Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 5, 2024

Administrator
The Villas At Robbinsdale
3130 Grimes Avenue North
Robbinsdale, MN 55422

RE: CCN: 245417
Cycle Start Date: July 28, 2024

Dear Administrator:

On July 28, 2024, 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:

Alex Warren, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us
Cell: 651-279-5375 Office: 218-302-6186

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 28, 2024 (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 28, 2025 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

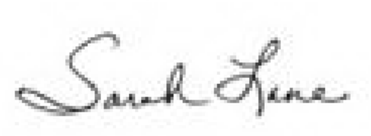
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245417	A. BUILDING _____ B. WING _____	C 07/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT ROBBINSDALE	3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 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
E 000	Initial Comments On 7/22/24 - 7/28/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 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.	E 000		
F 000	INITIAL COMMENTS On 7/22/24 - 7/25/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H5417219C / MN00081864 H54175267C / MN00085897 H54175266C / MN00087789 H54175223C / MN00090182 H54175263C / MN00104536 H54176109C / MN00105120 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.	F 000		

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

Electronically Signed | 08/09/2024

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.

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F 000	Continued From page 1 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.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without	F 550		8/28/24

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F 550	Continued From page 2 interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure timely assistance with incontinence care when requested to promote dignity for 1 of 1 residents (R41) reviewed for dignity. Findings include: R41's quarterly Minimum Data Set dated 6/27/24, indicated R41 was cognitively intact, had diagnoses of kidney failure, anxiety, and depression, was frequently incontinent of urine and bowel, and fully dependent on staff for toileting needs. R41 was able to understand and was easily understood. R41's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 3/18/24, identified R41 as incontinent of bowel and bladder, dependent on staff for toileting, did not transfer to the toilet, and wore a brief "on check and change" due to mobility. R41 was at risk for skin breakdown. R41's care plan dated 4/11/24, included R41 was incontinent of bladder, used disposable briefs, and instructed staff to offer R41 assistance to check and change upon rising, before and after	F 550	Immediate corrective action: R41 was provided incontinence cares. Care plan reviewed and noted to be up to date. Corrective action as it applies to others: A full house audit was completed of all residents to identify those who need two-assist with incontinence -cares as all other residents who require assistance of two staff with incontinence cares have the potential to be affected. Complete interviews with residents regarding timeliness of incontinent cares and update care plans as needed. Education provided to all staff regarding resident rights, answering call lights, leaving call lights active until resident needs are met, and assisting coworkers as needed to complete cares to uphold resident dignity. Date of compliance: All education and full house audits to be completed by August 28, 2024. Recurrence will be prevented by: Director of Nursing or designee will audit residents who require two-assist with incontinence cares for timeliness of cares and if they are treated with dignity 2 x per week for 2 weeks, once weekly x 2 weeks, then	

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F 550	Continued From page 3 meals, at night, and as needed for incontinence. The care plan identified staff were to provide "CARES IN PAIRS ONLY", assist of two staff with checking and changing, and R41 "will let staff know when [they] need to be changed." During continuous observation on 7/24/24, the following occurred: -At 11:05 a.m., R41 stated staff had not yet changed their incontinent brief that morning and they were wet. R41 turned on their call light for assistance. -At 11:06 a.m., trained medication aide (TMA)-A entered R41's room and R41 stated they needed to be changed. TMA-A left the room and walked toward the nursing desk. -At 11:08 a.m., TMA-A returned to R41's room, told R41 another person was coming, turned off the call light, and left the room. -At 11:37 a.m., two aides began transporting residents to the dining room for lunch. -At 12:05 p.m., nursing assistant (NA)-A and NA-B approached R41's room and then stepped away. They returned at 12:08 p.m., donned gowns and gloves, knocked on R41's door, and entered the room to change R41's incontinence brief. During interview on 7/24/24 at 12:29 p.m., NA-A stated they did the best they could to attend to everyone's needs timely. During interview on 7/24/24, at 12:35 a.m., TMA-A stated they told NA-B R41 needed to be changed, however NA-B was working with another resident and two NAs were on break. During interview on 7/24/24 at 12:39 p.m., NA-B	F 550	monthly x 2 months until determined by QAPI to decrease frequency of audits. Corrections will be monitored by the Director of Nursing or designee.	

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F 550	Continued From page 4 stated they were with other residents when TMA-A told then R41 needed to be changed and could not attend to R41 right away. During interview on 7/24/24 at 12:45 p.m., R41 stated it made them feel "hot" and forgotten when they had to wait so long for help, and it happened often. During subsequent interview on 7/24/24 at 1:33 p.m., TMA-A stated R41 required two staff to provide cares and TMA-A could not care for R41 alone, which delayed care. They stated they tried to put themselves in the residents' place and would feel 'really bad' if they had to wait an hour to be changed out of a wet brief like R41 did. During interview on 7/24/24 at 1:50 p.m., registered nurse (RN)-A stated any staff person could respond to call lights, and if they could not provide what the resident needed, they were expected to leave the light on and pass a message to someone who could appropriately addressed the resident's concern. The light should not be turned off until the resident's needs were met. They indicated staff should respond as soon as possible and did not identify an acceptable response time, however indicated an hour wait to have a brief change could impact a resident's sense of dignity and was "not good". During interview on 7/25/24 at 10:51 a.m., director of nursing (DON) stated staff should respond to call lights in under 15 minutes, depending upon the situation, and the light should be left on until the resident's needs have been met. They stated waiting for care was challenging for the resident and the staff did everything possible to provide care, however DON would not	F 550		

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F 550	Continued From page 5 like to be left for that extended period from a dignity perspective. The Resident Rights Policy dated 1/24, included it is the practice of the facility to uphold the rights of all residents as outlined in the Combined Federal and State Bill of Rights. The Combined Federal and State Resident Bill of Rights dated 6/18/19, included the resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. The resident has a right to be treated with respect and dignity.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively re-assess for ability or safety, document resident education regarding risks, and care plan the self-administration of medications for 1 of 1 resident (R41) known to obtain their own medication from outside sources, who was observed to have such medications at bedside.	F 554	Immediate corrective action: Medications were removed from R41's room with her permission. Self-administration assessment was completed. Resident deemed to be unable to self-administer her medications. Care plan updated. Risks and benefits completed with resident and education provided regarding	8/28/24

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F 554	Continued From page 6 Findings include: R41's quarterly Minimum Data Set (MDS) dated 6/27/24, included R41 was cognitively intact, had diagnoses of dysphasia (difficulty swallowing), malnutrition, attention deficit hyperactivity disorder, depression, and anxiety, and required set-up or clean-up for eating. R41's care plan dated 4/10/24, included R41 completed a risk/benefit form due to their desire to continue and inappropriate diet and unwillingness to elevate the head of the bed to prevent aspiration. A care plan intervention dated 12/6/22, indicated R41 required assistance to eat but refused. R41's MHM Self Adminsitration of Medication Evaluation dated 10/2/23, indicated R41 was capable of self-administering oral, topical, and opthalmic medications. R41's medical record lacked additional assessments. R41's Order Summary Report dated 7/25/24, included: *Guaifenesin Extended Release (ER) Tablet (and expectorant), 600 milligram(mg), give 600 mg by mouth two times per day for abnormal amount of sputum starting 5/31/24. *"DO NOT LEAVE MEDICATION IN ROOM!! Every shift for Medication safety" starting 7/9/24. During observation on 7/22/24 at 4:22 p.m., two staff entered R41's room to assist with cares. They emerged at 4:37 p.m. During observation and interview on 7/22/24 at 5:10 p.m., R41 was lying in bed with a tray table	F 554	ordering medications via delivery service without MD/NP knowledge. Corrective action as it applies to others: All residents who self-administer medications have the potential to be affected. Residents who were identified as self-administering medications had a self-administration assessment completed, MD/NP updated, and care plans reviewed for accuracy. Risks and benefits were completed with residents who did not pass the self-administration assessment. All new admissions will be evaluated for self-administration if appropriate. Education provided to nursing staff regarding self-administration of medications, when self-administration assessment is to be completed, physician to be notified, risks and benefits completed, and care plan updated. Date of Compliance: All education and self-administration assessments to be completed by August 28, 2024. Recurrence will be prevented by: Director of Nursing or designee will audit self-administration assessments to ensure thoroughness and completion, that care plans have been updated, and risks and benefits have been reviewed with residents 2 x per week for 2 weeks, once weekly x 2 weeks, then monthly x 2 months until determined by QAPI to decrease frequency of audits. Corrections will be monitored by the Director of Nursing or designee.	

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F 554	Continued From page 7 over their bed covered in various items. On the front side closest to the resident was a bottle of guaifenesin 400 mg, and a bottle of eye drops. In a container toward the center of the table was a nearly empty bottle of nystatin powder, and a bottle of ear wax remover. R41 indicated they were kept there for her use. The eye drops, ear wax remover, and nystatin bottle labels appeared older and slightly worn. The guaifenesin bottle appeared to be less so. During interview on 7/24/24 at 10:29 a.m., registered nurse (RN)-B stated a resident needed to be assessed for safety and have a provider order prior to being able to keep medications at bedside to ensure they knew when and how to use them and avoid potential complications. During observation on 7/24/24 at 10:59 a.m., one bottle of guaifenesin, one bottle of eye drops, and one bottle of ear wax remover and one bottle of nystatin remained situated on the top of R41's bedside table. During observation on 7/24/24 at 11:06 a.m., trained medication aide (TMA)-A entered R41's room to respond to their call light. TMA-A stood next to R41's bed and tray table, with R41's medications within sight approximately 12 inches from where TMA-A was standing. TMA-A left the room and returned, once again standing next to the medications on R41's table. During observation on 7/24/24 at 12:08 p.m., nursing assistant (NA)-A and NA-B entered R41's room to assist with cares. NA-A stood next to R41's bed and moved the table containing the medications to the side. Cares were provided, and at approximately 12:25 p.m., the table with	F 554		

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F 554	Continued From page 8	F 554		

the medications was moved back within reach of R41.

During interview on 7/24/24 at 1:50 p.m., registered nurse (RN)-A stated if a resident wished to self-administer medications, staff completed an assessment, observed the resident taking the medications to ensure they were safe, educated the resident, and informed the provider to obtain an order. The resident would be reassessed annually or with a significant change. R41 kept nystatin and a mentholated ointment in their room for their use. When asked about the instructions to not leave medications in R41's room, RN-A stated it was to direct the nursing staff to ensure R41 took their prescribed oral medications while the nurse was in the room because R41 could choke on them since she preferred to lay in bed and not sit upright. RN-A stated R41 should not have anything like Tylenol or other pills "sitting around" for safety purposes, however R41 had a track record of ordering her own medications, or having friends bring them in. They indicated staff, including nurses and social services, were in R41's room quite often, and RN-A expected staff to notice if there were bottles of pills on the table. RN-A walked to R41's room and verified the presence of the bottle of guaifenesin and removed it from the room. The bottle had been opened and was approximately ¾ full of large white pills approximately ½ inch long. RN-A confirmed they were a potential choking hazard for R41, however was not concerned with the other medications in R41's possession.

During interview on 7/25/24 at 10:51 a.m., director of nursing (DON) stated if a resident wanted to self-administer medications or was found to have outside medications in their

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F 554	Continued From page 9	F 554		

possession, a nurse completed the self-administration assessment, watched the resident demonstrate their ability to take them safely, and if successful, informed nurse practitioner so they could place an order. The care plan would then be updated to indicate which medications the resident could self-administer. DON stated the instructions to ensure medications were not left in R41's room were to ensure the nurses watched R41 take them and did not apply to creams or powders. DON stated sometimes R41 ordered her own medication from outside sources, and their personal assistant also brought items in. They indicated it was within R41's rights, and the DON was not authorized to see what R41 had in their possession. While R41 tended to hoard items in their room, DON stated if they noticed medications out in plain view, they would ask the resident if they could take it. The stated R41 would likely tell them it was "none of their business" and kick staff out of the room. DON stated they were not aware R41 had the guaifenesin in their room. They confirmed R41 had not been recently assessed for safe self-administration of medications, did not have a risk/benefit discussion documented regarding outside medications, and expressed concern regarding possible interactions between the prescribed medication given by staff and those obtained by the resident and self-administered.

The Self-Administration of Medications policy dated 2/24, included, as part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. If it is

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F 554	Continued From page 10 deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. The decision that a resident can safely self-administer medications is re-assessed periodically based on changes in the resident's medical and/or decision-making status. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party.	F 554		
F 684 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 comprehensively assess and monitor non-pressure related skin conditions for 1 of 2 residents (R40) reviewed for skin concerns, and failed to monitor resident weights for 1 of 1 residents (R40) reviewed who took a diuretic and had a history of weight fluctuations. Findings include: R40's quarterly Minimum Data Set (MDS) dated 7/17/24, identified R40 was cognitively impaired,	F 684	Immediate corrective action: R40 had a thorough skin assessment completed, and weight was obtained by nursing staff. R40 orders were obtained from MD for weight frequency and parameters for notifying physician. Care plan updated to reflect changes. Corrective action as it applies to others: All other residents have the potential to be affected. Weight orders reviewed for all residents to ensure order accuracy and frequency. Residents with known skin impairments reviewed for accurate	8/28/24

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F 684	Continued From page 11 had a diagnoses of alcohol use disorder, depression, and cellulitis, was incontinent of bowel and bladder, and required supervision for walking and toileting. R40's hospital discharge note dated 6/11/24, identified R40 was admitted to the hospital through the emergency department on 5/31/24, with severe dehydration, nausea, vomiting, diarrhea, shortness of breath, low blood pressure and high heart rate. Their weight at hospital admission on 5/31/24 was approximately 188.5 pounds. R40's hospital nutrition assessment date 6/5/24, included R40 weighed approximately 188.5 pounds on 5/31/24, and 246 pounds on 6/4/24, with the increase due to fluid gains. The note identified open abrasions to the right knee and both right and left cheeks. R40's care plan dated 6/11/24, included R40 had an alteration in skin integrity and instructed staff to monitor skin integrity daily during cares, complete a weekly skin inspection by nurse, treat open areas per order, and perform weekly measurements and assessments of wound(s). R40's nutritional care plan included a goal to maintain adequate nutritional status. R40's Nutrition Care Area Assessment (CAA) dated 6/18/24, identified "refer to nutrition evaluation". The Pressure Ulcer/Injury CAA included R40 was at risk for skin injury with contributing factors of weakness, pain, decreased mobility, and weight loss complicated by incontinence. R40's MHM Clinical Nutrition Evaluation V-5	F 684	assessments and orders. Care plans and care sheets updated to reflect any changes. Education provided to nursing staff regarding accuracy of skin assessments and orders for weight monitoring. Date of Compliance: All education on skin assessment completed, and weight to be completed by August 28, 2024. Recurrence will be prevented by: Director of Nursing or designee will audit the resident's skin assessments and weight orders 2 x per week for 2 weeks, once weekly x 2 weeks, then monthly x 2 months until determined by QAPI to decrease frequency of audits. Corrections will be monitored by the Director of Nursing or designee.	

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F 684	Continued From page 12 dated 7/18/24, indicated R40's most recent weight was 188 pounds, and usual body weight was 220 pounds. R40 lost 5 percent (%) or more in the past month or 10% or more during the past six months and was not on a prescribed weight loss regimen. The evaluation included R40 had no skin conditions, and staff were to monitor and document meal intakes and obtain weight per policy, and dietician to follow up as needed with changes in meal intakes, weights, and skin. R40's Order Summary Report dated 7/25/24, included: " Furosemide (a water pill) 40 milligrams (mg) daily for congestive heart failure starting 6/11/24 " Obtain admission weight on 6/11/24 " Weekly skin inspection by licensed nurse every Tuesday starting 6/11/24 " Hydrocortisone External Cream 1%, apply to skin as needed for skin rash, Apply to perineum affected area starting 7/15/24 " Hydrocortisone External Cream 1%, apply to skin two times per day for skin rash for 10 days, Apply to the perineum affected area of the skin two or three times per day as needed. The report lacked orders for R40's weight monitoring. R40's Weight Summary identified they weighed 188.5 pounds on 6/11/24 and 201.4 pounds on 7/24/24. There was no other evidence of weights in the medical record. R40's MHM Weekly Skin Inspection V-4 forms included the following: 6/11/24 and 6/18/24, lacked identification of open sores and/or scabs. 7/2/24 at 2:13 p.m., included R40 had scarring on	F 684		

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F 684	Continued From page 13 their face, arms, and legs from picking themselves, and lacked further assessment of those areas. 7/2/24 at 5:35 p.m., included R40 had "Rashes all over the body". 7/16/24, lacked identification of sores. 7/17, included R40 "minimized" picking their skin. 7/23/24, lacked identification of sores. During observation and interview on 7/22/24 at 2:07 p.m., R40 was seated on the side of their bed wearing a T-shirt and incontinence brief. R40 had numerous scabs and open sores on both arms, both legs, and their face, with a large one approximately 1 centimeter (cm) by 1 cm on their right cheek. R40 stated they had always had skin issues their whole life and had a "nervous thing with picking", but it had gotten "ten times worse" due to anxiety. They indicated they had some prescription medication to help with it. During interview on 7/24/24 at 10:18 a.m., nursing assistant (NA)-C stated the aides informed the nurses of any new or concerning skin issues and the nurse would come to assess and measure the area of concern. NA-C indicated R40 picked at their skin and had numerous scabs and thought it might be improving but was unsure. During interview on 7/24/24 at 10:29 a.m., registered nurse (RN)-B stated the nurses completed weekly skin checks, and if new skin concerns were identified, including sores, scabs, and scratches, they completed a risk management form, measured the area, wrote a note in the chart, and let the nurse manager know so they could take photos and monitor. They indicated they did not work at the facility often and	F 684		

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F 684	Continued From page 14 didn't know anything about R40's open sores other than they apply a cream. and indicated if wound documentation was not in the chart, they were not sure if it was being monitored. They stated if they noticed a new skin concerns, they would monitor it to identify if it was getting bigger and determine if a new treatment was required or identify any infection. During interview on 7/25/24 at 8:39 a.m., RN-C stated the facility had a lot of agency staff, and the residents saw different staff every day. They indicated R40's wounds were in the process of healing. Upon review of R40's medical record, RN-C confirmed there was no documentation regarding the sores on R40's face, arms, and legs, and when asked how they determined if they were improving or getting worse, they stated they just knew by observing them and passed the information to other staff through report. RN-C was not sure how agency staff would be able to determine if they were new, improving, or becoming worse without any previous documentation. Regarding weights, (RN)-C stated staff did not obtain R40's weight at admission and afterward because R40 could not sit in a chair or stand when they first arrived. They confirmed R40 should have been weighed weekly or monthly, however R40 was admitted by agency staff who did not enter the order for weights, which did not trigger staff to obtain them. They stated if nothing else, staff should have documented a reason for the lack of weights. During interview on 7/25/24 at 8:47 a.m., nurse practitioner (NP) stated the dieticians followed the resident weights closely and they provided updates about weight gain or loss. NP indicated R40 was taking furosemide, confirmed there was	F 684		

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F 684	Continued From page 15 no specific order for weights, and stated it was important to monitor weights for R40 due to diagnoses and medications. In addition, NP stated it was important to regularly assess skin and document findings regularly. During interview on 7/25/24 at 9:31 a.m., dietician (D) stated residents were expected to be weighed according to provider orders, but at least monthly. If a resident triggered for significant weight gain or loss their name would appear on a list and the dietician would complete an assessment and document interventions. They indicated if a resident refused to be weighed the staff used the most recent hospital weight until another could be obtained. Upon review of R40's medical record, D confirmed R40 should have been weighed at least monthly, however since there was one recorded early in June and again late July, they would consider that adequate. They verified R40 had a weight increase of 13 pounds and were unable to find evidence the dietary department had been informed. They indicated they needed to assess R40 to determine the cause and implement appropriate interventions based upon their medical status, but assumed if R40 needed to be weighed more often there would have been an order for it. During interview on 7/25/24 at 10:51 a.m., director of nursing (DON) stated staff obtained resident weights based upon provider orders, but at least monthly, but more often if a resident took a diuretic or had a history of weight gain or loss. They indicated monitoring was important to determine if action needed to be taken. DON stated staff completed resident skin assessments weekly and documented any scratched, sores, bruise, or other skin concerns on the medical	F 684		

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F 684	Continued From page 16 record so they could follow up and discuss with the interdisciplinary team. DON confirmed R40 had multiple sores on their body, the NP was aware, and R40 had a prescription cream to treat them, however the medical record lacked documentation. They indicated it was important to monitor to determine if they needed to change the treatment course. The Skin Assessment and Wound Management policy dated 3/124, included when a significant alteration in skin integrity is noted staff would initiate skin and wound evaluation and update the care plan. The Weight Protocol policy (undated) indicated all residents are weighed by nursing staff at a minimum of daily upon admission for three days, then weekly for four weeks, then monthly thereafter.	F 684		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by:	F 685		8/28/24

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F 685	Continued From page 17 Based on observation, interviews and document review, the facility failed to ensure that residents received proper follow-up recommendation for hearing assistive devices to maintain hearing abilities for 1 of 1 residents (R12) reviewed for hearing services. Findings include: R12's quarterly Minimum Data Set (MDS) dated 5/10/24, indicated she had intact cognition, had no rejections of care or rejections of evaluation of care, and had diagnoses of Alzheimer's dementia, anxiety, and high blood pressure. R12's Care Area Assessment (CAA) for communication dated 7/21/23, identified R12 appeared hard of hearing but did not wear hearing aids. The CAA indicated R12 was at risk for mixed messages. A hearing and vision assessment dated 5/20/24, identified R12 had adequate hearing and did not wear hearing aids. R12's care plan lacked documentation of communication needs. An audiology (hearing) provider progress note dated 2/12/24, identified an order for a medical consult to obtain medical clearance for hearing aids. A provider progress note dated 3/4/24, identified under the assessment and plan header for health maintenance, "audiology exam on February 12, 2024 revealed mild to severe sensorineural hearing loss in the right ear and moderate to profound sensorineural hearing loss in the left	F 685	Immediate corrective action: R12 medical clearance form was completed to move forward with obtaining hearing aids for the resident. Awaiting hearing aids currently. Corrective action as it applies to others: All other residents who have been seen by audiology have the potential to be affected. Most recent audiology notes reviewed for any recommendations or follow-up needed. Orders reviewed and care plans updated as needed. Education provided to health information director regarding reviewing visit notes, timeliness of follow-up, and involvement of nursing staff if needed to complete recommendations. Date of Compliance: All education and review of resident audiology notes and recommendations to be completed by August 28, 2024. Recurrence will be prevented by: Director of Nursing or designee will audit the resident's audiology notes to ensure follow-up and recommendations have been completed 2 x per week for 2 weeks, once weekly x 2 weeks, then monthly x 2 months until determined by QAPI to decrease frequency of audits. Corrections will be monitored by the Director of Nursing or designee.	

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F 685	Continued From page 18 era. Hearing aids were recommended, and are currently pending." A provider progress note dated 4/29/24, indicated under the assessment and plan header for health maintenance, "audiology exam on February 12, 2024 revealed mild to severe sensorineural hearing loss in the right ear and moderate to profound sensorineural hearing loss in the left era. Hearing aids were recommended, and are currently pending." A provider progress note dated 5/23/24, indicated under the assessment and plan header for health maintenance, "audiology exam on February 12, 2024 revealed mild to severe sensorineural hearing loss in the right ear and moderate to profound sensorineural hearing loss in the left era. Hearing aids were recommended, and are currently pending." On 7/22/24 at 2:32 p.m., R12 stated she saw an in-house audiologist "quite some time ago" and they recommended hearing aids. R12 stated those had not been delivered. R12 was observed turning her head so her ear was towards the surveyor's mouth when the surveyor was asking questions as well as watching the surveyor's mouth. R12 stated she's had a more difficult time hearing people as she's aged. During interview on 7/24/24 at 12:41 p.m., the medical records (MR) staff explained if a resident received an order for hearing devices that required medical clearance, a medical doctor needed to sign off on the order first. The MR staff stated the audiology staff typically emailed the list of residents that required medical clearance about a month after the appointment. The MR	F 685		

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F 685	Continued From page 19 staff stated R12's family member called social services (SS) and inquired about the hearing aids, and SS reached out to MR. When asked when the notification for R12's medical clearance request came in, the MR staff stated, they must have missed it in between when they sent the email and when R12's family reached out to SS. The MR staff stated R12's medical clearance request was sent to her provider on 7/16/24 and routed to her medical doctor on 7/18/24. The MR staff stated the communication between the audiology staff and the facility was problematic and stated they could improve their process. The MR staff stated nurse managers reviewed all progress notes for further recommendations and to ensure there were no missed orders. During interview on 7/25/24 at 9:54, SS confirmed R12's family member called to ask about the status of her hearing aids. SS could not remember what date the family member called, but stated the information was passed along to MR. During interview on 7/25/24 at 11:15 a.m., registered nurse (RN)-A confirmed nurse managers reviewed progress notes to ensure there were no missed orders. RN-A stated MR would be responsible for taking care of in-house provider orders, such as audiology. RN-A stated when staff received new orders from a provider, it was expected to be acted upon immediately. RN-A stated the audiology staff typically worked directly with the MR staff during and after visits, and if a progress note or after-visit summary (AVS) was uploaded into a resident's electronic health record (EHR), the implication was the orders had been reviewed. RN-A verbalized being unsure what the delay was between R12's	F 685		

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F 685	Continued From page 20 audiology visit and requesting medical clearance for the recommended hearing devices, but stated the expectation would be to document the delay, and what was being done and to update the provider, resident, and representative(s). RN-A stated the clinical significance was that R12 may not be able to hear, and her hearing loss could worsen. During interview on 7/25/24 at 11:39 a.m., the director of nursing (DON) stated in-house providers would send new orders and recommendations to the MR staff from their office after the visit. The DON stated if an order doesn't have a specific start time, the order should be processed as soon as it was received. The DON was unsure what the delay was between the order for R12's hearing aids and the request for medical clearance being sent to her medical doctor, but stated it was the facility's responsibility to ensure she could hear. A request for a facility policy pertaining to appointment follow-up or hearing and communication was requested but not received.	F 685		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		8/28/24

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THE VILLAS AT ROBBINSDALE	3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 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
F 812	Continued From page 21 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 3 ice dispensing machines were clean and free of excess mineral build up and cleaned on a regular schedule. This had potential to affect all residents of the nursing home, staff, and visitors who consumed food from the main production kitchen and/or ice and water from the fourth floor dining room ice machine. Findings include: During observation on 7/25/24 at 9:28 a.m., the fourth floor dining room ice and water dispenser had white, speckled, crust residue on the inside of the dispenser chutes, the drip tray, and other surfaces. During interview on 7/25/24 at 11:27 a.m., maintenance director (DOM) stated the third floor water and ice dispenser in the dining room was out of commission, and they worked on the fourth floor water and ice machine last night because the light came on which indicated it was time to complete maintenance, so DOM ordered the chemical cleaners and sanitizer to complete the cleaning. DOM stated the facility's system reminded them every month or every other month	F 812	Immediate corrective action: Ice machine was cleaned to remove excess mineral build up. Cleaning schedule updated and education provided to culinary director. Corrective action as it applies to others: All staff and visitors have the potential for being affected by additional ice dispensers in the building. Education provided to culinary director and culinary staff regarding ice machine cleanliness and cleaning schedules. Date of Compliance: All education and review of cleaning schedules to be completed by August 28, 2024. Recurrence will be prevented by: Culinary director or designee will complete cleaning audits of facility ice machines 5 x per week for 2 weeks, once weekly x 2 weeks, then monthly x 2 months until determined by QAPI to decrease frequency of audits. Corrections will be monitored by the culinary director or designee.	

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F 812	Continued From page 22 to check if the light of the water and ice dispenser was on that indicated a need for maintenance and cleaning. DOM stated they started working with the facility in March 2024, and this was the first time they would be cleaning and sanitizing the water and ice dispenser. Cleaning and sanitizing supplies were ordered and scheduled to come on 7/29/24. The machine also had a filter which needed replacement yearly to prevent sediment build-up. DOM stated staff still use the ice and water dispenser while waiting for the cleaning and sanitizing supplies and has observed the staff looking at the water which comes from the machine to make sure it is clear. During interview on 7/25/24 at 12:49 p.m., nursing assistant (NA)-C stated staff used the ice and water machine on the fourth floor today and had a cup of ice in a paper cup to give to a resident during meal service. During interview on 7/25/24 at 12:52 p.m., NA-A stated the ice and water dispenser on the third floor was not in operation and obtained ice and water from the fourth or second floor or the main kitchen brought up ice. During observation and interview on 7/25/24 at 1:44 p.m., the administrator expected maintenance to clean the water and ice machine when triggered in TELs (the facility communication system) and anytime in between when sediment visible. Administrator stated the fourth floor water and ice dispensing machine had two filters to counter the facility's hard water which caused sediment build-up every few days. One of the filters was dated 3/28/24. Admin confirmed the sediment on the fourth floor ice and water dispenser machine. It was important to	F 812		

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F 812	Continued From page 23 clean and sanitize the machine for its appearance and cleanliness, and there were infection control concerns if not cleaned and sanitized. The Scotsman Ice Systems Installation and User's Manual for Meridian Ice Maker-Dispensers models dated July 2018, recommended the ice making and ice dispensing system to be cleaned at a minimum of every 6 months and a Time to Clean Light glowed after 6 months of power time. Cleaning the machine would reset the light and timer controls. More frequent cleanings were required based on mineral content of the water, run time, and airborne contamination. A work history report undated, indicated ice machines and ice bins were cleaned 5/31/24. The facility policy Sanitization dated October 2008, directed staff to wash all equipment to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions. Ice machines and ice storage containers would be drained, cleaned and sanitized per manufacturer's instructions and facility policy.	F 812		

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	245417	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/23/2024**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/23/2024. 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	K 000		

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

Electronically Signed | 08/09/2024

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.

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K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 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	K 000		

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K 000	Continued From page 2 monitored for automatic fire department notification. The facility has a capacity of 75 beds and had a census of 69 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms	K 321		8/8/24

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K 321	Continued From page 3 (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.2, 19.3.2.1.3, 8.4.3.5, 8.3.3.1, and 7.2.1.8.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/23/2024 at 11:29 AM, it was revealed by observation that the door to the Maintenance Shop/ storage room door did not latch when self closing. An interview with the Administrator, Regional Maintenance Director, and Maintenance Director verified this deficient finding at the time of discovery.	K 321	K321 1. A detailed description of the corrective action taken or planned to correct the deficiency. The door closure was adjusted to ensure the maintenance shop/storage room door latched. All other doors that have door closures were audit and correction made where they were needed. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. The management staff have been educated that doors must fully latch, and audits are being completed for compliance. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. The facility is completing audits weekly X 4 weeks and then monthly x3 months. Findings will be reviewed at QAPI to ensure compliance. 4. Identify who is responsible for the corrective actions 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. 8/8/24	
K 712	Fire Drills	K 712		7/26/24

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K 712 SS=F	Continued From page 4 CFR(s): NFPA 101 Fire Drills 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 REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code section 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/23/2024 between 09:00 AM and 11:45 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that a fire drill had been conducted during the second shift during the fourth quarter of 2023. An interview with the Administrator, Regional Maintenance Director, and Maintenance Director verified this deficient finding at the time of discovery.	K 712	K712 1. A detailed description of the corrective action taken or planned to correct the deficiency. The Maintenance Director was educated that fire drills must be completed quarterly on all shifts and proper documentation must be maintained. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. The Maintenance Director will review fire drills conducted each quarter to ensure all drills are completed as scheduled and one drill per shift per quarter. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. The Maintenance Director will review with the Administrator the times and dates of which the fire drills will occur to meet the quarterly fire drills for each shift. 4. Identify who is responsible for the	

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K 712	Continued From page 5	K 712	corrective actions and monitoring of compliance. The Director of Maintenance is responsible for the corrective action and monitoring of fire drills 5. The actual or proposed date for completion of the remedy. 7/26/24	
K 901 SS=C	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to provide a Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/23/2024 between 09:00 AM and 11:45 AM, it was revealed by a review of available documentation that the NFPA 99 risk assessment that the facility provided at the time of the survey did not include chapters 10 and 11 of NFPA 99	K 901	K901 1. A detailed description of the corrective action taken or planned to correct the deficiency. A risk assessment was completed to per NFPA 99. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. The risk assessment was completed and will be updated annually and as needed. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.	7/26/24

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K 901	Continued From page 6 (2012 edition), Health Care Facilities Code. An interview with the Administrator, Regional Maintenance Director, and Maintenance Director verified this deficient finding at the time of discovery.	K 901	The risk assessment per regulations has been completed and the Director of Maintenance will review on an annual basis for any updates needed. 4. Identify who is responsible for the corrective actions and monitoring of compliance The Director of Maintenance is responsible. 5. The actual or proposed date for completion of the remedy. 8/8/24	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically	K 918		7/26/24

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K 918	Continued From page 7 exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/23/2024 between 09:00 AM and 11:45 AM, it was revealed by a review of available documentation that starting with the weekly generator inspection that happened on 3/4/2024 and continuing until the most recent inspection the inspection items were marked with "NA", so it was unable to be verified if the generator had been inspected weekly. An interview with the Regional Maintenance Director, and Maintenance Director verified this deficient finding at the time of discovery.	K 918	K918 1. A detailed description of the corrective action taken or planned to correct the deficiency. The Director of Maintenance was educated on the correct procedures to complete the documentation accurately. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. The Director of Maintenance was educated on the correct procedures to complete the documentation accurately for the generator test. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Audits will be completed to review completed documentation of the generator test that it is completed accurately. The facility is completing audits weekly X 4 weeks and then monthly x3 months. Findings will be reviewed at QAPI to ensure compliance. 4. Identify who is responsible for the	

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K 918	Continued From page 8	K 918	corrective actions and monitoring of compliance The Director of Maintenance is responsible for the accuracy of documentation of the generator test 5. The actual or proposed date for completion of the remedy. 7/26/24	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN	K 923		8/27/24

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

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K 923	Continued From page 9 NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain oxygen storage per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.2.6 and 11.6.2.3 (11). This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/23/2024 at 10:38 AM, it was revealed by observation that there were three green oxygen cylinders that were not chained or in a stand in resident room 414. An interview with the Administrator, Regional Maintenance Director, and Maintenance Director verified this deficient finding at the time of discovery.	K 923	K923 1. A detailed description of the corrective action taken or planned to correct the deficiency. The tanks were immediately removed from the room and placed in the oxygen room in the required stand. The hospice company was contacted regarding their vendor and how the tanks were delivered. They in turn called their vendor and educated them on proper protocol. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. The vendor was contacted that they did not follow NFPA 99 Health Care Facilities Code Section 11.3.26 and11.6.2.3(11). Facility staff educated on oxygen allowed in resident room 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. The hospice company contacted their vendor in which they order from and will monitor their deliveries. The Director of Nursing or designee will Audit oxygen	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245417	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT ROBBINSDALE	**3130 GRIMES AVENUE NORTH** **ROBBINSDALE, MN 55422**

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K 923	Continued From page 10	K 923	deliveries for compliance. 4. Identify who is responsible for the corrective actions and monitoring of compliance. The hospice vendor is responsible for corrective action and our Director of Nursing will monitor for compliance. 5. The actual or proposed date for completion of the remedy. 8/27/24	
K 930 SS=D	Gas Equipment - Liguid Oxygen Equipment CFR(s): NFPA 101 Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store liquid oxygen per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.7.4. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/23/2024 at 10:38 AM, it was revealed by observation that there was two liquid oxygen tanks that were not being used being stored in resident room 414. An interview with the Administrator, Regional Maintenance Director, and Maintenance Director verified this deficient finding at the time of discovery.	K 930	K930 1. A detailed description of the corrective action taken or planned to correct the deficiency. The tanks were immediately removed from the room and placed in the oxygen room in. The hospice company was contacted regarding the amount of oxygen tanks delivered. They in turn called their vendor and educated them on proper protocol. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. The vendor was contacted that they did not follow NFPA 99 Health Care Facilities Code Section 11.3.26 and11.6.2.3(11). Facility staff educated on oxygen in resident	8/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245417	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/23/2024**

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K 930	Continued From page 11	K 930	rooms. Facility staff educated on oxygen allowed in resident room. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. The hospice company contacted their vendor in which they order from and will monitor their deliveries. The Director of Nursing or designee will Audit oxygen deliveries for compliance. 4. Identify who is responsible for the corrective actions and monitoring of compliance The hospice vendor is responsible for corrective action and our Director of Nursing will monitor for compliance. 5. The actual or proposed date for completion of the remedy. 8/27/24	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 5, 2024

Administrator
The Villas At Robbinsdale
3130 Grimes Avenue North
Robbinsdale, MN 55422

RE: CCN: 245417
Cycle Start Date: July 28, 2024

Dear Administrator:

On September 3, 2024, 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,

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