Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 29, 2026

Administrator
THE VILLAS AT ROSEVILLE
1000 LOVELL AVENUE
ROSEVILLE, MN 55113

RE: CCN: 245326
Cycle Start Date: April 30, 2026

Dear Administrator:

On June 24, 2026, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

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Electronically delivered

June 29, 2026

Administrator
THE VILLAS AT ROSEVILLE
1000 LOVELL AVENUE
ROSEVILLE, MN 55113

Re: Reinspection Results
Event ID: 1F34DA-H2

Dear Administrator:

On June 16, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 30, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

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May 13, 2026

Administrator
THE VILLAS AT ROSEVILLE
1000 LOVELL AVENUE
ROSEVILLE, MN 55113

RE: CCN:245326

Cycle Start Date: April 30, 2026

Dear Administrator:

On April 30, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- 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" and/or an "E" tag), i.e., the plan of correction should be directed to:

Lynn Nelson, RN Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: Lynn.nelson@state.mn.us
Office: 651-201-4392 Mobile: 651-279-5474

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 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 July 30, 2026 (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 October 30, 2026 (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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.
A copy of the Department’s informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

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May 13, 2026

Administrator
THE VILLAS AT ROSEVILLE
1000 LOVELL AVENUE
ROSEVILLE, MN 55113

Re: State Nursing Home Licensing Orders
Event ID: 1F34DA-H1

Dear Administrator:

The above facility survey was completed on April 30, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Lynn Nelson, RN Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: Lynn.nelson@state.mn.us
Office: 651-201-4392 Mobile: 651-279-5474

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 feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245326	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT ROSEVILLE	1000 LOVELL AVENUE , ROSEVILLE, Minnesota, 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments Citation Finding On 4/27/26 through 4/30/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		05/21/2026
F0000	INITIAL COMMENTS On 4/27/26 through 4/30/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H53261684C (2993758), H53261682C (2992457), H53261613C (2991789), H53261575C (2961525), H53261580C (2802274), H53261577C (2799706), H53261579C (2675906), H53261578C (2659889). NO deficiencies were cited. H53261576C/2807684 was unsubstantiated with incidental findings at F742. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		05/21/2026

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245326	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

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F0801 SS = F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services.	F0801	response to question: course will be finished by august 2026	06/04/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245326	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

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F0801 SS = F	Continued from page 2 (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to employ either a full-time registered dietician (RD) or a qualified dietary manager (DM) to carry out the functions of the food and nutrition service since January of 2020, which had the potential to affect all 54 residents who resided in the facility. Findings include: Qualifications for the Culinary Services Director (CSD) was requested however was not received. During the initial kitchen tour on 4/27/26 at 10:45 a.m., CSD stated she worked full time at the facility and there was also a registered dietician (RD) who worked one day a week but was available by phone for questions whenever needed. During a follow up interview on 4/30/26 at 10:40 a.m., the surveyor asked the CSD to see her certification and she stated she had recently enrolled in the certified dietary manager (CDM) program about a month ago and didn't have any other certification	F0801		06/04/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245326	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

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F0801 SS = F	Continued from page 3 or training for food services. She had originally enrolled during COVID but didn't finish. During interview on 4/30/26 at 1:00 p.m., the administrator stated they have a registered dietician who worked at the facility once a week and was on call if they needed anything. They also have a CSD, who started working as the kitchen manager in January of 2020 and was currently enrolled in school for her CDM license. The administrator further stated she thought the CSD just had to be enrolled in the program in order for her to be qualified as the CSD. A facility policy regarding qualifications for dietary staff was requested but not received.	F0801		06/04/2026
F0604 SS = D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1),483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical . . . restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical . . . restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document	F0604	Pillows in R44's bed were immediately removed and placed above sheets as a positioning aid that R44 can easily move/remove at any time. All residents have the potential to be affected. DON and ADON completed a full-house review and checked each current resident's bed to ensure pillows were not being used as restraints. All nursing staff will be educated on restraints and appropriate use of pillows as positioning aids. DON/designee will audit residents in bed to ensure pillows are not being used in a way that restricts movement by checking beds to ensure pillows are not being used as restraints. At least 3 resident beds will be reviewed during each audit, which will be conducted 3 times per week for 2 weeks, then weekly for 2 weeks, then monthly for 2 months or until compliance is achieved. Results of audits will be brought to QAPI committee by DON for input on the frequency of audits.	06/04/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245326	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

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THE VILLAS AT ROSEVILLE	1000 LOVELL AVENUE , ROSEVILLE, Minnesota, 55113

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F0604 SS = D	Continued from page 4 review, the facility failed to ensure freedom of movement was not restricted when a pillow was placed adjacent to the resident's body, underneath the fitted sheet which could not be removed easily by the resident for 1 of 1 resident (R44) reviewed for potential restraints. Findings include: R44's quarterly Minimum Data Set (MDS) dated 4/14/26, indicated R44 was dependent on staff for all activities of daily living (ADLs), transfers and mobility. R44's diagnoses included dementia and acquired absence of right leg below the knee. R44's care plan revised 4/30/26, identified R44 had "impaired cognitive function/dementia or impaired thought processes," and was at risk for falls. The care plan further indicated R44 had alteration in mood and behavior and would put self on floor and crawl. The care plan instructed staff to keep bed in a low position and place a mat on the floor to allow resident to safely crawl. During observation on 4/27/26 at 12:56 p.m., nursing assistant (NA)-A and NA-B entered R44's room to transfer R44 into bed using a mechanical lift. Incontinent care was performed and a new brief placed. R44 was positioned in the middle of the bed, with the right side of the bed against the wall. NA-A lowered R44's bed to the lowest position, provided the call light, and placed a pillow along the left side of R44's torso underneath the fitted bottom sheet. During observation on 4/28/26 at 3:48 p.m., R44 was taken to his room to be transferred back to bed. After the transfer, NA-C placed a pillow along the left side of R44 under the fitted bottom sheet, bed lowered, and mat placed on floor. During interview on 4/28/26 at 3:59 p.m., NA-C stated R44's pillow was placed under the fitted sheet to prevent the pillow from falling out if R44 became agitated. NA-C did not think R44 could remove the pillow from under the sheet. During interview on 4/28/26 at 4:05 p.m., registered nurse (RN)-A stated R44 had fall intervention in place such as call light in reach, bed in the lowest position, and a mat on the floor. The mat was in place to prevent injury in case R44 would roll out of bed. RN-A stated pillows were used as positioning aids and should never be placed under the fitted sheet since that could restrain R44's movement. During interview on 4/29/26 at 11:49 a.m., RN-B	F0604		06/04/2026

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F0604 SS = D	Continued from page 5 stated pillows were used for position and should never be placed under the fitted sheet. RN-B stated if a resident could not easily remove a pillow and it prevented them from getting out of bed, it would be considered a restraint. During interview on 4/29/26 at 1:07 p.m., director of nursing (DON) expected resident pillows would not be placed under fitted sheets as that could be considered a restraint. A facility policy regarding restraints was requested but not provided.	F0604		06/04/2026
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to provide care conferences for 1 of 1 resident	F0657	R53 had a care conference on 5/13/26. All residents have the potential to be affected. All residents have been reviewed for a care conference within the past quarter. Social services received education on care conference frequency and proper documentation of care conferences. Audits will be conducted by the NHA or designee to ensure care conferences are being held in accordance with the MDS schedule following each comprehensive assessment. Audits will be completed daily Monday–Friday for 2 weeks, then 3 times per week for 2 weeks, then weekly for 1 month or until compliance is achieved. Results of audits will be brought to the QAPI committee for input on continued monitoring frequency.	06/04/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245326	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT ROSEVILLE	1000 LOVELL AVENUE , ROSEVILLE, Minnesota, 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0657 SS = D	Continued from page 6 (R53) reviewed for care conferences. Findings include: R53's quarterly Minimum Data Set (MDS) dated 2/23/26, identified R53 was cognitively intact with diagnoses of traumatic brain injury (TBI) and seizure disorder. R53's electronic health record (EHR) lacked indication of care conferences since admission dated 8/20/25. R53's care plan dated 11/25/25, indicated R53 was a vulnerable adult, at risk for decreased cognitive and physical abilities related to diagnoses of TBI, depression, opioid dependence, legal blindness and dizziness. When interviewed on 4/27/26 at 1:07 p.m., R53 stated she didn't remember being invited or involved in any meetings about her care at the facility. When interviewed on 4/29/26 at 11:11 a.m., social service director (SS)-A confirmed the EMR lacked documentation of care conferences for R53. SS-A and social service designee (SS)-B were responsible for scheduling conferences. Information was sent to the inter-disciplinary team (IDT), resident, and their family/representatives. Furthermore, the expectation for care conferences was to have one within 48 hours of admission, quarterly and as needed. When interviewed on 4/30/26 at 9:49a.m., registered nurse (RN)-B stated care conferences were coordinated with the interdisciplinary team (IDT), resident and their family occurred within the first 48 hours of admission, quarterly and with any significant change in the resident's condition. This ensured individual needs of the resident were met. When interviewed on 4/30/26 at 2:45 p.m., the director of nursing (DON) stated resident care conferences were expected to be done within 48 hours of admission, quarterly, with significant changes and as needed. The importance of care conferences was to align cares with resident's needs, revisit concerns and follow up with the plan of care. An undated policy titled Care Planning-Interdisciplinary Team dated indicated comprehensive care plan was to be developed within 7 days. The IDT would make every effort would be made to have the resident and their family attend the	F0657		06/04/2026

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F0657 SS = D	Continued from page 7 care conferences.	F0657		06/04/2026
F0685 SS = D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure recommended provider referral for ophthalmology care was followed up on for 1 of 1 resident (R21) reviewed for missed appointments. Findings include: R21's quarterly Minimum Data Set dated 2/12/26, indicated R21 was cognitively intact, required setup or clean-up assistance to total dependence with most activities of daily living (ADLs), and substantial to maximal assistance with transfers and mobility. R21did not display rejection of care behaviors. R21's diagnoses included ataxia (a neurological condition causing lack of muscle coordination) and need for assistance with personal care. R21's provider visit note dated 1/20/26, indicated, "Patient requested to speak to me regarding a small left [sic] tag underneath his left eye." The visit notes further indicated under orders placed today, "Ophthalmology appt for skin tag under L eye" and follow up summary, "Yellowish colored skin tag below left eye. Will put in a referral for ophthalmology." R21's provider order dated 1/20/26, instructed, "Ophthalmology appt for skin tag under L eye." During observation and interview on 4/29/26 at	F0685	R21 has ophthalmology appointment scheduled for 6/11/26. All current residents were reviewed for open/pending referrals to validate that referrals had been followed up on appropriately and appointments had been scheduled. Education provided to staff responsible for scheduling appointments regarding the process for timely follow-up on referrals. All orders for referrals will be entered into a shared tracking. The spreadsheet will include resident name and date of referral/provider order, with designated fields to document appointment scheduling and completion of services. NHA or designee will audit the referral tracking spreadsheet to ensure all provider referral orders are entered, appointments are scheduled timely, and completion of services is documented. Audits will be conducted daily Monday–Friday for 2 weeks, then 3 times per week for 2 weeks, then weekly for 1 month or until compliance is achieved. Results of audits will be brought to the QAPI committee for input on continued monitoring frequency.	06/04/2026

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F0685 SS = D	Continued from page 8 11:06 a.m., R21 stated he remembered talking to the doctor about this (pointing to the approximately 1cm flesh colored raised area just under his left eye) and was told it was a skin tag and that they would look into getting it removed. R21 continued, “But that never happened.” During interview on 4/29/26 at 11:40 a.m., licensed practical nurse (LPN)-A stated all appointment referrals were handled by the medical records director (MRD). During interview on 4/30/26 at 10:45 a.m., registered nurse (RN)-B stated would expect all appointments to be scheduled timely for routine referrals within 30 days and within 24 hours if an urgent matter. RN-B stated the facility used) for in-house routine dental care and would find an external dental clinic for urgent care. During interview on 4/29/26 at 1:07 p.m., director of nursing (DON) stated MRD would be the one to make arrangements routine and non-routine appointment scheduling either through Health Drive (HD - an outside source for medical and dental support for long term care facilities) or an outside clinic. DON stated HD was used for routine dental, podiatry, and audiology appointments and any other services needed would be made through an outside clinic. During interview on 4/30/26 at 8:43 a.m., MRD stated she was responsible for making all arrangements for referrals to include scheduling the appointment and transportation to an external clinic if needed. MRD stated she had just seen R21’s ophthalmology referral last week and had not made any arrangements yet. MRD could not explain why the ophthalmology referral was not seen back in January when originally ordered other than it must have been lost in the folders of paperwork around her office while she was attempting to reorganize. During follow up interview on 4/30/26 at 10:49 a.m., DON stated would expect appointment referrals to be made timely as ordered. DON stated R21should have had arrangements for ophthalmology appointment by now. During interview on 4/30/26 at 11:40 a.m., nurse practitioner (NP) stated would have expected appointment referrals to be followed up on timely. NP stated would expect staff to act on provider orders as soon as possible and would have expected R21 to have been seen by ophthalmology by now since that referral was placed in January.	F0685		06/04/2026

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F0685 SS = D	Continued from page 9 A facility policy on appointment scheduling or provider orders was requested but not provided.	F0685		06/04/2026
F0742 SS = D	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure coordination of mental health care services for 1 of 1 residents (R4) who had a referral to obtain psychiatrist services. Findings include: R4's quarterly Minimum Data Set (MDS) dated 4/21/26, identified R4 was cognitively intact with diagnoses of borderline personality disorder, post-traumatic stress disorder and major depressive disorder. R4's provider order dated 3/11/26, indicated psychiatry to see R4 next week, social work to get in touch with case manager to expedite transfer to a setting that would support her mental health, also seeking changes to her psychiatric medications due to her increased anxiety, and R4 requested female caregivers. R4's care plan dated 4/21/26, indicated R4 was at risk for altered behavior related to trauma. R4 required a referral for psychiatry services, collaboration with social services and psychiatry improved social connections and minimize symptomology. R4's psychiatry provider notes were requested however were not provided. When interviewed on 4/27/26 at 2:50 p.m., R4 stated her post-traumatic stress disorder, anxiety and depression made her feel that she wasn't heard and	F0742	R4 sees her own outside mental health practitioner weekly and prefers to continue seeing them instead of facility's mental health services. Residents with psychiatric diagnoses have the potential to be affected. All residents with psychiatric diagnoses were reviewed to ensure any referrals/orders for metal health services had been appropriately followed up on and coordinated. Social services and nurse management educated on coordinating mental health care services for residents and process for doing so. Process involves a working spreadsheet shared between nursing, social services, and administration to track the status of residents requiring mental health services and ensure completion of necessary steps for coordination of services. NHA or designee will audit the shared spreadsheet to ensure coordination of mental health care services for residents with referrals. Audits will be completed daily Monday–Friday for 2 weeks, then 3 times weekly for 2 weeks, then weekly for 1 month or until compliance is achieved. Results of audits will be reported to the QAPI committee by the NHA for review and input on audit frequency.	06/04/2026

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F0742 SS = D	Continued from page 10 understood by staff. R4 used an IPAD to speak with a grief therapist but was not offered any additional therapy or mental health support. When interviewed on 4/29/26 at 11:26 a.m., nursing assistant (NA)-C stated if a resident was having behaviors, stress-based outbursts, the care was to use therapeutic communication, acknowledge their concerns, respond calmly, and explain the situation without judgement, meet the resident where they are at. When interviewed on 4/30/26 at 9:46 a.m., registered nurse (RN)-B stated provider orders were to be followed. If referrals made, it was important, so all caregivers were on the same page and were able to provide cohesive care. RN-B stated she was unaware of the referral for psychiatrist for R4. When interviewed on 4/30/26 at 9:63a.m., service director (SS)-A stated the process to obtain an appointment for psychiatric services were offered on admission, as ordered and as needed. The social services department was responsible for scheduling appointments with the outside psychiatrist team. SS-A stated R4's order was not completed because social services was unaware of the order. When interviewed on 4/30/26 at 1:46 p.m., director of nursing (DON) The DON staff were expected to place provider orders into the medical record as soon as possible. The expectation was to have outside psychiatric appointments set up per orders. It was important to provide/arrange psychological counselling services to meet the needs of the resident, what was driving behaviors, provide proper care, it was a collaborative approach to the behaviors. DON further stated they were not sure why R4's order was missed and it was unknown if the R4 accepted or declined the additional services and would look into it. No further information was provided. A policy titled Trauma Care dated 2/24/23 indicated the inter-disciplinary team monitor effects of approaches to ensure they are implemented and care plans updated.	F0742		06/04/2026
F0791 SS = D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care.	F0791	R21 had dental appointment on 5/4/26. All residents have the potential to be affected. All current residents were reviewed for open/pending referrals to validate that referrals had been followed up on appropriately and appointments had been scheduled.	06/04/2026

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F0791 SS = D	Continued from page 11 §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure emergency dental referral for infected tooth was followed up on for 1 of 1 resident (R21) reviewed for dental services.	F0791	Continued from page 11 Education provided to staff responsible for scheduling appointments regarding the process for timely follow-up on referrals. All orders for referrals will be entered into a shared tracking. The spreadsheet will include resident name and date of referral/provider order, with designated fields to document appointment scheduling and completion of services. NHA or designee will audit the referral tracking spreadsheet to ensure all provider referral orders are entered, appointments are scheduled timely, and completion of services is documented. Audits will be conducted daily Monday–Friday for 2 weeks, then 3 times per week for 2 weeks, then weekly for 1 month or until compliance is achieved. Results of audits will be brought to the QAPI committee for input on audit frequency.	06/04/2026

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F0791 SS = D	Continued from page 12 Findings include: R21's quarterly Minimum Data Set (MDS) dated 2/12/26, indicated R21 was cognitively intact, required setup or clean-up assistance with oral hygiene, and substantial to maximal assistance with transfers and mobility. R21did not display rejection of care behaviors. R21's diagnoses included ataxia (a neurological condition causing lack of muscle coordination) and need for assistance with personal care. R21's provider visit note dated 11/11/25, "Patient currently reports severe toothache described as horrible, with examination revealing left upper molar decay with partial breakage and erythema around gum line." The visit notes further indicated under orders placed today, "Referral to dentist for definitive treatment of infected left upper tooth" and follow up summary, "Escalate priority for dental appointment scheduling." R21's provider orders dated 11/12/25, instructed, "Referral to dentist for treatment of infected left upper tooth." During interview on 4/29/26 at 11:06 a.m., R21 stated he had a tooth infection a while ago and was supposed to see a dentist but never did. R21 stated he was using a special mouthwash which seemed to help. During interview on 4/29/26 at 11:40 a.m., licensed practical nurse (LPN)-A stated all appointment referrals were handled by the medical records director (MRD). During interview on 4/30/26 at 10:45 a.m., registered nurse (RN)-B stated would expect all appointments to be scheduled timely for routine referrals within 30 days and within 24 hours if an urgent matter. RN-B stated the facility used an outside provider source for medical and dental support for in-house routine dental care and would find an external dental clinic for urgent care. During interview on 4/29/26 at 1:07 p.m., director of nursing (DON) stated MRD would be the one to make arrangements routine and non-routine appoint scheduling either through outside provider source for medical and dental support for in-house routine dental care or an outside clinic. DON stated the outside provider source for medical and dental support for in-house routine dental care was used for routine dental, podiatry, and audiology appointments.	F0791		06/04/2026

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F0791 SS = D	Continued from page 13 During interview on 4/30/26 at 8:43 a.m., MRD stated she was responsible for making all arrangements for referrals that included scheduling the appointment and transportation to an external clinic if needed. MRD stated residents would be seen as needed when the outside provider source for medical and dental support came to the facility or for routine appointments such as annual or bi-annual dental care. MRD stated she thought she had set up an appointment for R21 to see them, but R21 refused the care. MRD was unable to locate any evidence that R21 was ever seen by outside provider source for medical and dental support or was on a list to be seen them, or any documented refusal of care. MRD stated if there was an emergency need, she would try to get them sent out to an outside clinic for treatment. MRD stated had worked at this facility for four years and could not recall ever making urgent dental arrangements and did not know if there was a specific procedure to do so. MRD stated the outside provider source for dental support was at the facility on 11/11/25, 2/17/26, 3/17/26, and 4/14/26. MRD confirmed R21 was not listed as being seen at any of those visits. During phone interview on 4/30/26 at 9:32 a.m., the appointment coordinator for the outside provider source for dental support stated R21 was not enrolled in for dental care and had only elected podiatry services with them. During follow up interview on 4/30/26 at 9:47 a.m., MRD stated she was mixed up earlier and that R21 was only signed up for podiatry care and would not have been scheduled for dental care. MRD stated R21 needed an external dental clinic of his choice and an appointment should have been arranged back in November when originally scheduled and could not explain why it was missed. During follow up interview on 4/30/26 at 10:49 a.m., DON stated would expect appointment referrals to be made timely as ordered. DON stated R21should have been seen by a dentist by now. During interview on 4/30/26 at 11:40 a.m., nurse practitioner (NP) expected appointment referrals to be followed up on timely. NP stated they would expect staff to act on provider orders as soon as possible and would have expected R21 to have been seen by a dentist back in November as ordered. A facility policy on appointment scheduling or provider orders was requested but not provided.	F0791		06/04/2026

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/27/26 through 4/30/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed. The following complaints were reviewed: H53261684C (2993758), H53261682C (2992457),	20000		06/04/2026

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

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20000	Continued from page 1 H53261613C (2991789), H53261575C (2961525), H53261576C (2807684), H53261580C (2802274), H53261577C (2799706), H53261579C (2675906), H53261578C (2659889). NO licensing orders were issued. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor’s findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. 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.	20000		06/04/2026
20510	Use of Restraints CFR(s): MN Rule 4658.0300 Subp. 2 Subp. 2. Freedom from restraints. Residents must be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.	20510	corrected	06/04/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/30/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT ROSEVILLE	**1000 LOVELL AVENUE , ROSEVILLE, Minnesota, 55113**

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20510	Continued from page 2 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure freedom of movement was not restricted when a pillow was placed adjacent to the resident's body, underneath the fitted sheet which could not be removed easily by the resident for 1 of 1 resident (R44) reviewed for potential restraints. R44's quarterly Minimum Data Set (MDS) dated 4/14/26, indicated R44 was dependent on staff for all activities of daily living (ADLs), transfers and mobility. R44's diagnoses included dementia and acquired absence of right leg below the knee. R44's care plan revised 4/30/26, identified R44 had "impaired cognitive function/dementia or impaired thought processes," and was at risk for falls. The care plan further indicated R44 had alteration in mood and behavior and would put self on floor and crawl. The care plan instructed staff to keep bed in a low position and place a mat on the floor to allow resident to safely crawl. During observation on 4/27/26 at 12:56 p.m., nursing assistant (NA)-A and NA-B entered R44's room to transfer R44 into bed using a mechanical lift. Incontinent care was performed and a new brief placed. R44 was positioned in the middle of the bed, with the right side of the bed against the wall. NA-A lowered R44's bed to the lowest position, provided the call light, and placed a pillow along the left side of R44's torso underneath the fitted bottom sheet. During observation on 4/28/26 at 3:48 p.m., R44 was taken to his room to be transferred back to bed. After the transfer, NA-C placed a pillow along the left side of R44 under the fitted bottom sheet, bed lowered, and mat placed on floor. During interview on 4/28/26 at 3:59 p.m., NA-C stated R44's pillow was placed under the fitted sheet to prevent the pillow from falling out if R44 became agitated. NA-C did not think R44 could remove the pillow from under the sheet. During interview on 4/28/26 at 4:05 p.m., registered nurse (RN)-A stated R44 had fall intervention in place such as call light in reach, bed in the lowest position, and a mat on the floor. The mat was in place to prevent injury in case R44 would roll out of bed. RN-A stated pillows were used as positioning aids and should never be placed under the fitted sheet since that could restrain R44's movement.	20510		06/04/2026

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20510	Continued from page 3 During interview on 4/29/26 at 11:49 a.m., RN-B stated pillows were used for position and should never be placed under the fitted sheet. RN-B stated if a resident could not easily remove a pillow and it prevented them from getting out of bed, it would be considered a restraint. During interview on 4/29/26 at 1:07 p.m., director of nursing (DON) expected resident pillows would not be placed under fitted sheets as that could be considered a restraint. A facility policy regarding restraints was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and/or revise policies to ensure restraints are based on a comprehensive resident assessment prior to initiation, with the least restrictive restraint used and incorporated into the plan of care. The DON or designee should educate staff to policies and procedures and perform measurable audits for restraint use to ensure all measures are followed. The results of those audits should be taken to QAPI to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20510		06/04/2026
21335	Providing Routine & Emergency Oral Health Ser CFR(s): MN Rule 4658.0725 Subp. 3 A&B Subp. 3. Emergency dental services. A. A nursing home must provide, or obtain from an outside resource, emergency dental services to meet the needs of each resident. Emergency dental services include services needed to treat: an episode of acute pain in teeth, gums, or palate; broken or otherwise damaged teeth; or any other problem of the oral cavity, appropriately treated by a dentist, that requires immediate attention. B. When emergency dental problems arise, a nursing home must contact a dentist within 24 hours, describe the dental problem, and document and implement the dentist's plans and	21335	corrected	06/04/2026

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21335	Continued from page 4 orders. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure emergency dental referral for infected tooth was followed up on for 1 of 1 resident (R21) reviewed for dental services. Findings include: R21's quarterly Minimum Data Set (MDS) dated 2/12/26, indicated R21 was cognitively intact, required setup or clean-up assistance with oral hygiene, and substantial to maximal assistance with transfers and mobility. R21did not display rejection of care behaviors. R21's diagnoses included ataxia (a neurological condition causing lack of muscle coordination) and need for assistance with personal care. R21's provider visit note dated 11/11/25, "Patient currently reports severe toothache described as horrible, with examination revealing left upper molar decay with partial breakage and erythema around gum line." The visit notes further indicated under orders placed today, "Referral to dentist for definitive treatment of infected left upper tooth" and follow up summary, "Escalate priority for dental appointment scheduling." R21's provider orders dated 11/12/25, instructed, "Referral to dentist for treatment of infected left upper tooth." During interview on 4/29/26 at 11:06 a.m., R21 stated he had a tooth infection a while ago and was supposed to see a dentist but never did. R21 stated he was using a special mouthwash which seemed to help. During interview on 4/29/26 at 11:40 a.m., licensed practical nurse (LPN)-A stated all appointment referrals were handled by the medical records director (MRD). During interview on 4/30/26 at 10:45 a.m., registered nurse (RN)-B stated would expect all appointments to be scheduled timely for routine referrals within 30 days and within 24 hours if an urgent matter. RN-B stated the facility used an outside provider source for medical and dental support for in-house routine dental care and would find an external dental clinic for urgent care.	21335		06/04/2026

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21335	Continued from page 5 During interview on 4/29/26 at 1:07 p.m., director of nursing (DON) stated MRD would be the one to make arrangements routine and non-routine appoint scheduling either through outside provider source for medical and dental support for in-house routine dental care or an outside clinic. DON stated the outside provider source for medical and dental support for in-house routine dental care was used for routine dental, podiatry, and audiology appointments. During interview on 4/30/26 at 8:43 a.m., MRD stated she was responsible for making all arrangements for referrals that included scheduling the appointment and transportation to an external clinic if needed. MRD stated residents would be seen as needed when the outside provider source for medical and dental support came to the facility or for routine appointments such as annual or bi-annual dental care. MRD stated she thought she had set up an appointment for R21 to see them, but R21 refused the care. MRD was unable to locate any evidence that R21 was ever seen by outside provider source for medical and dental support or was on a list to be seen them, or any documented refusal of care. MRD stated if there was an emergency need, she would try to get them sent out to an outside clinic for treatment. MRD stated had worked at this facility for four years and could not recall ever making urgent dental arrangements and did not know if there was a specific procedure to do so. MRD stated the outside provider source for dental support was at the facility on 11/11/25, 2/17/26, 3/17/26, and 4/14/26. MRD confirmed R21 was not listed as being seen at any of those visits. During phone interview on 4/30/26 at 9:32 a.m., the appointment coordinator for the outside provider source for dental support stated R21 was not enrolled in for dental care and had only elected podiatry services with them. During follow up interview on 4/30/26 at 9:47 a.m., MRD stated she was mixed up earlier and that R21 was only signed up for podiatry care and would not have been scheduled for dental care. MRD stated R21 needed an external dental clinic of his choice and an appointment should have been arranged back in November when originally scheduled and could not explain why it was missed. During follow up interview on 4/30/26 at 10:49 a.m., DON stated would expect appointment referrals to be made timely as ordered. DON stated R21should have been seen by a dentist by now.	21335		06/04/2026

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21335	Continued from page 6 During interview on 4/30/26 at 11:40 a.m., nurse practitioner (NP) expected appointment referrals to be followed up on timely. NP stated they would expect staff to act on provider orders as soon as possible and would have expected R21 to have been seen by a dentist back in November as ordered. A facility policy on appointment scheduling or provider orders was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop/revise and implement policies and procedures related to routine and emergency dental agreements and educate staff on these requirements. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21335		06/04/2026
21426	Tuberculosis Prevention And Control CFR(s): MN St. Statute 144A.04 Subd. 3 (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure first and second Tuberculin Skin Tests (TST, test to screen for active Tuberculosis) was completed for 2 of 5 residents (R4, R20) reviewed for Tuberculosis (TB) screening. Findings include:	21426	corrected	06/04/2026

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21426	Continued from page 7 R4 R4's admission Minimum Data Set (MDS) dated 1/17/26, indicated R4 was admitted on 1/17/26, had intact cognition and diagnoses of post-traumatic stress disorder (PTSD) and renal failure. R4's immunization record indicated she had her first step TST on 1/18/26. It lacked documentation a second step TST had been completed. R20 R20's quarterly Minimum Data Set (MDS) dated 4/16/26, indicated R20 was admitted on 12/9/23, had moderately impaired cognition and diagnoses of dementia and heart failure. R20's immunization record indicated he had his first step TST on 12/9/23. It lacked documentation a second step TST had been completed. During interview on 4/30/26 at 11:06 a.m., the director of nursing (DON) stated the facility offered the Pneumovax, COVID, and Influenza vaccinations to residents upon admission. They also complete Tuberculosis screening on admission as well as the first Tuberculin Skin Test (TST) within the first week. The DON also verified R4 had his first step TST completed on 1/18/26 but did not have a 2nd step TST. R20 had his first step TST completed on 12/9/23 but did not have a 2nd step TST. A facility policy on Tuberculosis screening and prevention dated 7/31/23, indicated all new admissions without documentation of a previous positive TST or IGRA or documentation of a previous treatment for latent TB infection or TB disease, a TST will be done within 72 hours after admission if there is no documented TST result within 90 days prior to admission. If the first step is non-reactive, the second test will be administered 1-3 weeks later. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop/revise and implement policies and procedures related to TB testing and educate staff on these requirements. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21426		06/04/2026

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21475	Social Services: General Requirements CFR(s): MN Rule 4658.1005 Subp. 1 Subpart 1. General requirements. A nursing home must have an organized social services department or program to provide medically related social services to each resident. A nursing home must make referrals to or collaborate with outside resources for a resident who is in need of additional mental health, substance abuse, or financial services. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure coordination of mental health care services for 1 of 1 residents (R4) who had a referral to obtain psychiatrist services. Findings include: R4’s quarterly Minimum Data Set (MDS) dated 4/21/26, identified R4 was cognitively intact with diagnoses of borderline personality disorder, post-traumatic stress disorder and major depressive disorder. R4’s provider order dated 3/11/26, indicated psychiatry to see R4 next week, social work to get in touch with case manager to expedite transfer to a setting that would support her mental health, also seeking changes to her psychiatric medications due to her increased anxiety, and R4 requested female caregivers. R4’s care plan dated 4/21/26, indicated R4 was at risk for altered behavior related to trauma. R4 required a referral for psychiatry services, collaboration with social services and psychiatry improved social connections and minimize symptomology. R4's psychiatry provider notes were requested however were not provided. When interviewed on 4/27/26 at 2:50 p.m., R4 stated her post-traumatic stress disorder, anxiety and depression made her feel that she wasn’t heard and understood by staff. R4 used an IPAD to speak with a grief therapist but was not offered any additional therapy or mental health support. When interviewed on 4/29/26 at 11:26 a.m., nursing assistant (NA)-C stated if a resident was having behaviors, stress-based outbursts, the care was to	21475	corrected	06/04/2026

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21475	Continued from page 9 use therapeutic communication, acknowledge their concerns, respond calmly, and explain the situation without judgement, meet the resident where they are at. When interviewed on 4/30/26 at 9:46 a.m., registered nurse (RN)-B stated provider orders were to be followed. If referrals made, it was important, so all caregivers were on the same page and were able to provide cohesive care. RN-B stated she was unaware of the referral for psychiatrist for R4. When interviewed on 4/30/26 at 9:63a.m., service director (SS)-A stated the process to obtain an appointment for psychiatric services were offered on admission, as ordered and as needed. The social services department was responsible for scheduling appointments with the outside psychiatrist team. SS-A stated R4's order was not completed because social services was unaware of the order. When interviewed on 4/30/26 at 1:46 p.m., director of nursing (DON) The DON staff were expected to place provider orders into the medical record as soon as possible. The expectation was to have outside psychiatric appointments set up per orders. It was important to provide/arrange psychological counselling services to meet the needs of the resident, what was driving behaviors, provide proper care, it was a collaborative approach to the behaviors. DON further stated they were not sure why R4's order was missed and it was unknown if the R4 accepted or declined the additional services and would look into it. No further information was provided. A policy titled Trauma Care dated 2/24/23 indicated the inter-disciplinary team monitor effects of approaches to ensure they are implemented and care plans updated. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop and/or revise policies and procedures to ensure medically related social services are provided to each resident throughout their stay and upon discharge and make referrals to or collaborate with outside resources for a resident who is in need of additional mental health, substance abuse, or financial services. The facility should identify other residents who are at risk for the deficient practice, review, re-educate staff to policies and procedures, and audit services to be provided by social services for a measurable amount of time. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further	21475		06/04/2026

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21475	Continued from page 10 monitoring or compliance. TIME PERIOD FOR CORRECTION: 21 DAYS	21475		06/04/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245326	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **04/29/2026**

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 04/29/2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, The Villas at Roseville was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K0000		06/04/2026

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245326	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **04/29/2026**

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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: The Villas At Roseville is a 2-story building with no basement. The building was constructed at two different times. The original building was built in 1968 and was determined to be of Type II(222) construction. In 1992, an addition was constructed to the Northside that was determined to be of Type II(222) construction. Because the original building and the one addition are of the same type of construction, the facility was surveyed as one building. The facility has a capacity of 63 beds and had a census of 53 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		06/04/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245326	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **04/29/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT ROSEVILLE	**1000 LOVELL AVENUE , ROSEVILLE, Minnesota, 55113**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0353 SS = E Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. These deficient findings could a patterned impact on the residents within the facility. Findings include: On 04/29/2026, at 11:30 AM, it was revealed by observation that storage within the south linen closet was within 18" of the sprinkler head. An interview with the Regional Maintenance Director and the Maintenance Director verified these deficient findings at the time of discovery.	K0353	Linen under sprinkler was immediately moved so that sprinkler had at least 18 inches of clearance. All linen closets were checked to ensure linen was not stored within 18 inches of sprinkler/sprinklers had at least 18 inches of clearance. Maintenance director and housekeeping/laundry staff educated regarding mandatory 18in sprinkler clearance requirement. Colored tape has been placed on the wall in linen closets 18 inches below sprinklers to mark where linen must be under. Maintenance director will audit all three linen closets at various times to ensure that sprinklers have at least 18inches of clearance. Audits will be conducted on all three linen closets daily M-F for two weeks, then three times a week for two weeks, then once weekly for two weeks or until compliance is met.	06/04/2026