



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 20, 2026

Administrator
THE ESTATES AT ROSEVILLE LLC
2727 NORTH VICTORIA
ROSEVILLE, MN 55113

RE: CCN: 245105

Cycle Start Date: August 6, 2026

Dear Administrator:

On August 6, 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 November 6, 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 February 6, 2027 (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,

A handwritten signature in black ink, appearing to read "Melissa Poepping". The signature is fluid and cursive, with the first name "Melissa" and last name "Poepping" clearly distinguishable.

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



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August 20, 2026

Administrator

THE ESTATES AT ROSEVILLE LLC

2727 NORTH VICTORIA

ROSEVILLE, MN 55113

Re: State Nursing Home Licensing Orders

Event ID: 284F05-H1

Dear Administrator:

The above facility survey was completed on August 6, 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: 245105		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/06/2026	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT ROSEVILLE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2727 NORTH VICTORIA , 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			E0000			
	A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on (8/3/26-8/6/26) during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.						
F0000	INITIAL COMMENTS			F0000			
	On 8/3/26-8/6/26, a standard recertification survey (S5105043-0) was conducted at your facility. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.						
	The following complaints were reviewed: H51053561C (2594236) H51053562C (2570430), NO deficiencies were cited.						
	The following complaint was reviewed: H51053560C (2651819) An incidental finding was discovered and cited at F925.						
	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.						
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary			F0812	Dietary employee was educated on the appropriate use of beard restraints and how they must be worn to completely cover facial hair during food preparation and immediately went and put a beard guard on. No residents were affected by this practice.		09/23/2026
	CFR(s): 483.60(i)(1)(2)						
	§483.60(i) Food safety requirements.						
	The facility must -						
	§483.60(i)(1) - Procure food from sources approved				All culinary staff will be educated on the importance of wearing a beard guard anytime they are working		

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

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F0812 SS = F	Continued from page 1 or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the proper use of beard restraints during food preparation. This practice had the potential to affect all 134 residents who received food from the kitchen. Findings include: During observation and interview on 8/5/26 at 9:33 a.m., cook (C-A) prepared carrots without wearing a beard restraint. C-A acknowledged knowing a beard restraint was required, stated management had previously instructed him to wear one, and acknowledged having been previously counseled for not wearing a beard restraint. During an interview on 8/5/26 at 9:52 a.m., the assistant director of culinary services (ADCS) stated dietary staff are expected to wear hairnets or beard restraints whenever preparing food. The ADCS confirmed C-A should have been wearing a beard restraint while preparing food. During an interview on 8/6/26 at 12:45 p.m., the administrator stated employees are expected to keep their hair covered while preparing food. A facility dietary policy dated 10/2017, directed staff to wear hair restraints, including beard restraints, while in kitchen and food preparation areas, in accordance with Minnesota Department of Health (MDH) guidelines, to prevent hair from contacting food.			F0812	Continued from page 1 with food or in the kitchen areas. Audits will be done by dietary manager and/or designee of culinary staff wearing beard guards weekly x4 weeks and monthly x2 months to ensure compliance. Findings will be brought to monthly QAPI for input on the need to increase, decrease, or discontinue the audits. Date of compliance 9/23/26		09/23/2026

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F0925 SS = F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to implement effective and timely pest control measures to reduce and/or eliminate a roach infestation for 1 of 1 resident (R76) reviewed for environment. This had the potential to affect all 142 residents who resided in the facility. Findings include: R76's comprehensive Minimum Data Set (MDS) dated 5/19/26 identified R76 had diagnoses which included congestive heart failure (CHF), pulmonary edema, hyperlipidemia, and thyroid disorder. In addition, R76's MDS identified she was cognitively intact. During an interview on 8/3/26 at 11:02 a.m., R76 stated she had previously seen cockroaches in the dining room. R76 stated she had even caught some of the cockroaches about a month ago in the dining room while staff were present. R76 stated she has been seeing cockroaches in the dining room for the last year. During an observation and interview on 8/4/26 at 12:26 p.m., a roach measuring approximately 1/2" long was observed crawling across the floor by the sink in the long-term care dining room. Registered nurse (RN)-B stepped on the roach and used a paper towel to pick it up and throw it in the trash. When asked if the insect was a roach or if she had seen roaches in the dining room, RN-B shrugged and stated, ""Well, you know, people keep food in their rooms". During an observation on 8/4/26 at 12:50 p.m., no residents or staff were noted to be in the dining room after the lunch meal was cleared. The floor of the dining room was observed to have noodles, lettuce pieces, and carrot bits on the floor. During an observation on 8/4/26 at 12:52 p.m., inspection of the cabinets under the sink area in the dining room revealed a clear plastic bin with no cover on the lower shelf which contained a covered plate with a meal from lunch. A quarter-sized hole was noted in the top of the plate cover.			F0925	Pest control measures were initiated to reduce and eliminate roach sitings and fruit flies. Inspection, treatment, environmental cleaning, and monitoring. Plate cover with hole was removed and tossed. There have been no roach sitings in the kitchen or dining areas as day of survey. Food crumbs were cleaned by heater and under the steam table. Floor was cleaned behind refrigerators. Maintenance Director will remove countertop in LTC dining room and replace with new. In addition, food was immediately removed from the dining room cabinets. Pest control inspections and monitoring will be completed weekly to ensure the environment is safe and homelike for all residents. Staff will be educated not to store food in cabinets. Audits will be completed of pest control measures and cleanliness weekly x4 weeks and monthly x2 to ensure compliance. Results will be brought to monthly QAPI for input until roach infestation has been eliminated. Date of compliance 9/23/26		09/23/2026

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F0925 SS = F	Continued from page 3 Condensation was noted inside the cover. A roach measuring approximately 1/2" in length was observed crawling alongside the plate and then out of the cabinet. The floor near the adjacent refrigerator and the bases of the lower cabinets were characterized by black buildup and crumb-like debris. During an observation and interview on 8/4/26 at 3:50 p.m., the plate previously observed in the cabinet in the dining room was noted to be on the counter. Dietary aide (DA)-B stated that roaches were frequently seen in the kitchen and sometimes in the dining room. She stated that fruit fly traps were also everywhere. DA-B stated that they cleaned the counters and mopped the floors every night in the kitchen, but the roaches still came back. During an observation and interview on 8/4/26 at 3:57 p.m., a napkin, spoon and Cheerio were observed under the refrigerator in the dining room. A 6-inch long red-colored buildup was also noted under the refrigerator. Caulking was observed to be missing from around the sink and a one-foot-long section of the countertop backsplash was noted to be pulled away from the wall by 1/2". The countertop was warped and black discoloration was observed around the sink. The bottom of the cabinet underneath the sink was marked with brown coffee-colored staining. Two open boxes of cereal were found on the top shelf of one of the cabinets over the sink with the inner plastic bags unsealed and open to air. A second covered plate with remains from lunch (carrots and noodles) was found in an upper cabinet to the left of sink. When asked about this, DA-B stated, "the nurses' aides hide things". She said that if the nurses' aides work a second shift, they get a free meal and so they will sometimes store meals in the cabinets in the dining room. During an observation and interview on 8/5/26 at 7:25 a.m., Housekeeper(H)-A stated that he had only seen one roach lately and had mostly been seeing fruit flies. He stated housekeeping was responsible for cleaning and mopping the floors after meals. H-A pulled out the refrigerator in the dining room and stated there was old food under the fridge and it didn't look like housekeeping had cleaned under there in a while. He also said they should be checking this every shift. During an observation on 8/5/26 at 7:27 a.m., two fruit flies were noted in the sink area. Brown-colored food crumbs were noted along the baseboard near the heater and under the steam table. Three bits of			F0925			09/23/2026

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F0925 SS = F	Continued from page 4 wet lettuce were found on the floor near the steam table. H-A was observed cleaning behind the refrigerator. He stated, "Wow, there is a lot of stuff back here". During an interview on 8/5/26 at 7:43 a.m., the Director of Maintenance (DOM) confirmed that there was significant wearing of the laminate of the countertop around the sink in the dining room and that the caulking was missing. He also stated that he has been trying to obtain a new countertop for the past year. He mentioned that the facility recently switched from one pest control company to another and that the facility did have a pest control binder available for review. During an interview on 8/5/26 at 10:12 a.m., DA-A stated that she had only noticed roaches in the last year. She stated that she thought they had been spraying, but “it doesn't seem to be doing the trick”. She said cleanliness in general was an issue in the dining room. Dirty dishes with food often get left on the counter. At night, there was no one there to monitor. When asked, DA-A stated that no education has been provided to staff on roach prevention and mitigation strategies, but she knew staff should not be leaving food in the cupboards and on the countertops and that housekeeping should be cleaning under the refrigerator and along the baseboards. During an interview on 8/5/25 at 12:30 p.m., the area supervisor for the new pest control company, stated that he was a brand-new vendor and was contacted by the facility on 8/4/26. His plan was to "hit it hard". He stated that the first time they were at the facility was yesterday and he laid several traps for insects. The area supervisor stated that they now have a plan going forward to help the facility with their pest control issue, but because they need to use low toxicity methods, it may take some time to really minimize the presence of insects. The DOM, who was also present at this time, stated they had previously used a different pest control company, but they were unhappy with those services. An administrator for another associated facility stated she believed it was a couple weeks ago that they had consulted the pest control company. All three personnel were notified of the observations in the dining room related to plates of food being stored in the cupboards. The DOM stated he was unaware of this issue and would have to look into it. He further stated that he believed that food in the cabinets could worsen their pest control issues and staff shouldn't be doing that.			F0925			09/23/2026

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F0925 SS = F	Continued from page 5 Per an email correspondence from the Administrator on 8/5/26 at 1:30 p.m., “We were with a pest control company for a long time but had to change to different pest control company a month ago because we were having issues with them coming out consistently”. During an interview on 8/6/26 at 8:46 a.m., the Director of Housekeeping (DOH) stated that the daily cleaning of the four dining rooms in the facility included floors, tables/chairs, and sinks/countertops. He said housekeeping staff also checked the refrigerators for spills. The expectation was that the floors underneath any mobile equipment (e.g., steam tables) would be cleaned daily. Floors were supposed to be auto-scrubbed after the evening meal. Weekly deep cleaning of the dining rooms was expected to include cabinet interiors, refrigerator tops, and windowsills. The DOH stated he has not seen any roaches or noticed any other bugs in the facility. He expected his housekeeping staff to report any issues with pests to him, and he would forward that information to the DOM. During an interview on 8/6/26 at 10:45 a.m., the Director of Culinary Services (DCS) stated that he had maybe seen one or two roaches in the kitchen. He would expect that kitchen staff would notify him if they saw any roaches and he would then forward that information to the DOM. A Service Report dated 2/2/26 from the initial pest control company provided by the facility indicated that two units for straggler roaches had been spotted. Due to it being in memory care, glue boards were advised against. The document stated that the DOM has baited these rooms and all around for any roach issues. A second Service Report dated 3/23/26 provided by the facility indicated no pest activity was noted in the facility. Additional documentation regarding pest control measures taken by the facility in the last three months was requested but not received. Facility policies on maintenance and pest control were also requested but not received.			F0925			09/23/2026
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications			F0554	Residents R59’s ability to self-administer hydrocortisone cream and miconazole nitrate antifungal power was immediately assessed, documented and care plan has been updated. There were no adverse affects because of this practice.		09/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245105		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/06/2026	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT ROSEVILLE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2727 NORTH VICTORIA , ROSEVILLE, Minnesota, 55113			
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F0554 SS = D	Continued from page 6 if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure self-administration of medications was assessed and determined to be appropriate for 1 of 1 resident (R59) reviewed for the self-administration of medications. Findings include: R59's comprehensive Minimum Data Set dated 07/17/26, indicated R59 was cognitively intact and required varying levels of assistance with activities of daily living and mobility. R59 was occasionally incontinent of urine and required partial to moderate assistance with toileting. Diagnoses included bilateral subdural hematomas (bleeding between the brain and skull) related to a fall, congestive heart failure, hypertension (high blood pressure), atrial fibrillation (irregular heartbeat), and chronic kidney disease, R59's care plan dated 7/30/26, failed to identify interventions related to bedside storage or self-administration of topical medications. R59's medical record, reviewed on 8/3/26, lacked evidence of provider orders for 1% hydrocortisone cream and 2% miconazole nitrate powder. Record review also lacked evidence of an assessment to determine whether it was appropriate for R59 to self-administer these medications. During observation and interview on 8/3/2026 at 11:10 a.m., an open container of 1% hydrocortisone cream and a bottle of 2% miconazole nitrate antifungal powder were observed on R59's bedside table. The medications lacked pharmacy prescription labels. R59 stated that the cream and "crotch powder" were given to him by staff, and that he was allowed to use these as needed. During observation and interview on 8/4/2026 at 9:22 a.m., the container of 1% hydrocortisone cream and bottle of 2% miconazole nitrate powder were again observed on R59's bedside table. R59 reiterated that staff provided these and he could use both when he wanted. During interview on 8/5/2026 at 10:30 a.m., nursing assistant (NA)-B stated that she had seen the containers of 1% hydrocortisone cream and 2%			F0554	Continued from page 6 All residents who self-administer medications/topical creams have been reviewed to ensure a current assessment has been completed and supports their ability to safely administer medications. Care plans have been updated. Education provided to licensed nurses regarding requirements for medication self-administration assessments. DON/designee will audit self-administration assessments weekly for four weeks and monthly x2 and bring findings to monthly QAPI. Date of compliance 9/23/26		09/23/2026

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F0554 SS = D	Continued from page 7 miconazole nitrate in R59's room, but she did not know how long they had been there. NA-B stated that NAs were supposed to be helping R59 apply these medications, but R59 preferred to do this himself and refused to allow staff to assist. NA-B also stated that R59 refused to allow staff to remove these medications from the room after self-administration. NA-B stated that she thought the medications were for R59's skin due to frequent episodes of incontinence, but she was unsure about the status of R59's skin as she had not seen it. During interview on 8/5/2026 at 10:55 a.m., licensed practical nurse (LPN)-C stated that orders should be in the system for all medications, including those that are topically administered. LPN-C did not know if R59 had been assessed to determine if it was appropriate for him to self-administer medications. During observation and interview on 8/5/2026 at 11:05 a.m., LPN-B stated that the 1% hydrocortisone cream should not be in R59's room. LPN-B removed the 1% hydrocortisone cream from R59's room and told R59 that it needed to be kept in the medication cart. LPN-B examined the container of 2% miconazole nitrate and stated that this particular brand was "in-house". LPN-B exited R59's room without removing the 2% miconazole nitrate. During subsequent interview on 8/5/26 at 11:15 a.m., LPN-B stated that orders should be in the system for both the hydrocortisone cream and the antifungal powder. After reviewing the orders, LPN-B stated that there was an order for nystatin powder, but no orders for the 1% hydrocortisone cream or the 2% miconazole nitrate. During third interview on 8/5/2026 at 12:29 p.m., LPN-B stated that the orders for 1% hydrocortisone cream and 2% miconazole powder may be part of the standing house orders for skin and wound management. She stated that she would inform the survey team if she was able to obtain additional clarification. LPN-B also stated that a self-administered medication form should be completed at least annually for every patient who is self-administering medications. She stated that there was not a completed self-administration form for R59 and therefore, R59 should not be self-administering anything. On 8/5/26, a review of the facility's document Standing Orders for Nursing Facilities and Skilled Nursing Facilities signed by a provider on 01/07/26, did not list orders for 1% hydrocortisone cream or 2% miconazole.			F0554			09/23/2026

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F0554 SS = D	Continued from page 8 During interview on 8/6/2026 at 7:55 a.m., registered nurse (RN)-A stated that she was not aware of any form or assessment that needed to be completed for the self-administration of medications. She stated that residents were generally allowed to have lotions, creams, and antifungal powder at bedside. During interview on 8/6/2026 at 8:02 a.m., LPN-D stated that she thought there was a form for the self-administration of medications, but she was unable to locate it within the facility's electronic medical record system. LPN-D then stated that she did not know where the form was or when it should be filled out. During interview on 8/6/2026 at 11:50 a.m., the Director of Nursing (DON) stated that the expectation was that all residents be assessed prior to being able to self-administer medications. She also stated that the expectation was for provider orders to be in the system for any self-administered medications. The facility's policy titled Medication and Treatment Orders Policy dated 8/2021, stated that a written prescriber's order must be obtained for any treatment or medication administration provided to a client. A policy regarding the self-administration of medications was requested but not received. A copy of the facility's form titled MHM Self Administration of Medication Evaluation dated 2013, indicated the parameters that must be satisfied if a resident requests to self-administer medication.			F0554			09/23/2026
F0638 SS = D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure quarterly Minimum Data Set (MDS) was completed in a timely manner for 1 of 1 residents (R39) reviewed for MDS completion. Findings include: The Centers for Medicare & Medicaid Services (CMS)			F0638	The quarterly assessment was not completed within the required timeframe because the systems assessment calendar reset and the assessment was not identified as due at the time but was found later and completed. Residents R39 MDS was completed and submitted. The MDS schedule was reviewed to ensure all future assessments are completed in a timely manner. The resident was not affected by this practice. An audit was conducted of quarterly MDS assessments and to make sure they are being completed timely. Any identified areas will be corrected. Education was provided to all licensed nursing staff and MDS staff, to ensure timely completion for quarterly MDS and to check calendar. MDS coordinator/DON will audit quarterly MDS		09/23/2026

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F0638 SS = D	Continued from page 9 Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2025, identified a Quarterly Assessment is a non-comprehensive assessment required no later than 92 days after the previous assessment of any type to monitor gradual changes in the resident's condition between comprehensive assessments. R39's Face Sheet located in the facility's electronic medical record (EMR) indicated an initial admission date of 3/18/24. R39's MDS dated 7/23/26, identified moderate cognitive impairment and diagnoses that included Alzheimer's disease, dementia with agitation, type 2 diabetes with nerve damage, and high blood pressure. During document review on 8/6/26, R39's MDS assessments identified the previous quarterly assessment was dated 3/24/26. The next quarterly assessment was due by 6/24/26; however, it was not completed until 7/23/26, 29 days beyond the required timeframe. During an interview on 8/6/26, at 12:36 p.m., the director of nursing (DON) stated quarterly MDS assessments are completed every three months in accordance with the RAI schedule and are important for monitoring resident status and quality outcomes. The DON stated the facility uses PointClickCare (PCC) to track upcoming MDS assessments and acknowledged R39's quarterly assessment was not completed within the required timeframe because the facility's assessment calendar reset and the assessment was not identified as due. The DON confirmed the facility follows the RAI Manual when completing MDS assessments.			F0638	Continued from page 9 weekly for four weeks and monthly x2 and bring findings to monthly QAPI. Date of compliance 9/23/26		09/23/2026
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing,			F0755	The resident's medication orders were reviewed against the MAR and current provider orders. Any discrepancies were corrected and 2% miconazole nitrate powder was removed from the room and resident was told why they can't have that in their room without orders and assessment, and staff were educated to follow current provider orders and accurately document medication administration. All residents' current medication orders and MARs were reviewed to ensure medication administration was correctly documented for all residents and that orders need be in the system for all medications, including any topicals and/or self-administered medications.		09/23/2026

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F0755 SS = D	Continued from page 10 and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to follow provider orders for medication and failed to ensure medication administration was correctly documented for 1 of 1 resident (R59) reviewed for medication administration. Findings include: R59's comprehensive Minimum Data Set dated 7/28/26, indicated R59 was cognitively intact and independent with eating and upper body dressing. R59 required moderate assistance with lower body dressing and toileting. He used a wheelchair for mobility. Diagnoses included bilateral subdural hematomas (bleeding between the brain and skull) related to a fall, congestive heart failure, and chronic kidney disease. R59's MDS indicated he was occasionally incontinent of urine. R59's nursing progress note dated 7/24/26 at 12:57 p.m., indicated a message was sent to the provider informing them of redness to the resident's groin upon skin inspection yesterday related to moisture. The resident wore a pull up and was incontinent at times with refusal of care noted. R59's provider order dated 7/25/26, specified nystatin external powder 100000 Unit/GM to be applied to the groin topically three times a day for 14 days for candidiasis related to rash and other			F0755	Continued from page 10 Audit will be completed on medication administration weekly x4 and monthly x2 to ensure compliance. Results will be brought to monthly QAPI for input. Date of compliance 9/23/26		09/23/2026

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F0755 SS = D	Continued from page 11 nonspecific skin eruption. R59's medical record lacked evidence of a provider order for 2% miconazole nitrate powder. During observation and interview on 8/3/26 at 11:10 a.m., a container of 2% miconazole nitrate antifungal powder was observed on R59's bedside table. The medication lacked a pharmacy prescription label. R59 stated the "crotch powder" was given to him by staff, and he was allowed to use it as needed. During observation and interview on 8/4/26 at 9:22 a.m., the container of 2% miconazole nitrate powder was again observed on R59's bedside table. R59 reiterated that staff had provided this and he could use the powder whenever he wanted. During an interview on 8/5/26 at 10:30 a.m., nursing assistant (NA)-B stated she had seen the container of 2% miconazole nitrate in R59's room but did not know how long it had been there. NA-B stated that NAs were supposed to be helping R59 apply this medication, but R59 preferred to do this himself and refused to allow staff to assist. NA-B also stated R59 refused to allow staff to remove this medication from the room after self-administration. NA-B stated she thought the medication was for R59's skin due to frequent episodes of incontinence, but she was unsure about the status of R59's skin as she had not seen it. During an interview on 8/5/26 at 10:55 a.m., licensed practical nurse (LPN)-C stated orders should be in the system for all medications, including any topicals and/or self-administered medications. During observation and interview on 8/5/26 at 11:05 a.m., LPN-B examined the container of 2% miconazole nitrate and stated this brand was "in-house". LPN-B exited R59's room without removing the 2% miconazole nitrate. During a subsequent interview on 8/5/26 at 11:15 a.m., LPN-B stated orders should be in the system for the antifungal powder. After reviewing the orders, LPN-B stated there was an order for nystatin powder but no order for 2% miconazole nitrate powder. A review of R59's medication administration record (MAR) on 8/5/26, indicated the nystatin powder was administered earlier that morning by trained medical assistant (TMA)-A. During an interview on 8/5/26 at 12:12 p.m., R59			F0755			09/23/2026

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F0755 SS = D	Continued from page 12 stated he had not administered the 2% miconazole nitrate or any other powder today and staff had not administered anything either. R59 stated again that he applied this himself. When asked if staff had ever assessed him for the use of this powder or provided any education on it, he stated he did not remember that. During an interview on 8/5/26 at 12:19 p.m., TMA-A stated she was responsible for administering R59's medications. TMA-A pulled the bottle of nystatin powder she typically administered to R59 from the medication cart. She confirmed this was the correct medication listed in the order set. TMA-A stated the nystatin powder had remained in the cart this morning and was not given. She stated it was ordered to be given three times per day. TMA-A stated R59 told her he would do it later. She said she charted it as being administered, as R59 later told her he had done it himself. TMA-A then pulled a separate bottle of 2% miconazole nitrate from the medication cart which was identical to the bottle of 2% miconazole nitrate in R59's room. When asked to examine the bottle of 2% miconazole nitrate, TMA-A stated she could not really read the label, but she thought this was the same medication as the nystatin. During an interview on 8/5/26 at 12:29 p.m., LPN-B stated the orders for the 2% miconazole nitrate powder might be part of the standing house orders for skin and wound management. She stated she would inform the survey team if she was able to obtain additional clarification. On 8/5/26, a review of the facility's document Standing Orders for Nursing Facilities and Skilled Nursing Facilities signed by a provider on 1/7/26, did not list orders for 2% miconazole nitrate. During an interview on 8/6/26 at 7:55 a.m., registered nurse (RN)-A stated residents were generally allowed to have lotions, creams, and antifungal powder at bedside and orders should be in the system for all medications. During an interview on 8/6/26 at 11:50 a.m., the Director of Nursing (DON) stated the expectation was for provider orders to be in the system for all medications, including those that are self-administered and/or kept at bedside. She stated no medications should be administered without a provider order. She also stated the expectation was for staff to document medication administration accurately in the chart.			F0755			09/23/2026

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F0755 SS = D	Continued from page 13 The facility's policy titled Medication and Treatment Orders Policy dated 8/2021, indicated a written prescriber's order must be obtained for any treatment or medication administration provided to a client. A policy regarding the self-administration of medications was requested but not received.			F0755			09/23/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:			F0880	R31 and R83 have no new infections noted and are at baseline. R31 remains on contact precautions. R83 remains on contact precautions with no new signs or symptoms of infection for both residents. All residents on precautions, EBP and contact precautions have the ability to be affected by this practice. Nursing staff will be educated on infection prevention practices and appropriate PPE use. Nursing staff will be educated on hand hygiene and donning and doffing of PPE upon entry and exit. Audits will be completed on staff providing care to residents requiring PPE to ensure appropriate donning and doffing is being completed. Audits will be completed weekly for hand hygiene. Audits will be completed by DON or designee weekly x4 and monthly 2x. Findings will be brought to monthly QAPI and corrective actions will be provided as needed.		09/23/2026

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F0880 SS = D	Continued from page 14 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff followed proper personal protective equipment was used for 2 of 3 residents (R31, R83) observed who required infection control precautions. Findings include: R31 R31's comprehensive Minimum Data Set (MDS) assessment dated 8/1/26, was in process and was unavailable for review. R31's electronic medical record (EMR), reviewed on 8/1/26, indicated diagnoses that included acute pancreatitis (inflammation of the pancreas), acute pyelonephritis (kidney infection), and severe sepsis with septic shock. R31's provider orders dated 8/1/26, indicated the			F0880			09/23/2026

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F0880 SS = D	Continued from page 15 resident was on contact precautions for a methicillin-resistant Staphylococcus aureus (MRSA) infection (an antibiotic-resistant infection that spreads through contact) and staff were instructed to follow contact precaution procedures. R31's care plan dated 8/1/26, indicated the resident required contact isolation precautions. The care plan instructed all staff to follow isolation precautions, implement infection control precautions according to protocol, and ensure a contact precaution sign was posted on the resident's door. During an observation on 8/4/26 at 8:35 a.m., Licensed Practical Nurse (LPN)-E entered R31's room without performing hand hygiene or donning personal protective equipment (PPE). LPN-E removed the resident's water pitcher, filled it at the ice and water machine, returned it to the resident's room, and did not perform hand hygiene or don PPE before re-entering the room. During an observation on 8/4/26 at 8:37 a.m., Nursing Assistant (NA)-D entered R31's room without performing hand hygiene or donning PPE. NA-D delivered the resident's breakfast tray, placed it on the bedside table, exited the room, and did not perform hand hygiene upon leaving. During an observation on 8/6/26 at 8:48 a.m., LPN-D entered R31's room with a portable vital signs machine without performing hand hygiene or donning PPE. LPN-D obtained the resident's vital signs and administered medications. Upon exiting the room, LPN-D did not perform hand hygiene or disinfect the portable vital signs machine before taking it into another area. During an interview on 8/4/26 at 8:51 a.m., NA-D verified a contact precaution sign was visibly posted on the door to R31's room. NA-D acknowledged she had not followed the required contact precaution procedures. She stated PPE supply bins were in the hallway but were not positioned outside R31's room. NA-D confirmed she should have performed hand hygiene and donned PPE before entering the room. During an interview on 8/4/26 at 8:54 a.m., LPN-E acknowledged she had not followed the required contact precaution procedures despite the contact precaution sign being visibly posted on R31's door. LPN-E confirmed she had not performed hand hygiene or donned PPE. LPN-E stated staff were expected to follow each resident's care plan because it contained resident-specific care instructions. She further stated staff were expected			F0880			09/23/2026

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F0880 SS = D	Continued from page 16 to follow provider orders because they defined the treatments required for each resident. During an interview on 8/6/26 at 10:30 a.m., LPN-D stated all staff were expected to follow the contact precaution instructions posted on the sign outside R31's room. LPN-D acknowledged she had not followed the required contact precautions and had failed to disinfect equipment when leaving the room. LPN-D stated the purpose of contact precautions was to minimize the spread of infection. R83 R83's comprehensive MDS assessment dated 7/26/26 indicated he was cognitively intact and required maximum assistance with personal hygiene, dressing, and oral hygiene. Diagnoses included intracranial abscess and granuloma (inflammatory lesions in the brain) and sepsis due to methicillin-susceptible Staphylococcus aureus (MSSA). R83's provider orders dated 7/27/26 indicated the resident was on contact precautions. R83's care plan dated 7/28/26 indicated contact precautions were required due to the resident's current infection. During an observation on 8/5/26 at 2:16 p.m., Nursing Assistant (NA)-E entered R83's room without performing hand hygiene or donning personal protective equipment (PPE) required for contact precautions. NA-E obtained the resident's vital signs and disinfected the vital signs machine after leaving the room. During an observation on 8/6/26 at 9:22 a.m., Licensed Practical Nurse (LPN)-D entered R83's room without performing hand hygiene or donning PPE. LPN-D administered the resident's medications and exited the room without performing hand hygiene. During an interview on 8/5/26 at 2:26 p.m., NA-E stated contact precautions were only necessary when providing direct resident care. NA-E acknowledged she had not performed hand hygiene or utilized PPE before entering the room. NA-E confirmed a contact precaution sign was visibly posted on the resident's door. After reviewing the sign, NA-E stated she should have donned PPE and performed hand hygiene before entering R83's room.			F0880			09/23/2026

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F0880 SS = D	Continued from page 17 During an interview on 8/6/26 at 10:00 a.m., Registered Nurse (RN)-C stated all staff were expected to follow the contact precaution instructions posted on the resident's door. RN-C stated PPE was to be donned before entering the resident's room. RN-C further stated it was important to follow provider orders and the care plan to ensure resident safety and provide appropriate individualized therapeutic care. During an interview on 8/6/26 at 2:26 p.m., LPN-D acknowledged she had not worn PPE before entering R83's room. LPN-D stated that after reading the contact precaution sign, she recognized she should have followed the posted instructions by donning PPE and performing hand hygiene before entering the room. LPN-D stated contact precautions were used to reduce the risk of spreading infections. During an interview on 8/6/26 at 10:39 a.m., the Regional Nursing Consultant (RNC) stated every staff member was expected to follow all instructions posted on the contact precaution signage and understand the rationale for the precautions to help prevent the spread of infections. The RNC further stated staff received education on the different transmission-based precautions (TBP) during new hire orientation, annual skills fairs, annual training, and as needed. During an interview on 8/6/26 at 10:46 a.m., the Director of Nursing (DON) stated staff were expected to follow transmission-based precaution (TBP) protocols. The DON further stated staff were expected to follow provider orders as part of their scope of practice and provide the care necessary for each individual resident. The DON stated care plans were expected to be followed by each discipline to ensure residents received individualized care necessary for their well-being. A policy titled "Contact Precautions," dated 7/31/23, directed staff to implement contact precautions to prevent the transmission of infectious agents, including epidemiologically important microorganisms spread through direct or indirect contact with the resident or the resident's environment. The policy instructed staff to perform hand hygiene, noting that multidrug-resistant organisms (MDROs) were primarily transmitted by contaminated hands of healthcare personnel. The policy further stated the single most effective method of reducing the transmission of MDROs was hand antisepsis before and after resident contact, including after glove removal. Additionally, the policy directed staff to don gloves and a gown upon			F0880			09/23/2026

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F0880 SS = D	Continued from page 18 entering the resident's room and to remove the gown and perform hand hygiene before leaving the resident care area.			F0880			09/23/2026
F0921 SS = D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident rooms were kept in good working condition for 1 of 1 resident (R45) reviewed for a safe, clean, comfortable, and homelike environment. Findings include: R45's quarterly Minimum Data Set (MDS) dated 7/28/26, identified R45 was severely cognitively impaired. R45's diagnoses included Alzheimer's dementia, chronic kidney disease, hypertension, and depression. During an observation on 8/3/26 at 2:50 p.m., R45 was lying in bed. The bed was positioned with the long side against the wall. Next to R45's bed at the height of the bed, the wallpaper seam was loose to the wall light and approximately 2 feet of the wallpaper was peeling away from the seam exposing a beige wall and some loose white matter on the wall where the wallpaper had been affixed. During an interview on 8/5/26 at 11:36 a.m., the maintenance director (M)-A observed R45's room and stated the wallpaper needed to be repaired. M-A stated loose wallpaper may be a safety issue due to the possibility of lead paint in buildings but they did not believe the facility had lead paint. They stated the normal process was for staff to put in a maintenance work order for repairs. During an interview on 8/5/26 at 11:46 a.m., nursing assistant (NA)-A stated the wallpaper in R45's room had been damaged for a few months, and they had observed R45 pulling at the wallpaper and removing pieces. NA-A stated they let the nurse know when repairs are needed and the nurse enters a			F0921	R45's room was inspected and the wallpaper will be repaired to ensure a homelike environment. The resident was not affected by this practice. Resident rooms on Victoria unit with wallpaper will be inspected to identify any peeling and any identified wallpapers will be replaced or repaired. Maintenance and nursing staff will be educated on reporting environmental concerns including peeling wallpaper and to report concerns to administration and maintenance for correction or submit via TELS system. Maintenance will audit resident rooms weekly 4x weeks and monthly x2 to ensure compliance and address identified concerns. Findings will be brought to QAPI Date of compliance is 9/23/26		09/23/2026

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F0921 SS = D	Continued from page 19 maintenance request on the computer. During an interview on 8/6/26 at 8:39 a.m., licensed practical nurse (LPN)-A stated they had not been told of the wallpaper damage in R45's room and they were not aware that R45 was pulling on the wallpaper. LPN-A was concerned that R45 removed pieces but stated R45 did not usually put things in their mouth. LPN-A expected staff to let nurses know when repairs were needed so a maintenance request could be entered. LPN-A stated they do not have a process to go room to room looking at the walls. During an interview on 8/6/26 at 9:31 a.m., interim director of nursing (DON) and regional nursing consultant (RNC) stated resident rooms should not have peeling wallpaper. RNC stated they needed to make sure the resident could not rip the wallpaper off and expressed a concern that anything nonedible could be a problem. RNC stated M-A informed them of R45's wallpaper, had secured the wallpaper with tape, and was working with nursing to make the room available for the painter. Maintenance work orders for R45's room were reviewed for 1/1/26 through 8/5/26. No maintenance requests were placed for wallpaper repair in R45's room. Facility maintenance policy was requested but not received.			F0921			09/23/2026

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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 8/3/26-8/6/26 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: H51053561C (2594236) H51053562C (2570430), NO licensing orders were issued. H51053560C (2651819)			20000			

Office of Primary Care and Health Systems Management

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

Minnesota Department of Health

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20000	Continued from page 1 with a related deficiency. 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				
21390	Infection Control CFR(s): MN Rule 4658.0800 Subp. 4 A-I Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk		21390			09/23/2026	

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21390	Continued from page 2 of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff followed proper personal protective equipment was used for 2 of 3 residents (R31, R83) observed who required infection control precautions. Findings include: R31 R31's comprehensive Minimum Data Set (MDS) assessment dated 8/1/26, was in process and was unavailable for review. R31's electronic medical record (EMR), reviewed on 8/1/26, indicated diagnoses that included acute pancreatitis (inflammation of the pancreas), acute pyelonephritis (kidney infection), and severe sepsis with septic shock. R31's provider orders dated 8/1/26, indicated the resident was on contact precautions for a methicillin-resistant Staphylococcus aureus (MRSA) infection (an antibiotic-resistant infection that spreads through contact) and staff were instructed to follow contact precaution procedures. R31's care plan dated 8/1/26, indicated the resident			21390			09/23/2026

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21390	Continued from page 3 required contact isolation precautions. The care plan instructed all staff to follow isolation precautions, implement infection control precautions according to protocol, and ensure a contact precaution sign was posted on the resident's door. During an observation on 8/4/26 at 8:35 a.m., Licensed Practical Nurse (LPN)-E entered R31's room without performing hand hygiene or donning personal protective equipment (PPE). LPN-E removed the resident's water pitcher, filled it at the ice and water machine, returned it to the resident's room, and did not perform hand hygiene or don PPE before re-entering the room. During an observation on 8/4/26 at 8:37 a.m., Nursing Assistant (NA)-D entered R31's room without performing hand hygiene or donning PPE. NA-D delivered the resident's breakfast tray, placed it on the bedside table, exited the room, and did not perform hand hygiene upon leaving. During an observation on 8/6/26 at 8:48 a.m., LPN-D entered R31's room with a portable vital signs machine without performing hand hygiene or donning PPE. LPN-D obtained the resident's vital signs and administered medications. Upon exiting the room, LPN-D did not perform hand hygiene or disinfect the portable vital signs machine before taking it into another area. During an interview on 8/4/26 at 8:51 a.m., NA-D verified a contact precaution sign was visibly posted on the door to R31's room. NA-D acknowledged she had not followed the required contact precaution procedures. She stated PPE supply bins were in the hallway but were not positioned outside R31's room. NA-D confirmed she should have performed hand hygiene and donned PPE before entering the room. During an interview on 8/4/26 at 8:54 a.m., LPN-E acknowledged she had not followed the required contact precaution procedures despite the contact precaution sign being visibly posted on R31's door. LPN-E confirmed she had not performed hand hygiene or donned PPE. LPN-E stated staff were expected to follow each resident's care plan because it contained resident-specific care instructions. She further stated staff were expected to follow provider orders because they defined the treatments required for each resident. During an interview on 8/6/26 at 10:30 a.m., LPN-D stated all staff were expected to follow the contact precaution instructions posted on the sign outside R31's room. LPN-D acknowledged she had not			21390			09/23/2026

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21390	Continued from page 4 followed the required contact precautions and had failed to disinfect equipment when leaving the room. LPN-D stated the purpose of contact precautions was to minimize the spread of infection. R83 R83's comprehensive MDS assessment dated 7/26/26 indicated he was cognitively intact and required maximum assistance with personal hygiene, dressing, and oral hygiene. Diagnoses included intracranial abscess and granuloma (inflammatory lesions in the brain) and sepsis due to methicillin-susceptible Staphylococcus aureus (MSSA). R83's provider orders dated 7/27/26 indicated the resident was on contact precautions. R83's care plan dated 7/28/26 indicated contact precautions were required due to the resident's current infection. During an observation on 8/5/26 at 2:16 p.m., Nursing Assistant (NA)-E entered R83's room without performing hand hygiene or donning personal protective equipment (PPE) required for contact precautions. NA-E obtained the resident's vital signs and disinfected the vital signs machine after leaving the room. During an observation on 8/6/26 at 9:22 a.m., Licensed Practical Nurse (LPN)-D entered R83's room without performing hand hygiene or donning PPE. LPN-D administered the resident's medications and exited the room without performing hand hygiene. During an interview on 8/5/26 at 2:26 p.m., NA-E stated contact precautions were only necessary when providing direct resident care. NA-E acknowledged she had not performed hand hygiene or utilized PPE before entering the room. NA-E confirmed a contact precaution sign was visibly posted on the resident's door. After reviewing the sign, NA-E stated she should have donned PPE and performed hand hygiene before entering R83's room. During an interview on 8/6/26 at 10:00 a.m., Registered Nurse (RN)-C stated all staff were expected to follow the contact precaution instructions posted on the resident's door. RN-C stated PPE was to be donned before entering the resident's room. RN-C further stated it was important to follow provider orders and the care plan			21390			09/23/2026

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21390	Continued from page 5 to ensure resident safety and provide appropriate individualized therapeutic care. During an interview on 8/6/26 at 2:26 p.m., LPN-D acknowledged she had not worn PPE before entering R83's room. LPN-D stated that after reading the contact precaution sign, she recognized she should have followed the posted instructions by donning PPE and performing hand hygiene before entering the room. LPN-D stated contact precautions were used to reduce the risk of spreading infections. During an interview on 8/6/26 at 10:39 a.m., the Regional Nursing Consultant (RNC) stated every staff member was expected to follow all instructions posted on the contact precaution signage and understand the rationale for the precautions to help prevent the spread of infections. The RNC further stated staff received education on the different transmission-based precautions (TBP) during new hire orientation, annual skills fairs, annual training, and as needed. During an interview on 8/6/26 at 10:46 a.m., the Director of Nursing (DON) stated staff were expected to follow transmission-based precaution (TBP) protocols. The DON further stated staff were expected to follow provider orders as part of their scope of practice and provide the care necessary for each individual resident. The DON stated care plans were expected to be followed by each discipline to ensure residents received individualized care necessary for their well-being. A policy titled "Contact Precautions," dated 7/31/23, directed staff to implement contact precautions to prevent the transmission of infectious agents, including epidemiologically important microorganisms spread through direct or indirect contact with the resident or the resident's environment. The policy instructed staff to perform hand hygiene, noting that multidrug-resistant organisms (MDROs) were primarily transmitted by contaminated hands of healthcare personnel. The policy further stated the single most effective method of reducing the transmission of MDROs was hand antisepsis before and after resident contact, including after glove removal. Additionally, the policy directed staff to don gloves and a gown upon entering the resident's room and to remove the gown and perform hand hygiene before leaving the resident care area. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON), ICP, or designee could review facility policies/procedures regarding contact			21390			09/23/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
21390	Continued from page 6 and or/enhanced barrier precautions for the resident and provide staff education regarding the policies and educate staff on appropriate PPE wear. They could also do environmental rounds, audits, and re-education anytime isolation precautions are placed. The ICP should have formal training to be completed according to regulation and head the above measures. The ICP, DON and/or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time, until the QAPI committee determines successful compliance or the need for ongoing monitoring.		21390			09/23/2026	
21665	Physical Environment CFR(s): MN Rule 4658.1400 A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident rooms were kept in good working condition for 1 of 1 resident (R45) reviewed for a safe, clean, comfortable, and homelike environment. Findings include: R45's quarterly Minimum Data Set (MDS) dated 7/28/26, identified R45 was severely cognitively impaired. R45's diagnoses included Alzheimer's dementia, chronic kidney disease, hypertension, and depression. During an observation on 8/3/26 at 2:50 p.m., R45 was lying in bed. The bed was positioned with the long side against the wall. Next to R45's bed at the height of the bed, the wallpaper seam was loose to the wall light and approximately 2 feet of the wallpaper was peeling away from the seam exposing a beige wall and some loose white matter on the wall where the wallpaper had been affixed. During an interview on 8/5/26 at 11:36 a.m., the		21665			09/23/2026	

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21665	Continued from page 7 maintenance director (M)-A observed R45’s room and stated the wallpaper needed to be repaired. M-A stated loose wallpaper may be a safety issue due to the possibility of lead paint in buildings but they did not believe the facility had lead paint. They stated the normal process was for staff to put in a maintenance work order for repairs. During an interview on 8/5/26 at 11:46 a.m., nursing assistant (NA)-A stated the wallpaper in R45’s room had been damaged for a few months, and they had observed R45 pulling at the wallpaper and removing pieces. NA-A stated they let the nurse know when repairs are needed and the nurse enters a maintenance request on the computer. During an interview on 8/6/26 at 8:39 a.m., licensed practical nurse (LPN)-A stated they had not been told of the wallpaper damage in R45’s room and they were not aware that R45 was pulling on the wallpaper. LPN-A was concerned that R45 removed pieces but stated R45 did not usually put things in their mouth. LPN-A expected staff to let nurses know when repairs were needed so a maintenance request could be entered. LPN-A stated they do not have a process to go room to room looking at the walls. During an interview on 8/6/26 at 9:31 a.m., interim director of nursing (DON) and regional nursing consultant (RNC) stated resident rooms should not have peeling wallpaper. RNC stated they needed to make sure the resident could not rip the wallpaper off and expressed a concern that anything nonedible could be a problem. RNC stated M-A informed them of R45's wallpaper, had secured the wallpaper with tape, and was working with nursing to make the room available for the painter. Maintenance work orders for R45’s room were reviewed for 1/1/26 through 8/5/26. No maintenance requests were placed for wallpaper repair in R45's room. Facility maintenance policy was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of providing a safe, clean, homelike environment. The DON should review and revise policies, if necessary, educate staff on those policies and provide specific time-frame monitoring audits to ensure compliance. The DON or designee should take the results of the			21665			09/23/2026

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21665	Continued from page 8 education and audits to QAPI to ensure appropriate oversight and/or the need to continue monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21665			09/23/2026

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NAME OF PROVIDER OR SUPPLIER THE ESTATES AT ROSEVILLE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2727 NORTH VICTORIA , ROSEVILLE, Minnesota, 55113			
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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 8/4/2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, The Estates of 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			09/23/2026

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: 245105		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 08/04/2026	
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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. The Estates of Roseville was built in 1965 as a 2-story building without a basement and was determined to be Type II (222) construction. In 1973 a 1-story addition was constructed to the west of the existing building and was determined to be Type II (222) construction. In 1983 a 2 story addition (Woodhill) was constructed to the south of the original building and was determined to be Type II (222) construction. In 1995 a dining room addition was constructed to the south wing of the 1973 addition and was determined to be Type II (222) construction. The facility has a capacity of 140 beds and had a census of 131 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K0000			09/23/2026

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K0321 SS = E Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 43.7.1.2, 19.3.2.1.2, 19.3.2.1.3, 8.4.3.5, 8.3.3.1, and 7.2.1.8.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include:			K0321	Self-closing devices were immediately installed on both identified storage room doors and are working properly. All repurposed/storage rooms in the facility will be inspected to ensure doors have functioning self-closing devices as required and are closing automatically. Doors that are identified to not have self-closing devices will be installed. Maintenance will be educated on door requirements and instructed to report and correct any doors that does not properly self-close and latch promptly. Date of compliance is 9/23/26 Audits will be done by maintenance weekly x2 weeks and monthly x2 months to ensure compliance and that doors have self-closing devices.		09/23/2026

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K0321 SS = E Bldg. 01	Continued from page 3 1. On 08/04/2026 at 10:48 AM, it was revealed by observation that a room near near room 276 was re-purposed as a HR storage room; however, the door was not equipped with a self-closing device, resulting in it not closing automatically. 2. On 08/04/2026 at 11:51 AM, it was revealed by observation that a room across from the kitchen was re-purposed into a storage room; however, the door was not equipped with a self-closing device, resulting in it not closing automatically. An interview with 2 Administrators, Maintenance Operations Manager, Regional Maintenance Director, Maintenance Director and the Administrator in Training verified these deficient findings at the time of discovery.			K0321			09/23/2026
K0353 SS = D 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 the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of			K0353	The wires wrapped around the sprinkler pipe near the Orchard nursing station was immediately removed and the area will be inspected more closely to ensure sprinkler system is unobstructed. Maintenance will be inspecting other areas throughout the facility to ensure nothing is wrapped around sprinkler pipes and remove if so. Maintenance staff will be educated on sprinkler pipes not having any wires wrapped around. Date of compliance is 9/23/26 Audits will be completed of sprinkler pipes around facility weekly x2 weeks and monthly x2 to ensure compliance. Results will be brought to monthly QAPI to ensure that no sprinklers are obstructed.		09/23/2026

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K0353 SS = D Bldg. 01	Continued from page 4 Water-Based Fire Protection Systems, section 5.2.2.2. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 08/04/2026 at 10:33 AM, it was revealed by observation that there were wires wrapped around the sprinkler pipe near the Orchard nurses station. An interview with 2 Administrators, Maintenance Operations Manager, Regional Maintenance Director, Maintenance Director and the Administrator in Training verified this deficient finding at the time of discovery.			K0353			09/23/2026

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E0000	Initial Comments			E0000			
	A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on (8/3/26-8/6/26) during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.						
F0000	INITIAL COMMENTS			F0000			
	On 8/3/26-8/6/26, a standard recertification survey (S5105043-0) was conducted at your facility. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.						
	The following complaints were reviewed: H51053561C (2594236) H51053562C (2570430), NO deficiencies were cited.						
	The following complaint was reviewed: H51053560C (2651819) An incidental finding was discovered and cited at F925.						
	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.						
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary			F0812	Dietary employee was educated on the appropriate use of beard restraints and how they must be worn to completely cover facial hair during food preparation and immediately went and put a beard guard on. No residents were affected by this practice.		09/23/2026
	CFR(s): 483.60(i)(1)(2)						
	§483.60(i) Food safety requirements.						
	The facility must -						
	§483.60(i)(1) - Procure food from sources approved				All culinary staff will be educated on the importance of wearing a beard guard anytime they are working		

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.

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F0812 SS = F	Continued from page 1 or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the proper use of beard restraints during food preparation. This practice had the potential to affect all 134 residents who received food from the kitchen. Findings include: During observation and interview on 8/5/26 at 9:33 a.m., cook (C-A) prepared carrots without wearing a beard restraint. C-A acknowledged knowing a beard restraint was required, stated management had previously instructed him to wear one, and acknowledged having been previously counseled for not wearing a beard restraint. During an interview on 8/5/26 at 9:52 a.m., the assistant director of culinary services (ADCS) stated dietary staff are expected to wear hairnets or beard restraints whenever preparing food. The ADCS confirmed C-A should have been wearing a beard restraint while preparing food. During an interview on 8/6/26 at 12:45 p.m., the administrator stated employees are expected to keep their hair covered while preparing food. A facility dietary policy dated 10/2017, directed staff to wear hair restraints, including beard restraints, while in kitchen and food preparation areas, in accordance with Minnesota Department of Health (MDH) guidelines, to prevent hair from contacting food.			F0812	Continued from page 1 with food or in the kitchen areas. Audits will be done by dietary manager and/or designee of culinary staff wearing beard guards weekly x4 weeks and monthly x2 months to ensure compliance. Findings will be brought to monthly QAPI for input on the need to increase, decrease, or discontinue the audits. Date of compliance 9/23/26		09/23/2026

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F0925 SS = F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to implement effective and timely pest control measures to reduce and/or eliminate a roach infestation for 1 of 1 resident (R76) reviewed for environment. This had the potential to affect all 142 residents who resided in the facility. Findings include: R76's comprehensive Minimum Data Set (MDS) dated 5/19/26 identified R76 had diagnoses which included congestive heart failure (CHF), pulmonary edema, hyperlipidemia, and thyroid disorder. In addition, R76's MDS identified she was cognitively intact. During an interview on 8/3/26 at 11:02 a.m., R76 stated she had previously seen cockroaches in the dining room. R76 stated she had even caught some of the cockroaches about a month ago in the dining room while staff were present. R76 stated she has been seeing cockroaches in the dining room for the last year. During an observation and interview on 8/4/26 at 12:26 p.m., a roach measuring approximately 1/2" long was observed crawling across the floor by the sink in the long-term care dining room. Registered nurse (RN)-B stepped on the roach and used a paper towel to pick it up and throw it in the trash. When asked if the insect was a roach or if she had seen roaches in the dining room, RN-B shrugged and stated, ""Well, you know, people keep food in their rooms". During an observation on 8/4/26 at 12:50 p.m., no residents or staff were noted to be in the dining room after the lunch meal was cleared. The floor of the dining room was observed to have noodles, lettuce pieces, and carrot bits on the floor. During an observation on 8/4/26 at 12:52 p.m., inspection of the cabinets under the sink area in the dining room revealed a clear plastic bin with no cover on the lower shelf which contained a covered plate with a meal from lunch. A quarter-sized hole was noted in the top of the plate cover.			F0925	Pest control measures were initiated to reduce and eliminate roach sitings and fruit flies. Inspection, treatment, environmental cleaning, and monitoring. Plate cover with hole was removed and tossed. There have been no roach sitings in the kitchen or dining areas as day of survey. Food crumbs were cleaned by heater and under the steam table. Floor was cleaned behind refrigerators. Maintenance Director will remove countertop in LTC dining room and replace with new. In addition, food was immediately removed from the dining room cabinets. Pest control inspections and monitoring will be completed weekly to ensure the environment is safe and homelike for all residents. Staff will be educated not to store food in cabinets. Audits will be completed of pest control measures and cleanliness weekly x4 weeks and monthly x2 to ensure compliance. Results will be brought to monthly QAPI for input until roach infestation has been eliminated. Date of compliance 9/23/26		09/23/2026

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F0925 SS = F	Continued from page 3 Condensation was noted inside the cover. A roach measuring approximately 1/2" in length was observed crawling alongside the plate and then out of the cabinet. The floor near the adjacent refrigerator and the bases of the lower cabinets were characterized by black buildup and crumb-like debris. During an observation and interview on 8/4/26 at 3:50 p.m., the plate previously observed in the cabinet in the dining room was noted to be on the counter. Dietary aide (DA)-B stated that roaches were frequently seen in the kitchen and sometimes in the dining room. She stated that fruit fly traps were also everywhere. DA-B stated that they cleaned the counters and mopped the floors every night in the kitchen, but the roaches still came back. During an observation and interview on 8/4/26 at 3:57 p.m., a napkin, spoon and Cheerio were observed under the refrigerator in the dining room. A 6-inch long red-colored buildup was also noted under the refrigerator. Caulking was observed to be missing from around the sink and a one-foot-long section of the countertop backsplash was noted to be pulled away from the wall by 1/2". The countertop was warped and black discoloration was observed around the sink. The bottom of the cabinet underneath the sink was marked with brown coffee-colored staining. Two open boxes of cereal were found on the top shelf of one of the cabinets over the sink with the inner plastic bags unsealed and open to air. A second covered plate with remains from lunch (carrots and noodles) was found in an upper cabinet to the left of sink. When asked about this, DA-B stated, "the nurses' aides hide things". She said that if the nurses' aides work a second shift, they get a free meal and so they will sometimes store meals in the cabinets in the dining room. During an observation and interview on 8/5/26 at 7:25 a.m., Housekeeper(H)-A stated that he had only seen one roach lately and had mostly been seeing fruit flies. He stated housekeeping was responsible for cleaning and mopping the floors after meals. H-A pulled out the refrigerator in the dining room and stated there was old food under the fridge and it didn't look like housekeeping had cleaned under there in a while. He also said they should be checking this every shift. During an observation on 8/5/26 at 7:27 a.m., two fruit flies were noted in the sink area. Brown-colored food crumbs were noted along the baseboard near the heater and under the steam table. Three bits of			F0925			09/23/2026

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F0925 SS = F	Continued from page 4 wet lettuce were found on the floor near the steam table. H-A was observed cleaning behind the refrigerator. He stated, "Wow, there is a lot of stuff back here". During an interview on 8/5/26 at 7:43 a.m., the Director of Maintenance (DOM) confirmed that there was significant wearing of the laminate of the countertop around the sink in the dining room and that the caulking was missing. He also stated that he has been trying to obtain a new countertop for the past year. He mentioned that the facility recently switched from one pest control company to another and that the facility did have a pest control binder available for review. During an interview on 8/5/26 at 10:12 a.m., DA-A stated that she had only noticed roaches in the last year. She stated that she thought they had been spraying, but “it doesn't seem to be doing the trick”. She said cleanliness in general was an issue in the dining room. Dirty dishes with food often get left on the counter. At night, there was no one there to monitor. When asked, DA-A stated that no education has been provided to staff on roach prevention and mitigation strategies, but she knew staff should not be leaving food in the cupboards and on the countertops and that housekeeping should be cleaning under the refrigerator and along the baseboards. During an interview on 8/5/25 at 12:30 p.m., the area supervisor for the new pest control company, stated that he was a brand-new vendor and was contacted by the facility on 8/4/26. His plan was to "hit it hard". He stated that the first time they were at the facility was yesterday and he laid several traps for insects. The area supervisor stated that they now have a plan going forward to help the facility with their pest control issue, but because they need to use low toxicity methods, it may take some time to really minimize the presence of insects. The DOM, who was also present at this time, stated they had previously used a different pest control company, but they were unhappy with those services. An administrator for another associated facility stated she believed it was a couple weeks ago that they had consulted the pest control company. All three personnel were notified of the observations in the dining room related to plates of food being stored in the cupboards. The DOM stated he was unaware of this issue and would have to look into it. He further stated that he believed that food in the cabinets could worsen their pest control issues and staff shouldn't be doing that.			F0925			09/23/2026

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F0925 SS = F	Continued from page 5 Per an email correspondence from the Administrator on 8/5/26 at 1:30 p.m., “We were with a pest control company for a long time but had to change to different pest control company a month ago because we were having issues with them coming out consistently”. During an interview on 8/6/26 at 8:46 a.m., the Director of Housekeeping (DOH) stated that the daily cleaning of the four dining rooms in the facility included floors, tables/chairs, and sinks/countertops. He said housekeeping staff also checked the refrigerators for spills. The expectation was that the floors underneath any mobile equipment (e.g., steam tables) would be cleaned daily. Floors were supposed to be auto-scrubbed after the evening meal. Weekly deep cleaning of the dining rooms was expected to include cabinet interiors, refrigerator tops, and windowsills. The DOH stated he has not seen any roaches or noticed any other bugs in the facility. He expected his housekeeping staff to report any issues with pests to him, and he would forward that information to the DOM. During an interview on 8/6/26 at 10:45 a.m., the Director of Culinary Services (DCS) stated that he had maybe seen one or two roaches in the kitchen. He would expect that kitchen staff would notify him if they saw any roaches and he would then forward that information to the DOM. A Service Report dated 2/2/26 from the initial pest control company provided by the facility indicated that two units for straggler roaches had been spotted. Due to it being in memory care, glue boards were advised against. The document stated that the DOM has baited these rooms and all around for any roach issues. A second Service Report dated 3/23/26 provided by the facility indicated no pest activity was noted in the facility. Additional documentation regarding pest control measures taken by the facility in the last three months was requested but not received. Facility policies on maintenance and pest control were also requested but not received.			F0925			09/23/2026
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications			F0554	Residents R59’s ability to self-administer hydrocortisone cream and miconazole nitrate antifungal power was immediately assessed, documented and care plan has been updated. There were no adverse affects because of this practice.		09/23/2026

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F0554 SS = D	Continued from page 6 if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure self-administration of medications was assessed and determined to be appropriate for 1 of 1 resident (R59) reviewed for the self-administration of medications. Findings include: R59's comprehensive Minimum Data Set dated 07/17/26, indicated R59 was cognitively intact and required varying levels of assistance with activities of daily living and mobility. R59 was occasionally incontinent of urine and required partial to moderate assistance with toileting. Diagnoses included bilateral subdural hematomas (bleeding between the brain and skull) related to a fall, congestive heart failure, hypertension (high blood pressure), atrial fibrillation (irregular heartbeat), and chronic kidney disease, R59's care plan dated 7/30/26, failed to identify interventions related to bedside storage or self-administration of topical medications. R59's medical record, reviewed on 8/3/26, lacked evidence of provider orders for 1% hydrocortisone cream and 2% miconazole nitrate powder. Record review also lacked evidence of an assessment to determine whether it was appropriate for R59 to self-administer these medications. During observation and interview on 8/3/2026 at 11:10 a.m., an open container of 1% hydrocortisone cream and a bottle of 2% miconazole nitrate antifungal powder were observed on R59's bedside table. The medications lacked pharmacy prescription labels. R59 stated that the cream and "crotch powder" were given to him by staff, and that he was allowed to use these as needed. During observation and interview on 8/4/2026 at 9:22 a.m., the container of 1% hydrocortisone cream and bottle of 2% miconazole nitrate powder were again observed on R59's bedside table. R59 reiterated that staff provided these and he could use both when he wanted. During interview on 8/5/2026 at 10:30 a.m., nursing assistant (NA)-B stated that she had seen the containers of 1% hydrocortisone cream and 2%			F0554	Continued from page 6 All residents who self-administer medications/topical creams have been reviewed to ensure a current assessment has been completed and supports their ability to safely administer medications. Care plans have been updated. Education provided to licensed nurses regarding requirements for medication self-administration assessments. DON/designee will audit self-administration assessments weekly for four weeks and monthly x2 and bring findings to monthly QAPI. Date of compliance 9/23/26		09/23/2026

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F0554 SS = D	Continued from page 7 miconazole nitrate in R59's room, but she did not know how long they had been there. NA-B stated that NAs were supposed to be helping R59 apply these medications, but R59 preferred to do this himself and refused to allow staff to assist. NA-B also stated that R59 refused to allow staff to remove these medications from the room after self-administration. NA-B stated that she thought the medications were for R59's skin due to frequent episodes of incontinence, but she was unsure about the status of R59's skin as she had not seen it. During interview on 8/5/2026 at 10:55 a.m., licensed practical nurse (LPN)-C stated that orders should be in the system for all medications, including those that are topically administered. LPN-C did not know if R59 had been assessed to determine if it was appropriate for him to self-administer medications. During observation and interview on 8/5/2026 at 11:05 a.m., LPN-B stated that the 1% hydrocortisone cream should not be in R59's room. LPN-B removed the 1% hydrocortisone cream from R59's room and told R59 that it needed to be kept in the medication cart. LPN-B examined the container of 2% miconazole nitrate and stated that this particular brand was "in-house". LPN-B exited R59's room without removing the 2% miconazole nitrate. During subsequent interview on 8/5/26 at 11:15 a.m., LPN-B stated that orders should be in the system for both the hydrocortisone cream and the antifungal powder. After reviewing the orders, LPN-B stated that there was an order for nystatin powder, but no orders for the 1% hydrocortisone cream or the 2% miconazole nitrate. During third interview on 8/5/2026 at 12:29 p.m., LPN-B stated that the orders for 1% hydrocortisone cream and 2% miconazole powder may be part of the standing house orders for skin and wound management. She stated that she would inform the survey team if she was able to obtain additional clarification. LPN-B also stated that a self-administered medication form should be completed at least annually for every patient who is self-administering medications. She stated that there was not a completed self-administration form for R59 and therefore, R59 should not be self-administering anything. On 8/5/26, a review of the facility's document Standing Orders for Nursing Facilities and Skilled Nursing Facilities signed by a provider on 01/07/26, did not list orders for 1% hydrocortisone cream or 2% miconazole.			F0554			09/23/2026

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F0554 SS = D	Continued from page 8 During interview on 8/6/2026 at 7:55 a.m., registered nurse (RN)-A stated that she was not aware of any form or assessment that needed to be completed for the self-administration of medications. She stated that residents were generally allowed to have lotions, creams, and antifungal powder at bedside. During interview on 8/6/2026 at 8:02 a.m., LPN-D stated that she thought there was a form for the self-administration of medications, but she was unable to locate it within the facility's electronic medical record system. LPN-D then stated that she did not know where the form was or when it should be filled out. During interview on 8/6/2026 at 11:50 a.m., the Director of Nursing (DON) stated that the expectation was that all residents be assessed prior to being able to self-administer medications. She also stated that the expectation was for provider orders to be in the system for any self-administered medications. The facility's policy titled Medication and Treatment Orders Policy dated 8/2021, stated that a written prescriber's order must be obtained for any treatment or medication administration provided to a client. A policy regarding the self-administration of medications was requested but not received. A copy of the facility's form titled MHM Self Administration of Medication Evaluation dated 2013, indicated the parameters that must be satisfied if a resident requests to self-administer medication.			F0554			09/23/2026
F0638 SS = D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure quarterly Minimum Data Set (MDS) was completed in a timely manner for 1 of 1 residents (R39) reviewed for MDS completion. Findings include: The Centers for Medicare & Medicaid Services (CMS)			F0638	The quarterly assessment was not completed within the required timeframe because the systems assessment calendar reset and the assessment was not identified as due at the time but was found later and completed. Residents R39 MDS was completed and submitted. The MDS schedule was reviewed to ensure all future assessments are completed in a timely manner. The resident was not affected by this practice. An audit was conducted of quarterly MDS assessments and to make sure they are being completed timely. Any identified areas will be corrected. Education was provided to all licensed nursing staff and MDS staff, to ensure timely completion for quarterly MDS and to check calendar. MDS coordinator/DON will audit quarterly MDS		09/23/2026

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F0638 SS = D	Continued from page 9 Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2025, identified a Quarterly Assessment is a non-comprehensive assessment required no later than 92 days after the previous assessment of any type to monitor gradual changes in the resident's condition between comprehensive assessments. R39's Face Sheet located in the facility's electronic medical record (EMR) indicated an initial admission date of 3/18/24. R39's MDS dated 7/23/26, identified moderate cognitive impairment and diagnoses that included Alzheimer's disease, dementia with agitation, type 2 diabetes with nerve damage, and high blood pressure. During document review on 8/6/26, R39's MDS assessments identified the previous quarterly assessment was dated 3/24/26. The next quarterly assessment was due by 6/24/26; however, it was not completed until 7/23/26, 29 days beyond the required timeframe. During an interview on 8/6/26, at 12:36 p.m., the director of nursing (DON) stated quarterly MDS assessments are completed every three months in accordance with the RAI schedule and are important for monitoring resident status and quality outcomes. The DON stated the facility uses PointClickCare (PCC) to track upcoming MDS assessments and acknowledged R39's quarterly assessment was not completed within the required timeframe because the facility's assessment calendar reset and the assessment was not identified as due. The DON confirmed the facility follows the RAI Manual when completing MDS assessments.			F0638	Continued from page 9 weekly for four weeks and monthly x2 and bring findings to monthly QAPI. Date of compliance 9/23/26		09/23/2026
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing,			F0755	The resident's medication orders were reviewed against the MAR and current provider orders. Any discrepancies were corrected and 2% miconazole nitrate powder was removed from the room and resident was told why they can't have that in their room without orders and assessment, and staff were educated to follow current provider orders and accurately document medication administration. All residents' current medication orders and MARs were reviewed to ensure medication administration was correctly documented for all residents and that orders need be in the system for all medications, including any topicals and/or self-administered medications.		09/23/2026

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F0755 SS = D	Continued from page 10 and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to follow provider orders for medication and failed to ensure medication administration was correctly documented for 1 of 1 resident (R59) reviewed for medication administration. Findings include: R59's comprehensive Minimum Data Set dated 7/28/26, indicated R59 was cognitively intact and independent with eating and upper body dressing. R59 required moderate assistance with lower body dressing and toileting. He used a wheelchair for mobility. Diagnoses included bilateral subdural hematomas (bleeding between the brain and skull) related to a fall, congestive heart failure, and chronic kidney disease. R59's MDS indicated he was occasionally incontinent of urine. R59's nursing progress note dated 7/24/26 at 12:57 p.m., indicated a message was sent to the provider informing them of redness to the resident's groin upon skin inspection yesterday related to moisture. The resident wore a pull up and was incontinent at times with refusal of care noted. R59's provider order dated 7/25/26, specified nystatin external powder 100000 Unit/GM to be applied to the groin topically three times a day for 14 days for candidiasis related to rash and other			F0755	Continued from page 10 Audit will be completed on medication administration weekly x4 and monthly x2 to ensure compliance. Results will be brought to monthly QAPI for input. Date of compliance 9/23/26		09/23/2026

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F0755 SS = D	Continued from page 11 nonspecific skin eruption. R59's medical record lacked evidence of a provider order for 2% miconazole nitrate powder. During observation and interview on 8/3/26 at 11:10 a.m., a container of 2% miconazole nitrate antifungal powder was observed on R59's bedside table. The medication lacked a pharmacy prescription label. R59 stated the "crotch powder" was given to him by staff, and he was allowed to use it as needed. During observation and interview on 8/4/26 at 9:22 a.m., the container of 2% miconazole nitrate powder was again observed on R59's bedside table. R59 reiterated that staff had provided this and he could use the powder whenever he wanted. During an interview on 8/5/26 at 10:30 a.m., nursing assistant (NA)-B stated she had seen the container of 2% miconazole nitrate in R59's room but did not know how long it had been there. NA-B stated that NAs were supposed to be helping R59 apply this medication, but R59 preferred to do this himself and refused to allow staff to assist. NA-B also stated R59 refused to allow staff to remove this medication from the room after self-administration. NA-B stated she thought the medication was for R59's skin due to frequent episodes of incontinence, but she was unsure about the status of R59's skin as she had not seen it. During an interview on 8/5/26 at 10:55 a.m., licensed practical nurse (LPN)-C stated orders should be in the system for all medications, including any topicals and/or self-administered medications. During observation and interview on 8/5/26 at 11:05 a.m., LPN-B examined the container of 2% miconazole nitrate and stated this brand was "in-house". LPN-B exited R59's room without removing the 2% miconazole nitrate. During a subsequent interview on 8/5/26 at 11:15 a.m., LPN-B stated orders should be in the system for the antifungal powder. After reviewing the orders, LPN-B stated there was an order for nystatin powder but no order for 2% miconazole nitrate powder. A review of R59's medication administration record (MAR) on 8/5/26, indicated the nystatin powder was administered earlier that morning by trained medical assistant (TMA)-A. During an interview on 8/5/26 at 12:12 p.m., R59			F0755			09/23/2026

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F0755 SS = D	Continued from page 12 stated he had not administered the 2% miconazole nitrate or any other powder today and staff had not administered anything either. R59 stated again that he applied this himself. When asked if staff had ever assessed him for the use of this powder or provided any education on it, he stated he did not remember that. During an interview on 8/5/26 at 12:19 p.m., TMA-A stated she was responsible for administering R59's medications. TMA-A pulled the bottle of nystatin powder she typically administered to R59 from the medication cart. She confirmed this was the correct medication listed in the order set. TMA-A stated the nystatin powder had remained in the cart this morning and was not given. She stated it was ordered to be given three times per day. TMA-A stated R59 told her he would do it later. She said she charted it as being administered, as R59 later told her he had done it himself. TMA-A then pulled a separate bottle of 2% miconazole nitrate from the medication cart which was identical to the bottle of 2% miconazole nitrate in R59's room. When asked to examine the bottle of 2% miconazole nitrate, TMA-A stated she could not really read the label, but she thought this was the same medication as the nystatin. During an interview on 8/5/26 at 12:29 p.m., LPN-B stated the orders for the 2% miconazole nitrate powder might be part of the standing house orders for skin and wound management. She stated she would inform the survey team if she was able to obtain additional clarification. On 8/5/26, a review of the facility's document Standing Orders for Nursing Facilities and Skilled Nursing Facilities signed by a provider on 1/7/26, did not list orders for 2% miconazole nitrate. During an interview on 8/6/26 at 7:55 a.m., registered nurse (RN)-A stated residents were generally allowed to have lotions, creams, and antifungal powder at bedside and orders should be in the system for all medications. During an interview on 8/6/26 at 11:50 a.m., the Director of Nursing (DON) stated the expectation was for provider orders to be in the system for all medications, including those that are self-administered and/or kept at bedside. She stated no medications should be administered without a provider order. She also stated the expectation was for staff to document medication administration accurately in the chart.			F0755			09/23/2026

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F0755 SS = D	Continued from page 13 The facility's policy titled Medication and Treatment Orders Policy dated 8/2021, indicated a written prescriber's order must be obtained for any treatment or medication administration provided to a client. A policy regarding the self-administration of medications was requested but not received.			F0755			09/23/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:			F0880	R31 and R83 have no new infections noted and are at baseline. R31 remains on contact precautions. R83 remains on contact precautions with no new signs or symptoms of infection for both residents. All residents on precautions, EBP and contact precautions have the ability to be affected by this practice. Nursing staff will be educated on infection prevention practices and appropriate PPE use. Nursing staff will be educated on hand hygiene and donning and doffing of PPE upon entry and exit. Audits will be completed on staff providing care to residents requiring PPE to ensure appropriate donning and doffing is being completed. Audits will be completed weekly for hand hygiene. Audits will be completed by DON or designee weekly x4 and monthly 2x. Findings will be brought to monthly QAPI and corrective actions will be provided as needed.		09/23/2026

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F0880 SS = D	Continued from page 14 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff followed proper personal protective equipment was used for 2 of 3 residents (R31, R83) observed who required infection control precautions. Findings include: R31 R31's comprehensive Minimum Data Set (MDS) assessment dated 8/1/26, was in process and was unavailable for review. R31's electronic medical record (EMR), reviewed on 8/1/26, indicated diagnoses that included acute pancreatitis (inflammation of the pancreas), acute pyelonephritis (kidney infection), and severe sepsis with septic shock. R31's provider orders dated 8/1/26, indicated the			F0880			09/23/2026

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F0880 SS = D	Continued from page 15 resident was on contact precautions for a methicillin-resistant Staphylococcus aureus (MRSA) infection (an antibiotic-resistant infection that spreads through contact) and staff were instructed to follow contact precaution procedures. R31's care plan dated 8/1/26, indicated the resident required contact isolation precautions. The care plan instructed all staff to follow isolation precautions, implement infection control precautions according to protocol, and ensure a contact precaution sign was posted on the resident's door. During an observation on 8/4/26 at 8:35 a.m., Licensed Practical Nurse (LPN)-E entered R31's room without performing hand hygiene or donning personal protective equipment (PPE). LPN-E removed the resident's water pitcher, filled it at the ice and water machine, returned it to the resident's room, and did not perform hand hygiene or don PPE before re-entering the room. During an observation on 8/4/26 at 8:37 a.m., Nursing Assistant (NA)-D entered R31's room without performing hand hygiene or donning PPE. NA-D delivered the resident's breakfast tray, placed it on the bedside table, exited the room, and did not perform hand hygiene upon leaving. During an observation on 8/6/26 at 8:48 a.m., LPN-D entered R31's room with a portable vital signs machine without performing hand hygiene or donning PPE. LPN-D obtained the resident's vital signs and administered medications. Upon exiting the room, LPN-D did not perform hand hygiene or disinfect the portable vital signs machine before taking it into another area. During an interview on 8/4/26 at 8:51 a.m., NA-D verified a contact precaution sign was visibly posted on the door to R31's room. NA-D acknowledged she had not followed the required contact precaution procedures. She stated PPE supply bins were in the hallway but were not positioned outside R31's room. NA-D confirmed she should have performed hand hygiene and donned PPE before entering the room. During an interview on 8/4/26 at 8:54 a.m., LPN-E acknowledged she had not followed the required contact precaution procedures despite the contact precaution sign being visibly posted on R31's door. LPN-E confirmed she had not performed hand hygiene or donned PPE. LPN-E stated staff were expected to follow each resident's care plan because it contained resident-specific care instructions. She further stated staff were expected			F0880			09/23/2026

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F0880 SS = D	Continued from page 16 to follow provider orders because they defined the treatments required for each resident. During an interview on 8/6/26 at 10:30 a.m., LPN-D stated all staff were expected to follow the contact precaution instructions posted on the sign outside R31's room. LPN-D acknowledged she had not followed the required contact precautions and had failed to disinfect equipment when leaving the room. LPN-D stated the purpose of contact precautions was to minimize the spread of infection. R83 R83's comprehensive MDS assessment dated 7/26/26 indicated he was cognitively intact and required maximum assistance with personal hygiene, dressing, and oral hygiene. Diagnoses included intracranial abscess and granuloma (inflammatory lesions in the brain) and sepsis due to methicillin-susceptible Staphylococcus aureus (MSSA). R83's provider orders dated 7/27/26 indicated the resident was on contact precautions. R83's care plan dated 7/28/26 indicated contact precautions were required due to the resident's current infection. During an observation on 8/5/26 at 2:16 p.m., Nursing Assistant (NA)-E entered R83's room without performing hand hygiene or donning personal protective equipment (PPE) required for contact precautions. NA-E obtained the resident's vital signs and disinfected the vital signs machine after leaving the room. During an observation on 8/6/26 at 9:22 a.m., Licensed Practical Nurse (LPN)-D entered R83's room without performing hand hygiene or donning PPE. LPN-D administered the resident's medications and exited the room without performing hand hygiene. During an interview on 8/5/26 at 2:26 p.m., NA-E stated contact precautions were only necessary when providing direct resident care. NA-E acknowledged she had not performed hand hygiene or utilized PPE before entering the room. NA-E confirmed a contact precaution sign was visibly posted on the resident's door. After reviewing the sign, NA-E stated she should have donned PPE and performed hand hygiene before entering R83's room.			F0880			09/23/2026

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F0880 SS = D	Continued from page 17 During an interview on 8/6/26 at 10:00 a.m., Registered Nurse (RN)-C stated all staff were expected to follow the contact precaution instructions posted on the resident's door. RN-C stated PPE was to be donned before entering the resident's room. RN-C further stated it was important to follow provider orders and the care plan to ensure resident safety and provide appropriate individualized therapeutic care. During an interview on 8/6/26 at 2:26 p.m., LPN-D acknowledged she had not worn PPE before entering R83's room. LPN-D stated that after reading the contact precaution sign, she recognized she should have followed the posted instructions by donning PPE and performing hand hygiene before entering the room. LPN-D stated contact precautions were used to reduce the risk of spreading infections. During an interview on 8/6/26 at 10:39 a.m., the Regional Nursing Consultant (RNC) stated every staff member was expected to follow all instructions posted on the contact precaution signage and understand the rationale for the precautions to help prevent the spread of infections. The RNC further stated staff received education on the different transmission-based precautions (TBP) during new hire orientation, annual skills fairs, annual training, and as needed. During an interview on 8/6/26 at 10:46 a.m., the Director of Nursing (DON) stated staff were expected to follow transmission-based precaution (TBP) protocols. The DON further stated staff were expected to follow provider orders as part of their scope of practice and provide the care necessary for each individual resident. The DON stated care plans were expected to be followed by each discipline to ensure residents received individualized care necessary for their well-being. A policy titled "Contact Precautions," dated 7/31/23, directed staff to implement contact precautions to prevent the transmission of infectious agents, including epidemiologically important microorganisms spread through direct or indirect contact with the resident or the resident's environment. The policy instructed staff to perform hand hygiene, noting that multidrug-resistant organisms (MDROs) were primarily transmitted by contaminated hands of healthcare personnel. The policy further stated the single most effective method of reducing the transmission of MDROs was hand antisepsis before and after resident contact, including after glove removal. Additionally, the policy directed staff to don gloves and a gown upon			F0880			09/23/2026

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F0880 SS = D	Continued from page 18 entering the resident's room and to remove the gown and perform hand hygiene before leaving the resident care area.			F0880			09/23/2026
F0921 SS = D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident rooms were kept in good working condition for 1 of 1 resident (R45) reviewed for a safe, clean, comfortable, and homelike environment. Findings include: R45's quarterly Minimum Data Set (MDS) dated 7/28/26, identified R45 was severely cognitively impaired. R45's diagnoses included Alzheimer's dementia, chronic kidney disease, hypertension, and depression. During an observation on 8/3/26 at 2:50 p.m., R45 was lying in bed. The bed was positioned with the long side against the wall. Next to R45's bed at the height of the bed, the wallpaper seam was loose to the wall light and approximately 2 feet of the wallpaper was peeling away from the seam exposing a beige wall and some loose white matter on the wall where the wallpaper had been affixed. During an interview on 8/5/26 at 11:36 a.m., the maintenance director (M)-A observed R45's room and stated the wallpaper needed to be repaired. M-A stated loose wallpaper may be a safety issue due to the possibility of lead paint in buildings but they did not believe the facility had lead paint. They stated the normal process was for staff to put in a maintenance work order for repairs. During an interview on 8/5/26 at 11:46 a.m., nursing assistant (NA)-A stated the wallpaper in R45's room had been damaged for a few months, and they had observed R45 pulling at the wallpaper and removing pieces. NA-A stated they let the nurse know when repairs are needed and the nurse enters a			F0921	R45's room was inspected and the wallpaper will be repaired to ensure a homelike environment. The resident was not affected by this practice. Resident rooms on Victoria unit with wallpaper will be inspected to identify any peeling and any identified wallpapers will be replaced or repaired. Maintenance and nursing staff will be educated on reporting environmental concerns including peeling wallpaper and to report concerns to administration and maintenance for correction or submit via TELS system. Maintenance will audit resident rooms weekly 4x weeks and monthly x2 to ensure compliance and address identified concerns. Findings will be brought to QAPI Date of compliance is 9/23/26		09/23/2026

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F0921 SS = D	Continued from page 19 maintenance request on the computer. During an interview on 8/6/26 at 8:39 a.m., licensed practical nurse (LPN)-A stated they had not been told of the wallpaper damage in R45's room and they were not aware that R45 was pulling on the wallpaper. LPN-A was concerned that R45 removed pieces but stated R45 did not usually put things in their mouth. LPN-A expected staff to let nurses know when repairs were needed so a maintenance request could be entered. LPN-A stated they do not have a process to go room to room looking at the walls. During an interview on 8/6/26 at 9:31 a.m., interim director of nursing (DON) and regional nursing consultant (RNC) stated resident rooms should not have peeling wallpaper. RNC stated they needed to make sure the resident could not rip the wallpaper off and expressed a concern that anything nonedible could be a problem. RNC stated M-A informed them of R45's wallpaper, had secured the wallpaper with tape, and was working with nursing to make the room available for the painter. Maintenance work orders for R45's room were reviewed for 1/1/26 through 8/5/26. No maintenance requests were placed for wallpaper repair in R45's room. Facility maintenance policy was requested but not received.			F0921			09/23/2026

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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 8/3/26-8/6/26 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: H51053561C (2594236) H51053562C (2570430), NO licensing orders were issued. H51053560C (2651819)			20000			

Office of Primary Care and Health Systems Management

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

Minnesota Department of Health

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20000	Continued from page 1 with a related deficiency. 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				
21390	Infection Control CFR(s): MN Rule 4658.0800 Subp. 4 A-I Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk		21390			09/23/2026	

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21390	Continued from page 2 of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff followed proper personal protective equipment was used for 2 of 3 residents (R31, R83) observed who required infection control precautions. Findings include: R31 R31's comprehensive Minimum Data Set (MDS) assessment dated 8/1/26, was in process and was unavailable for review. R31's electronic medical record (EMR), reviewed on 8/1/26, indicated diagnoses that included acute pancreatitis (inflammation of the pancreas), acute pyelonephritis (kidney infection), and severe sepsis with septic shock. R31's provider orders dated 8/1/26, indicated the resident was on contact precautions for a methicillin-resistant Staphylococcus aureus (MRSA) infection (an antibiotic-resistant infection that spreads through contact) and staff were instructed to follow contact precaution procedures. R31's care plan dated 8/1/26, indicated the resident			21390			09/23/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
21390	Continued from page 3 required contact isolation precautions. The care plan instructed all staff to follow isolation precautions, implement infection control precautions according to protocol, and ensure a contact precaution sign was posted on the resident's door. During an observation on 8/4/26 at 8:35 a.m., Licensed Practical Nurse (LPN)-E entered R31's room without performing hand hygiene or donning personal protective equipment (PPE). LPN-E removed the resident's water pitcher, filled it at the ice and water machine, returned it to the resident's room, and did not perform hand hygiene or don PPE before re-entering the room. During an observation on 8/4/26 at 8:37 a.m., Nursing Assistant (NA)-D entered R31's room without performing hand hygiene or donning PPE. NA-D delivered the resident's breakfast tray, placed it on the bedside table, exited the room, and did not perform hand hygiene upon leaving. During an observation on 8/6/26 at 8:48 a.m., LPN-D entered R31's room with a portable vital signs machine without performing hand hygiene or donning PPE. LPN-D obtained the resident's vital signs and administered medications. Upon exiting the room, LPN-D did not perform hand hygiene or disinfect the portable vital signs machine before taking it into another area. During an interview on 8/4/26 at 8:51 a.m., NA-D verified a contact precaution sign was visibly posted on the door to R31's room. NA-D acknowledged she had not followed the required contact precaution procedures. She stated PPE supply bins were in the hallway but were not positioned outside R31's room. NA-D confirmed she should have performed hand hygiene and donned PPE before entering the room. During an interview on 8/4/26 at 8:54 a.m., LPN-E acknowledged she had not followed the required contact precaution procedures despite the contact precaution sign being visibly posted on R31's door. LPN-E confirmed she had not performed hand hygiene or donned PPE. LPN-E stated staff were expected to follow each resident's care plan because it contained resident-specific care instructions. She further stated staff were expected to follow provider orders because they defined the treatments required for each resident. During an interview on 8/6/26 at 10:30 a.m., LPN-D stated all staff were expected to follow the contact precaution instructions posted on the sign outside R31's room. LPN-D acknowledged she had not			21390			09/23/2026

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21390	Continued from page 4 followed the required contact precautions and had failed to disinfect equipment when leaving the room. LPN-D stated the purpose of contact precautions was to minimize the spread of infection. R83 R83's comprehensive MDS assessment dated 7/26/26 indicated he was cognitively intact and required maximum assistance with personal hygiene, dressing, and oral hygiene. Diagnoses included intracranial abscess and granuloma (inflammatory lesions in the brain) and sepsis due to methicillin-susceptible Staphylococcus aureus (MSSA). R83's provider orders dated 7/27/26 indicated the resident was on contact precautions. R83's care plan dated 7/28/26 indicated contact precautions were required due to the resident's current infection. During an observation on 8/5/26 at 2:16 p.m., Nursing Assistant (NA)-E entered R83's room without performing hand hygiene or donning personal protective equipment (PPE) required for contact precautions. NA-E obtained the resident's vital signs and disinfected the vital signs machine after leaving the room. During an observation on 8/6/26 at 9:22 a.m., Licensed Practical Nurse (LPN)-D entered R83's room without performing hand hygiene or donning PPE. LPN-D administered the resident's medications and exited the room without performing hand hygiene. During an interview on 8/5/26 at 2:26 p.m., NA-E stated contact precautions were only necessary when providing direct resident care. NA-E acknowledged she had not performed hand hygiene or utilized PPE before entering the room. NA-E confirmed a contact precaution sign was visibly posted on the resident's door. After reviewing the sign, NA-E stated she should have donned PPE and performed hand hygiene before entering R83's room. During an interview on 8/6/26 at 10:00 a.m., Registered Nurse (RN)-C stated all staff were expected to follow the contact precaution instructions posted on the resident's door. RN-C stated PPE was to be donned before entering the resident's room. RN-C further stated it was important to follow provider orders and the care plan			21390			09/23/2026

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21390	Continued from page 5 to ensure resident safety and provide appropriate individualized therapeutic care. During an interview on 8/6/26 at 2:26 p.m., LPN-D acknowledged she had not worn PPE before entering R83's room. LPN-D stated that after reading the contact precaution sign, she recognized she should have followed the posted instructions by donning PPE and performing hand hygiene before entering the room. LPN-D stated contact precautions were used to reduce the risk of spreading infections. During an interview on 8/6/26 at 10:39 a.m., the Regional Nursing Consultant (RNC) stated every staff member was expected to follow all instructions posted on the contact precaution signage and understand the rationale for the precautions to help prevent the spread of infections. The RNC further stated staff received education on the different transmission-based precautions (TBP) during new hire orientation, annual skills fairs, annual training, and as needed. During an interview on 8/6/26 at 10:46 a.m., the Director of Nursing (DON) stated staff were expected to follow transmission-based precaution (TBP) protocols. The DON further stated staff were expected to follow provider orders as part of their scope of practice and provide the care necessary for each individual resident. The DON stated care plans were expected to be followed by each discipline to ensure residents received individualized care necessary for their well-being. A policy titled "Contact Precautions," dated 7/31/23, directed staff to implement contact precautions to prevent the transmission of infectious agents, including epidemiologically important microorganisms spread through direct or indirect contact with the resident or the resident's environment. The policy instructed staff to perform hand hygiene, noting that multidrug-resistant organisms (MDROs) were primarily transmitted by contaminated hands of healthcare personnel. The policy further stated the single most effective method of reducing the transmission of MDROs was hand antisepsis before and after resident contact, including after glove removal. Additionally, the policy directed staff to don gloves and a gown upon entering the resident's room and to remove the gown and perform hand hygiene before leaving the resident care area. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON), ICP, or designee could review facility policies/procedures regarding contact			21390			09/23/2026

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21390	Continued from page 6 and or/enhanced barrier precautions for the resident and provide staff education regarding the policies and educate staff on appropriate PPE wear. They could also do environmental rounds, audits, and re-education anytime isolation precautions are placed. The ICP should have formal training to be completed according to regulation and head the above measures. The ICP, DON and/or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time, until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21390			09/23/2026
21665	Physical Environment CFR(s): MN Rule 4658.1400 A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident rooms were kept in good working condition for 1 of 1 resident (R45) reviewed for a safe, clean, comfortable, and homelike environment. Findings include: R45's quarterly Minimum Data Set (MDS) dated 7/28/26, identified R45 was severely cognitively impaired. R45's diagnoses included Alzheimer's dementia, chronic kidney disease, hypertension, and depression. During an observation on 8/3/26 at 2:50 p.m., R45 was lying in bed. The bed was positioned with the long side against the wall. Next to R45's bed at the height of the bed, the wallpaper seam was loose to the wall light and approximately 2 feet of the wallpaper was peeling away from the seam exposing a beige wall and some loose white matter on the wall where the wallpaper had been affixed. During an interview on 8/5/26 at 11:36 a.m., the			21665			09/23/2026

Minnesota Department of Health

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21665	Continued from page 7 maintenance director (M)-A observed R45’s room and stated the wallpaper needed to be repaired. M-A stated loose wallpaper may be a safety issue due to the possibility of lead paint in buildings but they did not believe the facility had lead paint. They stated the normal process was for staff to put in a maintenance work order for repairs. During an interview on 8/5/26 at 11:46 a.m., nursing assistant (NA)-A stated the wallpaper in R45’s room had been damaged for a few months, and they had observed R45 pulling at the wallpaper and removing pieces. NA-A stated they let the nurse know when repairs are needed and the nurse enters a maintenance request on the computer. During an interview on 8/6/26 at 8:39 a.m., licensed practical nurse (LPN)-A stated they had not been told of the wallpaper damage in R45’s room and they were not aware that R45 was pulling on the wallpaper. LPN-A was concerned that R45 removed pieces but stated R45 did not usually put things in their mouth. LPN-A expected staff to let nurses know when repairs were needed so a maintenance request could be entered. LPN-A stated they do not have a process to go room to room looking at the walls. During an interview on 8/6/26 at 9:31 a.m., interim director of nursing (DON) and regional nursing consultant (RNC) stated resident rooms should not have peeling wallpaper. RNC stated they needed to make sure the resident could not rip the wallpaper off and expressed a concern that anything nonedible could be a problem. RNC stated M-A informed them of R45's wallpaper, had secured the wallpaper with tape, and was working with nursing to make the room available for the painter. Maintenance work orders for R45’s room were reviewed for 1/1/26 through 8/5/26. No maintenance requests were placed for wallpaper repair in R45's room. Facility maintenance policy was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of providing a safe, clean, homelike environment. The DON should review and revise policies, if necessary, educate staff on those policies and provide specific time-frame monitoring audits to ensure compliance. The DON or designee should take the results of the			21665			09/23/2026

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21665	Continued from page 8 education and audits to QAPI to ensure appropriate oversight and/or the need to continue monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21665			09/23/2026



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 30, 2026

Administrator
THE ESTATES AT ROSEVILLE LLC
2727 NORTH VICTORIA
ROSEVILLE, MN 55113

RE: CCN: 245105
Cycle Start Date: September 28, 2026

Dear Administrator:

On September 28, 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.

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized flourish at the end.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 30, 2026

Administrator
THE ESTATES AT ROSEVILLE LLC
2727 NORTH VICTORIA
ROSEVILLE, MN 55113

Re: Reinspection Results
Event ID: 284F05-H2

Dear Administrator:

On September 28, 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 August 6, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive-like script.

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