R12 attempted to exit the bund and entered room 924; resident asked "what does he are did" NA tapped R12 on with finger away from door and attempted to exit the unit me twice from approximately	2 635			
		on 11/28/18, at 1:26 p.m. alked from room to room				

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PRINTED: 12/31/2018 **FORM APPROVED** Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_ C B. WING 00497 11/29/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2727 NORTH VICTORIA** THE ESTATES AT ROSEVILLE LLC ROSEVILLE, MN 55113 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 2 835 Continued From page 23 2 8 3 5 around the unit and identified telling R12 to come out or move worked to redirect R12. On 11/28/18, at 1:45 p.m. R12 attempted to open door to the outside then paced in and out of dining room where activity was in progress. Activity assistant did not invite R12 to activity. On 11/29/18, at 7:09 a.m. R12 attempted to exit unit; nurse walked by and did not intervene then attempted to enter room 924 nurse stated no, no go the other way. At 7:22 a.m. R12 entered room 931; resident in 931 stated "you don't belong here there's nothing here for you now let's go this way" and opened door as R12 exited room. The resident in 931 further stated R12 invaded his privacy and indicated when R12 entered his room he just tells him to leave. During an interview on 11/29/18, at 8:52 a.m. LPN-C indicated it was normal for R12 to roam the unit and walk into others rooms all day and night. LPN-C stated they told R12 no or please get out of there. LPN-C explained she was unsure if R12 had any activities of interest and further stated R12's son had brought a couch and television for his room however, R12 did not ever

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currently listed.

watch it.

During an interview on 11/29/18, at 1:50 p.m. RN-B identified R12 liked television and would sit on the chair in his room and watched television for long periods of time and he especially enjoyed old movies. RN-B stated R12's television and movie preference was not written down however, was stated during verbal report. RN-B further indicated R12's preferences should have been added to his care sheet and confirmed it was not

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:	<del></del>		С	
		00497	B. WING			9/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
THE EST	TATES AT ROSEVILLE	. 1 1 (:	RTH VICTORI LE, MN 5511				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
	interim director of n expectation not to y redirect a resident t would have offered as a diversion and a preferences should A facility policy relative requested but not re	on 11/29/18, at 2:45 p.m. the tursing stated it was her well down the hallway to that she would expect the staff food, fluids and/ or television further identified these be listed on the care sheet.  Ited to dementia care was eceived.  The details of the care was eceived.  The details of the care was eceived.  The details of the care was eceived.					
	all activities of daily required limited assibalance was only a assist. R78's care pR78 was at risk for extra chair out of reclutter free environmovements, encou and to wear gripper	living. The MDS included R78 sistance for walking and ble to stabilize with human blan dated 10/26/18, identified falls and directed staff to keep sidents room to maintain a ment, observe for unsafe rage use of walker, low bed, socks at night.					
	10/15/18, indicated six months and to r pain and decreased incident reports ind	fall Review Evaluation dated she had two falls during past monitor for increased kneed mobility. A review of facility icated R78 had a history of 1/5/18, 10/21/18, 11/6/18, 1/18.					
	R78 was walking in assistance or walke approached R78 ar room held R78's left to her room. At 10:	ion on 11/28/18, at 9:45 a.m. common area without er; nursing assistant (NA)-D nd stated let's go back to your it hand and guided R78 back 10 a.m. R78 was observed room without walker; NA-D					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER:

Output

B. WING

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE EST	ATES AT ROSEVILLE LLC	TH VICTORI LE, MN 5511		
(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
2 835	Continued From page 25	2 835		
	guided R78 to her bed and verified R78's bed was able to go low to the floor, however it was supposed to be approximately two to three feet higher than the lowest position when occupied for ease of transfers. At 10:30 a.m. NA-D confirmed R78 did not have her walker within reach and it had been left in the dining room out of R78's reach since breakfast.			
	During an observation and interview on 11/29/18, at 10:46 a.m. NA-C confirmed R78 was lying in bed and her bed was approximately 3 feet higher than the lowest position, her walker was out of reach near the bathroom door and explained the extra chair in her room was for visitors and was supposed to be there.			
	During an interview on 11/29/18, at 1:45 p.m. registered nurse (RN)-B stated R78's fall interventions included bed to be in lowest height position, encourage use of walker when walking and no chairs should be left in R78's room. RN-B confirmed R78's fall interventions were not listed on the NA care sheet.			
	During an interview on 11/29/18, at 2:43 p.m. the interim director of nursing (DON) stated it was her expectation the NA care sheet was updated with current fall interventions to match the care plan.			
	The facility protocol Falls Prevention and Management Protocol revised date 7/2018, indicated "The purpose of this protocol is to identify resident at risk for falls, implement fall prevention interventions"			
Minnocota D	SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for falls and pain, and			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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THE EST	ATES AT ROSEVILLE	· I I (:	TH VICTOR			
0/ 0 ID	CHMMADV CTA	TEMENT OF DEFICIENCIES	LE, MN 551	PROVIDER'S PLAN OF CORRECTION	<b></b>	()/5)
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2 835	Continued From pa	ge 26	2 835			
	receiving the neces prevent pain. The designee, could con	ementia to assure they are sary treatment/services to director of nursing or nduct random audits of the ensure appropriate care and nented.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21426	MN St. Statute 144. Prevention And Cor	A.04 Subd. 3 Tuberculosis ntrol	21426			1/4/19
	maintain a comprehinfection control procurrent tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control plaunpaid employees, residents, and volume Health shall provide regarding implements	e provider must establish and nensive tuberculosis ogram according to the most is infection control guidelines distates Centers for Disease tion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of extechnical assistance intation of the guidelines.				
	by:	ent is not met as evidenced and document review, the		Corrected		

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(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ C B. WING 00497 11/29/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2727 NORTH VICTORIA** THE ESTATES AT ROSEVILLE LLC ROSEVILLE, MN 55113 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 21426 Continued From page 27 21426 facility failed to accurately record the results of tuberculosis(TB) skin tests (TST) for 2 of 3 residents (R57, R134). In addition, the facility failed to accurately complete the Baseline TB Screening Form for 2 of 3 resident (R134, R65). Findings include: Review of R65's Admission Record indicated an admission date of 10/2/18. Review of R65's Baseline TB Screening Forms indicated a step one TST was administered on 10/3/18. The form lacked evidence of time read and millimeters of induration (an increase in the fibrous elements in tissue commonly associated with inflammation). Further, R65's symptom screening form lacked a signature and date completed. Review of R57's Admission Record indicated an admission date of 11/6/18. Review of R57's Baseline TB Screening Form indicated a step one TST was administered on 10/11/18, but lacked a signature and date for the symptom screen. Review of R134's Admission Record indicated an admission date of 10/10/18. Review of R134's Baseline TB Screening Form dated 11/6/18, indicated the step one TST was administered on 11/7/18, at 7:40 p.m. and read on 11/9/18, at 4:00 p.m. indicating 48 hours had not passed prior to reading the results. In addition, the form lacked documentation of the induration of the results and the date the screening was completed. On 11/29/18, at 12:55 p.m. during an interview, the interim director of nursing (DON) stated the expectation was the Baseline TB Screening Forms should be thoroughly completed by the nurses. The DON added the nurses were taught how to fill them out during initial orientation. The

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE COMP	SURVEY LETED
		00497	B. WING		11/2	9/2018
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
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(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 SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	too early and there documented, and it for the symptom so was missing a signal documentation of the TST. The DON screening lacked a step one TST was a step one TST w	step one Mantoux was read was no induration lacked a signature and date reen. R65's symptom screen ature and date and lacked ne induration on step one of also verified R134's symptom signature and date and the read too early.  By's Tuberculosis Infection olicy dated 11/10, indicated the for symptoms and risk factor tial test should be completed admission. The policy also no of each mantoux was to be hours after administration of	21426			
	(21) days.	R CORRECTION: Twenty-one				
21630	MN Rule 4658.1350 Medications; Destru	Subp. 2 A.B. Disposition of uction	21630			1/4/19
	remaining in the nu discharge of a resid prescribed, or any of	on of medications. ions of controlled substances rsing home after death or dent for whom they were controlled substance anently must be destroyed in a				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					) DATE SURVEY COMPLETED	
		00497	B. WING		11/2	9/ <b>2018</b>
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		2727 NOR	TH VICTOR			
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21630	manner recomment or the consultant physical pharmacist must fur instructions and for kept on file in the number of the port of the properties of the part of the p	ded by the Board of Pharmacy narmacist. The board or the rnish the necessary ms, a copy of which must be ursing home for two years. ions of other prescription the nursing home after the of the resident for whom they	21630			
	by: Based on observati review, the facility for non-pharmacologic needed (PRN) antipadministration for 1 for unnecessary measurements findings include: R112's admission of the factor of the findings included demonstraumatic brain MDS indicated R11 anti-depressant measurements the reference period During an observati R112 was seated of out "help me, I'm has the reference period out "help me, I'm has the refere	al interventions prior to as osychotic medication of 5 resident (R112) reviewed edications.  Minimum Data Set (MDS) ated R112 had diagnoses nentia, depression and dysfunction. In addition, the 2 received antipsychotic and dication for seven days during		Corrected		

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	T OF PERIODEN OF THE		(VO) MUUTIBL	E CONCERNICATION	LOW DATE	OLIDVEN.
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE	LETED
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(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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				,		
21630	Continued From pa	ge 30	21630			
	assistant (NA) was	observed to walk by resident				
	without any interact	ion.				
	During an interview	on 11/28/18, at 1:31 p.m.				
		urse (LPN)-C confirmed R112				
		RN Zyprexa on 11/11/18,				
		and was unsure if there was				
		cating non-pharmacological				
		stered nurse (RN)-B verified				
	there was no docun					
	non-pharmacologic	al interventions used prior to				
		dministered and on $1\dot{1}/23/18$ ,				
	11/24/18, 11/25/18,	11/27/18 and 11/28/18 the				
	medication was also	o administered. RN-B stated				
	the non-pharmacolo	ogical documentation would be				
	found in the nurse p	progress notes. At 2:06 p.m.				
	RN-B stated staff w	ere to offer R112 a snack, call				
	spouse, television p	orior to medication				
	administration.					
		ders included Zyprexa				
		cation) 5 milligrams (mg) by				
		ot redirectable)" three times				
		mouth two times daily related				
		entia with behavioral				
		razodone Hydrochloride				
		00 mg by mouth at bedtime for				
		uring review of the Medication				
		ord for November 2018, it was				
		8, 11/11/18, 11/16/18, 11/23/18,				
		11/27/18, and 11/28/18, R112				
		RN Zyprexa however, the				
		ed documentation of				
		al interventions implemented				
		ion being administered.				
		interview on 11/29/18, at				
		sultant pharmacist (CP) stated				
		on for staff to attempt				
		al interventions prior to				
		tration. The CP identified he				
	was not able to loca	ate the non-pharmacological				1

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interventions on 11/22/18, however did not

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE COMP	SURVEY LETED
			A. BOILDING.		c	;
		00497	B. WING		1	9/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE ESTATES AT ROSEVILLE LLC			TH VICTORI			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	.E, MN 5511	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	COMPLETE DATE
21630	Continued From pa	ge 31	21630			
	During an interview RN-B confirmed the communicated on tassistants. During an interview interim director of nexpectation for non to be attempted and medical record prio A facility policy relatinterventions prior to	s pharmacy recommendation. on 11/29/18, at 1:57 p.m. e care plan was not he care sheet to the nursing on 11/29/18, at 2:48 p.m. the tursing (DON) stated it was her pharmacological interventions d documented in the electronic r to medication administration. ted to non-pharmacological o antipsychotic medication requested but not received.				
	administrator, direct consulting pharmace policies and proced medications. Nursing necessary to the immedications proper medications. The Date pharmacist, cousupplies on a regular	THOD OF CORRECTION: The tor of nursing (DON) and cist could review and revise lures for proper storage of any staff could be educated as apportance of labeling ly and discarding expired DON or designee, along with all audit medications and ar basis to ensure compliance.				
21830	Residents of HC Fa Subd. 10. Particip notification of family	pation in planning treatment;	21830			1/4/19
	in the planning of the includes the opport	neir health care. This right unity to discuss treatment and dividual caregivers, the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY PLETED	
		00497	B. WING		11/2	) 19/ <b>2018</b>
	PROVIDER OR SUPPLIER	2727 NOF	DRESS, CITY, S RTH VICTOR LE, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21830	opportunity to reque care conferences, a family member or o both. In the event t present, a family me chosen by the reside conferences.  (b) If a resident w unconscious or con communicate, the f efforts as required te either a family mem writing by the reside an emergency that admitted to the facil family member to p planning, unless the to believe the reside directive to the cont specified in writing to member included in notifying a family m family member to p planning, the facility efforts, consistent w practice, to determi executed an advance sident's health car this paragraph, "rea (1) examining the resident; (2) examining the resident in the poss (3) inquiring of ar family member con- whether the resider directive and wheth	ge 32  est and participate in formal and the right to include a ther chosen representative or hat the resident cannot be ember or other representative ent may be included in such who enters a facility is natose or is unable to acility shall make reasonable under paragraph (c) to notify there or a person designated in ent as the person to contact in the resident has been lity. The facility shall allow the articipate in treatment effacility knows or has reason ent has an effective advance errary or knows the resident has that they do not want a family in treatment planning. After ember but prior to allowing a articipate in treatment what make reasonable with reasonable medical ne if the resident has ce directive relative to the effective relative to the effections. For purposes of asonable efforts" include: expersonal effects of the eff	21830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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		00497	B. WING		1	9/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE ESTATES AT BOSEVILLETTIC:		· 1 1 C:	RTH VICTORI LE, MN 5511			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21830	(4) inquiring of the resident normally go whether the resider directive. If a facility designated emerger member to participa accordance with the liable to resident foothe notification of the emergency contact family member was patient's privacy rigo (c) In making reasonable facility shall attembers or a designative member or a designative to notify a family member or and the medical reasonable facility has been agency that the residentifying and notification and the mergency contact admission, the facility has been member or designated emerger agency or leasonable facility in a designated emerger service agency or leasonable facility in the facility subdivision is not liad damages on the grather family member.	e physician to whom the oes for care, if known, at has executed an advance y notifies a family member or ncy contact or allows a family ate in treatment planning in s paragraph, the facility is not r damages on the grounds that the family member or or the participation of the simproper or violated the of this. It is sonable efforts to notify a designated emergency contact, and to identify family gnated emergency contact by conal effects of the resident cords of the resident in the acility. If the facility is unable ember or designated within 24 hours after the ity shall notify the county cy or local law enforcement ident has been admitted and a unable to notify a family ated emergency contact. The reagency and local law by shall assist the facility in local law enforcement agency or implementing this able to the resident for ounds that the notification of or emergency contact or the family member was improper	21830			

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PRINTED: 12/31/2018 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_ C B. WING 00497 11/29/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2727 NORTH VICTORIA** THE ESTATES AT ROSEVILLE LLC ROSEVILLE, MN 55113 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 21830 Continued From page 34 21830 This MN Requirement is not met as evidenced by: Based on observation, interview and document Corrected review, the facility failed to provide choices related to morning rising routines for 3 of 3 residents (R42, R124, R64) reviewed for choices. Findings include: R42's quarterly Minimum Data Set (MDS) dated 9/25/18, indicated she was severely cognitively impaired, required extensive assist of one staff for bed mobility and transfers and was rarely or never understood. R15's care plan printed on 11/29/18, identified alteration in mobility and directed staff to assist with transfers using a mechanical stand. R124's quarterly MDS dated 11/6/18, indicated she was severely cognitively impaired and required extensive assist of one for bed mobility and transfers. R124's care plan printed on 11/29/18, identified alteration in mobility and directed staff to assist with transfers. R64's quarterly MDS dated 10/9/18, indicated she was severely cognitively impaired and required

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for transfers.

extensive assist of two for bed mobility and one

During an observation on 11/28/18, at 7:18 a.m. R64 was up in her wheelchair eyes closed and appeared to be asleep. At 8:14 a.m. R64, R124 and R42 were wheeled by staff to the dining room and seated in front of the table all three residents had their eyes closed and appeared to be asleep; At 9:06 a.m. R64, R124 and R42 were served their breakfast food and drink; staff tapped R124's shoulder and stated it was time to eat.

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Output

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

2727 NORTH VICTORIA

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			
21830	Continued From page 35	21830					
	R124 replied "I am so tired." The staff began to offer bites of food to R42 while her eye remained closed and needed verbal encouragement to open her mouth. R64 remained with her eyes closed and did not open her mouth despite staff attempts to tap her as they stated her name. At 9:33 a.m. R64 and R42 were in the dining room, both with eyes closed appearing to be asleep.  During an observation on 11/29/18, at 7:17 a.m. R64 was laying dressed in her bed covered with a blanket. Nursing assistant (NA)-B stated she assisted R64 to get dressed around 6:30 a.m.						
	then R64 told NA-B she was tired so NA-B assisted R64 back to bed.  During an observation and interview on 11/29/18, at 8:23 a.m. NA-B confirmed R42, R124 and R64 were seated in their wheelchairs with their eyes closed and asleep at the dining room table. NA-B stated R124 sometimes will inform staff she wanted to stay in bed and indicated they ask R124 if she was ready to wake up. NA-B stated R42 was at times already awake in the morning and if she was sleeping then they allow her a little						
	extra time and then get her ready for breakfast. NA-B explained R64 at time is "so sleepy" during the morning they dress her and assist her back to bed to rest until breakfast.  During an interview on 11/29/18, at 8:43 a.m.  NA-A explained she started with the first resident room number listed on her care sheet when getting residents up and ready for the day. NA-A indicated she would wait until closer to breakfast						
	to get a resident up if they were awake the night before. NA-A verified her care sheet did not indicate resident's preferred wake times.  During an interview on 11/29/18, at 8:59 a.m.						

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PRINTED: 12/31/2018 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_ C B. WING 00497 11/29/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2727 NORTH VICTORIA** THE ESTATES AT ROSEVILLE LLC ROSEVILLE, MN 55113 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 21830 Continued From page 36 21830 NA-C identified he went in the order of residents listed on his care sheet when waking residents up to get ready and stated "you need to get them to breakfast." NA-C explained residents who could talk could say no to waking up and some would scream so then you don't force them to wake up and those who don't refuse you wake them up and get them ready for the day. During an interview on 11/29/18, at 1:34 p.m. with registered nurse (RN)-B and social service (SS)-A; RN-B stated R64 would say "leave me alone" if she did not want to wake up, SS-A stated R124 would also say she was not ready to wake up and further stated R42's spouse wanted her up for every meal. RN-B identified the therapeutic recreation department completed an interview on personal preferences upon admission. During an interview on 11/29/18, at 2:12 p.m. therapeutic recreation assistant (TR)-A indicated they do ask about resident preferences, however they do not ask about preferred wake times. A facility policy related to resident choices was requested but not received. SUGGESTED METHOD OF CORRECTION: Social Service and/or their designee could develop /revise policies for resident choices and

Minnesota Department of Health STATE FORM

compliance.

(21) days.

educate all facility staff on those policies. The DON and/or designee could conduct resident interviews to ensure resident choices are being

TIME PERIOD FOR CORRECTION: Twenty-one

honored, reviewed then aduit to ensure

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(3) DATE SURVEY COMPLETED		
			A. BUILDING:	<del></del>		`		
		00497	B. WING		11/2	, 9/2018		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
THE ESTATES AT ROSEVILLE LLC 2727 NORTH VICTORIA ROSEVILLE, MN 55113								
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE		
21845	Continued From pa	ge 37	21845					
21845	MN St. Statute 144 Residents of HC Fa	.651 Subd. 13 Patients & ac.Bill of Rights	21845			1/4/19		
	informed consent mesident's participat Residents have the	mental research. Written, nust be obtained prior to a ion in experimental research. right to refuse participation. efusal shall be documented in record.						
	by: Based on interview facility failed to ensistatus order matcher request of Cardiopu	and document review, the ure the resident's resuscitation ed the resident's stated almonary Resuscitation (CPR) (R27) reviewed for advance		Corrected				
	Findings include:							
	obstructive pulmona malignant neoplash acute respiratory fa	cluded atrial fibrillation, chronic ary disease, angina pectoris, n of tongue, tracheostomy and ilure with hypoxia obtained record dated 11/28/18.						
	9/18/18, indicated F able to make himse understood others. very important to R	inimum Data Set (MDS) dated R27 was cognitively intact, was elf understood, and usually The MDS also indicated it was 27 to have family or a close scussions about his care.						
	Treatment (POLST "Cardiopulmonary F	Orders for Life Sustaining ) were reviewed and indicated Resuscitation" (CPR). R27 ne POLST on 10/11/18. The						

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X2)			(X3) DATE SURVEY COMPLETED		
		00407			(			
00437					11/2	9/2018		
	NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  2727 NORTH VICTORIA							
105 531		ROSEVILI	LE, MN 5511					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE		
21845	Continued From page 38		21845					
	POLST was signed and dated by a nurse practitioner on 10/11/18.							
	8/16/18, indicated F	ehensive care plan dated R27's current code status was esuscitation (CPR).						
	identified and order however, the medic documentation whe	ary Report dated 11/28/18, for DNI/DNR dated 11/21/18, cal record lacked other a clarification had been R27 from a Full code prior to						
	(LPN)-A assigned to know any resident of the orders tab in Pousually listed the co	6 a.m. licensed practical nurse of R27 stated if she needed to code status she would look at bint Click Care (PCC) which ode status on the top. LPN-At listed code status was						
		6 a.m. when asked what his tated he wanted staff to do im unresponsive.						
	(RN)-A verified the matching pertaining directive. RN-A stat to make sure it was had recently been a re-admitted to the fatime staff reviewed stated she would have polson and ord were supposed to greviewed the hospit	0 a.m. registered nurse medical records did not g to the resident advanced ed the nurses were supposed addressed. RN-A stated R27 at the hospital and was acility on 11/21/18, and at that I and verified the orders. She have expected them to verify lers matched and if not, they get a clarification. RN-A all discharge orders and status was DNI/DNR.						

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PRINTED: 12/31/2018 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_ C B. WING 00497 11/29/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2727 NORTH VICTORIA** THE ESTATES AT ROSEVILLE LLC ROSEVILLE, MN 55113 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 21845 Continued From page 39 21845 On 11/28/18, at 2:13 p.m. the interim director of nursing stated staff were to follow the policy regarding assessing the code status and stated "when residents come to the facility we ask the nurses to ask the resident their POLST wishes and we go by what the resident wants. When he was re-admitted from the hospital with the DNI/DNR order I would have expected the nurse to have clarified with the resident and in this situation the ball was dropped when he came back. We will start right away to audit." SUGGESTED METHOD OF CORRECTION: Social Service and/or their designee could develop /revise policies for resident choice for cade status and educate all facility staff on those policies. The DON and/or designee could conduct resident interviews to ensure resident choices are being honored, reviewed then adult to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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