



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered  
December 16, 2025

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

RE: CCN: 245105

Cycle Start Date: November 20, 2025

Dear Administrator:

On December 15, 2025, the Minnesota Departments of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

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](mailto:Melissa.Poepping@state.mn.us)



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December 16, 2025

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

Re: Reinspection Results  
Event ID: 1D7E8C-H2

Dear Administrator:

On December 15, 2025 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 November 20, 2025. 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, 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](mailto:Melissa.Poepping@state.mn.us)

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November 20, 2025

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

RE: CCN:245105  
Cycle Start Date: November 20, 2025

Dear Administrator:

On November 20, 2025, 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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

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

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

#### **DEPARTMENT CONTACT**

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

**Judy Loecken, Regional Operations Supervisor**  
**St. Cloud B District Office**  
**Health Regulation Division**  
**Minnesota Department of Health**  
**4140 Thielman Lane**  
**Saint Cloud, Minnesota 56301-4557**  
**Email: [judy.loecken@state.mn.us](mailto:judy.loecken@state.mn.us)**  
**Office: (320) 223-7300 Mobile: (320) 241-7797**

#### **PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE**

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

#### **VERIFICATION OF SUBSTANTIAL COMPLIANCE**

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

## **FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY**

If substantial compliance with the regulations is not verified by February 20, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by May 20, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

### **INFORMAL DISPUTE RESOLUTION (IDR)**

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: [https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\\_8.html](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html)

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

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

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

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 a large initial "M" and a long, sweeping underline.

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](mailto:Melissa.Poepping@state.mn.us)

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>245105</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>11/20/2025</b>
NAME OF PROVIDER OR SUPPLIER <b>The Estates at Roseville LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2727 NORTH VICTORIA , ROSEVILLE, Minnesota, 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
F0000	<p>INITIAL COMMENTS</p> <p>On 9/25/25 through 9/26/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaints were reviewed: H51055090C (iQIES# 2623400)</p> <p>H51055182C( iQIES# 2625938) with a finding at F684.</p> <p>An incidental finding was cited at F554.</p> <p>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.</p> <p>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.</p>	F0000		12/02/2025
F0554 SS = D	<p>Resident Self-Admin Meds-Clinically Approp</p> <p>CFR(s): 483.10(c)(7)</p> <p>§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and document review the facility failed to ensure a self-administration of medications assessment was completed, and orders obtained, for all medications kept at bedside for 1 of 1 resident (R3) observed with medications at their</p>	F0554	<p>R3 medications were removed from bedside and has since discharged from facility. All residents have the ability to be affected by this deficit practice.</p> <p>All residents who wish to self administer medications will have an assessment completed, orders obtained and careplanned for all medications to be kept at bedside.</p> <p>DNS or designee to initiate education to licensed nursing staff on self administration process of medications.</p> <p>DNS or designee to audit 5 residents per week time 4 weeks to ensure assessments are completed, orders obtained and careplanned for self administration.</p>	12/02/2025

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See 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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<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>245105</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>11/20/2025</b>
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F0554 SS = D	<p>Continued from page 1 bedside.</p> <p>Findings include:</p> <p>R3's quarterly minimum data set dated 9/11/25, indicated intact cognition with a diagnosis of stroke.</p> <p>R3's electronic medical record lacked a self-administration form.</p> <p>R3's care plan dated 6/1/25, lacked indication of self-administration of medications.</p> <p>R3's current provider order list on 9/26/25, lacked orders for muscle rub with lidocaine and artificial tears.</p> <p>On 9/25/2025 at 11:38 a.m., an opened bottle of Aspercreme with lidocaine (a pain relieving cream) and an opened bottle of artificial tears eye drops were observed on R3's bedside table. R3 was interviewed and stated he applied the Aspercreme to his arm when it was sore. He administered the eye drops when his eyes were scratchy. R3 stated staff did not administer the cream or eye drops and did not know if he had a doctor order for them.</p> <p>On 9/25/2025 at 1:56 p.m., licensed practical nurse (LPN)-A stated a resident needed to have a self-administration of medications form filled out before they could keep medications at their bedside. LPN-A confirmed R3 should not have any medications at his bedside.</p> <p>On 9/26/2025 at 10:38 a.m., LPN-C was stated if a resident wanted to self-administer medications, a self-administer form needed to be completed. The resident needed a provider order for the medication requested. LPN-C was unaware of a self-administration form for R3.</p> <p>On 9/26/2025 at 1:40 p.m., the director of nursing (DON) was stated if a resident requested to self-administer medications the nurse manager completed an assessment, then reached out to the provider for an order for the resident to keep medications in their</p>	F0554	<p>Continued from page 1</p> <p>DNS or designee to bring audit results to monthly QAPI to review with Medical Director and IDT and review results, will review and update audit schedule as appropriate.</p> <p>Date of completion: 12/2/25</p>	

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>245105</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>11/20/2025</b>
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F0554 SS = D	Continued from page 2 room. DON confirmed R3 did not have an order for the Aspercream, and the bottle had been removed from R3's room. Risks of a resident self-administering a medication were not using the correct dose or route.  The Self-administration of Medications policy dated 2/2024 instructed the interdisciplinary team to assess each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and care plan.	F0554		
F0684 SS = D	Quality of Care  CFR(s): 483.25  § 483.25 Quality of care  Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.  This REQUIREMENT is NOT MET as evidenced by:  Based on interview and document review, the facility failed to monitor a skin concern and notify the provider for 1 of 3 residents (R2) reviewed for wound care.  Findings include:  R2's 5-day minimum data set (MDS) dated 9/11/25 indicated severely impaired cognition. Diagnoses included metabolic encephalopathy and peripheral vascular disease. R2 was at risk to develop pressure injuries.  R2's admission form dated 9/5/25 and signed by licensed practical nurse (LPN)-A indicated "coccyx foam dressing, small 2x2 area of redness".  R2's Braden scale for predicting pressure sore risk form dated 9/6/25, indicated high risk for developing a pressure sore.	F0684	R2 is discharged from the facility.  All residents have the ability to be affected by this deficit practice. Will review all residents for skin concerns, notify provider to obtain orders and complete wound care per careplan.  DNS or designee to initiate education to licensed nursing staff on monitoring skin concerns, notifying providers and obtaining orders and complete wound care.  DNS or designee to audit 5 skin assessments per week times 4 weeks to ensure skin concerns are identified, providers are notified and orders obtained to complete wound cares.  DNS or designee to bring audit results to monthly QAPI to review with Medical Provider and IDT to review results and adjust audit schedules as appropriate.  Date of completion is 12/2/25	12/02/2025

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>245105</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>11/20/2025</b>
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F0684 SS = D	<p>Continued from page 3</p> <p>R2's care plan dated 9/6/25, indicated alteration in skin integrity related to wounds to bilateral lower extremities (both legs) with intervention to document on skin condition and keep providers informed of changes.</p> <p>R2's skin evaluation and skin risk factors form dated 9/7/25, indicated coccyx wound 1 centimeter (cm), pink. Foam dressing on coccyx.</p> <p>R2's nursing note dated 9/9/25, indicated R2's weekly skin inspection was not completed due to R2 confusion and being uncooperative.</p> <p>R2's weekly skin assessment dated 9/16/25, indicated a small red spot on coccyx, foam dressing applied.</p> <p>R2's daily skilled notes lack documentation of a skin concern on her coccyx.</p> <p>R2's treatment administration record (TAR) lacked indication of daily monitoring to R2's coccyx.</p> <p>R2's provider orders from admission on 9/5/25 through discharge on 9/17/25, lack orders for a foam dressing applied to R2's coccyx.</p> <p>R2's provider note dated 9/17/25, signed by nurse practitioner (NP)-A, indicated R2 discharged to an assisted living on 9/17/25, and lacked indication and orders for a skin concern on R2's coccyx.</p> <p>On 9/25/2025 at 3:33 p.m., registered nurse from an assisted living (RN-AL) stated during R2's admission skin assessment on 9/17/25 she discovered a 5 centimeter (cm) by 5 cm pressure injury to R2's coccyx. R2's admission orders lacked information and orders for a skin concern on R2's coccyx.</p> <p>On 9/25/2025 at 1:56 p.m., LPN-A was interviewed and stated a skin check should be completed immediately on all new admissions. LPN-A could not recall if she informed the nurse manager or the provider about the redness on R2's coccyx.</p>	F0684		

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F0684 SS = D	<p>Continued from page 4</p> <p>On 9/25/2025 at 4:08 p.m., LPN-B stated if a resident had a new skin concern the area of concern should be measured, documented in a nurse's note, a risk management completed, and reported to the nurse manager, provider, and family. If the area of concern was on the coccyx, the nurse should notify the provider to obtain an order for wound care. LPN-B confirmed all wound dressings needed to have a provider order even if the dressing was just for protection.</p> <p>On 9/26/2025 at 9:06 a.m., registered nurse (RN)-A stated a skin check needed to be completed for all new admissions. All skin concerns needed to be documented, and the nurse manager needed to be informed.</p> <p>On 9/26/2025 at 10:38 a.m., LPN-C stated when a new resident admitted to the facility the floor nurse should complete a head-to-toe skin check then alert either LPN-C or the RN manager of any skin concerns. The RN manager checked for orders and requested any needed provider orders. LPN-C rounded weekly with the wound nurse practitioner. If a resident had a skin concern that was not open a nursing order to monitor was placed in the TAR. LPN-C could not recall if R2 had an area of concern on her coccyx and did not have access to R2's medical record to check. If LPN-C had been notified of an area of redness she would have assessed the area and placed a nursing order to monitor in the TAR.</p> <p>On 9/26/2025 at 1:55 p.m., (NP)-A confirmed he was the nurse practitioner caring for R2 at the facility. NP-A stated the nurses should notify him of all skin concerns including redness on the coccyx. A nurse assessed the area of redness to determine if the redness was from pressure to the area or moisture related skin breakdown (MASD). The provider was contacted for orders related to the cause of the redness. Orders could include barrier cream or a protective dressing. NP-A stated he was not alerted to any redness to R2's coccyx. All areas of redness should be monitored at least once a day. Pressure injuries can develop quickly depending on the resident's ability to reposition self but typically not in a few hours. Risk factors for pressure ulcers include old age, frail skin, and inability to reposition self. Early identification of pressure injuries was important so the area received the proper skin care. Pressure injuries caught early were easier to heal.</p> <p>On 9/26/2025 at 1:40 p.m., the director of nursing (DON) stated the floor nurse completing the admission</p>	F0684		

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F0684 SS = D	Continued from page 5 should complete a skin check. All skin concerns were documented on the admission form. If there was a wound, the nurse should look for dressing change orders and reach out to the provider for any needed orders. When a nurse placed a dressing based on standing orders a nursing note should be written about why the dressing was placed and the nurse manager and provider should be notified. DON confirmed documentation of an area of redness to R2's coccyx with no notes or orders from the provider. DON stated she was not informed of redness to R2's coccyx. Based only on the documentation it was difficult to determine if the area of redness was from pressure or moisture related. DON stated it was important to assess areas of redness and alert the provider so orders can be obtained to prevent the area from turning into something bigger.  The Skin Assessment and Wound Management policy dated 2/2025 instructed to notify the nurse manager, wound nurse, provider, and resident representative for any new significant alterations in skin integrity or pressure ulcers.	F0684		



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Electronically delivered  
November 20, 2025

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

Re: State Nursing Home Licensing Orders  
Event ID: 1D7E8C-H1

Dear Administrator:

The above facility survey was completed on November 20, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

**Judy Loecken, Regional Operations Supervisor**  
**St. Cloud B District Office**  
**Health Regulation Division**  
**Minnesota Department of Health**  
**4140 Thielman Lane**  
**Saint Cloud, Minnesota 56301-4557**  
**Email: [judy.loecken@state.mn.us](mailto:judy.loecken@state.mn.us)**  
**Office: (320) 223-7300 Mobile: (320) 241-7797**

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

Please feel free to call me with any questions.



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

Minnesota State Department of Health

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>11/20/2025</b>
NAME OF PROVIDER OR SUPPLIER <b>The Estates at Roseville LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2727 NORTH VICTORIA , ROSEVILLE, Minnesota, 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
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 9/25/25 through 9/26/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.</p>	20000		12/02/2025

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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20000	Continued from page 1  The following complaints were reviewed: H51055090C (iQIES# 2623400)  H51055182C (iQIES# 2625938) with a licensing order issued at 20875.  An incidental finding was cited at 21565.  Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction.  You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html</a> . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.  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.	20000		
20875	Adequate and Proper Nursing Care; Monitor TPR  CFR(s): MN Rule 4658.0520 Subp. 2 I  Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include:	20875	Corrected	12/02/2025

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20875	<p>Continued from page 2</p> <p>I. Monitoring resident temperature, pulse, respiration, and blood pressure as often as indicated by the resident's condition but at least weekly.</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review, the facility failed to monitor a skin concern and notify the provider for 1 of 3 residents (R2) reviewed for wound care.</p> <p>Findings include:</p> <p>R2's 5-day minimum data set (MDS) dated 9/11/25 indicated severely impaired cognition. Diagnoses included metabolic encephalopathy and peripheral vascular disease. R2 was at risk to develop pressure injuries.</p> <p>R2's admission form dated 9/5/25 and signed by licensed practical nurse (LPN)-A indicated "coccyx foam dressing, small 2x2 area of redness".</p> <p>R2's Braden scale for predicting pressure sore risk form dated 9/6/25, indicated high risk for developing a pressure sore.</p> <p>R2's care plan dated 9/6/25, indicated alteration in skin integrity related to wounds to bilateral lower extremities (both legs) with intervention to document on skin condition and keep providers informed of changes.</p> <p>R2's skin evaluation and skin risk factors form dated 9/7/25, indicated coccyx wound 1 centimeter (cm), pink. Foam dressing on coccyx.</p> <p>R2's nursing note dated 9/9/25, indicated R2's weekly skin inspection was not completed due to R2 confusion and being uncooperative.</p> <p>R2's weekly skin assessment dated 9/16/25, indicated a small red spot on coccyx, foam dressing applied.</p> <p>R2's daily skilled notes lack documentation of a skin concern on her coccyx.</p>	20875		

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20875	<p>Continued from page 3</p> <p>R2's treatment administration record (TAR) lacked indication of daily monitoring to R2's coccyx.</p> <p>R2's provider orders from admission on 9/5/25 through discharge on 9/17/25, lack orders for a foam dressing applied to R2's coccyx.</p> <p>R2's provider note dated 9/17/25, signed by nurse practitioner (NP)-A, indicated R2 discharged to an assisted living on 9/17/25, and lacked indication and orders for a skin concern on R2's coccyx.</p> <p>On 9/25/2025 at 3:33 p.m., registered nurse from an assisted living (RN-AL) stated during R2's admission skin assessment on 9/17/25 she discovered a 5 centimeter (cm) by 5 cm pressure injury to R2's coccyx. R2's admission orders lacked information and orders for a skin concern on R2's coccyx.</p> <p>On 9/25/2025 at 1:56 p.m., LPN-A was interviewed and stated a skin check should be completed immediately on all new admissions. LPN-A could not recall if she informed the nurse manager or the provider about the redness on R2's coccyx.</p> <p>On 9/25/2025 at 4:08 p.m., LPN-B stated if a resident had a new skin concern the area of concern should be measured, documented in a nurse's note, a risk management completed, and reported to the nurse manager, provider, and family. If the area of concern was on the coccyx, the nurse should notify the provider to obtain an order for wound care. LPN-B confirmed all wound dressings needed to have a provider order even if the dressing was just for protection.</p> <p>On 9/26/2025 at 9:06 a.m., registered nurse (RN)-A stated a skin check needed to be completed for all new admissions. All skin concerns needed to be documented, and the nurse manager needed to be informed.</p> <p>On 9/26/2025 at 10:38 a.m., LPN-C stated when a new resident admitted to the facility the floor nurse should complete a head-to-toe skin check then alert either LPN-C or the RN manager of any skin concerns. The RN manager checked for orders and requested any needed provider orders. LPN-C rounded weekly with the wound nurse practitioner. If a resident had a skin</p>	20875		

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20875	<p>Continued from page 4 concern that was not open a nursing order to monitor was placed in the TAR. LPN-C could not recall if R2 had an area of concern on her coccyx and did not have access to R2's medical record to check. If LPN-C had been notified of an area of redness she would have assessed the area and placed a nursing order to monitor in the TAR.</p> <p>On 9/26/2025 at 1:55 p.m., (NP)-A confirmed he was the nurse practitioner caring for R2 at the facility. NP-A stated the nurses should notify him of all skin concerns including redness on the coccyx. A nurse assessed the area of redness to determine if the redness was from pressure to the area or moisture related skin breakdown (MASD). The provider was contacted for orders related to the cause of the redness. Orders could include barrier cream or a protective dressing. NP-A stated he was not alerted to any redness to R2's coccyx. All areas of redness should be monitored at least once a day. Pressure injuries can develop quickly depending on the resident's ability to reposition self but typically not in a few hours. Risk factors for pressure ulcers include old age, frail skin, and inability to reposition self. Early identification of pressure injuries was important so the area received the proper skin care. Pressure injuries caught early were easier to heal.</p> <p>On 9/26/2025 at 1:40 p.m., the director of nursing (DON) stated the floor nurse completing the admission should complete a skin check. All skin concerns were documented on the admission form. If there was a wound, the nurse should look for dressing change orders and reach out to the provider for any needed orders. When a nurse placed a dressing based on standing orders a nursing note should be written about why the dressing was placed and the nurse manager and provider should be notified. DON confirmed documentation of an area of redness to R2's coccyx with no notes or orders from the provider. DON stated she was not informed of redness to R2's coccyx. Based only on the documentation it was difficult to determine if the area of redness was from pressure or moisture related. DON stated it was important to assess areas of redness and alert the provider so orders can be obtained to prevent the area from turning into something bigger.</p> <p>The Skin Assessment and Wound Management policy dated 2/2025 instructed to notify the nurse manager, wound nurse, provider, and resident representative for any new significant alterations in skin integrity or pressure ulcers.</p> <p>SUGGESTED METHODS OF CORRECTION: The director of</p>	20875		

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20875	Continued from page 5 nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure all resident skin concerns are assessed by a registered nurse and provider notified. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee.  TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20875		
21565	Administration of Medications Self Admin  CFR(s): MN Rule 4658.1325 Subp. 4  Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician.  This LICENSURE REQUIREMENT is NOT MET as evidenced by:  Based on observation, interview, and document review the facility failed to ensure a self-administration of medications assessment was completed, and orders obtained, for all medications kept at bedside for 1 of 1 resident (R3) observed with medications at their bedside.  Findings include:  R3's quarterly minimum data set dated 9/11/25, indicated intact cognition with a diagnosis of stroke.  R3's electronic medical record lacked a self-administration form.  R3's care plan dated 6/1/25, lacked indication of self-administration of medications.  R3's current provider order list on 9/26/25, lacked orders for muscle rub with lidocaine and artificial tears.  On 9/25/2025 at 11:38 a.m., an opened bottle of Aspercreme with lidocaine (a pain relieving cream) and	21565	Corrected	12/02/2025

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21565	<p>Continued from page 6 an opened bottle of artificial tears eye drops were observed on R3's bedside table. R3 was interviewed and stated he applied the Aspercreme to his arm when it was sore. He administered the eye drops when his eyes were scratchy. R3 stated staff did not administer the cream or eye drops and did not know if he had a doctor order for them.</p> <p>On 9/25/2025 at 1:56 p.m., licensed practical nurse (LPN)-A stated a resident needed to have a self-administration of medications form filled out before they could keep medications at their bedside. LPN-A confirmed R3 should not have any medications at his bedside.</p> <p>On 9/26/2025 at 10:38 a.m., LPN-C was stated if a resident wanted to self-administer medications, a self-administer form needed to be completed. The resident needed a provider order for the medication requested. LPN-C was unaware of a self-administration form for R3.</p> <p>On 9/26/2025 at 1:40 p.m., the director of nursing (DON) was stated if a resident requested to self-administer medications the nurse manager completed an assessment, then reached out to the provider for an order for the resident to keep medications in their room. DON confirmed R3 did not have an order for the Aspercream, and the bottle had been removed from R3's room. Risks of a resident self-administering a medication were not using the correct dose or route.</p> <p>The Self-administration of Medications policy dated 2/2024 instructed the interdisciplinary team to assess each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and care plan.</p> <p>SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee should review and revise policies for self-administration of medication according to evidence-based practices/procedures. Nursing staff should be educated as necessary to the importance of ensuring the resident is deemed capable of administering their own medications initially, quarterly, annually, or with a change to a resident's</p>	21565		

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21565	Continued from page 7 physical or mental ability to do so. Nursing staff should also ensure there is a physician's order in place, prior to a nurse/medication aide administering medication. The DON or designee, should audit any/all resident's medical records, to ensure compliance with appropriate medication administration. The DON or designee should take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance.  TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		