



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered  
March 3, 2021

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

RE: CCN: 245105  
Cycle Start Date: January 26, 2021

Dear Administrator:

On February 9, 2021, we notified you a remedy was imposed. On March 1, 2021 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 27, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective February 24, 2021 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of February 9, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 26, 2021. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

Melissa Poepping, Health Program Representative Senior  
Program Assurance | Licensing and Certification  
Minnesota Department of Health  
P.O. Box 64970  
Saint Paul, Minnesota 55164-0970  
Phone: 651-201-4117  
Email: melissa.poepping@state.mn.us



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Electronically delivered

March 3, 2021

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

Re: Reinspection Results  
Event ID: 6M5Z12

Dear Administrator:

On March 1, 2021 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 26, 2021. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

Melissa Poepping, Health Program Representative Senior  
Program Assurance | Licensing and Certification  
Minnesota Department of Health  
P.O. Box 64970  
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 Submitted  
February 9, 2021

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

RE: CCN: 245105  
Cycle Start Date: January 26, 2021

Dear Administrator:

On January 26, 2021, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

#### **REMOVAL OF IMMEDIATE JEOPARDY**

On January 22, 2021, the situation of immediate jeopardy to potential health and safety cited at F600 was removed. However, continued non-compliance remains at the lower scope and severity of G.

#### **REMEDIES**

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 24, 2021.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 24, 2021 (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 24, 2021,(42 CFR 488.417 (b)).

The Estates At Roseville Llc

February 9, 2021

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You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

### **NURSE AIDE TRAINING PROHIBITION**

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective January 26, 2021. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

### **SUBSTANDARD QUALITY OF CARE**

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, The Estates At Roseville Llc is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective January 26, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

## **ELECTRONIC PLAN OF CORRECTION (ePOC)**

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

## **DEPARTMENT CONTACT**

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

**Terri Ament, Unit Supervisor**  
**Duluth District Office**  
**Licensing and Certification Program**  
**Health Regulation Division**  
**Minnesota Department of Health**  
**Duluth Technology Village**  
**11 East Superior Street, Suite 290**  
**Duluth, Minnesota 55802-2007**  
**Email: [teresa.ament@state.mn.us](mailto:teresa.ament@state.mn.us)**  
**Office: (218) 302-6151 Mobile: (218) 766-2720**

## **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 their 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

The Estates At Roseville Llc

February 9, 2021

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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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY**

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 26, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.**

#### **APPEAL RIGHTS DENIAL OF PAYMENT**

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

**[Tamika.Brown@cms.hhs.gov](mailto:Tamika.Brown@cms.hhs.gov)**

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services  
Departmental Appeals Board, MS 6132  
Director, Civil Remedies Division  
330 Independence Avenue, S.W.  
Cohen Building – Room G-644  
Washington, D.C. 20201  
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding

The Estates At Roseville Llc

February 9, 2021

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this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

#### **APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION**

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services  
Departmental Appeals Board, MS 6132  
Director, Civil Remedies Division  
330 Independence Avenue, S.W.  
Cohen Building – Room G-644  
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

#### **INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)**

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process  
Minnesota Department of Health  
Health Regulation Division  
P.O. Box 64900  
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:  
[https://mdhprovidercontent.web.health.state.mn.us/ltc\\_idr.cfm](https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm)

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period

The Estates At Roseville Llc

February 9, 2021

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allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

[https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\\_8.html](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html)

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.

Feel free to contact me if you have questions.

Sincerely,

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

Melissa Poepping, Health Program Representative Senior  
Program Assurance | Licensing and Certification  
Minnesota Department of Health  
P.O. Box 64970  
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: 03/01/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245105</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/26/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>THE ESTATES AT ROSEVILLE LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2727 NORTH VICTORIA ROSEVILLE, MN 55113</b>		
(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	
F 000	<p><b>INITIAL COMMENTS</b></p> <p>On 1/21/21, through 1/26/21, a complaint investigation was completed at your facility by the Minnesota Department of Health. Your facility was found not in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>This survey resulted in an Immediate Jeopardy (IJ) and substandard quality of care at F600 related to staff to resident physical abuse. The IJ began on 1/16/21, when licensed practical nurse (LPN)-A grabbed R1's right arm resulting in an injury and the facility failed to ensure all residents residing on the Lexington unit were protected from LPN-A, who was allowed to continue working after causing substantial injury to R1's right arm. The facility administrator was notified of the IJ on 1/21/21, at 4:30 p.m. The IJ was removed on 1/22/21, at 12:10 p.m. but non-compliance remained at the lower scope and severity of G, actual harm, that is not immediate jeopardy.</p> <p>In addition, the above findings constituted substandard quality of care, and an extended survey was conducted on 1/22/21.</p> <p>The following complaints were found to be SUBSTANTIATED: H5105173C, H5105178C</p> <p>The following complaint was found to be UNSUBSTANTIATED: H5105174C H5105175C H5105176C H5105177C</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/11/2021

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.

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

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F 000	Continued From page 1 H5105179C  The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000			
F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1)  §483.12 Freedom from Abuse, Neglect, and Exploitation 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)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents were protected	F 600	R1 remains in the facility and is free from abuse and neglect. LPN-A has been	1/27/21	

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F 600	<p>Continued From page 2</p> <p>from abuse by staff for 1 of 4 residents (R1) reviewed for an allegation of abuse. The facility's failure to protect residents resulted in an immediate jeopardy situation. This had the potential to affect all 30 residents residing in the Lexington unit. In addition, an extended survey was completed.</p> <p>The IJ began on 1/16/21, when licensed practical nurse (LPN)-A allegedly grabbed R1's right arm resulting in an injury, and the facility failed to ensure all residents residing on the Lexington unit were protected from LPN-A, who was allowed to continue working on the Lexington unit after causing an injury to R1's right arm. The facility administrator was notified of the IJ on 1/21/21, at 4:30 p.m. The IJ was removed on 1/22/21, at 12:10 p.m. but non-compliance remained at the lower scope and severity of H, actual harm, that is not immediate jeopardy.</p> <p>Findings Include:</p> <p>R1's Admission Record printed 1/22/21, indicated R1's diagnoses included malignant neoplasm of upper left lung, hypertension (high blood pressure) and chronic obstructive pulmonary disease.</p> <p>R1's quarterly Minimum Data Set (MDS) assessment dated 12/1/20, indicated R1 was cognitively intact, and had no physical or verbal behavioral issues.</p> <p>An untitled facility incident report dated 1/16/21, indicated LPN-A had entered R1's room to assist R2 with a transfer to his bed. R1 was noted to be located on his own side of the room, but had went to R1's side of the room. The report indicated R1</p>	F 600	<p>terminated and no longer works at facility.</p> <p>Residents will remain free from abuse and neglect within the facility. All residents interviewed to ensure immediate safety. All residents interviewed regarding their rights to be free from abuse, neglect and exploitation specific to ensuring their safety at the facility from both other residents and staff and care needs being met. Any residents who reported concerns with abuse, neglect and/or exploitation were reported to the appropriate state agency and/or facility internal Complaint and Grievance Process.</p> <p>Re-education was initiated and will remain ongoing with staff on Abuse Prohibition/Vulnerable Adult Plan specific to reporting, types of abuse including intentional and unintentional process including staff suspension(s). Staff education also initiated on how to de-escalate resident behaviors. Staff education also consists of Resident Rights. Staff abuse quizzes initiated. Resident education included how/who to report any incidents of abuse, neglect and/or exploitation to within the facility, corporate compliance hotline, MDH and Ombudsman.</p> <p>Audits of residents safety questionnaires will consist of 10 residents daily for 2 weeks, weekly for 4 weeks then monthly for 3 months. Audits of Staff Knowledge questionnaires regarding abuse will be completed with 5 staff weekly for 4 weeks,</p>		

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F 600	Continued From page 3 LPN-A had been angry and upset because LPN-A had turned on the room light. R1 was noted to have been yelling at LPN-A to turn out the light, he grabbed LPN's shirt and threatened to hit her. LPN-A grabbed R1's right upper arm to push him away, in self-defense. Nursing assistant (NA)-A entered the room, verbally redirected R1, and brought R1 back to his own side of the room. At that time, R1's right upper arm was noted to have a bruise measuring 4.5 centimeters (cm) long by 7.5 cm wide. R1's right upper arm also had five 1 cm skin tears from LPN-A's fingernails, when she had grabbed R1's arm. The report further indicated R1's description of the incident, "Every night she comes in room about 12 AM and turns on all the lights" and "I got angry." R1 stated he went over to roommates' side of the room to show her how to use the light cord to turn the light on above his bed. R1 stated he grabbed her shirt to get her attention, and that is when she "grabbed my arm, caused me to bleed and this bruise." The incident report also included NA-A's description of the incident. NA-A stated he had been walking down R1's hallway to answer a call light, and he heard LPN-A yelling out from R1's room. When NA-A entered R1's room, he observed R1 yelling at LPN-A, and it appeared R1 was going to strike at LPN-A. NA-A observed R1 grab the top of LPN-A's shirt. NA-A stated he did not see LPN-A grab R1's arm, but believed LPN-A had caused the injury to R1's right arm. The report indicated the facility took immediate action that included cleansing right arm with wound cleaner and Bacitracin was applied to R1's skin tears. R1 had refused a dressing. In addition, registered nurse (RN)-A had discussed the incident with LPN-A, and at the time of the report, LPN-A stated R1 had become angry because she turned all the lights in the room instead of just	F 600	monthly for 3 months. QAPI Committee will review audits to ensure completion and/or continuation of monitoring process.  Administrator and/or designee is responsible party.		

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NAME OF PROVIDER OR SUPPLIER  <b>THE ESTATES AT ROSEVILLE LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2727 NORTH VICTORIA ROSEVILLE, MN 55113</b>		
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F 600	<p>Continued From page 4</p> <p>turning on the light over R2's bed. LPN-A denied touching R1, and was told to no longer provide cares for R1.</p> <p>On 1/21/21, at 9:55 a.m. R1 was interviewed and stated on 1/16/21, he had gotten up to walk over to R2's side of the room. R1 stated he went over to show LPN-A how to use the light cord above R2's bed, instead of turning on the main light in the room. R1 stated he grabbed LPN-A's sweatshirt hood to get her attention, and that's when LPN-A grabbed his right arm and caused the injury. A large bruise was noted on R1's right upper arm that was deep purple in color. R1's arm also had 5 skin tears. R1 stated, "[LPN-A] grabbed my arm and caused this injury, and I want something done about it." R1 further stated he had seen LPN-A walking down the hallway the following day and it was very upsetting, "She should have had at least a week off for doing this to my arm."</p> <p>On 1/21/21, at 11:01 a.m. the administrator and the director of nursing (DON) were interviewed and stated there had been an incident involving LPN-A and NA-A on 1/16/21, at approximately 11:45 p.m. The administrator stated RN-A had sent her a text message indicating there had been an issue involving LPN-A grabbing R1's arm in possible self-defense. This resulted in R1 sustaining a bruise and skin tear marks from LPN-A's fingernails. The administrator stated she had called the facility back around 12:26 a.m. and asked RN-A to explain the situation again to her. The administrator stated RN-A relayed to her in the phone conversation R1 had been upset with LPN-A regarding the light, and R1 had went over to R2's side of the room, grabbed LPN-A's sweatshirt, and threatened to punch her. The</p>	F 600			

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F 600	<p>Continued From page 5</p> <p>administrator also stated RN-A had told her NA-A observed R1's injury, and had told RN-A that LPN-A had caused R1's injuries. The administrator stated she instructed RN-A to go interview R1 to get his side of the story, and report back to her. The administrator stated RN-A did not call her back that night, nor was additional investigation completed by the facility related to the allegation until 1/18/21. The administrator stated R1 had not changed his story about the incident, nor did R1 have a history of physical aggression towards staff or residents. The administrator stated after the incident was reported to her, LPN-A had been instructed to not provide cares for R1, however, LPN-A was still allowed to provide cares for other residents residing on the unit. The administrator verified the incident had not been reported the State Agency (SA) until 1/18/21, at 12:17 p.m. even though RN-A had reported immediately to her that LPN-A may have caused the injuries to R1's right arm. The administrator further stated all allegations of potential or actual abuse are required to be reported immediately and no later than 2 hours to the SA. The administrator verified LPN-A was suspended on 1/18/21, related to the allegation of abuse.</p> <p>LPN-A's employee time punch form dated 1/21/21, indicated LPN-A worked the date of 1/16/21, from 10:00 p.m. until 3:05 p.m. the following day, 1/17/21. LPN-A's employee time punch form dated 1/21/21, indicated LPN-A worked the date of 1/17/21, from 10:00 p.m. till 6:00 a.m..</p> <p>On 1/21/21, at 12:36 p.m. LPN-A was interviewed and stated she had been working the night of 1/16/21. LPN-A stated she had heard yelling and</p>	F 600			

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F 600	<p>Continued From page 6</p> <p>profanity coming from R1 and R2's room. LPN-A stated R1 and R2 were standing next to R2's bed holding each other. LPN-A stated R2 cannot walk, so she immediately thought she needed to help prevent R2 from falling. LPN-A stated she wrapped her arms around R2, and held him close to her body. LPN-A stated R1 was holding onto R2's wheelchair (W/C) out of her reach, but she was able to stretch to reach R2's W/C and place him in his chair. LPN-A stated she placed R2 in his W/C and left the room. When asked if R1 had grabbed her shirt, LPN-A stated, "No one grabbed me." When asked if she had grabbed R1's arm, LPN-A stated, "I have nothing to talk about."</p> <p>On 1/22/21, at 6:46 a.m. RN-A was interviewed and stated she was the RN supervisor the night of 1/16/21. RN-A stated NA-A had reported to her there was issue involving LPN-A and R1. RN-A stated she went to R1's room and observed R1 seated on his bed. RN-A stated R1 had told her "look at my arm" and she could see a large bruise with fingermarks. RN-A stated R1 repeated to her again that LPN-A did this to him. RN-A stated R1 said he was angry with LPN-A because she would come in the room every night and turn on the room light, verses the individual light over the bed. RN-A stated R1 stated he went to R2's side of the room and grabbed LPN-A's shirt. RN-A stated R1 told her LPN-A grabbed him, and caused the injuries to his arm. RN-A stated R1 kept repeating that LPN-A did this to him. RN-A stated she immediately contacted the administrator via text asking for help with the situation. RN-A started to cry, and stated she did everything she was told to do. RN-A stated LPN-A was very hard to understand, and was hysterical when she was trying to talk to her following the incident. RN-A stated getting help on the night</p>	F 600			

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F 600	<p>Continued From page 7</p> <p>shift is very hard, but she had given the administrator the information relating to R1's report of abuse by LPN-A causing the injuries to his arm. RN-A stated she even went to another unit to get help from RN-B. RN-A stated RN-B went and talked to R1, and he reported the same to her that LPN-A caused the injury to his right arm. RN-A stated the DON also called her later that morning, and discouraged her from sending LPN-A home. RN-A stated she was instructed to by the DON to interview R1 again to see if there were any differences in his story. RN-A stated, " I had the feeling like the [DON] was trying to get him to say the injury was caused by [LPN-A] in self-defense, but R1 had already told her [LPN-A] caused the injury." RN-A stated she felt it was a reportable incident. RN-A further stated she had reported to the administrator and the DON what R1 and NA-A had told her. RN-A stated the incident was reported later to the SA, and an incident report had been filled out immediately as potential abuse. RN-A stated she believed the administrator and DON were going to report this immediately as abuse. RN-A stated LPN-A should have been sent home, however, she was instructed by the DON to allow her to continue working the night shift and the dayshift.</p> <p>On 1/22/21, at 7:50 a.m. RN-B was interviewed. RN-B stated on 1/16/21, she had gone to R1's room to complete an interview and assess R1's injury to his right upper arm. RN-B stated R1 told her LPN-A had come into the room around midnight to provide cares for his roommate, and LPN-A had turned the main light on instead of R2's light above his bed. RN-B stated R1 told her LPN-A would do that all the time, and it would wake him up. RN-B stated R1 told her he wanted to show LPN-A that she should use the light</p>	F 600			

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F 600	<p>Continued From page 8</p> <p>above the bed, and went over to R2's side of the room, where he grabbed LPN-A's jacket, and LPN-A grabbed his arm. RN-B stated the information R1 shared with her that night was the same as R1 relayed to RN-A at the time of the incident.</p> <p>The facility policy Abuse Prohibition/Vulnerable Adult Plan revised 7/5/19, defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. The policy directed staff to ensure residents were not subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends or other individuals, or self-abuse. The policy further directed the immediate supervisor, "If this is staff to resident alleged or suspected abuse, the staff person will be immediately suspended until the investigation is completed."</p> <p>The facility implemented corrective action to prevent recurrence on 1/22/21, at 12:10 p.m. The facility completed interviews and questionnaires with all residents regarding their rights to be free from abuse, neglect, and exploitation, specific to ensuring their safety at the facility from both other residents and staff, and that there care needs were being met. Any residents who reported concerns with abuse, neglect and/or exploitation were reported to the appropriate state agency and/or facility internal Complaint &amp; Grievance Process. Staff were educated on how/who to report any incidents of abuse, neglect, and/or exploitation to within the facility, to the corporate compliance hotline, to the SA and Ombudsman.</p>	F 600			

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F 600	Continued From page 9 In addition, staff education had been initiated and will remain ongoing regarding Abuse Prevention/Prohibition specific to reporting, types of abuse including intentional and unintentional and investigation process including staff suspension(s). Staff education also included how to deescalate resident behaviors. and staff were educated on resident rights. This was verified through staff interview and documentation review.	F 600			
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)  §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:  §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.  §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the	F 609		1/27/21	

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F 609	<p>Continued From page 10 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review, the facility failed to ensure allegations of abuse were reported within 2 hours to the State Agency (SA) for 1 of 4 residents (R1) reviewed for abuse.</p> <p>Findings include:</p> <p>R1's Admission Record printed 1/22/21, indicated R1's diagnoses included malignant neoplasm of upper left lung, hypertension (high blood pressure) and chronic obstructive pulmonary disease.</p> <p>R1's quarterly Minimum Data Set (MDS) assessment dated 12/1/20, indicated R2 was cognitively intact, and had no physical or verbal behavioral issues.</p> <p>An untitled facility incident report dated 1/16/21, indicated LPN-A had entered R1's room to assist R2 with a transfer to his bed. R1 was noted to be located on his own side of the room, but had went to R1's side of the room. The report indicated R1 had been angry and upset because LPN-A had turned on the room light. R1 was noted to have been yelling at LPN-A to turn out the light, he grabbed LPN's shirt and threatened to hit her. LPN-A grabbed R1's right upper arm to push him away, in self-defense. Nursing assistant (NA)-A entered the room, verbally redirected R1, and brought R1 back to his own side of the room. At that time, R1's right upper arm was noted to have a bruise measuring 4.5 centimeters (cm) long by 7.5 cm wide. R1's right upper arm also had five 1 cm skin tears from LPN-A's fingernails, when she</p>	F 609	<p>R1 remains in the facility free from abuse and neglect.</p> <p>Resident allegations of abuse and/or neglect will be reported timely per Abuse Prohibition/Vulnerable Adult Plan</p> <p>Re-education was initiated and will be ongoing with staff on Abuse Prohibition/Vulnerable Adult Plan specific to timeliness of reporting</p> <p>Audits of 3 OHFC reports specific to timeliness of reporting will be completed weekly X 4 weeks, monthly for 3 months and then reviewed at QAPI to ensure completion and/or continuation of monitoring process.</p> <p>Administrator and/or designee is responsible party</p>		

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F 609	<p>Continued From page 11</p> <p>had grabbed R1's arm. The report further indicated R1's description of the incident, "Every night she comes in room about 12AM and turns on all the lights" and "I got angry." R1 stated he went over to roommates' side of the room to show her how to use the light cord to turn light on above his bed. R1 stated he grabbed her shirt to get her attention, and that is when she "grabbed my arm, caused me to bleed and this bruise." The incident report also included NA-A's description of the incident. NA-A stated he had been walking down R1's hallway to answer a call light, and he heard LPN-A yelling out from R1's room. When NA-A entered R1's room, he observed R1 yelling at LPN-A, and it appeared R1 was going to strike at LPN-A. NA-A observed R1 grab the top of LPN-A's shirt. NA-A stated he did not see LPN-A grab R1's arm, but believed LPN-A had caused the injury to R1's right arm. The report indicated the facility took immediate action that included cleansing right arm with wound cleaner and Bacitracin was applied to R1's skin tears. R1 had refused a dressing. In addition, registered nurse (RN)-A had discussed the incident with LPN-A, and at the time of the report, LPN-A stated R1 had become angry because she turned all the lights in the room instead of just turning on the light over R2's bed. LPN-A denied touching R1, and was told to no longer provide cares for R1.</p> <p>On 1/21/21, at 9:55 a.m. R1 was interviewed and stated on 1/16/21, he had gotten up to walk over to R2's side of the room. R1 stated he went over to show LPN-A how to use the light cord above R2's bed, instead of turning on the main light in the room. R1 stated he grabbed LPN-A's sweatshirt hood to get her attention, and that's when LPN-A grabbed his right arm and caused</p>	F 609			

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F 609	<p>Continued From page 12</p> <p>the injury. A large bruise was noted on R1's right upper arm that was deep purple in color. R1's arm also had 5 skin tears. R1 stated, "LPN-A grabbed my arm and caused this injury, and I want something done about it." R1 further stated he had seen LPN-A walking down the hallway the following day and it was very upsetting, "She should have had at least a week off for doing this to my arm."</p> <p>On 1/21/21, at 11:01 a.m. the administrator and the director of nursing (DON) were interviewed and stated there had been an incident involving LPN-A and NA-A on 1/16/21, at approximately 11:45 p.m. The administrator stated RN-A had sent her a text message indicating there had been an issue involving LPN-A grabbing R1's arm in possible self- defense. This resulted in R1 sustaining a bruise and skin tear marks from LPN-A's fingernails. The administrator stated she had called the facility back around 12:26 a.m. and asked RN-A to explain the situation again to her. The administrator stated RN-A relayed to her in the phone conversation R1 had been upset with LPN-A regarding the light, and R1 had went over to R2's side of the room, grabbed LPN-A's sweatshirt, and threatened to punch her. The administrator also stated RN-A had told her NA-A observed R1's injury, and had told RN-A that LPN-A had caused R1's injuries. The administrator stated she instructed RN-A to go interview R1 to get his side of the story, and report back to her. The administrator stated RN-A did not call her back that night, nor was additional investigation completed by the facility related to the allegation until 1/18/21. The administrator verified the incident had not been reported the State Agency (SA) until 1/18/21, at 12:17 p.m. even though RN-A had reported</p>	F 609			

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F 609	<p>Continued From page 13</p> <p>immediately to her that LPN-A may have caused the injuries to R1's right arm. The administrator further stated all allegations of potential or actual abuse are required to be reported immediately and no later than 2 hours to the SA. The administrator verified LPN-A was suspended on 1/18/21, related to the allegation of abuse.</p> <p>On 1/22/21, at 6:46 a.m. during interview registered nurse (RN)-A stated she was the RN supervisor the night of 1/16/21. RN-A stated NA-A had reported to her there was issue of alleged abuse involving LPN-A and R1. RN-A stated she immediately reported the incident to facility administrator as potential abuse because she believed it was a reportable incident.</p> <p>The facility policy Abuse Prohibition/Vulnerable Adult Plan revised 7/5/19, directed all staff are responsible for reporting suspected abuse which shall be reported to office of health facility complaints (OHFC) online reporting process not later than 2 hours after forming the suspicion of abuse.</p>	F 609			



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered  
February 9, 2021

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

Re: State Nursing Home Licensing Orders  
Event ID: 6M5Z11

Dear Administrator:

The above facility was surveyed on January 21, 2021 through January 26, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at [https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\\_8.html](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html). The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

The Estates At Roseville LLC

February 9, 2021

Page 2

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

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

**Terri Ament, Unit Supervisor**  
**Duluth District Office**  
**Licensing and Certification Program**  
**Health Regulation Division**  
**Minnesota Department of Health**  
**Duluth Technology Village**  
**11 East Superior Street, Suite 290**  
**Duluth, Minnesota 55802-2007**  
**Email: [teresa.ament@state.mn.us](mailto:teresa.ament@state.mn.us)**  
**Office: (218) 302-6151 Mobile: (218) 766-2720**

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.



Melissa Poepping, Health Program Representative Senior  
Program Assurance | Licensing and Certification  
Minnesota Department of Health  
P.O. Box 64970  
Saint Paul, Minnesota 55164-0970  
Phone: 651-201-4117  
Email: [melissa.poepping@state.mn.us](mailto:melissa.poepping@state.mn.us)

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00497</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/26/2021</b>
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NAME OF PROVIDER OR SUPPLIER  <b>THE ESTATES AT ROSEVILLE LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2727 NORTH VICTORIA ROSEVILLE, MN 55113</b>
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2 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p><b>NH LICENSING CORRECTION ORDER</b></p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.</p> <p>INITIAL COMMENTS: On 1/21/21, through 1/26/21, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be not in compliance with the MN State Licensure.</p> <p>The following complaints were found to be SUBSTANTIATED:</p>	2 000		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE  
02/11/21

Minnesota Department of Health

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2 000	Continued From page 1  H5105173C, H5105178C  The following complaint was found to be UNSUBSTANTIATED: H5105174C H5105175C H5105176C H5105177C H5105179C  The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults  Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:  (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report	21980		1/27/21

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21980	<p>Continued From page 2</p> <p>as described above.</p> <p>(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.</p> <p>(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.</p> <p>(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse were reported within 2 hours to the State Agency (SA) for 1 of 4 residents (R1) reviewed for abuse.</p> <p>Findings include:</p> <p>R1's Admission Record printed 1/22/21, indicated R1's diagnoses included malignant neoplasm of upper left lung, hypertension (high blood pressure) and chronic obstructive pulmonary</p>	21980	<p>R1 remains in the facility free from abuse and neglect.</p> <p>Resident allegations of abuse and/or neglect will be reported timely per Abuse Prohibition/Vulnerable Adult Plan</p> <p>Re-education was initiated and will be ongoing with staff on Abuse Prohibition/Vulnerable Adult Plan specific to timeliness of reporting</p>	

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21980	<p>Continued From page 3</p> <p>disease.</p> <p>R1's quarterly Minimum Data Set (MDS) assessment dated 12/1/20, indicated R2 was cognitively intact, and had no physical or verbal behavioral issues.</p> <p>An untitled facility incident report dated 1/16/21, indicated LPN-A had entered R1's room to assist R2 with a transfer to his bed. R1 was noted to be located on his own side of the room, but had went to R1's side of the room. The report indicated R1 had been angry and upset because LPN-A had turned on the room light. R1 was noted to have been yelling at LPN-A to turn out the light, he grabbed LPN's shirt and threatened to hit her. LPN-A grabbed R1's right upper arm to push him away, in self-defense. Nursing assistant (NA)-A entered the room, verbally redirected R1, and brought R1 back to his own side of the room. At that time, R1's right upper arm was noted to have a bruise measuring 4.5 centimeters (cm) long by 7.5 cm wide. R1's right upper arm also had five 1 cm skin tears from LPN-A's fingernails, when she had grabbed R1's arm. The report further indicated R1's description of the incident, "Every night she comes in room about 12AM and turns on all the lights" and "I got angry." R1 stated he went over to roommates' side of the room to show her how to use the light cord to turn light on above his bed. R1 stated he grabbed her shirt to get her attention, and that is when she "grabbed my arm, caused me to bleed and this bruise." The incident report also included NA-A's description of the incident. NA-A stated he had been walking down R1's hallway to answer a call light, and he heard LPN-A yelling out from R1's room. When NA-A entered R1's room, he observed R1 yelling at LPN-A, and it appeared R1 was going to strike at LPN-A. NA-A observed</p>	21980	<p>Audits of 3 OHFC reports specific to timeliness of reporting will be completed weekly X 4 weeks, monthly for 3 months and then reviewed at QAPI to ensure completion and/or continuation of monitoring process.</p> <p>Administrator and/or designee is responsible party</p>	

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21980	<p>Continued From page 4</p> <p>R1 grab the top of LPN-A's shirt. NA-A stated he did not see LPN-A grab R1's arm, but believed LPN-A had caused the injury to R1's right arm. The report indicated the facility took immediate action that included cleansing right arm with wound cleaner and Bacitracin was applied to R1's skin tears. R1 had refused a dressing. In addition, registered nurse (RN)-A had discussed the incident with LPN-A, and at the time of the report, LPN-A stated R1 had become angry because she turned all the lights in the room instead of just turning on the light over R2's bed. LPN-A denied touching R1, and was told to no longer provide cares for R1.</p> <p>On 1/21/21, at 9:55 a.m. R1 was interviewed and stated on 1/16/21, he had gotten up to walk over to R2's side of the room. R1 stated he went over to show LPN-A how to use the light cord above R2's bed, instead of turning on the main light in the room. R1 stated he grabbed LPN-A's sweatshirt hood to get her attention, and that's when LPN-A grabbed his right arm and caused the injury. A large bruise was noted on R1's right upper arm that was deep purple in color. R1's arm also had 5 skin tears. R1 stated, "LPN-A grabbed my arm and caused this injury, and I want something done about it." R1 further stated he had seen LPN-A walking down the hallway the following day and it was very upsetting, "She should have had at least a week off for doing this to my arm."</p> <p>On 1/21/21, at 11:01 a.m. the administrator was interviewed and stated there had been an incident involving LPN-A and NA-A on 1/16/21, at approximately 11:45 p.m. The administrator stated RN-A had sent her a text message indicating there had been an issue involving LPN-A grabbing R1's arm in possible self-</p>	21980		

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21980	<p>Continued From page 5</p> <p>defense. This resulted in R1 sustaining a bruise and skin tear marks from LPN-A's fingernails. The administrator stated she had called the facility back around 12:26 a.m. and asked RN-A to explain the situation again to her. The administrator stated RN-A relayed to her in the phone conversation R1 had been upset with LPN-A regarding the light, and R1 had went over to R2's side of the room, grabbed LPN-A's sweatshirt, and threatened to punch her. The administrator also stated RN-A had told her NA-A observed R1's injury, and had told RN-A that LPN-A had caused R1's injuries. The administrator stated she instructed RN-A to go interview R1 to get his side of the story, and report back to her. The administrator stated RN-A did not call her back that night, nor was additional investigation completed by the facility related to the allegation until 1/18/21. The administrator verified the incident had not been reported the State Agency (SA) until 1/18/21, at 12:17 p.m. even though RN-A had reported immediately to her that LPN-A may have caused the injuries to R1's right arm. The administrator further stated all allegations of potential or actual abuse are required to be reported immediately and no later than 2 hours to the SA. The administrator verified LPN-A was suspended on 1/18/21, related to the allegation of abuse.</p> <p>On 1/22/21, at 6:46 a.m. during interview registered nurse (RN)-A stated she was the RN supervisor the night of 1/16/21. RN-A stated NA-A had reported to her there was issue of alleged abuse involving LPN-A and R1. RN-A stated she immediately reported the incident to facility administrator as potential abuse because she believed it was a reportable incident.</p> <p>The facility policy Abuse Prohibition/Vulnerable</p>	21980		

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21980	<p>Continued From page 6</p> <p>Adult Plan revised 7/5/19, directed all staff are responsible for reporting suspected abuse which shall be reported to office of health facility complaints (OHFC) online reporting process not later than 2 hours after forming the suspicion of abuse.</p> <p>SUGGESTED METHOD OF CORRECTION:</p> <p>The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure allegations of abuse are reported timely to the State Agency.</p> <p>The Director of Nursing or designee could educate all appropriate staff on the policies and procedures.</p> <p>The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	21980		