STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Roseville LLC	2727 North Victoria Roseville, MN 55113

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE], 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 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.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.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.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.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.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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.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.R2's skin evaluation and skin risk factors form dated 9/7/25, indicated coccyx wound 1 centimeter (cm), pink. Foam dressing on coccyx. R2's nursing note dated 9/9/25, indicated R2's weekly skin inspection was not completed due to R2 confusion and being uncooperative.R2's weekly skin assessment dated [DATE], indicated a small red spot on coccyx, foam dressing applied.R2's daily skilled notes lack documentation of a skin concern on her coccyx.R2's treatment administration record (TAR) lacked indication of daily monitoring to R2's coccyx.R2's provider orders from admission on [DATE] through discharge on [DATE], lack orders for a foam dressing applied to R2's coccyx.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. 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.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.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.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. 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. 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 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	injuries caught early were easier to heal. 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.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.