



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 29, 2026

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

RE: CCN: 245105

Cycle Start Date: June 10, 2026

Dear Administrator:

On June 10, 2026, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted immediate jeopardy (Level J),

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On June 2, 2026, the situation of immediate jeopardy to potential health and safety cited at F689 was removed.

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 location.

- **Civil money penalty, (42 CFR 488.430 through 488.444).**

You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

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 \$13,343; 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 June 10, 2026. 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.

The CMS location may notify you of their determination regarding any imposed remedies.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires 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 § 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 June 10, 2026. 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.

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

Sincerely,

A handwritten signature in black ink, appearing to read 'Melissa Poepping', written in a cursive style.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245105	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER The Estates at Roseville LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2727 NORTH VICTORIA , ROSEVILLE, Minnesota, 55113	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 6/8/26 to 6/10/26, an abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was reviewed H51052731C (3032295) and a deficiency was issued at F689 at PAST NON-COMPLIANCE. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.	F0000		
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to provide adequate supervision to prevent elopement for 1 of 1 residents (R1) who was identified as an elopement risk and had exit-seeking behavior. This resulted in Immediate Jeopardy (IJ) for R1 when he left the facility and independently wheeled his wheelchair approximately 0.6 miles from the facility before being found, which placed R1 at	F0689	"Past Noncompliance - no plan of correction required"	

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0689 SS = SQC-J	<p>Continued from page 1 likelihood for serious harm or death.</p> <p>The IJ began on 6/1/26 when R1 exited the building without staff awareness through the secured unit doors and then through an unknown door to the outside of the building. After a Good Samaritan contacted the facility related to their observation of a potential facility resident, R1 was found on a residential street near a highway/collector road (a road that has more traffic than a residential street because the road is used to travel through parts of the city and neighborhoods). The administrator, director of nursing, regional nurse consultant, and regional social services consultant were notified of the immediate jeopardy on 6/10/26 at 5:11 p.m. The facility had implemented immediate corrective action on 6/2/26 to prevent recurrence, so the IJ was issued at past non-compliance.</p> <p>Findings include:</p> <p>R1's Admission Record identified R1 was admitted to the facility 5/11/23 with diagnoses which included dementia, major depressive disorder, and type 2 diabetes mellitus.</p> <p>R1's annual Minimum Data Set (MDS) dated 3/27/26, indicated R1 had severe cognitive impairment, required staff assistance for ambulation, and used a wheelchair. R1 had wandering behaviors and delusions.</p> <p>R1's Care Plan, dated 5/12/23, identified R1 was at risk for elopement related to diagnosis of dementia, and directed staff to invite R1 to activities and gatherings, keep family informed, ensure R1 followed the sign out policy when leaving facility, and to answer door alarms promptly. Additionally, R1's vulnerable adult care plan section, dated 5/25/23, indicated R1 had decreased cognitive and physical abilities related to dementia and major depressive disorder and had history of delusional thoughts, wandering, and thoughts that he would be "better off dead". Interventions directed staff to implement safety monitoring as needed to ensure R1's safety and monitor for signs of emotional distress or mood and behavior changes.</p> <p>R1's Elopement Risk Evaluation dated 3/27/26, indicated R1 scored a 4 which identified R1 required an elopement care plan. The assessment indicated</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 2</p> <p>R1 was on a secured memory care unit and had no prior attempts to leave the facility.</p> <p>R1's progress notes dated from 3/11/26 to 6/1/26, indicated the following exit-seeking behaviors:</p> <ul style="list-style-type: none"> -On 3/22/26 at 5:26 a.m., R1 was wandering and exit-seeking as he wanted to go to the bank and thought a hand sanitizer was a coin machine. R1 did not believe he had a bed at the facility and was successfully redirected after "several attempts". -On 3/23/26 at 4:43 a.m., R1 was exit-seeking, pushing on unit doors, and stated, "I'm going to get a haircut!" and "I need to get out of here!". R1 was upset with redirection. -On 4/7/26 at 6:59 a.m., R1 was near an exit door and requested the door to be opened. R1 was redirected to watch television. -On 4/17/26 at 5:20 a.m., R1 was exit-seeking, pushing on exit doors, and sounding the exit door alarms. R1 appeared agitated and was redirected multiple times. -On 5/14/26 at 6:00 a.m., R1 was trying to exit throughout the night and was awake most of the overnight shift. -On 5/19/26 at 5:03 a.m., R1 was kicking, pushing on exit doors, and sounding the exit door alarms during the overnight shift. Redirection and reassurance were provided and not effective. -On 5/27/26 at 5:30 a.m., R1 was exit-seeking and redirection from exit doors was effective. -On 5/31/26 at 6:01 a.m., R1 was exit-seeking twice. <p>R1's progress note dated 6/1/26 at 11:17 p.m., indicated R1 was found outside of the facility by staff after someone called the facility around 8:50 p.m. to report they saw a person in a wheelchair looking confused outside. R1 stated he was visiting a friend and had no skin issues along with stable vital signs upon returning to the facility. 15-minute checks were initiated, and management was notified. Report was given to the night shift to monitor R1 closely, and R1 currently slept in his room.</p> <p>R2's care plan interventions dated 6/2/26, directed staff to follow elopement policy, monitor and</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 3 document exit-seeking behavior, a wander guard was in place and staff were to monitor for proper functioning. R2's care plan intervention dated 6/5/26, directed staff to complete 30-minute checks.</p> <p>During interview on 6/8/26 at 4:17 p.m., nursing assistant (NA)-A stated R1 moved independently around the unit in his wheelchair. He "always" wanted to get out the door to see his daughter, go outside, and/or find his key for his car. NA-A would remind R1 the facility was his home, give him snacks or water, or turn on the television to help calm him. NA-A stated R1 was not safe to leave the unit or be outside by himself as R1 would not know where he was going. NA-A stated on 6/1/26 he saw R1 around 7:00 p.m. in the unit dining area. As staff were helping other residents to bed, they heard a resident was missing. In response, NA-A checked R1's room and did not see him. NA-A stated there was a code to exit the unit and the door alarmed when a resident pushed on the door and held it without the code or when the door was open for a certain period of time; however, the door alarm had not sounded.</p> <p>During interview on 6/8/26 at 5:33 p.m., NA-B stated R1 had days when he was calm and other days when he was aggressive and exit-seeking. On 6/1/26 R1 was "aggressive" from the beginning of her shift, which started at 2:00 p.m. R1 was pushing on the unit exit door, and NA-B redirected him away from the door about every ten minutes. NA-B reported this to the nurse, and the nurse told NA-B to monitor R1. Around 7:00 p.m., R1 had calmed; however, NA-B continued to monitor him. Around 7:40 p.m. to 7:50 p.m., R1 wanted to watch the television in his room, so NA-A wheeled him to his room and left him to watch television alone. After, NA-B went to assist another resident with a shower which took her about 30 minutes and then went to help another resident, without checking on R1 in between. While NA-B was assisting other residents, she heard a resident was in a wheelchair outside the building and the missing resident protocol was activated. NA-B stated it was "8 something" when R1 was returned to the unit. R1 had been wearing pants, a shirt, and a sweater. NA-B stated the unit exit door had an alarm which sounded if a resident pushed on the door without the code; however, did not hear any alarm sound on 6/1/26. NA-B indicated another resident, whose spouse resided on the secured unit, may have entered the unit to visit their spouse, in which R1 may have exited at that time. NA-B stated the facility changed the code which</p>	F0689		

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F0689 SS = SQC-J	<p>Continued from page 4 staff were to safeguard since the elopement, and staff were educated to no longer give the code to family members or other visitors. Additionally, the other resident's spouse, who resided inside the secured unit, was moved off the secured unit, mitigating the risk of the secured residents exiting the unit unsupervised during visitor entry to the unit</p> <p>During interview on 6/8/26 at 6:54 p.m., the director of nursing (DON) stated she did not know how R1 exited the building as R1 resided on a secured unit with a door alarm, and the door would beep if it was pushed to exit the unit without the use of the code. The DON stated multiple facility exit doors were equipped with a wander guard system, and the exit door would have sounded an alarm, and locked, if R1 had a wander guard on. The DON stated facility staff completed an audit on residents in the secured memory care units and reviewed elopement assessments and care plans. The DON stated the facility had changed the secured unit door code multiple times since R1's elopement and changed the code whenever it became known to family members or visitors.</p> <p>During interview on 6/9/26 at 12:51 p.m., NA-C stated R1 was often more "aggressive" in the evening and appeared as his normal self on 6/1/26. NA-C stated they heard the code "pink (term used to signify a missing resident)" on 6/1/26 and helped search for R1. NA-C stated she did not know when or how R1 got off the secured unit, but there was a resident couple (spouses) who were going on and off the unit often and thought R1 could have gotten out with them or someone else. NA-C stated the facility "fixed" that issue by moving the two family members to the LTC area of the facility. NA-C stated R1 was returned to the unit around 9:00 p.m. or 9:15 p.m. NA-C stated she asked R1 where he was going after he returned to the unit, and R1 stated he was going to see his grandparents. NA-C stated R1 was not safe to be off the secured unit by himself because R1 had a "memory diagnosis". NA-C stated the facility changed the code to exit the secured unit and were not allowed to tell family or visitors the code.</p> <p>During an interview on 6/9/26 at 1:10 p.m., LPN-A stated R1 had a longstanding history of wandering and exit-seeking behaviors, which were exhibited on 6/1/26, and thus R1 required close monitoring, including observation by a nursing assistant, and staff awareness to prevent him from leaving the unit.</p>	F0689		

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<p>F0689 SS = SQC-J</p>	<p>Continued from page 5 LPN-A last saw R1 in the dining area around 8:00 p.m. and, after returning from break at approximately 8:30 p.m., LPN-A heard someone call a "Code Pink. LPN-A responded to the code and learned staff received a report of a resident down the street. LPN-A stated staff were looking for a different resident when he was told the resident missing was R1. R1 was located by other staff and returned to the unit. LPN-A completed an assessment with no injuries or concerns noted, notified the administrator, initiated staff interviews, and implemented 15-minute checks for R1. LPN-A stated R1 was not safe to be outside the facility independently because R1 could not make appropriate decisions.</p> <p>During follow-up interview on 6/9/26 at 3:10 p.m., the DON stated the administrator received a phone call first about R1's elopement, and she received a call on 6/1/26 around 9:20 p.m. to 9:30 p.m. after R1 was found. In response, R1 was placed on 15-minute checks. This changed to 30-minute checks after the interdisciplinary (IDT) team review determined R1's behaviors and exit-seeking had decreased. The DON stated R1's behaviors and exit-seeking on 6/1/26 were not a change of condition. Additionally, facility staff and providers reviewed R1's medications. The DON stated the IDT team should have discussed wander guard use for R1 prior to his elopement, based on her expectation the IDT reviewed residents progress notes, such as R1's, and discussed any exit-seeking behaviors for any potential care plan adjustments.</p> <p>During interview on 6/9/26 at 3:45 p.m., the administrator stated they completed Code Pink drills since 6/1/26 and maintenance checked on doors and the wander guard system.</p> <p>During interview on 6/9/26 at 5:11 p.m., RN-B stated she was told to search the unit to make sure the residents on her unit were present and called other units to check for their residents. RN-B stated she and another staff member went looking for a missing resident in a car and headed North of the facility when they saw RN-A and another staff member with R1. RN-B stated R1 was found by himself and did not present with any behaviors.</p> <p>During interview on 6/9/26 at 5:20 p.m., RN-A stated they got a call from another unit that a stranger called the facility to report a male resident was on the street. RN-A stated they thought the</p>	<p>F0689</p>		

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<p>F0689 SS = SQC-J</p>	<p>Continued from page 6 resident on the street was one of her residents, because there was a resident she did not see on her secured unit or in the facility parking lot when she looked for him. RN-A told another staff member to call a Code Pink, and RN-A got into her car with another staff member to drive around the facility and look for the missing resident. RN-A stated she was on Victoria Street, approximately half a mile away from the facility, when she saw a male in a wheelchair who was alone and on the side of the street. RN-A stated R1 was not the resident she was looking for but recognized him as a resident of the facility. RN-A stated R1 wore shoes, pants, and a shirt. R1 was calm and stated he was going to his grandma's house. RN-A stated the weather was sunny. RN-A and the other staff member who was with her were able to get R1 into the car and return him to his secured unit. RN-A stated the resident she initially was looking for from the secured unit was found in the unit dining area behind a door where she had not looked.</p> <p>During interview on 6/10/26 at 10:53 a.m., nurse practitioner (NP)-A stated the triage line was called on 6/1/26 about R1 leaving the building unattended, and the facility followed up with her on 6/2/26. NP-A stated R1 was not safe to be in the community by himself and was at risk for "anything" when outside the building by himself. NP-A stated she would have wanted to be contacted if exit-seeking was an on-going issue after a few resident redirections. NP-A stated she knew R1 was restless at night but not specifically exit-seeking.</p> <p>During interview on 6/10/26 at 1:08 p.m., the medical director stated R1's mood changed quickly, and a wander guard may have reduced the likelihood of R1's elopement. The medical director stated R1 had poor insight and was at risk for crossing roads, getting hit, hypoglycemia, and dehydration depending on weather and how long R1 was out of the facility.</p> <p>During follow-up interview on 6/10/26 at 4:10 p.m., RN-B verified she saw R1 with RN-A and another staff member on the left side of a residential street near a highway route/collector road approximately 0.6 miles from the facility, or about a 12-minute walk. RN-B stated she saw approximately two cars pass them while searching, finding, and returning R1 to the facility.</p>	<p>F0689</p>		

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F0689 SS = SQC-J	<p>Continued from page 7</p> <p>During interview on 6/10/26 at 5:18 p.m., RN-C stated they received a call on 6/1/26 at 8:48 p.m. from a "good Samaritan" who stated they observed a resident rolling himself in a wheelchair heading North from the facility. RN-C stated she did not know who the caller was and knew the caller was driving. RN-C stated she told the nursing assistants to check the residents on her unit to ensure they were all in the facility. RN-C stated RN-B returned from break, and RN-C told RN-B to call the memory care units to tell staff there to check on their residents. RN-C stated RN-A and another staff member came to her and asked her about the phone call before they exited the building. A different staff member called a Code Pink approximately five to ten minutes after the phone call from the "good Samaritan" when staff realized a resident was missing from the facility. RN-C stated she got in her car and headed North from the facility, then saw RN-A and the other staff member had already located R1 and were returning him to the facility. RN-C stated the weather was warm and sunny but getting darker, and the time was approximately 9:30 p.m. when RN-C returned to the facility. RN-C stated the street she drove on was normally a "busy" street but was not at that time and about three cars passed by her while driving.</p> <p>The facility Elopement Policy dated 11/2025, directed staff to assure residents were assessed on an ongoing basis and had appropriate safety precautions in place quarterly, annually, and as needed due to significant changes.</p> <p>The past-noncompliance immediate jeopardy began on 6/1/26 and was removed on 6/2/26, when the facility implemented a systemic plan to ensure all residents were safe. The following actions were implemented prior to survey:</p> <ul style="list-style-type: none"> - Immediately implemented 15-minute checks for R1. -Placed a wander guard on R1 and updated the care plan. -Changed the door code to exit the unit with focus on only staff having the code. -Moved another resident's family member outside the secured unit to decrease visitation and risks associated with unit residents eloping. -Reviewed all like-residents who reside on secured units, and implemented wander guards where 	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245105	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER The Estates at Roseville LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2727 NORTH VICTORIA , ROSEVILLE, Minnesota, 55113	
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F0689 SS = SQC-J	Continued from page 8 appropriate, in addition to updating care plan. -Educated staff on door code and escalation of interventions, such as a wander guards, for residents identified to have exit-seeking behaviors. -Conducted elopement drills.	F0689		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 29, 2026

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

Re: Event ID: 234E63-H1

Dear Administrator:

The above facility survey was completed on June 10, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Melissa Poepping', written in a cursive style.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/10/2026
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20000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</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:</p> <p>On 6/8/26 to 6/10/26, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure requirements.</p> <p>The following complaint was reviewed H51052731C (3032295).</p> <p>Minnesota Department of Health (MDH) documents</p>	20000		

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/10/2026	
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20000	Continued from page 1 the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form	20000		