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	03/05/2025

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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 47083 Based on observation, interview and document review, the facility failed to ensure required nurse staff information was posted on a daily basis. This had the potential to affect all 58 residents residing in the facility and visitors who may wish to view the information. Findings include: On 3/4/25 at 9:43 a.m., the daily nurse staffing form posted at the nursing station was dated 1/23/25. This was located in a wall mounted frame under directions to view survey results. On 3/4/25 at 9:48 a.m., the director of nursing (DON) stated the daily staffing form should be updated daily. She stated it was very outdated. The DON stated the purpose of posting the document was to provide a rough idea of nurse to patient ratio. On 3/4/25 at 3:24 p.m., the administrator stated staff posting was intended to let people know we are meeting the regulations. The administrator stated she was not aware the posting had not been updated since 1/23/25. The administrator stated she had been responsible for the facility staffing over the previous two months. A policy regarding the nurse staff posting was requested but not received.

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47083 Based on interview and document review, the facility failed to ensure residents received the medications ordered by the provider for 1 out of 3 residents (R1) reviewed for significant medication errors, which resulted in hospitalization in the intensive care unit (ICU). This resulted in an immediate jeopardy (IJ) for R1 when the facility omitted her apixaban (medication that decreases clotting ability of blood) for six days, for a total of 12 doses, R1 had a stroke and was sent to the hospital. The facility implemented corrective action prior to the investigation so the deficiency was issued at Past Noncompliance. The IJ began on 2/18/25 at 4:00 p.m., when R1 missed her first dose of apixaban (Eliquis). The director of nursing (DON), administrator, social worker, and corporate clinical nurse were notified of the IJ on 3/5/25 at 11:50 a.m. The IJ was removed on 2/24/25 prior to the start of the survey and was therefore Past Noncompliance. Findings include: R1 was admitted to the facility on [DATE]. R1's care plan dated 2/18/25, indicated R1 was on anticoagulant medication. R1's admission Minimum Data Set, dated dated dated [DATE], indicated she had diagnoses of encephalopathy, atrial fibrillation (A-fib), and heart failure. R1's admission orders, dated 2/17/25, from the hospital, directed to administer apixaban 2.5 milligrams (mg) two times daily. R1's admission orders, dated 2/17/25, directed during your hospital stay, we transitioned you from warfarin (anticoagulant medication) to apixaban for your blood thinner. You should continue to take this as prescribed. R1's Medication Administration Record (MAR) order, entered on 2/17/25, directed give apixaban 2.5 mg two times a day for anticoagulant for one day. The MAR indicated R1 received the medication on 2/17/25 at 4:00 p.m., and 2/18/25 at 8:00 a.m. R1's MAR order entered on 2/24/25 directed give apixaban 2.5 mg two times a day for AFib. The MAR indicated R1 received the medication on 2/24/25 at 8:00 p.m., and on 2/25/25 at 8:00 a.m. A progress note, on 2/24/25 at 4:31 p.m., indicated R1 had a medication error due to missed apixaban doses. A physician note, on 2/25/25 at 2:12 p.m., indicated R1 was sent to the hospital for new onset slurred speech, left sided facial droop and left sided weakness. Patient missed recent doses of apixaban. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A physician note, on 2/25/25 at 2:27 p.m., indicated R1's order for twice daily apixaban was entered as a one-time order. R1 was bridged from warfarin to apixaban. R1 received a dose the evening of 2/17/25 and in the morning on 2/18/25. R1 received her next dose in the evening on 2/24/25 and in the morning on 2/25/25, prior to the cerebrovascular accident (CVA) that occurred this afternoon. On 3/4/25, at 12:52 p.m., family member (FM)-A stated R1 had suffered a stroke and remained hospitalized . FM-A stated R1 was receiving hospice care in the hospital and could no longer take food or drink by mouth. On 3/4/25, at 2:27 p.m., registered nurse (RN)-A stated she was working on 2/17/25 when R1 was admitted to the facility. RN-A stated she did not complete verifying accuracy of R1's medications, but she signed them off in the computer system, when she had to abruptly leave her shift. RN-A stated two nurses are expected to verify the accuracy of all orders. On 3/4/25 at 3:05 p.m., the health unit coordinator (HUC) stated she made an error by entering an end date for R1's apixaban. On 3/4/25 at 3:45 p.m., the director of nursing (DON) stated the HUC mistakenly entered an end date for apixaban. The DON stated the process was to have two nurses verify the orders. The first nurse would indicate the verification was complete by documenting in the computer system and on the admission checklist. The first nurse (RN-A) did not complete the verification when she abruptly had to leave her shift, although she documented this was complete in the computer system. RN-A did not document this was complete on the admission checklist. The DON stated the second nurse missed noting an end date was entered for the apixaban. The second nurse signed admission checklist, indicating she verified the accuracy of the orders. The DON stated the policy for medication orders was not followed. On 3/4/25 at 4:24 p.m., FM-B stated she requested to review R1's medication list at a care conference on 2/24/25. FM-B discovered apixaban was omitted. FM-B stated at time of this interview, R1 was unresponsive and could no longer eat, drink, or swallow. FM-B stated R1 was actively dying. On 3/5/25 at 8:38 a.m., medical doctor (MD)-A stated, I think it was the direct cause of her having a stoke. The apixaban was supposed to prevent that. Much less likely that she would be in her current state on hospice. On 3/5/25 at 12:54 p.m., pharmacist-A stated apixaban stays in the system for 3 days. He stated it is for blood clot prevention only and would not work on existing blood clots. On 3/5/25 at 2:40 p.m., MD-A stated apixaban takes 48 to 60 hours to reach the desired therapeutic level. MD-A stated the half-life (time required for the quantity of the medication to reduce to half its initial value) of apixaban was 12 hours. MD-A stated during R1's previous hospitalization on [DATE] a CT of her head indicated she did not have a stroke at that time. MD-A stated apixaban would stay in the body's system for a couple of days. R1 had known atrial fibrillation, giving time for the left atrial appendage (area of the upper left corner of the left chamber of the heart) thrombus (blood clot) to form. MD-A stated R1 had an angiogram (medical imaging of the heart) while hospitalized , with a thrombectomy (medical procedure to remove a blood clot) attempt that was not successful. MD-A stated this resulted in the blood clot in R1's brain, causing a stroke. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A facility policy, Medication and Treatment Orders, dated 2/24, directed orders for medications and treatments will be consistent with principles of safe and effective order writing. The past noncompliance IJ began on 2/18/25. The IJ was removed and the deficient practice was corrected by 2/24/25, after the facility implemented a systemic plan that included the following actions: review of procedure for transcribing orders, audit of all residents on apixaban, DON audit of all new resident orders, immediate education for all staff involved (HUCs, trained medication aides, licensed practical nurses, and RNs) with order transcription and further education on the medication apixaban.