



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 14, 2026

Administrator
THE VILLAS AT ROBBINSDALE
3130 GRIMES AVENUE NORTH
ROBBINSDALE, MN 55422

RE: CCN:245417

Cycle Start Date: July 17, 2026

Dear Administrator:

On July 17, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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
Office: (320) 223-7300 Mobile: (320) 426-0175

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 October 17, 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 January 17, 2027 (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

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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245417		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/17/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ROBBINSDALE				STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH , ROBBINSDALE, Minnesota, 55422			
(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
E0000	Initial Comments On 7/13/26 through 7/17/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			E0000			08/26/2026
F0000	INITIAL COMMENTS On 7/13/26 through 7/17/26, a standard recertification survey (S#S54174040-0) was conducted at your facility. Complaint investigations were also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H54172768C (#3033623), H54173259C (#3071143), H54173260C (#2709017), H54173263C (#2693489), H54173264C (#2644082), H54173265C (#2620828), H54173266C (#2588447), H54173267C (#1134472), H54173268C (#1134507), H54173269C (#1134466), H54173271C (#2629195),			F0000			08/26/2026

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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F0000	Continued from page 1 NO deficiencies were cited. 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.			F0000			08/26/2026
F0755 SS = F	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is			F0755	Immediate Correction Action: The facility immediately reconciled all narcotic medications on the two identified carts and ensured that the index in the narcotic log matched the narcotic cards that were housed on the cart. Any narcotic cards that were either removed or completed were crossed out in the narcotic book index. The individual staff identified as missing logging the last dose of Carisoprodol given was provided written education regarding logging administered medication in the narcotic book. Any nurse that was identified as counting without using the index was provided an educational moment regarding the process of narcotic counting. Corrective Action, as applies to others: This deficient practice had the ability to effect all residents. All other medication carts were audited to ensure the narcotic log book matched the narcotics available on the cart. No missing medications were identified during the audit. Any discrepancies in the narcotic index were immediately corrected. The Medication Storage in the Facility policy was reviewed and remains current. Education Provided: All nurses were educated regarding using the narcotic log book index to log newly received narcotics, counting shift to shift using the index, and what to do when a narcotic card goes empty and/or is destroyed. Reoccurrence will be prevented by audits being completed by Director of Nursing/Designee with 5 audits weekly for 2 weeks, then 5 audits bimonthly for 2 months, then monthly until determined by QAPI		08/26/2026

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F0755 SS = F	Continued from page 2 maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure they had an accurate accounting of controlled substances in 2 of 2 medication carts reviewed for medication storage. Findings include: During an observation on 7/16/26 at 11:57 a.m., of the fourth-floor south medication cart with registered nurse (RN)-A a comparison of the narcotic control book and the narcotic cards was made. Page 81 carisoprodol (a prescription skeletal muscle relaxant used for the short-term relief of acute, painful muscle spasms and injuries) 250 milligrams (mg) showed there should have been one pill left in the card. RN-A was not able to find a matching card with the medication in the locked medication drawer. The last time the medication was dispensed was on 6/1/26. During an interview on 7/16/26 at 12:17 p.m., RN-A verified the count had been incorrect since 6/1/26. During an interview on 7/16/26 at 12:27 p.m., RN-D stated they control the count from the narcotic drawer by calling out the card and page number, then said it would be better to count from the book. RN-D checked the drawer and was not able to find the card to match page 81. During an observation on 7/16/26 at 12:31 p.m., the DON and RN-D performed a narcotic count using the index page to control the count. There were no corresponding cards to match the following pages: 114 Hydromorphone 2 mg (a powerful prescription opioid medication used to treat moderate to severe pain) 115 buprenorphine 2 mg (a partial opioid agonist prescribed to treat opioid disorder and to manage severe chronic or acute pain) 118 alprazolam 1 mg (benzodiazepine used to treat anxiety, panic, and anxiety caused by depression) 120 tramadol 25 mg (opioid pain medicine used to treat moderate to moderately severe pain) 129 tramadol 50 mg 130 buprenorphine 2 mg			F0755	Continued from page 2 to decrease frequency of audits.		08/26/2026

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F0755 SS = F	Continued from page 3 131 oxycodone 5 mg (strong opioid pain medicine) 132 oxycodone 5 mg 133 tramadol 50 mg 134 alprazolam 1 mg 139 oxycodone 5 mg 141 butal/APAP 50-30 (prescription medicine used to treat tension headaches) 142 oxycodone/APAP 10-325 mg 143 oxycodone 10 mg 144 carisoprodol 250 mg 146 alprazolam 0.5 mg 152 oxycodone 5 mg 154 oxycodone 5 mg 155 oxycodone 5 mg 156 alprazolam 157 butal/APAP 50-325 mg 159 buprenorphine 2 mg 161 oxycodone 162 alprazolam 0.5 mg 163 buprenorphine 2 mg 165 oxycodone 10 mg 166 alprazolam 1 mg 167 alprazolam 0.5 mg During an interview on 7/16/26 at 12:41 p.m., the DON stated the facility was not following the process for narcotic counts and did not have control of their narcotics. During an observation on 7/16/26 at 12:42 p.m., the DON and licensed practical nurse (LPN)-C completed a narcotic count using the index page and found the same concern, medications listed as still current in the index page but no card to match. The Don stated			F0755			08/26/2026

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F0755 SS = F	Continued from page 4 the narcotics had not been crossed out when they were used or destroyed. During an interview on 7/16/26 at 12:49 p.m., the DON stated narcotics should be signed into the index page and crossed out on the index page when the medication was completed or when the medication was destroyed. During an interview on 7/17/26 at 10:37 a.m., the consultant pharmacist (CP) stated she would expect staff to sign narcotics into the book using the index page. CP also stated she would expect the staff to perform a narcotic count at each shift change using the index page of the narcotic book and if there were any discrepancies she would expect them to look into the concern immediately and resolve and or report the concern. She stated the purpose of the shift count was to ensure they maintained an accurate accounting of the controlled substances. CP stated staff should log the narcotic into the book, sign the narcotic out of the book when it was dispensed or when the narcotic was destroyed. The policy Medication Storage in the facility – controlled substance storage dated 1/2026, identified at each shift change or when keys were transferred a physical inventory of all controlled substances, including refrigerated items would be conducted by two licensed nurses and would be documented. Any discrepancies would be reported to the DON or designee immediately and every reasonable effort would be made to reconcile the discrepancy.	F0755		08/26/2026
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents	F0578	Immediate Correction Action: Facility staff reviewed the POLST with R46 and R48 to ensure POLST was current and up to date. R46 and R48 advance directives were corrected immediately. Corrective Action as it applies to others: This deficient practice had the potential to affect all residents. A full house audit was completed to ensure all advance directives were in the correct chart for all residents. No other POLSTs were found to be in the wrong chart. The POLST documentation Policy and Procedure was reviewed and remains current. Education was provided to Health information director and the Nurse Managers to ensure uploads into the resident charts are completed accurately. Reoccurrence will be prevented by Medical Records	08/26/2026

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F0578 SS = D	Continued from page 5 concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the correct physician provider orders for life-sustaining treatment (POLST) were in the correct chart for 1 of 1 resident (R46) reviewed for resuscitation orders. Findings include: R46's Diagnosis Report dated 7/16/26, identified R46 had diagnoses which included hypo-osmolality and hyponatremia (this state causes water to shift into cells, leading to potentially dangerous cellular swelling, particularly in the brain), cellulitis of left lower limb, anxiety disorder, depressive disorder, and neoplasm of unspecified behavior of endocrine glands and other parts of nervous system. R46's quarterly Minimum Data Set (MDS) dated 5/14/26, identified R46 was cognitively intact. R46's Order Summary Report identified R46 had an order dated 4/10/26, for do not resuscitate (DNR). R46's care plan dated 2/9/26, identified R46 had code status identified as a problem, interventions included to arrange a medical doctor consultation as necessary, review the resident's advance directive			F0578	Continued from page 5 by completing weekly audits of 5 residents' POLSTs, including new admissions, x 2 weeks. Then 3 resident audits weekly for 2 weeks and then monthly X 2 months until determined by QAPI to decrease frequency of audits.		08/26/2026

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F0578 SS = D	Continued from page 6 as needed per the resident's and/or family's request, and staff were directed to follow the POLST guidelines. R46's POLST dated 4/13/26, identified she had checked DNR and had signed the documentation of discussion. During a record review on 7/14/26 at 9:32 a.m., R46's electronic medical record (EMR) banner identified R46 showed DNR. During a record review on 7/14/26 at 9:33 a.m., R46's EMR record showed R48's POLST had been scanned into R46's record. R48's POLST identified she wished to have cardiopulmonary resuscitation (CPR), and the documentation of discussion was dated 6/16/26. During an interview on 7/14/26 at 9:43 a.m., R46 stated her wishes were to not have CPR . During an interview on 7/14/26 at 12:23 p.m., licensed practical nurse (LPN)-A reviewed R46's EMR and verified the EMR banner identified R46's was listed as DNR. LPN-A then reviewed the POLST in R46's EMR, she verified R48's POLST was in R46's EMR. LPN-A verified the wrong POLST was in R46's EMR. During an interview on 7/14/26 at 12:42 p.m., the director of nursing (DON) stated she had heard the wrong POLST was in R46's EMR. The DON stated having the wrong POLST in an EMR could lead to someone receiving CPR who didn't want it and the opposite someone who wanted CPR might not receive it. During an interview on 7/16/26 at 12:56 p.m., the DON stated the process for the POLST was to go over the resident's wishes upon admission with them, then the POLST would be completed and scanned into the EMR. The DON stated admissions or medical records would scan the document into the medical records. The POLST Documentation Procedure dated 4/2025, identified the wishes of the resident or the resident representative would be discussed and verified, an order would be obtained if needed, the order would be placed in the EMR, and the POLST document would be uploaded into the miscellaneous section of the EMR. The procedure identified "a routine audit of the POLST documentation should be completed to ensure consistent and accurate documentation of the POLST form, physician orders, the care plan and			F0578			08/26/2026

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F0578 SS = D	Continued from page 7 entry in PCC (point click care)."	F0578				08/26/2026	
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic;	F0605	Immediate Correction Action: R6 had an orthostatic blood pressure taken to monitor antipsychotic medication side effects per requirement. The provider was updated with the results. The nurse that documented the orthostatic blood pressure incorrectly was educated on taking and documenting orthostatic blood pressures. Corrective Action as it applies to others: Full house audit was completed for all other residents who are on an antipsychotic medication to ensure their orthostatic blood pressures were taken accurately. Education was provided to all nurses regarding completing accurate orthostatic blood pressure to monitor residents who use antipsychotic medication and proper documentation in the resident's medical record. Reoccurrence will be prevented by the Director of Nursing or designee by reviewing 5 residents who are on antipsychotic medications for orthostatic blood pressures to ensure ortho blood pressure is being taken, and accurate documentation is being completed until determined by QAPI to decrease frequency of audits.			08/26/2026	

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NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ROBBINSDALE				STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH , ROBBINSDALE, Minnesota, 55422			
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F0605 SS = D	Continued from page 8 (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in			F0605			08/26/2026

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F0605 SS = D	Continued from page 9 §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure physician-ordered monitoring for potential adverse effects related to antipsychotic medication use was completed when orthostatic blood pressures (BP) were not obtained as ordered for 1 of 5 residents (R6) reviewed for unnecessary medication use. Findings include: R6's quarterly Minimum Data Set (MDS) dated 5/19/26, indicated R6 was cognitively intact and required assistance with activities of daily living (ADLs). Diagnoses included dementia, bipolar, sleep apnea, hyperlipidemia, and insomnia. R6's physician orders printed 7/17/26, identified an order for risperidone Oral Tablet 0.5 milligrams (mg) by mouth at bedtime for bipolar disorder. R6's physician orders further identified an order to obtain monthly orthostatic blood pressures (lying, sitting, standing blood pressures) due to antipsychotic medication use, initiated 2/1/26. R6's electronic medical record (EMR) was reviewed from March 2026 through July 2026. May 2026 R6's lying, sitting, and standing blood pressure were all recorded as 116/68, June 2026 R6's lying, sitting, and standing blood pressure were all recorded as 111/68, and July 2026 R6's lying, sitting and standing blood pressure were all recorded as 121/68. When interviewed on 7/16/26 at 10:25 a.m. licensed practical nurse (LPN)-B stated orthostatic blood pressures were done by doing a blood pressure while the resident was lying down, leave the blood pressure cuff on. The resident should be assisted to			F0605			08/26/2026

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F0605 SS = D	Continued from page 10 sit on the edge of the bed with another blood pressure completed while they were sitting. Then have the resident stand up if they were able to and do a third blood pressure. When interviewed on 7/16/26 at 11:09 a.m. registered nurse (RN)-B stated orthostatic blood pressures were expected to be done monthly, RN-B reviewed R6's orthostatic blood pressures and stated there was only one blood pressure that was done and that one reading was recorded for each of the three blood pressures rather than three different readings being done in succession. When interviewed on 7/16/26 at 11:35 a.m. director of nursing (DON) stated the expectation was for the nurses to do orthostatic blood pressures once monthly with lying, sitting, and standing blood pressures being done one after the other as residents receiving antipsychotic medications have a tendency for their blood pressures to drop when they changed positions. DON stated they were not aware that the nurses were not doing the orthostatic blood pressures correctly. Facility policy regarding monitoring orthostatic blood pressures was requested, however, none was provided.			F0605			08/26/2026
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 observation, interview and document review, the facility failed to ensure oxygen orders were followed as written for 1 of 1 resident (R48) reviewed for oxygen therapy. Findings include:			F0684	Immediate Correction Action: R48 oxygen saturations were checked, and R48 oxygen level was adjusted per doctor's order. Risks vs benefits were completed with the resident regarding following physician orders for oxygen administration. Corrective Action, as applies to others: all other residents who utilize oxygen therapy were reviewed to ensure that their concentrators/tanks were checked to ensure their oxygen setting matched their physician orders. Education was provided to all nursing staff regarding monitoring of concentrator/tanks to ensure oxygen settings matched physician orders. Nursing assistant staff were educated to inform the nurse if the resident was requesting to have their oxygen increased due to shortness of breath and/or for comfort. Reoccurrence will be prevented by: the director of		08/26/2026

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F0684 SS = D	Continued from page 11 R48's admission Minimum Data Set (MDS) dated 6/4/26, identified R48 had diagnoses which included chronic obstructive pulmonary disease (COPD [a long-term lung condition that blocks airflow and makes it hard to breathe]), chronic pain, hypertension, and rheumatoid arthritis (a long-term autoimmune disease where the immune system attacks the lining of joints). R48's Order Summary Report identified R48 had an order for two liters of oxygen per nasal cannula continuously due to COPD related to hypoxia dated 6/16/26. R48's care plan, reviewed on 7/14/26, identified R48 had an alteration in oxygen/gas exchange, respiratory status related to chronic respiratory failure, and asthma. Interventions included the following: raise the head of the bed for comfort, monitor oxygen levels saturations as ordered and as needed, administer oxygen as ordered, monitor for cyanosis, accessory muscle use, shortness of breath, increased respirations, and difficulty coughing up sputum, and to keep the medical doctor informed of changes. During an observation on 7/13/26 at 2:36 p.m., R48's oxygen was noted to be at three liters per nasal cannula. On 7/16/26 at 8:51 a.m., R48's oxygen was observed at three liters per nasal cannula. Registered nurse (RN)-A verified the oxygen was at three liters and not at two liters as ordered. RN-A stated staff needed to follow the orders to prevent hypercapnia (a medical condition where a person would have too much carbon dioxide in their blood). RN-A stated staff should follow the orders as written and stated the day nurse said they often had to turn the oxygen down from the night shift. During an interview on 7/16/26 at 12:56 p.m., the director of nursing (DON) stated staff were expected to follow the oxygen orders as written and stated it could "actually hurt" a resident with COPD by giving them too much oxygen. The DON stated staff were expected to call the provider if they thought a resident needed more oxygen. The facility's Medication and Treatment Orders policy, dated 2/2024, identified medications "shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medication in this state."			F0684	Continued from page 11 nursing or designee will audit residents who use oxygen therapy to ensure that they are using the correct liter flow as ordered by the physician. Two residents will be audited weekly for 4 weeks, then monthly until determined by QAPI to decrease frequency of audits.		08/26/2026

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F0689 SS = D	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 observation, interview and document review, the facility failed to ensure tobacco products were maintained in a secured, locked container when not in use for 1 of 1 residents (R53) reviewed for smoking safety. Findings include: R53's quarterly Minimum Data Set (MDS) dated 6/16/26, indicated R53 refused to answer brief interview for mental status (BIMS) questions and was independent with activities of daily living. A previous BIMS assessment completed on 6/15/26 indicated R53 had severe cognitive impairment. R53's smoking evaluation dated 3/29/26, identified R53 as a smoker and was educated on safety and storage. The resident handled the cigarettes and lighter independently and stored them in a drawer. R53's care plan dated 4/12/26, indicated R53 currently smoked at the facility and was given a metal box for the smoking materials. The goal was R53 would follow the facility smoking policy with an intervention of risk and benefit of smoking violations, smoking assessment as needed for example if there was a change in resident's condition. The care plan also identified R53 used smokeless tobacco. R53 rolled own cigarettes and kept them in a lock box in the room. R53 was given the risks and consequences of inappropriate smoking or storage in the lock box. On 07/13/26 at 2:33 p.m., an open lock box containing loose tobacco was observed sitting on a small table next to the resident's bed. Loose			F0689	Immediate Correction Action: R53 smoking materials were secured in facility provided lock box and education was provided to the resident regarding safe storage of smoking materials and the facility smoking policy. Corrective action as it applies to others: all other residents who smoke, who are able to keep their own smoking materials, were provided with a lock box if they did not have one and were educated on the importance of securing all of their smoking materials. Education Provided: Education was provided to all residents who smoke to secure their smoking materials properly and the facility smoking policy was re-reviewed at that time. All staff were educated to monitor smoking materials to ensure that they are secured when the resident is not in their room. Staff were educated to notify Social Services, DON, or administrator if a resident was not storing materials appropriately. Reoccurrence will be prevented by: Social Services or designee will audit the residents who use tobacco to ensure that their smoking materials are being secure. 3 residents will be audited weekly for 3 weeks, then 2 audits for 2 weeks, then monthly until determined by QAPI to decrease frequency of audits.		08/26/2026

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F0689 SS = D	Continued from page 13 tobacco was also observed on the tabletop. The lock box was wide open. At 2:36 p.m., R53 independently left the nursing unit to smoke. The opened lock box containing tobacco remained on the table next to the resident's bed. At 3:47 p.m. R53 again left the unit to smoke. The lock box remained open with tobacco accessible on the table next to the bed. On 07/14/2026 at 2:54 p.m. R53 independently left the unit, the lock box remained open on the small table with loose tobacco inside. On 07/15/2026 at 7:55 a.m., R53 was out of the room, the lock box was open on the small table next to the bed with loose tobacco inside the box and scattered across the tabletop. At 8:08 a.m. R53 was in the dining room, the lock box remained open with tobacco inside the box and scattered across the tabletop. At 2:41 p.m. R53 left the unit, the lock box remained open on the table with tobacco inside and scattered across the tabletop. On 07/16/2026 at 8:17 a.m., R53's lock box remained open on the small table with tobacco inside and a small amount of tobacco on the tabletop. During an interview on 7/16/26 at 11:00 a.m., registered nurse (RN)-C stated that residents who independently smoked were provided a lock box to store tobacco products. RN-C stated It was up to resident to lock it. RN-C further stated R53 would not allow the staff to lock the box. During an interview on 7/16/26 at 11:35 a.m., director of nursing (DON) stated smoking materials were expected to be stored in a locked drawer or a locked box when it was not in use. DON acknowledged R53 was not safely storing tobacco products and identified the potential risk of other residents accessing the tobacco products if left unsecured. The facility's Resident Smoking policy dated 11/2025, indicated if a resident identified as a current smoker the storage of supplies was determined by the facility based on the resident's smoking assessment.			F0689			08/26/2026

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F0759 SS = D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure they were free of a medication error rate of five percent or greater. The facility had a medication error rate of 7.41% with 2 errors out of 27 opportunities for error involving 1 of 4 residents (R19) who were observed during the medication passes. Findings include: R19's quarterly Minimum Data Set (MDS) dated 6/4/26, identified R19 had diagnoses which included coronary artery disease, hypertension, diabetes mellitus, hyperlipidemia, and multiple sclerosis. R19's Order Summary Report dated 7/16/26, identified R19 had the following orders: insulin aspart (a fast-acting, man-made insulin) per sliding scale 150-199 = 8 units subcutaneously (sq) 200-249 =10 units 250-299 = 12 units 300-349 = 14 units 350-399 = 16 units 400-999 = 18 units call provider if over 400 and administer 18 units dated 6/5/26 insulin glargine (a long-acting man-made insulin) 12 units sq two times per day dated 6/5/26 Januvia (an oral agent taken once daily to manage blood sugars) 50 milligrams (mg) by mouth one time a day dated 7/9/26 During an observation on 7/15/26 at 7:49 a.m., licensed practical nurse (LPN)-C scrubbed the hub of the insulin pen, attached an insulin needle and drew up 12 units of insulin aspart. LPN-C did not	F0759	Immediate Correction Action: Written education was immediately provided to the nurse involved in R19s insulin administration regarding priming insulin pens prior to administering scheduled dose. R19's blood sugars were reviewed. Corrective Action, as applies to others: A facility wide audit of all individuals currently taking insulin was completed. All nurses were educated on insulin administration and priming 2 units and discarding prior to loading prescribed dose. The medication order and treatment policy was reviewed and remains current. Education Provided: All nurses were educated on insulin administration priming 2 units and discarding prior to loading administrating dose. Reoccurrence will be prevented by: the Director of nursing or designee will complete 3 insulin administration audits a week for 2 weeks, then 3 audits bimonthly for 2 months, then monthly until determined by QAPI to decrease frequency of audits.	08/26/2026

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F0759 SS = D	Continued from page 15 waste two units of insulin prior to drawing up the 12 units of insulin. Next LPN-C scrubbed the hub of insulin glargine, attached an insulin needle and drew up 12 units of insulin. Again LPN-C failed to waste two units of insulin prior to drawing up the insulin. During an interview on 7/15/26 at 8:06 a.m., LPN-C verified she did not prime the insulin needles prior to drawing up the insulins, stating a prior nurse manager had told her it was not necessary. During an interview on 7/15/26 at 8:38 a.m., the director of nursing (DON) stated she expected nurses to prime the insulin needles with two units of insulin prior to drawing up the insulin dose to ensure the resident received the full dose as ordered. During an interview on 7/15/26 at 9:05 a.m., the consultant pharmacist (CP) stated in general the insulin needle should be primed with two units of insulin to push air out of the needle to ensure the resident received the ordered dose of insulin. The Medication and Treatment Orders policy dated 2/2024, did not address priming insulin needles.			F0759			08/26/2026
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the			F0761	Immediate Correction Action: The 2nd floor refrigerator was replaced immediately due to maintaining inadequate temperatures. The 4th floor refrigerator was immediately monitored for appropriate temperature and was found to be within range. Corrective action as it applies to others: All residents have the potential to be affected by this practice. The 3rd floor refrigerator was monitored to ensure that the temperature was within range. The facility's medication storage policy was reviewed and remains current. Education was provided to all nurses and nurse managers that daily temperatures must be taken and recorded. If there any temperature discrepancies are identified, staff must adjust the temperature and/or take the refrigerator out of service and contact maintenance. Reoccurrence will be prevented by the director of nursing or designee will audit medication storage refrigerators 3 times weekly x 2 weeks, then 1 x week x 2 weeks, then monthly until determined by QAPI to decrease frequency of audits.		08/26/2026

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F0761 SS = D	Continued from page 16 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure the medication refrigerators in 2 of 2 medication rooms were at the proper temperature for medication storage. Findings include: During an observation on 7/16/26 at 10:58 a.m., with the director of nursing (DON), the refrigerator in the second-floor medication room had a temperature reading of 30 degrees Fahrenheit (F). A review of the July temperature log identified eight of the recorded temperatures were below 36 degrees F. A copy of the July temperatures was requested but not provided. The refrigerator contained the following: Lantus insulin (a long-acting basal insulin to treat type 1 and type 2 diabetes) Novolog insulin (a rapid-acting insulin used to control high blood sugars) Latanoprost eye drops (used to treat high pressure inside the eye) Timolol eye drops (used to treat high pressure inside the eye) Formoterol (bronchodilator used to treat chronic obstructive pulmonary disease and asthma) Methylprednisolone (corticosteroid used to suppress the immune system and reduce severe inflammation in conditions like arthritis, asthma, severe allergies, and flare-ups of multiple sclerosis) Bisacodyl suppositories (a fast-acting, rectal stimulant laxative to treat occasional constipation) During an observation and interview on 7/16/26 at 11:16 a.m., with the DON of the fourth-floor medication room, the medication temperature reading was 39 degrees F. There were no temperatures recorded for July. A request for the past three months of temperatures was requested but not provided. The refrigerator had insulins, emergency kits and inhalers. A copy of the contents was requested but not provided. The DON stated staff were expected to record the medication			F0761			08/26/2026

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F0761 SS = D	Continued from page 17 refrigerators daily and to report any concerns if the temperature was out of the safe range. During an interview on 7/16/26 at 11:27 a.m., the consultant pharmacist (CP) said the facility needed to check the manufacturer's directions for each medication to determine if it was still viable and would consider the last recorded temperature out of range to be when the medication was no longer considered to be refrigerated. The CP stated they would expect the facility to take corrective action when the temperature was out of the safe temperature range. The facility's Medication Storage policy, dated 1/2026, identified the refrigerator temperature should be maintained between 36 degrees to 46 degrees F.	F0761		08/26/2026	
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F0880	Immediate Correction Action: R48 was reviewed and identified as requiring contact precautions. The facility reviewed signage and orders to ensure that the proper signage was posted on the resident's door. The NA that was identified as not wearing appropriate PPE was educated immediately on the use of contact precautions. Corrective Action, as applies to others: All residents that require contact precautions have the ability to be affected by this practice. A full-house audit was completed to ensure that residents on contact precautions had appropriate signage on their door. Immediate education was completed with CNA not following contact precautions for R48. Education Provided: All staff were educated on isolation precautions including the difference between contact precautions and EBP. Staff were educated that when a resident requires contact precautions that appropriate PPE must be worn every time when entering the resident's room. The facility's Infection Prevention and Control- Contact Precautions Policy was reviewed and remains current. Reoccurrence will be prevented by: Audits to be completed by infection control preventionist or designee 3 x weekly on residents who are requiring contact precautions for 2 weeks, weekly x 2 weeks, then monthly for 2 months, then PRN based on audit findings until determined by QAPI to decrease frequency of audits.	08/26/2026	

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NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ROBBINSDALE				STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH , ROBBINSDALE, Minnesota, 55422			
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F0880 SS = D	Continued from page 18 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff wore appropriate personal protective equipment (PPE) prior to entering 1 of 1 resident's (R48) room who was in contact precautions. Findings include: R48's admission Minimum Data Set (MDS) dated 6/4/26, identified R48 had diagnoses which included			F0880			08/26/2026

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F0880 SS = D	Continued from page 19 chronic obstructive pulmonary disease (COPD [a long-term lung condition that blocks airflow and makes it hard to breathe]), chronic pain, hypertension, and rheumatoid arthritis (a long-term autoimmune disease where the immune system attacks the lining of joints). R48’s Order Summary Report identified R48 had an order for contact precautions dated 7/14/26. R48’s care plan, reviewed on 7/14/26, identified R48 had isolation precautions related to left hand ring finger abscess initiated on 7/14/26. The goal was listed as “All staff to follow isolation precautions”. Interventions included to follow infection control precautions, and to place a sign on the resident’s door. During an observation on 7/14/26 at 2:01 p.m., a staff was observed standing by R48’s bed, staff were not wearing any personal protective equipment (PPE). During an observation on 7/15/26 at 12:39 p.m., nursing assistant (NA)-A was observed delivering a meal tray to R48, they were not wearing any PPE. During an interview on 7/15/26 at 12:43 p.m., NA-A stated when someone was in contact isolation staff should wear an isolation gown and gloves whenever they entered the room. NA-A verified they did not do this when they delivered the meal tray and situated R48 for lunch. During an interview on 7/16/26 at 9:41 a.m., the infection preventionist (IP) stated staff were trained on isolation precautions on hire, annually, and when there were changes. IP stated staff were expected to read the isolation sign posted on the door and to follow the directions on the sign. During an interview on 7/16/26 at 12:56 p.m., the director of nursing (DON) stated staff were expected to gown and glove every time they entered a resident’s room if the resident was in contact isolation. The DON stated this was important to do to prevent the spread of infection. The sign “Contact Precautions”, undated, identified staff must put on gloves and gloves before entry into the room. The facility's Infection Prevention and Control – Contact Precautions policy, dated 7/31/23, identified healthcare personnel caring for residents in contact precautions should wear a gown and gloves for all			F0880			08/26/2026

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F0880 SS = D	Continued from page 20 interactions that may involve contact with the resident.	F0880		08/26/2026	
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has	F0883	Immediate Correction Action: R6 and R46 were identified without current pneumonia vaccines and facility staff completed new vaccine consent forms with the residents. R6 and R46 consented to receive the pneumonia vaccine and vaccines were administered on 7/23 and 7/28 respectively. Corrective Action, as applies to others: All other residents who require pneumonia vaccines have the potential to be affected by this practice. A facility wide audit was completed for current pneumonia vaccine of all residents. Like residents were identified and immediately given consent forms and education about pneumonia vaccines. Refusals documented in immunization tab of PCC, and all residents consenting to the current recommended vaccine were administered. Education Provided: Education was completed with Infection control preventionist to offer current pneumonia vaccine per policy upon admission and annually for all residents. All nurses were educated on completing the administration and documentation of vaccines when it is in the EMAR on shift to complete. Reoccurrence will be prevented by: Audits will be completed by Infection preventionist or designee of 5 residents, including all new admissions, weekly to ensure the resident is current with the pneumonia vaccine x4 weeks, then 4 audits monthly for 3 months, then PRN based on audit findings to ensure both admission and annually are completed until determined by QAPI to decrease frequency of audits.	08/26/2026	

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F0883 SS = D	Continued from page 21 the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 5 residents (R6, R46) reviewed for immunizations were offered and/or provided the pneumococcal vaccination series as recommended by the Centers for Disease Control (CDC) to help reduce the risk of associated infection(s). Findings included: A CDC Pneumococcal Vaccine Timing for Adults feature, dated 3/2025, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over 50 years old had received no prior pneumococcal vaccine should receive PCV20 or PCV21, those who had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after 65 years old. R6’s face sheet dated 7/17/26, indicated R6 was 84 years old. The immunization report dated 7/17/26, indicated R6 received a PPSV23 on 8/1/07 followed by PCV13 on 10/17/14. The record lacked evidence of shared clinical decision making with the physician for PCV20 at least 5 years after the last pneumococcal dose. The record lacked evidence that R6 was offered or received PCV20. R46’s face sheet dated 7/17/26, indicated R46 was 63 years old. The immunization report dated			F0883			08/26/2026

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F0883 SS = D	Continued from page 22 7/17/26, indicated R46 received a PPSV23 on 10/18/22. The record lacked evidence of shared clinical decision making with the physician for PCV20 at least 5 years after the last pneumococcal dose. The record lacked evidence that R6 was offered or received PCV20. During interview on 7/15/26 at 8:28 a.m. registered nurse (RN)-B stated when a resident admitted they looked at immunizations the resident had already received. If the resident was eligible for a vaccine, the resident was talked to regarding which vaccinations were due and obtained consent or refusal. If consented, the vaccination was administered and documentation of receipt of the vaccination or refusal was indicated in the resident's medical record. RN-B stated annually when it was time for influenza vaccinations all residents were reviewed for other vaccinations, they may be due for and were again offered. When interviewed on 7/16/26 at 11:35 a.m. director of nursing (DON) reviewed R6 and R46 electronic medical records, stated both residents should have been offered the PCV20 and were not. The expectation was for pneumococcal to be offered and administered if they consented when admitted and then vaccinations were to be reviewed and offered if not up to date at least yearly when influenza vaccinations were done. Facility Pneumococcal policy dated 2/24 indicated all residents would be assessed for current immunization status and eligibility to receive the pneumococcal vaccine, within thirty days of admission the resident would be offered the vaccine. The policy further indicated the pneumococcal vaccination would be administered per physician order and CDC recommendations and would be documented in the residents' medical record, if the resident refused vaccination the date of refusal would be documented in the medical record.			F0883			08/26/2026
F0628 SS = B	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is			F0628	Immediate Corrective Action taken: R73 information for the monthly ombudsmen report that was missing was sent to the Ombudsmen Office. Corrective action as applies to others: All residents who discharge or transfer from the facility have the potential to be affected by this practice. The June and July Ombudsmen reports were reviewed to make sure no other residents were missed from		08/26/2026

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F0628 SS = B	Continued from page 23 documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable	F0628	Continued from page 23 the report. Education was provided to the social service department about ensuring accuracy of the reporting process and was shown a new process to complete so no names will missed going forward. Reoccurrence will be prevented by: administrator or designee will audit the monthly report against all discharges to ensure a resident name is not missed. Audits will be completed monthly for 5 months, until determined by QAPI to decrease the frequency of audits.	08/26/2026

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F0628 SS = B	Continued from page 24 before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental			F0628			08/26/2026

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F0628 SS = B	Continued from page 25 disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or			F0628			08/26/2026

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F0628 SS = B	Continued from page 26 therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the Ombudsman was notified of a facility transfer for 1 of 1 resident (R73). Findings include: R73's admission record dated 7/16/26, indicated diagnosis included acute cystitis (medical inflammation of the bladder, usually caused by a bacterial infection) without hematuria (red blood cells in the urine), adult failure to thrive, transient ischemic attack (TIA) and cerebral infarction without residual deficits, other symptoms and signs involving cognitive functions and awareness. R73's provider progress note dated 5/19/26, indicted R73 was being transferred to a memory care center. R73's discharge instructions and summary dated 5/19/26, indicated it was a facility-initiated discharge and must notify the Ombudsman.			F0628			08/26/2026

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F0628 SS = B	Continued from page 27 The facility's Monthly Notice to MN Office for Long-Term Care (LTC) of Emergency Acute Care Transfers and Discharges dated June 2026 lacked R73's name being faxed to the LTC Ombudsman. An interview on 7/14/26 at 2:16 p.m., social services designee (SSD) stated R73 had been transferred. SSD stated R73 was not on the list of transfers and discharges that were faxed to the LTC Ombudsman. SSD stated R73 should have been on the list. SSD stated R73 should have been put on the discharge log that was completed. At 3:27 p.m., SSD stated "it was human error on my part". The facility policy Ombudsman Hospital Transfer Report dated 8/2025, indicated the report would be sent monthly, typically within the first 5 days of the month for the previous month. Run the report in PCC (Point Click Care), using the following instructions: go to Admin tab, reports, action summary, ensure your date range is correct, action code-clear it all and the scroll to the bottom and click "Transfer out to hospital", "Discharge Date", Discharge/Transfer New Facility". Ensure all payer types are selected, click show to/from description, run report. Then fax the report to the Ombudsman. Once faxed print a fax confirmation.			F0628			08/26/2026

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NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ROBBINSDALE				STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH , ROBBINSDALE, Minnesota, 55422			
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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 07/15/2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, The Villas at Robbinsdale was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145			K0000			07/22/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245417		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT ROBBINSDALE				STREET ADDRESS, CITY, STATE, ZIP CODE 3130 GRIMES AVENUE NORTH , ROBBINSDALE, Minnesota, 55422			
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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Villas At Robbinsdale is a 4-story building without a basement that was built in 1968 and determined to be of Type II(222) construction. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 75 beds and had a census of 74 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K0000			07/22/2026
K0712 SS = F Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills			K0712	1. A detailed description of the corrective action taken or planned to correct the deficiency. A NOC fire shift drill was performed to add the staggered time of the drills. 2. Address the measure that will be put in place to		07/22/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245417		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
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K0712 SS = F Bldg. 01	Continued from page 2 Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/15/2026 at 10:10 AM, it was revealed by a review of available documentation that the fire drills conducted during the third shift were not being carried out at varied times. An interview with the Administrator, Maintenance Operations Director, Regional Maintenance Director, Maintenance Director and the Maintenance Technician verified this deficient finding at the time of discovery.			K0712	Continued from page 2 ensure the deficiency does not recur. The Maintenance Director has been educated that he must ensure the NOC shift drills are at staggered time. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. The facility will complete audits on a quarterly bases when the drills are scheduled to ensure the drill times are staggered 4. Identify who is responsible for the corrective action and monitoring of compliance. The Director of Maintenance is responsible for the corrective action and monitoring. 5. The actual or proposed date for completion of the remedy. The NOC drill was completed on 7/22/26 to start the staggering pattern.		07/22/2026
K0372 SS = D Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in			K0372	1. A detailed description of the corrective action taken or planned to correct the deficiency. The junction box cover was replaced above the smoke compartment doors. All other smoke compartment doors were checked for compliance. 2. Address the measure that will be put in place to ensure the deficiency does not recur. The Maintenance Director has been educated that he must ensure all junction box covers are in place after work has been completed. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. The facility will complete audits after any work has been performed above the smoke compartments doors. 4. Identify who is responsible for the corrective action and monitoring of compliance. The Director of Maintenance is responsible for the corrective action		07/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245417		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
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K0372 SS = D Bldg. 01	Continued from page 3 REMARKS. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.2. This deficient finding could have a isolated impact on the residents within the facility. Findings Include: On 7/15/2026 at 10:41 AM, it was revealed by observation that the smoke barrier in 2 South was not properly sealed because an electrical junction box was open and unsealed. An interview with the Administrator, Maintenance Operations Director, Regional Maintenance Director, Maintenance Director and the Maintenance Technician verified this deficient finding at the time of discovery.			K0372	Continued from page 3 and monitoring. 5. The actual or proposed date for completion of the remedy. The junction box cover was replaced on 7/15/26.		07/16/2026



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 17, 2026

Administrator
THE VILLAS AT ROBBINSDALE
3130 GRIMES AVENUE NORTH
ROBBINSDALE, MN 55422

RE: CCN: 245417
Cycle Start Date: July 17, 2026

Dear Administrator:

On September 9, 2026, the Minnesota Department(s) of Health and Public Safety, 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.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us