STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245326	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at Roseville	1000 Lovell Avenue Roseville, MN 55113

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and document review, the facility failed to employ either a full-time registered dietician (RD) or a qualified dietary manager (DM) to carry out the functions of the food and nutrition service since January of 2020, which had the potential to affect all 54 residents who resided in the facility. Findings include: Qualifications for the Culinary Services Director (CSD) was requested however was not received. During the initial kitchen tour on 4/27/26 at 10:45 a.m., CSD stated she worked full time at the facility and there was also a registered dietician (RD) who worked one day a week but was available by phone for questions whenever needed. During a follow up interview on 4/30/26 at 10:40 a.m., the surveyor asked the CSD to see her certification and she stated she had recently enrolled in the certified dietary manager (CDM) program about a month ago and didn't have any other certification or training for food services. She had originally enrolled during COVID but didn't finish. During interview on 4/30/26 at 1:00 p.m., the administrator stated they have a registered dietician who worked at the facility once a week and was on call if they needed anything. They also have a CSD, who started working as the kitchen manager in January of 2020 and was currently enrolled in school for her CDM license. The administrator further stated she thought the CSD just had to be enrolled in the program in order for her to be qualified as the CSD. A facility policy regarding qualifications for dietary staff was requested but not received.

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.

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure freedom of movement was not restricted when a pillow was placed adjacent to the resident's body, underneath the fitted sheet which could not be removed easily by the resident for 1 of 1 resident (R44) reviewed for potential restraints.Findings include:R44's quarterly Minimum Data Set (MDS) dated [DATE], indicated R44 was dependent on staff for all activities of daily living (ADLs), transfers and mobility. R44's diagnoses included dementia and acquired absence of right leg below the knee.R44's care plan revised 4/30/26, identified R44 had impaired cognitive function/dementia or impaired thought processes, and was at risk for falls. The care plan further indicated R44 had alteration in mood and behavior and would put self on floor and crawl. The care plan instructed staff to keep bed in a low position and place a mat on the floor to allow resident to safely crawl.During observation on 4/27/26 at 12:56 p.m., nursing assistant (NA)-A and NA-B entered R44's room to transfer R44 into bed using a mechanical lift. Incontinent care was performed and a new brief placed. R44 was positioned in the middle of the bed, with the right side of the bed against the wall. NA-A lowered R44's bed to the lowest position, provided the call light, and placed a pillow along the left side of R44's torso underneath the fitted bottom sheet.During observation on 4/28/26 at 3:48 p.m., R44 was taken to his room to be transferred back to bed. After the transfer, NA-C placed a pillow along the left side of R44 under the fitted bottom sheet, bed lowered, and mat placed on floor.During interview on 4/28/26 at 3:59 p.m., NA-C stated R44's pillow was placed under the fitted sheet to prevent the pillow from falling out if R44 became agitated. NA-C did not think R44 could remove the pillow from under the sheet.During interview on 4/28/26 at 4:05 p.m., registered nurse (RN)-A stated R44 had fall intervention in place such as call light in reach, bed in the lowest position, and a mat on the floor. The mat was in place to prevent injury in case R44 would roll out of bed. RN-A stated pillows were used as positioning aids and should never be placed under the fitted sheet since that could restrain R44's movement.During interview on 4/29/26 at 11:49 a.m., RN-B stated pillows were used for position and should never be placed under the fitted sheet. RN-B stated if a resident could not easily remove a pillow and it prevented them from getting out of bed, it would be considered a restraint.During interview on 4/29/26 at 1:07 p.m., director of nursing (DON) expected resident pillows would not be placed under fitted sheets as that could be considered a restraint.A facility policy regarding restraints was requested but not provided.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to provide care conferences for 1 of 1 resident (R53) reviewed for care conferences. Findings include:R53's quarterly Minimum Data Set (MDS) dated [DATE], identified R53 was cognitively intact with diagnoses of traumatic brain injury (TBI) and seizure disorder.R53's electronic health record (EHR) lacked indication of care conferences since admission dated 8/20/25.R53's care plan dated 11/25/25, indicated R53 was a vulnerable adult, at risk for decreased cognitive and physical abilities related to diagnoses of TBI, depression, opioid dependence, legal blindness and dizziness.When interviewed on 4/27/26 at 1:07 p.m., R53 stated she didn't remember being invited or involved in any meetings about her care at the facility.When interviewed on 4/29/26 at 11:11 a.m., social service director (SS)-A confirmed the EMR lacked documentation of care conferences for R53. SS-A and social service designee (SS)-B were responsible for scheduling conferences. Information was sent to the inter-disciplinary team (IDT), resident, and their family/representatives. Furthermore, the expectation for care conferences was to have one within 48 hours of admission, quarterly and as needed.When interviewed on 4/30/26 at 9:49a.m., registered nurse (RN)-B stated care conferences were coordinated with the interdisciplinary team (IDT), resident and their family occurred within the first 48 hours of admission, quarterly and with any significant change in the resident's condition. This ensured individual needs of the resident were met. When interviewed on 4/30/26 at 2:45 p.m., the director of nursing (DON) stated resident care conferences were expected to be done within 48 hours of admission, quarterly, with significant changes and as needed. The importance of care conferences was to align cares with resident's needs, revisit concerns and follow up with the plan of care. An undated policy titled Care Planning-Interdisciplinary Team dated indicated comprehensive care plan was to be developed within 7 days. The IDT would make every effort would be made to have the resident and their family attend the care conferences.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure recommended provider referral for ophthalmology care was followed up on for 1 of 1 resident (R21) reviewed for missed appointments. Findings include:R21's quarterly Minimum Data Set, dated [DATE], indicated R21 was cognitively intact, required setup or clean-up assistance to total dependence with most activities of daily living (ADLs), and substantial to maximal assistance with transfers and mobility. R21did not display rejection of care behaviors. R21's diagnoses included ataxia (a neurological condition causing lack of muscle coordination) and need for assistance with personal care.R21's provider visit note dated 1/20/26, indicated, Patient requested to speak to me regarding a small left [sic] tag underneath his left eye. The visit notes further indicated under orders placed today, Ophthalmology appt for skin tag under L eye and follow up summary, Yellowish colored skin tag below left eye. Will put in a referral for ophthalmology.R21's provider order dated 1/20/26, instructed, Ophthalmology appt for skin tag under L eye.During observation and interview on 4/29/26 at 11:06 a.m., R21 stated he remembered talking to the doctor about this (pointing to the approximately 1cm flesh colored raised area just under his left eye) and was told it was a skin tag and that they would look into getting it removed. R21 continued, But that never happened.During interview on 4/29/26 at 11:40 a.m., licensed practical nurse (LPN)-A stated all appointment referrals were handled by the medical records director (MRD).During interview on 4/30/26 at 10:45 a.m., registered nurse (RN)-B stated would expect all appointments to be scheduled timely for routine referrals within 30 days and within 24 hours if an urgent matter. RN-B stated the facility used) for in-house routine dental care and would find an external dental clinic for urgent care.During interview on 4/29/26 at 1:07 p.m., director of nursing (DON) stated MRD would be the one to make arrangements routine and non-routine appointment scheduling either through Health Drive (HD - an outside source for medical and dental support for long term care facilities) or an outside clinic. DON stated HD was used for routine dental, podiatry, and audiology appointments and any other services needed would be made through an outside clinic.During interview on 4/30/26 at 8:43 a.m., MRD stated she was responsible for making all arrangements for referrals to include scheduling the appointment and transportation to an external clinic if needed. MRD stated she had just seen R21's ophthalmology referral last week and had not made any arrangements yet. MRD could not explain why the ophthalmology referral was not seen back in January when originally ordered other than it must have been lost in the folders of paperwork around her office while she was attempting to reorganize.During follow up interview on 4/30/26 at 10:49 a.m., DON stated would expect appointment referrals to be made timely as ordered. DON stated R21should have had arrangements for ophthalmology appointment by now.During interview on 4/30/26 at 11:40 a.m., nurse practitioner (NP) stated would have expected appointment referrals to be followed up on timely. NP stated would expect staff to act on provider orders as soon as possible and would have expected R21 to have been seen by ophthalmology by now since that referral was placed in January.A facility policy on appointment scheduling or provider orders was requested but not provided.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure coordination of mental health care services for 1 of 1 residents (R4) who had a referral to obtain psychiatrist services. Findings include:R4's quarterly Minimum Data Set (MDS) dated [DATE], identified R4 was cognitively intact with diagnoses of borderline personality disorder, post-traumatic stress disorder and major depressive disorder.R4's provider order dated 3/11/26, indicated psychiatry to see R4 next week, social work to get in touch with case manager to expedite transfer to a setting that would support her mental health, also seeking changes to her psychiatric medications due to her increased anxiety, and R4 requested female caregivers. R4's care plan dated 4/21/26, indicated R4 was at risk for altered behavior related to trauma. R4 required a referral for psychiatry services, collaboration with social services and psychiatry improved social connections and minimize symptomology.R4's psychiatry provider notes were requested however were not provided. When interviewed on 4/27/26 at 2:50 p.m., R4 stated her post-traumatic stress disorder, anxiety and depression made her feel that she wasn't heard and understood by staff. R4 used an IPAD to speak with a grief therapist but was not offered any additional therapy or mental health support. When interviewed on 4/29/26 at 11:26 a.m., nursing assistant (NA)-C stated if a resident was having behaviors, stress-based outbursts, the care was to use therapeutic communication, acknowledge their concerns, respond calmly, and explain the situation without judgement, meet the resident where they are at.When interviewed on 4/30/26 at 9:46 a.m., registered nurse (RN)-B stated provider orders were to be followed. If referrals made, it was important, so all caregivers were on the same page and were able to provide cohesive care. RN-B stated she was unaware of the referral for psychiatrist for R4.When interviewed on 4/30/26 at 9:63a.m., service director (SS)-A stated the process to obtain an appointment for psychiatric services were offered on admission, as ordered and as needed. The social services department was responsible for scheduling appointments with the outside psychiatrist team. SS-A stated R4's order was not completed because social services was unaware of the order. When interviewed on 4/30/26 at 1:46 p.m., director of nursing (DON) The DON staff were expected to place provider orders into the medical record as soon as possible. The expectation was to have outside psychiatric appointments set up per orders. It was important to provide/arrange psychological counselling services to meet the needs of the resident, what was driving behaviors, provide proper care, it was a collaborative approach to the behaviors. DON further stated they were not sure why R4's order was missed and it was unknown if the R4 accepted or declined the additional services and would look into it. No further information was provided. A policy titled Trauma Care dated 2/24/23 indicated the inter-disciplinary team monitor effects of approaches to ensure they are implemented and care plans updated.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure emergency dental referral for infected tooth was followed up on for 1 of 1 resident (R21) reviewed for dental services.Findings include:R21's quarterly Minimum Data Set (MDS) dated [DATE], indicated R21 was cognitively intact, required setup or clean-up assistance with oral hygiene, and substantial to maximal assistance with transfers and mobility. R21did not display rejection of care behaviors. R21's diagnoses included ataxia (a neurological condition causing lack of muscle coordination) and need for assistance with personal care.R21's provider visit note dated 11/11/25, Patient currently reports severe toothache described as horrible, with examination revealing left upper molar decay with partial breakage and erythema around gum line. The visit notes further indicated under orders placed today, Referral to dentist for definitive treatment of infected left upper tooth and follow up summary, Escalate priority for dental appointment scheduling.R21's provider orders dated 11/12/25, instructed, Referral to dentist for treatment of infected left upper tooth.During interview on 4/29/26 at 11:06 a.m., R21 stated he had a tooth infection a while ago and was supposed to see a dentist but never did. R21 stated he was using a special mouthwash which seemed to help.During interview on 4/29/26 at 11:40 a.m., licensed practical nurse (LPN)-A stated all appointment referrals were handled by the medical records director (MRD).During interview on 4/30/26 at 10:45 a.m., registered nurse (RN)-B stated would expect all appointments to be scheduled timely for routine referrals within 30 days and within 24 hours if an urgent matter. RN-B stated the facility used an outside provider source for medical and dental support for in-house routine dental care and would find an external dental clinic for urgent care. During interview on 4/29/26 at 1:07 p.m., director of nursing (DON) stated MRD would be the one to make arrangements routine and non-routine appoint scheduling either through outside provider source for medical and dental support for in-house routine dental care or an outside clinic. DON stated the outside provider source for medical and dental support for in-house routine dental care was used for routine dental, podiatry, and audiology appointments.During interview on 4/30/26 at 8:43 a.m., MRD stated she was responsible for making all arrangements for referrals that included scheduling the appointment and transportation to an external clinic if needed. MRD stated residents would be seen as needed when the outside provider source for medical and dental support came to the facility or for routine appointments such as annual or bi-annual dental care. MRD stated she thought she had set up an appointment for R21 to see them, but R21 refused the care. MRD was unable to locate any evidence that R21 was ever seen by outside provider source for medical and dental support or was on a list to be seen them, or any documented refusal of care. MRD stated if there was an emergency need, she would try to get them sent out to an outside clinic for treatment. MRD stated had worked at this facility for four years and could not recall ever making urgent dental arrangements and did not know if there was a specific procedure to do so. MRD stated the outside provider source for dental support was at the facility on 11/11/25, 2/17/26, 3/17/26, and 4/14/26. MRD confirmed R21 was not listed as being seen at any of those visits. During phone interview on 4/30/26 at 9:32 a.m., the appointment coordinator for the outside provider source for dental support stated R21 was not enrolled in for dental care and had only elected podiatry services with them.During follow up interview on 4/30/26 at 9:47 a.m., MRD stated she was mixed up earlier and that R21 was only signed up for podiatry care and would not have been scheduled for dental care. MRD stated R21 needed an external dental clinic of his choice and an appointment should have been arranged back in November when originally scheduled and could not explain why it was missed.During follow up interview on 4/30/26 at 10:49 a.m., DON stated would expect appointment referrals to be made timely as ordered. DON stated R21should have been seen by a dentist by now. During interview on 4/30/26 at 11:40 a.m., nurse practitioner (NP) expected appointment referrals to be followed up on timely. NP stated they would expect staff to act on provider orders as soon as possible and would have expected R21 to (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have been seen by a dentist back in November as ordered.A facility policy on appointment scheduling or provider orders was requested but not provided.