



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 7, 2025

Administrator

The Estates at Roseville LLC
2727 NORTH VICTORIA
ROSEVILLE, MN 55113

RE: CCN: 245105

Cycle Start Date: May 21, 2025

Dear Administrator:

On July 21, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 5, 2025

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

RE: CCN: 245105
Cycle Start Date: May 21, 2025

Dear Administrator:

On May 21, 2025, 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:

Renee McClellan, 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: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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 August 21, 2025 (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 November 21, 2025 (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>

The Estates At Roseville LLC

June 5, 2025

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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 "M. Poepping", with a stylized, cursive 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/08/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245105	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/21/2025
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT ROSEVILLE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2727 NORTH VICTORIA ROSEVILLE, MN 55113		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments	E 000			
	On 5/18/25 through 5/21/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance.				
	The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.				
F 000	INITIAL COMMENTS	F 000			
	On 5/18/25 through 5/21/25, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.				
	The following complaints were reviewed with no deficiencies cited: H51054790C (MN00102416), H51054815C (MN00102495), H51054813C (MN00102835), H51054812C (MN00105119), H51054810C (MN00106079), H51054809C (MN00108583), H51054811C (MN00109771), H51054772C (MN00110391), H51054816C (MN00111308), and H51054791C (MN00111453).				
	Additionally, the following complaint was reviewed: H51054814C (MN00110905) with a deficiency cited at F558.				
	Lastly, the following complaint was reviewed: H51055067C (MN00112662) with deficient practice identified related to an incidental finding F880.				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/13/2025

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

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F 000	Continued From page 1	F 000			
	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.				
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure call lights were within reach for 2 of 2 residents (R42, R440) reviewed for call lights. Findings include: R42's quarterly Minimum Data Set (MDS) dated 3/12/25, indicated R42 had severe cognitive impairment and diagnoses of dementia and anxiety. Furthermore, R42 required extensive assist with transfers. R42's care plan revised 3/27/25, indicated R42	F 558	R42 and R440 have call light within reach. All residents have the ability to be affected by call lights not within reach. All residents have their call lights within reach. DNS or designee to initiate education to nursing staff on placing call light within reach for resident. DNS or designee to audit resident call light placement of 10 residents per week		7/2/25

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 558	Continued From page 2 had an alteration in mobility related to dementia and anxiety. The care plan directed staff to provide extensive assist of 1 for toileting and transfers and to keep call light within reach at all times. An observation on 5/18/25 at 2:05 p.m., R42 was lying in bed resting. R42's call light was lying on the floor on the left side of their bed. The call light was pushed up against the wall and was tangled in a second soft touch call light. An observation on 5/19 at 1:47 p.m., R42 was lying in awake. R42's call light was on the floor on the left side of the bed. The call light was still pushed up against the wall tangled in with a soft touch call light. When interviewed on 5/19/25 at 1:50 p.m., nursing assistant (NA)-E verified R42 did not have their call light in reach. NA-E untangled the call lights and clipped the red push button call light to R42's blanket. NA-E pushed the call light and looked outside the door to ensure that was the correct call light for R42. NA-E stated residents need to have the call lights at within reach. When interviewed on 5/20/25 at 11:26 p.m., registered nurse (RN)-B stated call lights should be within reach of residents. RN-B further stated R42 was able to communicate some and wasn't sure if they would use it, and still should be in place in case. When interviewed on 5/20/25 at 2:25 p.m., the Director of Nursing (DON) expected call lights to be in a place where residents reach them. Even if the resident may not use it all the time, it still	F 558	to ensure within reach. DNS to bring audit results and review at monthly QAPI with IDT and Medical Director and adjust schedule accordingly.		

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F 558	Continued From page 3 needed to be in place. R440's admission MDS dated 2/3/25, indicated R440 had moderate cognitive impairment, required extensive assistance with transfers, bed mobility, locomotion in manual wheelchair and personal hygiene. R440's diagnoses included fracture of thoracic vertebra, osteoporosis with current fracture, and low back pain. R440's care plan (CP) dated 1/29/25, indicated R440 was at risk for falling due to back pain, impaired mobility, and other diagnoses. The CP instructed staff to keep room clean and free of clutter, and to ensure call light was in reach. R440's falls risk assessment on 1/30/25 indicated R440 was at risk for falls and had one to two falls in the past six months, taking narcotics, dependent for cares, incontinent and hands on assistance for mobility. During interview on 5/21/25 with family member (FM)-B on behalf of R440 stated on dates: -1/29/25 R440 called reported could not find call light, FM-B called nurses desk to ask them for assistance with R440. -2/3/25 FM-B called and talked with licensed practical nurse (LPN- E) to report call light not in reach.	F 558			

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F 558	Continued From page 4 -2/5/25 R440 called FM-B reported needed help, unable to find call light. -2/6/25 at 4:50 p.m., FM-B observed the call light was at R440 feet in bed out of reach. A staff member stated to FM-B that the call light was under the bed earlier that day. -2/8/25 at 4:30 p.m., FM-B observed R440 in wheelchair the call light was across the room on the bed out of reach. -2/11/25 FM-C observed R440 in wheelchair the call light was across the room under the bed, out of reach. During documentation review a progress note on 2/5/25 at 5:49 a.m., FM-B called around 5:15 a.m., stated that R440 called her because she can't find the call light. FM-B went on to say that this is starting to happen every day and what are we going to do about it. Unidentified nursing assistant (NA) grabbed another call light with a clip and clipped to clothing. R440 asked NA how to use call light and NA said she demonstrated how to use. R440 had used call light shortly after to ask when breakfast is coming. During interview on 5/21/25 with LPN-E stated call lights are expected to be answered timely, they need to be next to resident, within arm reach. Confirmed conversation with FM-B about the call light being out of reach. During interview on 5/21/25 with RN-C stated the process for call lights and the location was to be answered promptly. The call light needs to be with hands reach of residents.	F 558			

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F 558	Continued From page 5	F 558			
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and	F 604			7/2/25

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F 604	Continued From page 6 document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure freedom of movement was not restricted for 2 of 2 residents (R122, R335) who were observed during activities. Findings include: R122's admission Minimum Data Set (MDS) dated 3/24/25, indicated R122 had severe cognitive impairment a diagnosis of dementia. R122 required supervision assistance with verbal cues or touching/steadying when going from sitting to standing. R122's electronic medical record lacked indication an assessment was done to determine if R122 could independently unlock their wheelchair breaks. R122's orders lacked indication R122 had orders for locked brakes when in the wheelchair. R122's social service progress note dated 5/9/25 at 8:52 a.m., R133 had been attempting to self-transfer and attempting to climb up and over the wheelchair while sitting at the table. R122's nursing progress note dated 5/13/25 at 1:43 p.m., R133 continued to self-transfer in the supervised area and had been non-directable. R122's nursing progress note dated 5/13/25 at 8:05 p.m., R122 complained of their back hurting while sitting in the wheelchair. R122 continued to	F 604	R122 and R335 have freedom of movement during activities. All residents who utilize wheelchairs have the ability to be affected by this. All residents have freedom of movement during activities. DNS or designee to initiate education with nursing staff on ensuring freedom of movement at activities while in their wheelchairs. DNS or designee to audit resident brakes of 5 residents in wheelchairs a week to ensure they are free from restraints. DNS to bring audit results and will review with IDT and Medical Director at QAPI and adjust schedules accordingly.		

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F 604	Continued From page 7 self-transfer and lean forward. R122 was assisted into a broda chair for comfort and make no other attempts to self-transfer. R122's care plan dated 3/25/25, indicated R122 was at risk for falls related to dementia. Interventions included to keep R122 in the supervised area when out of bed and to ensure wheelchair in good working condition, including locks. R122's care plan lacked indication R122 required locked brakes when in the wheelchair. R335 was recently admitted on 5/14/25, and had diagnoses of Parkinson's Disease () and dementia. R335's provider and nursing orders lacked indication R335 had orders to lock wheelchair breaks when in the wheelchair. R335's physical therapy progress note dated 5/15/25, indicated R335 was dependent to lock/unlock breaks and was able to self-propel in the wheelchair. R335's care plan dated 5/15/25, indicated R335 was a risk for falls related to Parkinson's Disease and dementia. R335 required assistance with transfers. R335's care plan lacked indication R335 required locked brakes when in the wheelchair. An observation on 5/19/25 at 2:01p.m., R122 and R335 were in the common area during an activity. R122 was sitting in their wheelchair with breaks locked pushed in at a table. R335 was sitting in their wheelchair with the breaks locked in the entrance to the back portion of the common area and just behind activities aide (AA)-A. At 2:04	F 604			

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F 604	Continued From page 8 p.m., R122 attempted to stand up and the wheelchair started to tip back so R122 sat back down. R122 attempted to push back and move back on the wheelchair however was not able to as the breaks were locked. Nursing assistant (NA)-M walked over and R122 needed to use the bathroom. NA- unlocked R122's breaks and pushed out of the common area. At 2:17 p.m., NA-M wheeled R122 back into the common area. R122 was pushed up to a table and NA- locked the wheelchair breaks. At 2:20 p.m., R122 was trying to stand up. R122's wheelchair tipped back some and R122 then sat back down. R122 attempted to use feet to bush back and was not able due to the breaks being locked. At 2:22 p.m., R335 was attempting to propel their chair forward with their feet, however, was not able to as the breaks were locked. At 2:25 p.m., R335 again was trying to propel their chair forward and trying to reach for the wall to assist, however was not able to move the chair and not able to reach the wall. AA-A had turned around and briefly talked with R335. When AA-A went back to baking, R335 again started to reach for the wall and attempt to move their chair with their feet. R335 then put hands on the breaks and attempted to move the handles, however, was not able to. R335 started calling out for their husband. AA-A came over to talk to R335 and R335 stopped calling out. At 2:30 p.m., R335 once again attempted to propel their chair forward with their feet and was reaching for the wall without being able to move. AA-A walked past R335 to the sink in the back of the room. R335 began asking for he husband. AA-A came back through and stopped to talk to R335 and offered a snack. At 2:39 p.m., R122 was again attempting to stand up. R122's wheelchair was tipping back	F 604			

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F 604	Continued From page 9 some. AA-A came over and requested R122 to sit back down and R122 did. When interviewed on 5/19/25 at 2:54 p.m., AA-A and NA-L stated some residents need breaks locked so they don't fall. AA-A further stated R122 did not have anti-rollback breaks on and could tip over the chair if he pushed back. R122 was always trying to get up or self-transfer. NA-L was not sure if R122 or R335 could unlock their breaks or if having breaks on was care planned. When interviewed on 5/20/25 at 10:40 a.m., NA-K stated residents wheel chairs should not be locked as it would restrict their movement. When interviewed on 5/20/25 at 11:33 a.m., registered nurse (RN)-B stated wheelchair breaks could not be locked unless the resident could unlock them. RN-B further state R122 and R335 would not be able to unlock their breaks due to their confusion. If breaks were needed to be on, there should be an assessment done. RN-B further stated if the residents want to stand or move, they need to be able to. When interviewed on 5/20/25 at 2:24 p.m., the Director of Nursing (DON) was not aware of an assessment that was done to determine if residents could unlock their wheelchair breaks. DON further stated wheelchair breaks should not be locked unless the resident can unlock them, otherwise it would be considered a restraint. A facility document titled Informed Consent for use of Physical Restraints, no date, directed nursing staff to complete a comprehensive assessment for the use of a restraint, educate risks and benefits of the use and obtain a written	F 604			

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F 604	Continued From page 10	F 604			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F 690			7/2/25

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F 690	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide monthly catheter changes for 1 of 1 resident (R46) reviewed for catheters. Findings include: R46's annual Minimum Data Set (MDS) dated 4/4/25, indicated moderately impaired cognition, diagnoses of multiple sclerosis (MS), neuromuscular dysfunction of the bladder, calculus of the kidney, and no rejection of care behaviors. It further indicated R46 was dependent on staff for toileting hygiene and had a suprapubic catheter. R46's care plan dated 4/4/25, indicated an alteration in elimination related to: neuromuscular dysfunction of the bladder and had a suprapubic (s/p) catheter. It further indicated the following interventions: -assist of 1-2 with toileting every 2 hours and as needed (PRN). -provide assistance with peri-cares (morning) AM, hour of sleep (HS), and PRN. -encourage adequate fluid intake -encourage good pericare -monitor skin integrity -keep call light within reach -monitor for signs and symptoms (S/S) of a urinary tract infection (UTI). -monitor s/p catheter output -change s/p catheter per policy -s/p catheter care per policy R46's physician's orders dated 4/10/24, indicated to change suprapubic catheter monthly and PRN.	F 690	R46 has monthly changes of catheter scheduled and prn. All residents who utilize catheters have the ability to be affected by this. All residents who have a catheter have scheduled and prn change dates. DNS or designee to initiated education to nursing staff on ensuring catheters have change dates. DNS or designee to audit 5 residents a week with catheters to ensure they have scheduled change dates. DNS to bring audit results and will review with IDT and Medical Director at monthly QAPI and adjust schedules accordingly.		

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F 690	Continued From page 12 R46's Medical Adminstration Record (MAR) and Treatment Administration Record (TAR) for the months of November of 2024-April of 2025 lacked documentation R46's catheter had been changed since admission. R46's progress notes for the month of April and May of 2025, lacked documentation the suprapubic catheter had been changed. During interview on 5/21/25 9:06 a.m., registered nurse (RN)-F stated nurses should follow the physician or urology orders when determining how often a resident's catheter should be changed. During interview on 5/21/25 12:00 p.m., registered nurse (RN)-E from MN Urology stated R46 should be getting her catheter changed every 4 weeks and as needed (PRN). If it doesn't get changed every 4 weeks, it can lead to an increased risk of infection, sepsis, and hydronephrosis (swelling of the kidneys). During interview on 5/21/25 9:46 a.m., the nurse manager licensed practical nurse (LPN)-B verified there was no documentation of R46's suprapubic catheter being changed since admission. During interview on 5/21/25 at 10:06 a.m., the director of nursing (DON)/Infection Preventionist (IP) stated the doctor's orders should be followed and R46 should be getting the catheter changed according to those orders. A facility policy regarding catheter care was requested and received, however did not address the time frame of when a residents catheter	F 690			

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F 690	Continued From page 13	F 690			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure provider orders to wean supplemental oxygen were followed for 1 of 1 residents (R34) reviewed for oxygen use. Findings include: R34's annual Minimum Data Set (MDS) dated 4/2/25, indicated R34 had severe cognitive impairment and diagnoses of chronic respiratory failure and dementia. Furthermore, R34 had no trouble breathing or shortness of breath and no oxygen use. R34's discharge summary dated 4/15/25, indicated R34 had been hospitalized for sepsis, pneumonia and urinary tract infection. The summary indicated R34 had acute hypoxic respiratory insufficiency (low blood oxygen saturations) from the pneumonia and instructed to be weaned off supplemental oxygen as able. This summary included an order for oxygen continuous per nasal cannula and to wean as	F 695	R34 had provider orders to wean supplemental oxygen and has been successfully weaned to discontinued. All residents who utilize oxygen have the ability to be affect by this. All residents who utilize oxygen were reviewed and those who have orders for weaning orders were intiated. DNS or designee to initiate education to nursing staff on ensuring provider orders to wean supplemental oxygen are followed through. DNS or designee to audit 5 residents a week on supplemental oxygen and provider orders. DNS to bring audit results and will review with IDT and Medical Director at monthly QAPI and adjust schedules accordingly.	7/2/25	

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F 695	Continued From page 14 able to keep oxygen saturation greater or equal to 90%. R34's provider order dated 4/24/25, indicated R34 required continuous oxygen and directed staff to wean as able to maintain oxygen saturation greater or equal to 90%. R34's treatment administration record (TAR) dated 5/2025, indicated R34's oxygen weaning order had been checked off, however lacked indication of what R34's oxygen flow rate was for any attempts. R34's oxygen saturation summary for 5/2025, indicated R34 was on oxygen via nasal canula for all but two checks. The summary did not indicate what the flow rate was for the oxygen when checked. Two checks had R34 on RA, but the following was again on nasal canula. R34's nursing progress notes reviewed for 5/2025, lacked indication there had been an attempt to wean R34 from their oxygen. R24's care plan revised 4/21/25, indicated R24 had alteration in oxygen exchange and a goal of oxygen saturations greater than 90%. Interventions directed staff to administer oxygen as ordered. An observation on 5/9/25 at 1:57 p.m., R34 was sitting up in their bed with oxygen in place via a nasal canula. R34's oxygen tank was set at 2L. When interviewed on 5/20/25 at 11:12 a.m., registered nurse (RN)-B stated when a resident required oxygen, the providers orders were followed. When there are orders to wean oxygen, we would monitor oxygen saturations about every			F 695			

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F 695	Continued From page 15 hour or so to see how low the oxygen rate could be. Documentation would be in the vital sign section of the medical record or in a progress note. RN-B stated R34 had been on oxygen for a long time and thought it was needed long term. RN-B verified the orders to wean R34's oxygen and stated this had not been attempted the past few days. RN-B then verified the oxygen saturations in the vital sign documentation and was not able to determine if any weaning had taken place. RN-B further stated they could not see any weaning attempts for R34's oxygen in the progress notes either and was not sure when the last time weaning was attempted for R34. When interviewed on 5/20/25 at 2:24 p.m., the Director of Nursing (DON) stated residents on oxygen had oxygen saturations checked each shift. If there were orders to wean, the nursing staff were expected to watch and titrate the oxygen and document in the chart. DON thought the order for oxygen weaning had been discontinued for R34 and verified it had been active since her last hospitalization. DON further verified nurses had not been documenting attempts to wean oxygen and would need to further investigate this.	F 695			
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed	F 700			7/2/25

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F 700	Continued From page 16 rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to attempt alternative devices before the installation of bed rails on resident's beds, identify medical needs to be met with bed rail use, and assess potential entrapment zones for 4 of 4 residents (R76, R23, R103, and R35) reviewed for bed rails. Findings include: R76 R76's quarterly Minimum Data Set (MDS) dated 5/6/25, identified moderately impaired cognition, no functional impairment to upper and lower body, partial/moderate assistance required to roll left and right, substantial/maximal assistance for sit to lying, lying to sitting on edge of bed, sit to stand and chair/bed to chair transfer. Diagnoses included stroke and depression.			F 700	R76, R23, R103 and R35 had alternative devices offered/attempted, identified medical needs to be met with bed rail use and assessed the potential entrapment zones for bed rails. All residents who have bed rails have the potential to be affected by this. All residents who have existing bed rails were reviewed for alternative devices, identified medical needs to be met and assessed the potential entrapment zones for bed rails. DNS or designee to initiate education to nursing staff on offering alternative devices before attempting the installation of bed rails, to identify medical needs to be met with bed rail use and assessing the potential entrapment zones for bed		

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F 700	Continued From page 17 R76's care plan dated 1/31/25, identified an alteration in mobility related to weakness with interventions for PT (physical therapy) per MD (medical doctor) order, one staff assist for ambulation, assist with movement in/out of bed, one staff assist for transfers. Prior to 5/20/25, the care plan lacked intervention of bed rails. R76's IDT (interdisciplinary team) Care Conference dated 4/28/25, included a section for positioning devices which was left blank for type of positioning device, team reviewed risk and benefits and if bed mobility evaluation was completed. Prior to 5/20/25, R76 lacked a bed mobility device evaluation. R23 R23's quarterly MDS dated 4/24/25, identified severely impaired cognition, no functional impairment to upper and lower body, total dependence to roll left and right, substantial/maximal assistance for sit to lying, lying to sitting on edge of bed, sit to stand and chair/bed to chair transfer. Diagnoses included dementia, anxiety and depression. R23's care plan dated 8/22/18, identified ADL (activity of daily living) performance deficit related to dementia and pain with interventions for prn (as needed) assist of one staff, independent. The care plan lacked current use of bed rails. The care plan history showed a "resolved" intervention of assist bars on bed initiated 4/17/21 and resolved on 9/12/22. R23's IDT Care Conference dated 4/15/25, included a section for positioning devices which			F 700	rails. DNS or designee to audit 5 residents a week who either have requested for bed rails or have exiting bed rails to ensure proper alternative devices were offered/attempted before the installation, have identified medical needs to be met by bed rail use and assessed for potential entrapment zones for bed rails. DNS to bring audit results and will review with IDT and Medical Director at monthly QAPI and adjust schedules accordingly.		

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F 700	Continued From page 18 was left blank for type of positioning device, team reviewed risk and benefits and if bed mobility evaluation was completed. R23's Bed Mobility Device Evaluation dated 7/26/24, identified the resident was able to state a preference about bed mobility device and resident/representative requested a bed mobility device of grab bars. Resident/representative was informed on risks/benefits of bruising, skin tears, entrapment, entanglement). The section for alternatives attempted prior to placement of assist was marked N/A (non-applicable). The section for consideration of removal of bed mobility device or other possible alternatives was left blank. The facility had not evaluated alternatives to bed rails. R103 R103's quarterly MDS dated 5/1/25, identified severely impaired cognition, no functional impairment to upper and lower body, substantial/maximal assistance to roll left and right, substantial/maximal assistance for sit to lying, lying to sitting on edge of bed, sit to stand and chair/bed to chair transfer. Diagnoses included stroke and dementia. R103's care plan dated 10/24/24, identified an alteration in mobility related to TIA (transient ischemic attack; a brief period of symptoms like a stroke cause by blockage of blood flow) with interventions of one staff assist with transfer's, ambulation and movement in/out of bed. Prior to 5/20/25, the care plan lacked intervention of bed rails. R103's IDT Care Conference dated 3/25/25, included a section for positioning devices which			F 700			

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F 700	Continued From page 19 was left blank for type of positioning device, team reviewed risk and benefits and if bed mobility evaluation was completed. Prior to 5/20/25, R103 lacked a bed mobility device evaluation. R35 R35's quarterly MDS dated 3/12/25, identified moderately impaired cognition, no functional impairment to upper and lower body, total dependence to roll left and right and from lying to sitting on side of bed, substantial/maximal assistance required sit to lying, sit to stand, and chair/bed to chair transfers. Diagnoses included dementia with behavior disturbance, anxiety and depression. R35's care plan dated 5/25/21, identified an alteration in mobility related to reduced mobility, syncope (fainting) and collapse, with interventions of one staff assist for transfers, one staff ext (extensive) assist with movement in and out of bed. Grab bars to aid in bed mobility was initiated on 12/19/23. R35's IDT Care Conference dated 3/25/25, included a section for positioning devices which was left blank for type of positioning device, team reviewed risk and benefits and if bed mobility evaluation was completed. R35's Bed Mobility Device Evaluation dated 3/19/24, identified the resident was able to state a preference about bed mobility device and resident/representative requested a bed mobility device of grab bars. Resident/representative was informed on risks/benefits of bruising, skin tears, entrapment, entanglement. The section for			F 700			

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F 700	Continued From page 20 alternatives attempted prior to placement of assist bars was marked N/A (non-applicable). The section for consideration of removal of bed mobility device or other possible alternatives was left blank. The facility had not evaluated alternatives to bed rails During an observation on 05/18/25 at 1:54 p.m., R76 was in bed with bilateral bed rails identified as "Assist Rail" (a half rail that mounts to the midsection of the bed) in place. R76 stated he used the bed rails for exercises. During an interview on 5/20/25 at 7:33 a.m., trained medication assistant (TMA)-A stated R76 used the bed rails for transfers and bed mobility. During an interview and observation on 5/20/25 at 7:53 a.m., maintenance assistant (MA)-A stated their process was to place bed rails on a resident bed after nursing assessment. Additionally, nurses needed to let maintenance know if the rails were loose so they could adjust. MA-A accompanied surveyor into R23's room where the bed rails were observed to be loose. MA-A tightened the rails. MA-A stated the rails were the same brand as the bed frame so they were compatible, they would ensure a snug fit when installing. Next, entered R76's room together and the bed rails were loose, and were then tightened by MA-A. MA-A stated their department should have been notified about the loose rails. During an observation on 5/20/25 at 745 a.m., R76, R103, R35 and R23's rooms were observed to have bilateral bed rails in place. During an interview on 5/20/25 at 10:06 a.m., the	F 700			

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F 700	Continued From page 21 director of rehab (DOR) stated they might give recommendations for bed rails, however nursing did the assessments and then maintenance would do the install. During an interview on 5/20/25 at 10:18 a.m., licensed practical nurse (LPN)-A, stated if a resident, family, or therapy suggested a bed rail, nursing would complete a bed mobility device evaluation, get consent, obtain an order for grab bars from the provider, and enter a request for maintenance to install. LPN-A stated maintenance was responsible to ensure the bed and rails were compliant. During an interview on 5/20/25 at 10:38 a.m., R76's resident representative (RR)-A stated she had not asked for bed rails but has seen R76 use his to get out of bed. RR-A stated the facility had not talked to her about rails prior to today. RR-A stated R76 had confusion and that was why he was in the dementia unit. During an interview on 5/21/25 at 10:07 a.m., the director of maintenance (DM) stated the resident beds came with the bed rails, and were the same brand so considered them to be compatible together. The DM stated the process for installing bed rails was for nursing to submit an order. Maintenance would install the rails onto the bed frames and look for gaps. The DM stated he was unsure of the exact measurements for entrapment zones. Manufacturer guidelines were not available for the beds or rails. During a phone call interview on 5/21/25 at 11:07 a.m., the bed and rail manufacturer customer support representative (CSR) stated the product number for the bed rails identified them as	F 700			

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F 700	Continued From page 22 "discontinued" and could not provide manufacturer's guidelines, and would need to search further for the guidelines. Photos of the rails and product stickers were emailed to the CSR for review. During an interview on 5/21/25 at 1:53 p.m., the director of nursing (DON) stated there was not a current process to document alternative devices attempted before installing bed rails. Entrapment zones should be monitored by maintenance and nursing or therapy should complete an evaluation of the resident's medical need for the device. During follow up e-mails on 5/21/25 at 2:50 p.m., the CSR provided a bed user manual which identified the rails as compatible with the bed, however, noted to be a discontinued model. The CSR was not able to provide information about entrapment zones. Manufacturer's guidelines Invacare Carroll CS Bed User Manual dated 2018 identified Patient entrapment from the use of bed side rails may cause injury or death. The Invacare mattress MUST fit firmly against the bed frame AND bed side rails to prevent patient entrapment. Follow the manufacturer's instructions. Monitor patient frequently. Read and understand the User Manual prior to using this equipment. An increased risk of patient entrapment may occur over time due to mattress compression. Periodically monitor gaps between the bed, mattress, and/or bed rail. Where gaps occur, patient entrapment is possible and the mattress should be. The user manual lacked description of the entrapment zones measurements for the bed rails.	F 700			

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F 700	Continued From page 23 Manufacturer's guidelines for the Invacare bed rails was requested and not provided. The Food and Drug Administration's Guide to Bed Safety, revised April 2010, indentified "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high risk patients. The FDA also identified, "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help determine how best to keep the patient safe." The facility policy titled Safe Resident Handling Program dated 3/2020, identified when residents received care and required assistance from facility employee to move (e.g. transferring, lifting, repositioning), that assistance would be provided in a manner that was safe to both the resident and employee. The policy lacked a process to attempt alternative devices before the installation of bed rails on resident's beds, identify medical needs to be met with bed rail use, and resources to assess for risk of entrapment. The Nursing Form Schedule Grid dated 4/16/25, identified a Bed Mobility Device Evaluation should be completed before the initial MDS, quarterly, annually, with significant change and as needed.	F 700			
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a	F 710			7/2/25

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F 710	Continued From page 24 recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the provider maintained coordination of care with an outside provider in order to ensure an appropriate diagnoses and end date for an antibiotic, for 1 of 1 resident (R46) reviewed for prophylactic antibiotics. Findings include: R46's annual Minimum Data Set (MDS) dated 4/4/25, indicated moderately impaired cognition, diagnoses of multiple sclerosis (MS), neuromuscular dysfunction of the bladder, calculus of the kidney and had no rejection of care behaviors. It further indicated R46 was dependent on staff for toileting hygiene, had a catheter, was always incontinent of bowel, and received an antibiotic on a routine basis. R46's urology after visit summary dated 3/15/25, indicated: start taking Ciprofloxacin 500 milligram	F 710	R46 has received coordination of care between outside provider and provider with an appropriate diagnosis and end date of an antibiotic for a prophylactic antibiotic, medication was discontinued. All residents who receive antibiotics have potential to be affected. All residents reviewed who have antibiotics for appropriate diagnosis and end date of antibiotic. DNS or designee to education nursing staff on coordination of care between providers to ensure appropriate diagnosis and end date of an antibiotic. DNS or designee to audit 5 residents on antibiotics weekly for end dates. DNS to bring audit results and review with		

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F 710	Continued From page 25 (mg) tablet. Take 1 tablet (500 mg) by mouth two times daily before meals for nephrolithiasis (kidney stone). R46's monthly signed physician orders dated 3/15/25, indicated Ciprofloxacin HCl oral tablet. Give 500 mg by mouth two times a day for calculus of the kidney (kidney stones). The PA continued to sign orders for Cipro even though it lacked an end date. R46's pharmacy recommendation dated 3/27/25, indicated the resident had continued on Ciprofloxacin 500 mg. BID since 3/15/25. Please clarify duration of therapy. It further indicated the PA failed to choose/document one of the 3 options given (agree, disagree, or other) and hand wrote prophylactic-urology, signed, and dated the recommendation on 3/28/25. The DON also hand wrote "noted," signed and dated on 4/2/25. R46's monthly signed physician's orders dated 4/15/25, indicated Ciprofloxacin HCl oral tablet. Give 500 mg by mouth two times a day for prophylactic related to calculus of kidney before meals. Take at least 2 hours before or 6 hours after antacids or products containing magnesium, aluminum, calcium, iron, or zinc. The orders were signed by the PA on 5/2/25. The PA continued to sign orders for Cipro even though it lacked an end date. The medical record lacked justification of continued antibiotic use. During interview on 5/21/25 at 1:52 p.m., the Assistant Director of Nursing (ADON) verified the original order for Cipro was for post surgical stent	F 710	IDT and Medical Director at montly QAPI and adjust schedules accordingly.		

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F 710	Continued From page 26 placement in regards to kidney stone removal, and was not supposed to be given past 14 days, but they continued it prophylactically. The ADON stated she got the information from what the provider wrote on the pharmacist recommendation. During interview on 5/21/25 at 9:06 a.m. RN-F stated when a resident returns from the hospital with new physician's orders, the HUC or admitting nurse were responsible for entering them and then a 2nd nurse had to verify the orders. If there was a discrepancy (doesn't have an end date) then the nurse should call the provider to clarify the order. During interview on 5/21/25 at 9:34 a.m., licensed practical nurse (LPN)-C stated when a resident returns from the hospital with new physician's orders and there was a discrepancy (an antibiotic without an end date), they should call the hospital or the provider to get clarification During interview on 5/21/25 12:00 p.m., registered nurse (RN)-E from MN Urology-stated R46 was originally prescribed Cipro twice a day for 14 days on 2/4/25, because she had an infection prior to having a scheduled medical procedure and they wanted to clear it before then. RN-E verified R46 should no longer be on the anitbiotic and the provider didn't prescribe any refills so she wasn't sure how R46 was still receiving the medication. During interview on 5/21/25 at 12:52 p.m., the physician's assistant (PA) stated the process for when a doctor's order for a medication doesn't have an end date was to call the provider and get clarification. The PA further stated he didn't think	F 710			

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F 710	Continued From page 27 R46 should be on Cipro (antibiotic) prophylactically but had contacted the urology clinic and they never got back to him stating his "hands were tied." The surveyor asked how the prescription for Cipro kept getting refilled when the original order didn't have any refills. The PA stated he didn't know. The PA also stated he documented that he contacted urology in a progress note before her appointment (unknown date) but never heard back from them. R46's medical record lacked documentation the PA had followed up with the urology clinic. During interview on 5/21/25 at 1:24 p.m., the medical director (MD) stated "We don't like using antibiotics prophylactically and there was no reason to do so for UTI's." He further stated his expectation was for the provider to contact the urologist and follow through in order to get an end date for the antibiotic and doing their due dilligence. R46's progress note dated 3/17/25, indicated LPN-B placed call to the urologist office regarding stop date for antibiotic, awaiting a return call. The progress note lacked the name of which antibiotic she was referring to. R46's progress notes lacked any indication LPN-B had followed through with the urology clinic since 3/17/25. During interview on 5/21/25 9:46 a.m. the nurse manager LPN-B stated when a resident returns from the hospital with new orders, the Health Unit Coordinator (HUC) should enter the orders and leave it pending for a nurse to confirm. Ideally, it should be the nurse manager but if that's not possible, then the admitting nurse can confirm it. If there were any discrepancies (no end date for an antibiotic), they should call the provider for	F 710			

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F 710	Continued From page 28 clarification. LPN-B further stated she was aware R46's was taking Cipro (antibiotic) and that it didn't have an end date. She had been in contact with R46's urologist and asked about an end date but she hadn't heard back from them. She had also spoken to the PA about it but verified there was no documentation regarding their conversation. R46 has had a couple of hospitalizations and each time a resident was hospitalized they discontinue the physician's orders and when they return to the facility, they need to get new orders. During interview on 5/21/25 at 10:06 a.m., the director of nursing (DON)/Infection Preventionist (IP) stated it was the nurse managers responsibility to ensure the doctor's orders are up to date and being followed. If a resident returns to the facility with physician's orders and there was a discrepancy, the provider should be called for clarification. The last time R46 went to the hospital, she reached out to the urologist and asked if they wanted the antibiotic (Cipro) stopped. The surveyor requested documentation of contact with the urologist regarding an end date for the antibiotic and none was received.	F 710			
F 757 SS=D	No policy provided. Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or	F 757			7/2/25

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F 757	Continued From page 29 §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure there was an end date or to investigate and/or document the justification for a prophylactic antibiotic for 1 of 1 resident (R46). Findings include: R46's annual Minimum Data Set (MDS) dated 4/4/25, indicated moderately impaired cognition, diagnoses of multiple sclerosis (MS), neuromuscular dysfunction of the bladder, calculus of the kidney, and had no rejection of care behaviors. It further indicated R46 was dependent on staff for toileting hygiene, had a catheter, was always incontinent of bowel, and received an antibiotic on a routine basis. R46's care plan dated 4/4/25, indicated an alteration in elimination related to: neuromuscular dysfunction of the bladder and had a suprapubic (s/p) catheter. It further indicated the following interventions:	F 757	R46 prophylactic antibiotic has been discontinued. All residents who receive antibiotic medications have the potential to be affected. All residents who receive antibiotics were reviewed and either have documentation with justification for a prophylactic antibiotic or have an end date. DNS or designee to educate nursing staff on antibiotic medications needing documentation with justification or an end date. DNS or designee to audit 5 residents on antibiotics weekly. DNS to bring audit results and review with IDT and Medical Director at monthly QAPI and adjust schedules accordingly.		

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F 757	Continued From page 30 -assist of 1-2 with toileting every 2 hours and as needed (PRN). -provide assistance with peri-cares (morning) AM, hour of sleep (HS), and PRN. -encourage adequate fluid intake -encourage good peri care -monitor skin integrity -keep call light within reach -monitor for signs and symptoms (S/S) of a urinary tract infection (UTI). -monitor s/p catheter output -change s/p catheter per policy -s/p catheter care per policy R46's urology after visit summary dated 3/15/25, indicated: start taking Ciprofloxacin 500 milligram (mg) tablet. Take 1 tablet (500 mg) by mouth two times daily before meals for nephrolithiasis (kidney stone). R46's monthly signed physician orders dated 3/15/25, indicated Ciprofloxacin HCl oral tablet. Give 500 mg by mouth two times a day for calculus of the kidney (kidney stones). The PA continued to sign orders for Cipro even though it lacked have an end date. R46's pharmacy recommendation dated 3/27/25, indicated: resident has continued on Ciprofloxacin 500 mg. twice a day (BID) since 3/15/25. Please clarify duration of therapy. It further indicated the Physician Assistant (PA) failed to choose/document one of the 3 options given (agree, disagree, or other) and hand wrote prophylactive-urology, signed, and dated the recommendation on 3/28/25. The DON also hand wrote "noted," signed and dated on 4/2/25. R46's monthly signed physician's orders dated	F 757			

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F 757	Continued From page 31 4/15/25, indicated Ciprofloxacin HCl Oral tablet. Give 500 mg by mouth two times a day for prophylactic related to calculus of kidney before meals. Take at least 2 hours before or 6 hours after antacids or products containing magnesium, aluminum, calcium, iron, or zinc. The PA continued to sign orders for Cipro even though it lacked an end date. The medical record lacked justification of continued antibiotic use. During interview on 5/21/25 at 1:52 p.m., the Assistant Director of Nursing (ADON) verified the original order for Cipro was for post surgical stent placement in regards to kidney stone removal, and was not supposed to be given past 14 days, but they continued it prophylactically. The ADON stated she got the information from what the PA had written on the pharmacist recommendation. During interview on 5/21/25 at 9:06 a.m. RN-F stated when a resident returns from the hospital with new physician's orders, the HUC or admitting nurse were responsible for entering them and then a 2nd nurse had to verify the orders. If there was a discrepancy (doesn't have an end date) then the nurse should call the provider to clarify the order. During interview on 5/21/25 at 9:34 a.m., licensed practical nurse (LPN)-C stated when a resident returns from the hospital with new physician's orders and there was a discrepancy (an antibiotic without an end date), they should call the hospital or the provider to get clarification During interview on 5/21/25 12:00 p.m., registered nurse (RN)-E from MN Urology-stated	F 757			

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F 757	Continued From page 32 R46 was originally prescribed Cipro on 2/4/25, twice a day for 14 days because she had an infection prior to having a scheduled medical procedure and they wanted to clear it before then. RN-E verified R46 should no longer be on the antibiotic and the provider didn't prescribe any refills so she wasn't sure how R46 was still receiving the medication. During interview on 5/21/25 at 12:52 p.m., the physician's assistant (PA) stated the process for when a doctor's order for a medication doesn't have an end date was to call the provider and get clarification. The PA further stated he didn't think R46 should be on Cipro (antibiotic) prophylactically but had contacted the urology clinic and they never got back to him stating his "hands were tied." The surveyor asked how the prescription for Cipro kept getting refilled when the original order didn't have any refills. The PA stated he didn't know. The PA also stated he documented that he contacted urology in a progress note before her appointment (unknown date) but never heard back from them. R46's medical record lacked documentation the PA had followed up with the urology clinic. During interview on 5/21/25 at 1:24 p.m., the medical director (MD) stated "We don't like using antibiotics prophylactically and there was no reason to do so for UTI's." He further stated his expectation was for the provider to contact the urologist and follow through in order to get an end date for the antibiotic and doing their due diligence. R46's progress note dated 3/17/25, indicated LPN-B placed call to the urology office regarding stop date for antibiotic, awaiting a return call. The	F 757			

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F 757	Continued From page 33 progress note lacked the name of which antibiotic she was referring to. R46's progress notes lacked any indication LPN-B had followed through with the urology clinic since 3/17/25. During interview on 5/21/25 9:46 a.m. the nurse manager LPN-B stated when a resident returns from the hospital with new orders, the Health Unit Coordinator (HUC) should enter the orders and leave it pending for a nurse to confirm. Ideally, it should be the nurse manager but if that's not possible, then the admitting nurse can confirm it. If there were any discrepancies (no end date for an antibiotic), they should call the provider for clarification. LPN-B further stated she was aware R46's was taking Cipro (antibiotic) and that it didn't have an end date. She had been in contact with R46's urologist and asked about an end date but was still waiting for a response and had not followed up with them since then. She had also spoken to the PA about it but verified there was no documentation regarding their conversation. During interview on 5/21/25 at 10:06 a.m., the director of nursing (DON)/Infection Preventionist (IP) stated it was the nurse managers responsibility to ensure the doctor's orders are up to date and being followed. If a resident returns to the facility with physician's orders and there was a discrepancy, the provider should be called for clarification. The last time R46 went to the hospital, she reached out to the urologist and asked if they wanted the antibiotic (Cipro) stopped. The surveyor requested documentation of contact with the urologist regarding an end date for the antibiotic and none was received. A facility policy on antibiotic stewardship dated 3/13/23, indicated the facility will engage the	F 757			

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F 757	Continued From page 34 Consultant Pharmacist to provide guidance with development and implementation of antibiotic protocols and assist in reviewing antibiotic orders and usage and provide recommendations when appropriate. During monthly med reviews, the Consultant Pharmacist will identify orders for antibiotics that are not consistent with antibiotic stewardship practices and make recommendations improved outcomes. The facility will review and revise, if needed, current practices to improve antibiotic use. Action Prior to calling a provider to communicate a suspected infection, the nurse will obtain and have the following information available: . Signs and symptoms of suspected infection (based on McGreer's criteria) . History of present illness . Current medication list . Allergies . Last INR results (if currently receiving warfarin) . All pertinent lab, imaging or test results Prescribers will provide complete antibiotic orders including the following elements: . Drug name . Dose . Frequency of administration . Duration of treatment (including start and stop date or total days of treatment) . Route of administration . Indications for use If a resident is admitted to the facility with orders for antibiotic therapy, the orders will be reviewed for appropriateness and completeness. Any pertinent supporting documentation will also be reviewed and obtained for the medical record. When a resident is discharged home, the antibiotic orders will be reviewed with the resident	F 757			

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F 757	Continued From page 35 and/or resident representative. Appropriate indications for antibiotic use include: . Criteria met for clinical definition of active infection or suspected sepsis; and . Pathogen susceptibility, based on culture and sensitivity, to antimicrobial (or treatment begun while culture is pending. . Empirical use of an antibiotic on clinical criteria may be appropriate. The Infection Preventionist, (IP), or designee, will review all antibiotic orders to determine if treatment is appropriate. Treatment is not appropriate if: . The organism is not susceptible to the antibiotic chosen. . The organism is susceptible to a narrower spectrum antibiotic. . Therapy was ordered for prolonged surgical prophylaxis. . Therapy was started awaiting culture, but no organism was isolated after 72 hours. Interventions that may resolve inappropriate treatment include: . Drug change . Dosage change . Duration change . Obtain culture . Discontinue antibiotic treatment The provider will be notified of the review findings and recommendations and a response will be documented in the resident ' s medical record.	F 757			
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry	F 801			7/2/25

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F 801	Continued From page 36 out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.	F 801			

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F 801	Continued From page 37 §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to employ either a full-time			F 801	Facility has full time coverage of qualified dietary staff per requirements.		

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F 801	Continued From page 38 registered dietician (RD) or a qualified culinary director (CD) to carry out the functions of the food and nutrition services. This had the potential to affect all 135 residents. Findings include: The dietician's license indicated the license was valid and expired 11/30/25. An email was sent to the administrator on 5/21/25 at 8:48 a.m., requesting timecards from September to current for the Dietician's time at the Estates at Roseville. The dietician's timecards were provided on 5/21/25 at 9:27 a.m., from September 2024, to May 2025, however, the timecards did not break down to identify what location the dietician was at per day and week, additionally, the time card showed the dietician had already clocked out at 4:00 p.m. on 5/21/25. An email from the administrator on 5/21/25 at 10:36 a.m., indicated the dietician was full time and further, "she's housed out of Roseville and for Monarch 30 hours a week is full time status (she's an 80 hour a pay period full time employee). Dietitian's usually help support other buildings, she has done this and so her hours also get coded that way." An email was sent to the administrator on 5/21/25 at 10:48 a.m., requesting a copy of the ACD and CD's certifications, credentials, education, and job descriptions. An email from the administrator on 5/21/25 at 12:12 p.m., indicated attachments for the CD's	F 801	All residents have the ability to be affected by this deficit practice. All residents were reviewed and have full time coverage of qualified dietary staff per requirement. Administrator or designee to educate Administrator of expectation of full time status at building of having qualified dietary staff per requirement. Administrator or designee to audit weekly X 4 weeks having full time coverage of qualified dietary staff per requirement. Administrator to bring audit results and review with IDT and Medical Director at monthly QAPI and adjust schedules accordingly.		

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F 801	Continued From page 39 degree and transcript. The attachment included CD's transcripts for Le Cordon Bleu College of Culinary Arts that indicated a certificate was awarded on 3/27/2009, that included coursework in culinary skills and sanitation, principles of butchery, baking and pastry fundamentals, garde manger, flavors of the world, restaurant production, and externship. The ACD's resume was provided on 5/21/25 at 12:57 p.m., that indicated ACD had experience as a culinary director and had a Bachelor's degree in Culinary Arts, however, proof of ACD's credentials, education, and certifications were not provided. During interview on 5/18/25 between 11:39 a.m., and 11:55 a.m., the assistant culinary director (ACD) stated he had been at the facility almost two weeks. ACD stated they had a culinary director who would be at the facility on 5/19/25, and further stated they had a dietitian, but did not know when she came to the facility and had been introduced to the dietitian once. During interview on 5/20/25 at 11:16 a.m., the corporate culinary director (CCD) stated the CD used to be the ACD, and was now the CD. Further, the CCD stated the CD was not a certified dietary manager and thought the facility signed him up for Serv Safe. During interview on 5/20/25 at 11:34 a.m., the administrator stated their dietitian was a certified dietary manager (CDM), and further stated the ACD was also CDM certified. During interview on 5/20/25 at 11:45 a.m., the dietitian stated she was a full time employee, but			F 801			

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F 801	Continued From page 40 split her time between two buildings and was not a CDM. During interview on 5/20/25 at 2:26 p.m., the CCD stated the CD started on 9/5/24, in the position of CD. Further, ACD was new and had Serv Safe and Certified Food Protection Manager (CFPM) and would bring certifications because human resources didn't have any certifications on file. CCD further stated the CD had a certificate from Cordon Blue and did not think this was in the CD's file. During interview on 5/20/25 at 2:30 p.m., the dietician stated she was full time, but went between facilities and further stated that was how they did it at Monarch and stated she also covered at Fridley and thought she worked at the Estates at Roseville three days and maybe more or maybe less. Then stated she worked 30 to 36 hours. Requested work logs since 9/1/2025, for the Estates at Roseville. During interview on 5/20/25 at 2:36 p.m., the CD stated he started in September 2024, as the CD and was not a CDM but was going to be signing up for classes soon. CD stated he graduated from Cordon Blue in 2009 or 2010 and had Serv Safe, but did not renew Serv Safe and did not have an associate's degree or higher, had not had experience in the position of a director of food and nutrition services in a nursing facility setting, and did not complete coursework in food management. During interview on 5/20/25 at 2:41 p.m., the dietician stated the administrator would email her time logs.	F 801			

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F 801	Continued From page 41 During interview on 5/21/25 at 8:43 a.m., registered nurse (RN)-D stated they did not have human resources in the building. On 5/21/25 at 10:12 a.m., attempted to contact the ACD by the phone number provided by the administrator and received an error message the call could not be completed as dialed. During interview on 5/21/25 at 11:16 a.m., the administrator stated the ACD had a CFPM and further stated the dietician worked 30 hours at the facility. Further, the administrator stated the dietician was a salaried employee and the purple lines on the dietician's time card was already set up for 8 hours because the dietician was salaried. The administrator stated the CD had been in the director role since 9/2024, and the facility was enrolling the CD today in the CDM program. Further, the administrator stated the ACD was new and did not have anything in his personnel file and expected human resources to have complete personnel files. During interview on 5/21/25 at 11:27 a.m., the ACD stated he did not have a CDM, but was a certified food protection manager and stated he had it for years, but was just recertified approximately 6 months ago and further stated human resources had a copy. ACD further stated he had a bachelor's degree in culinary, but did not have a copy and could get a copy and had been a director for the last 10 years and had completed coursework in foodborne illness, sanitation procedures, and food purchasing and receiving and worked 40 hours per week. During interview on 5/21/25 at 2:27 p.m., the administrator stated the ACD never made it into	F 801			

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F 801	Continued From page 42 the facility today and further stated she sent all the information she had. Additionally, the ACD started on 4/9/25, and didn't start on the floor until 5/7/25. No additional information was provided regarding staff credentials, certifications, or a break down of the dietician's actual hours worked at the facility. A job description, Culinary Services Assistant Director, signed by the ACD on 4/14/25, indicated under qualifications, must have a desire and commitment to work with geriatric residents and understand their special needs, must have strong clear communication, must be able to follow directions, must be able to perform essential functions, must qualify for employment after criminal background check, per guidelines of the Minnesota Department of Human Services. A job description, Culinary Director, indicated the CD was responsible for managing the culinary service department in providing quality food and nutritional services to residents. The position provides therapeutic meal service based on RDA requirements and standards set forth for quality food provision. The director provides supervision and leadership to all culinary services personnel to assure that services are provided in a consistent quality manner. Under a heading, Education and Experience, indicated must be a graduate of or currently enrolled in an approved Culinary Services Director's course that meets the requirements for State and Federal long term care regulations. Must have management and leadership qualities with a basic understanding of budgeting, food purchasing and menu planning, must have strong clear communication is a must as well as a commitment to improving the knowledge and skill of culinary services to older	F 801			

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F 801	Continued From page 43	F 801			
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide the ordered therapeutic diet for 1 of 1 resident (101) reviewed for provision of modified diet. Findings include: R101's quarterly Minimum Data Set (MDS) dated 5/6/25, indicated R101 was cognitively intact, was independent with eating, required a mechanically altered diet, and did not experience mouth or facial pain, discomfort or difficulty with chewing. R101's diagnoses included cerebral infarction due to thrombosis (clot) of left middle cerebral artery, aphasia (difficulty speaking), and type 2 diabetes. R101's care plan dated 5/15/25, indicated R101 had an alteration in nutritional status related to cerebral infarction. The care plan indicated R101 required regular diet, thin liquids, and soft, bite-sized textures (SB6). R101's dental care area assessment (CAA) dated 8/5/24, indicated R101 had "inflamed or bleeding gums or loose natural teeth."	F 805			7/2/25

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F 805	Continued From page 44 R101's clinical nutritional evaluation dated 4/30/25, indicated R101 required a regular diet of SB6 texture. R101's diet order dated 1/20/25, indicated, "Regular diet, IDDSI [International Dysphagia Diet Standardization Initiative] Level 6; Soft and Bite Sized texture, IDDSI level 0: Thin Liquids consistency." The order status was "active." R101's dental extraction consultation note dated 5/7/25, indicated R101 should eat a softer diet for two days and resume normal diet when comfortable. R101's post-op order dated 5/7/25, indicated, "Eat adequate but softer diet for first 2 days, drinking plenty of fluids but avoiding very hot or cold fluids. Resume normal diet as comfortable." The order status was "active." R101's diet order history printed 5/20/25, indicated, "Regular diet, IDDSI Level 5; Minced and Moist texture, IDDSI level 0: Thin Liquids consistency" had a start dated of 5/7/25 and an end date of 5/9/25. The order status was "completed." R101's progress notes dated 5/7/25 through 5/18/25, lacked evidence of mouth/dental comfort assessment or diet preference conversation. During interview on 5/18/25 at 4:47 p.m., R101 stated he used to get a level 6 diet due to a history of stroke and since his dental extraction, his diet was downgraded to a level 5. R101 stated a level 5 looked like mush on his plate and was not very appetizing. R101 stated he was never reevaluated or asked his comfort level in order to			F 805			

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F 805	Continued From page 45 advance his diet. During observation and interview on 5/19/25 at 12:42 p.m., R101's lunch meal included three mounds of unidentifiable minced food. R101 stated, "Oh yay" and could not tell me what he was eating. R101's lunch meal ticket indicated, "5 Minced & Moist." R101 stated he would love to go back to his previous diet as his teeth feel great and that no one had assessed his mouth in two weeks. During observation and interview on 5/20/25 at 9:06 a.m., nursing assistant (NA)-A delivered R101's breakfast meal and confirmed it was a level 5 texture. NA-A meals were served according to what was on the meal tickets which were printed in dietary, and NAs just confirmed the meal matched the meal ticket. R101 stated level 5 was "mush" and not sure what he was being served most of the time. During interview on 5/20/25 at 10:42 a.m., trained medical assistant (TMA)-B stated residents were admitted with diet orders and changes could occur after a change of condition. TMA-B stated typically speech therapy (ST) would have to do an assessment and then order a new diet. TMA-B stated following a dental procedure the diet could be downgraded temporarily and then the resident could be reassessed by the nurse who could upgrade the diet again. During interview on 5/20/25 at 10:54 a.m., registered nurse (RN)-A stated if a diet needed to be downgraded due to a procedure, there would be a limiting order with an end date and the resident would be reassessed prior to upgrading the diet again. RN-A stated there was always a	F 805			

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F 805	Continued From page 46 nurse in the dining room and present at meals for assessments. If the resident took meals in their room, the nurse should still assess intakes and confirm diets were appropriate. During interview on 5/20/25 at 11:07 a.m., culinary director (CD) and corporate culinary director (CCD) stated nursing would supply the kitchen with a diet communication form with any changes in diet. CD and CCD further stated the order would also be in PCC sent down by nursing and also an order would be entered into in PCC (point click care). PCC interfaced with the dietary system from where the meal tickets were printed. CCD stated the temporary order stop date should trigger a reassessment and then the original order could be restarted. CCD further stated the resident should receive the diet that was ordered and active in PCC and could not explain why R101's meal ticket printed level 5 when the current active order was for a level 6. During interview on 5/20/25 at 12:46 p.m., licensed practical nurse (LPN)-B stated would expect residents to receive the meal that was ordered. During interview on 5/20/25 at 2:42 p.m., director of nursing (DON) stated expectation diets would be provided as ordered. Facility policy Therapeutic Diets dated October 2017, indicated, "Diet will be determined in accordance with the resident's informed choices, preferences, treatment goals and wishes." The policy further indicated, "The dietician, nursing staff, and attending physician will regularly review the need for, and resident acceptance of, prescribed therapeutic diets." The policy	F 805			

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F 805	Continued From page 47	F 805			
F 812 SS=E	instructed the dietician and nursing staff to document in the medical record information relating to the resident's response to their therapeutic diet." Food Procurement,Store/Prepare/Serve-Sanitary 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 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 food items were labeled and dated, milk was discarded past the best by date, cups were not stored in food bins, dented cans did not remain on the shelf, and failed to ensure kitchen floors and equipment were clean. Findings include:	F 812			7/2/25
			All food items are labeled, dated, milk discarded by best by date, cups removed from food bins, dented cans removed from the shelves and kitchen floor and equipment are clean. All residents have the ability to be affected by this deficit practice. All residents have all food items labeled, dated, milk discarded by best by date, cups removed		

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F 812	Continued From page 48 An email from the administrator dated 5/20/25 at 3:16 p.m., indicated floors have been cleaned weekly, sweeping and mopping after the truck delivers so last done was on Tuesday the week prior. Further, the facility developed a formal log on 5/20/25, to show the documentation going forward. The administrator stated the brown circle in dry storage under the rack had been there for two years and they mopped it, deck scrubbed it and will have the floor tech tackle it. During the initial tour of the kitchen on 5/18/25, from 11:39 a.m., to 11:55 a.m., with the assistant culinary director (ACD), observed the following: Freezers: A bag of fish with no label or date, ACD stated there should be a label and a date. A bag of approximately 22 pieces of chicken with no label or date and ACD stated it looked like chicken and verified there was no label or date. a bag of tator tots with no label or date and ACD stated it should be labeled and dated. A garbage bag of breadsticks, ACD stated the facility had lasagna the day prior and added it should have been labeled and dated. An opened box of approximately 15 hamburgers were opened to the air in the freezer and ACD stated they should be closed. Cooler: A gallon of milk with a best by date of 5/11/25, ACD asked staff if the milk could be thrown out. Dry Storage: Two cups were located in a dry storage bin of bread crumbs and ACD stated the cups should not be in the bin. One 6 pound can of diced peaches in light syrup	F 812	from food bins, dented cans removed from the shelves and kitchen floor and equipment is clean. Administrator or designee to educate culinary staff on expectations of food procurement, store/prepare/serve-sanitary. Administrator or designee to audit kitchen weekly X 4 weeks to ensure proper food procurement, store/prepare/serve-sanitary. Administrator to bring audit results and review with IDT and Medical Director at monthly QAPI and adjust schedules accordingly.		

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F 812	Continued From page 49 with multiple dents, ACD stated the can should not be in with the other cans at all. On the floor below wheeled shelving, was approximately a 12 inch by 12 inch area with a thick brown stain, ACD stated had been in the room since he started approximately two weeks prior and looked like something that got spilled and was never wiped up. During interview on 5/20/25 at 11:16 a.m., the corporate culinary director, (CCD) stated she thought floors should be cleaned weekly, but didn't know what the facility was doing. CCD further stated she thought the brown area on the floor should be cleaned with hot water and scraped. CCD further stated cans were returned if dented and should be kept separate and not on the shelf. Verified a 6 pound 10 ounce can of applesauce that was dented and stated she would not have that on the shelf and removed it. Further, CCD stated milk should be used by the best by date and food items in bags should be closed, labeled and dated. A policy was requested for food storage handling along with logs when the floors were last cleaned. CCD stated the culinary director (CD) was not a certified dietary manager and thought they were signing the CD up for Serv Safe. During interview on 5/20/25 at 2:26 p.m., the CCD stated they implemented a cleaning log today for the CD to track and stated ACD cleaned the floor last Tuesday and verified nothing was documented. During interview and observation on 5/21/25 at 12:18 p.m., cook (C)-A stated one of the ovens didn't have a knob on it and observed and there was a brownish substance along the oven doors	F 812			

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F 812	Continued From page 50 with brown flakey particles on the handles. C-A stated it was last cleaned a month ago and stated it was a buildup of greese on the Blodgett stove and further stated it fell mostly on C-A to clean and didn't get attended to more often due to staffing. During interview and observation on 5/21/25 at 2:01 p.m., CD verified the dirty ovens and stated they would be on a cleaning list and stated they should be done weekly and looked at the stove and stated he wiped it down Monday and stated he would be talking to the night cooks to make sure they wipe down the oven fronts and the table tops and under the tables where there was a lot of buildup. The CD verified there was no cleaning log to show ovens had been wiped down and stated he would have logs when he wasn't running around as much. A policy, Food Receiving and Storage, dated October 2017, indicated food services or other designated staff will maintain clean food storage areas at all times. Dry foods that are stored in bins will be removed from original packaging, labeled and dated (use by date). All foods stored in the refrigerator or freezer will be covered, labeled and dated. Wrappers of frozen foods must stay intact until thawing.	F 812			
F 880 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	F 880			7/2/25

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F 880	Continued From page 51 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: (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	F 880			

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F 880	Continued From page 52 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 appropriate transmission-based precautions (TBP) for 1 of 1 residents (R388) who required enhanced respiratory precautions for COVID-19 and for 1 of 1 residents (R123) who required enhanced barrier precautions (EBP) for dressing changes. Findings include: R388's Medical Diagnoses form indicated R388 had COVID-19 on 5/16/25. Further, the form indicated R388 was on enhanced respiratory precautions related to COVID-19 and his last day of isolation was on 5/22/25, and R388 could come out of isolation on 5/23/25.	F 880	R388 has discharged and R1234 does not require enhanced barrier precautions as dressing changes were discontinued. All residents who have infections requiring enhanced barrier precautions are at risk by this deficit. All residents reviewed have proper protocols for enhanced barrier precautions as well as staff wearing proper precautions. DNS or designee to educate all staff on enhanced barrier precautions and wearing proper precautions. DNS or designee to audit 5 residents a week X 4 weeks with required precautions to ensure staff are wearing proper		

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F 880	Continued From page 53 R388's care plan dated 5/18/25, indicated R388 had COVID-19 and interventions included monitoring for signs and symptoms of COVID-19, restrict from group activities and exposure until symptoms have resolved, complete vital signs per orders. The care plan lacked information on what PPE to donn and when PPE should be donned. R388's progress notes dated 5/17/25, indicated R388 was admitted to the facility with a recent COVID-19 infection. During interview and observation on 5/20/25 at 8:46 a.m., nursing assistant (NA)-F entered R388's room with a surgical mask on and asked R388 what he wanted for breakfast. NA-F stated he thought R388 had COVID and stated when going into the room, he is supposed to wear a gown, mask, goggles, and gloves and an N95 mask and NA-F stated he only wore the surgical mask because he did not provide any cares for R388. NA-F verified signage indicated R388 had enhanced respiratory precautions signage. During interview and observation on 5/20/25 at 8:49 a.m., NA-G went into R388's room with a gown, gloves, and surgical mask and verified R388 had signage for enhanced respiratory precautions and stated R388 had COVID. NA-G stated he did not donn goggles or an N95 mask because he was not changing a brief and was only delivering breakfast. NA-G verified the signage on the door that indicated R388 was on enhanced barrier precautions and enhanced respiratory precautions. During interview on 5/20/25 at 8:55 a.m., licensed practical nurse (LPN)-C stated when a resident was on enhanced respiratory precautions, staff	F 880	precautions. DNS to bring audit results and review with IDT and Medical Director at monthly QAPI and adjust schedules accordingly.		

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F 880	Continued From page 54 were required to wear an N95, gloves, gown, and goggles whenever they go in the room and verified R388 was on precautions until 5/22/25. LPN-C stated PPE was important to donn because COVID circulates and staff need to donn appropriate PPE because R388 had COVID. During interview on 5/20/25 at 9:00 a.m., registered nurse (RN)-C stated when a resident had COVID, they were on isolation precautions for a 10 day period and when on enhanced respiratory precautions, all services were provided in the resident's room. RN-C stated she expected staff donn PPE whenever they enter the room because they want to protect staff and other residents from catching COVID. RN-C further stated she thought staff needed additional education regarding the difference between enhanced barrier precautions and enhanced respiratory precautions. During interview on 5/21/25 at 10:06 a.m., the director of nursing stated enhanced respiratory precautions was strictly for COVID and staff were required to donn PPE including an N95, and eye protection even if dropping off a tray. R123 R123's admission MDS dated 4/8/2025, indicated R123 had moderate impaired cognition and diagnoses of dementia and frostbite to bilateral hands. R123's provider order dated 5/7/25 instructed staff to follow EBP while providing wound cares and other high contact activities.	F 880			

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F 880	Continued From page 55 R123's care plan dated 4/3/25, indicated R123 required EBP related to frostbite of bilateral hands and surgical amputations. Furthermore the care plan directed staff to don personal protective equipment per EBP precautions when providing high contact cares. An observation on 5/20/25 at 10:45 a.m., registered nurse (RN)- B entered R123's room to perform a dressing change to their bilateral hands. R123's door had a sign that stated EBP and instructed staff to don gown and gloves when performing cares that require contact with the resident. RN-B performed hand hygiene and donned gloves, however, did not don a gown. RN-B proceeded to complete the dressing change for R123's left hand and right hand without concerns. RN-B then removed gloves, performed hand hygiene before exiting R123's room. When interviewed on 5/20/25 at 11:10 a.m., RN-B stated R123 was on EBP and verified she should have worn a gown when completing the dressing changes. When interviewed on 5/21/25 at 10:06 a.m., the Director of Nursing (DON), who was also the infection preventionist (IP) stated enhanced respiratory precautions were for residents who were positive for COVID-19. Staff were expected to use all the PPE that was needed, even if staff even for dropping off a meal tray. The PPE required was gown, gloves and 95 respirator mask. EBP was placed for residents who had wounds, catheters... etc. When a resident was on EBP, staff was expected to follow the sign on the doors and don PPE during high contact cares.	F 880			

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F 880	Continued From page 56 A policy, COVID Policy, updated 12/6/24, indicated the facility followed standard and transmission based precautions (TBP) to prevent the transmission of COVID-19 within the facility. Further, staff entering the room of a patient with suspected or confirmed COVID infection should utilize enhanced respiratory precautions and utilize an approved N95 respirator, gown, gloves, and eye protection. A facility policy titled Enhanced Barrier Precautions revised 4/1/24, directed staff to implement EBP for residents with wounds (chronic, unhealed surgical wounds, etc) or indwelling medical devices. The policy further directed staff to wear appropriate PPE for any residents with wound care (any skin opening requiring a dressing).	F 880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245105		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/20/2025	
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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 05/20/2025, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, The Estates of Roseville Llc 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			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/13/2025

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

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K 000	Continued From page 1 State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: The 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			K 000			

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K 000	Continued From page 2 1973 addition and was determined to be Type II (222) construction. The facility has a capacity of 140 beds and had a census of 138 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000			
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include:	K 372	Facility has sealed up the penetration site of the smoke barrier near the environmental services door. All residents could have an isolated impact on this deficit practice. All smoke barriers were assessed and are up to code, no other penetration sites noted.		7/2/25

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K 372	Continued From page 3 On 05/20/2025 at 10:50 AM, it was revealed by observation that there was a penetration in the smoke barrier near the environmental services door. An interview with the Administrator, Regional Maintenance Director and the Maintenance Director. verified this deficient finding at the time of discovery.	K 372	Administrator or designee to educate Maintenance staff on smoke barriers. Administrator or designee to audit 5 smoke barriers a month to ensure no penetration sites. Administrator to bring audit results and review with IDT and Medical Director at monthly QAPI and adjust schedule accordingly.		
K 741 SS=D	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is	K 741		7/2/25	

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K 741	Continued From page 4 permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to implement per NFPA 101 (2012 edition), Life Safety Code or NFPA 99 (2012 edition), Health Care Facilities Code, section 19.7.4. This or deficient finding could have a isolated impact on the residents within the facility. Findings include: On 5/18/2025, based on observation by the Minnesota Department of Health survey team in resident room 810 "Found cigarette butts in her garabage. On 5/20/2025 at 12:02 PM, per Life Safety Surveyor there was not an observation of cigarette butts in the residents trash can. It was determined that the facility was not following their smoking policy. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 741	Facility is following their smoking policy as it has changed to a smoking facility outside in specific location with proper noncombustible receptacles for cigarette butts. All residents who smoke have the ability to be impacted. All residents who smoke have been educated on smoking policies and utilizing receptacles outside for cigarette butts. Administrator or designee to educate all staff and residents who identify as smoker on smoking policy specific to facility and expectations around utilizing receptacles outside for cigarette butts. Administrator or designee to audit 5 residents who smoke a week to ensure they are following proper facility smoking policy and using receptacles for cigarette butts. Administrator to bring audit results and review with IDT and Medical Director at monthly QAPI and adjust schedules accordingly.		