STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245326	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at Roseville	1000 Lovell Avenue Roseville, MN 55113

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49618 Based on interviews and record failed to provide pharmacy services for one of one resident (R1) reviewed for medication administration. R1 did not receive his anti-anxiety medication when it was available in the emergency medication dispensing kit. Findings include: R1's admission record printed on 4/26/24 indicated R1 was admitted to the facility on [DATE] with an admitting diagnosis of acute and chronic respiratory failure with hypoxia. R1's additional diagnoses included congestive heart failure, morbid obesity, opioid dependence, chronic pain syndrome, and low back pain. R1's brief interview for mental status (BIMS) assessment completed on 1/5/24 indicated R1 had a score of 15, which indicated R1 was cognitively intact. R1's medication administration record (MAR) indicated R1 missed a dose of lorazepam on 4/5/24 at 8:00 p. m. The nurse who signed that missed dose indicated a code 9, which stated Other/See Nurse Note. There was no progress note or nurses note for this missed medication. During an interview with R1 on 4/26/24 at 9:21 a.m., R1 stated the facility ran out of his lorazepam (anti-anxiety medication) about two weeks ago but had received it the day of the interview. R1 stated he had talked with his hospice nurse who stated if R1 ran out of Lorazepam, he should let the nurse know to get the medication through the emergency medication kit. R1 stated when he missed the lorazepam his anxiety increased, and he was restless. During an interview with registered nurse (RN)-A on 4/26/24 at 9:58 a.m., RN-A stated if the facility runs out of a resident's medication, the nurse should look in emergency medication kit. RN-A stated the facility pharmacy provides and refills medications in the emergency medication kit. RN-A stated the emergency medication kit includes lorazepam. During an interview with pharmacy manger (PM) on 4/26/24 at 11:13 a.m., the PM stated the facility has an emergency medication kit which included lorazepam. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview with the director of nursing (DON) on 4/26/24 at 11:50 a.m., the DON stated if a staff member who passes medications runs out of a resident's medications, her expectation would be to go to the emergency medication kit and get the medication from there. The DON stated the staff members who pass medications are trained on the emergency medication kit when the first start employment at the facility. During an email correspondence with the administrator on 4/26/24 at 4:02 p.m., the administrator stated the nurse should check with the emergency medication kit if a resident is out of a medication. The administrator stated the facility does not have a specific policy for what nurses should do if a resident runs out of medications as it is a standard nursing practice. A policy and procedure provided by the facility name Policies and Procedures: Pharmacy Services for Nursing Facilities by Polaris Pharmacy, effective May 2022, indicated if a current and active medication order cannot be located in the medication cart, the medication should be removed from the medication emergency kit. This statement is located on page 166 of the policy and procedure.