DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
October 28, 2022

Administrator
Robbinsdale A Villa Center
3130 Grimes Avenue North
Robbinsdale, MN 55422

RE: CCN: 245417
Cycle Start Date: October 5, 2022

Dear Administrator:

On October 26, 2022, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

Electronically delivered
October 12, 2022

Administrator
Robbinsdale A Villa Center
3130 Grimes Avenue North
Robbinsdale, MN 55422

RE: CCN: 245417
Cycle Start Date: October 5, 2022

Dear Administrator:

On October 5, 2022, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 January 5, 2023 (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 April 5, 2023 (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.

Feel free to contact me if you have questions.

Sincerely,

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

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Electronically delivered
October 12, 2022

Administrator
Robbinsdale A Villa Center
3130 Grimes Avenue North
Robbinsdale, MN 55422

Re: Event ID: 6ZRM11

Dear Administrator:

The above facility survey was completed on October 5, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

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 CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245417	A. BUILDING _____ B. WING _____	C 10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBBINSDALE A VILLA CENTER	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 000	INITIAL COMMENTS On 10/5/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H54174859C (MN87167). The following complaint was found to be SUBSTANTIATED at H54174954C (MN87298); however, no deficiencies were cited due to action implemented by the facility prior to the survey, a deficiency was cited at F609. 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 that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown	F 609		10/25/22

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

Electronically Signed | 10/13/2022

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 609	Continued From page 1 source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to report to the state agency (SA) an allegation of neglect for the misadministration of an opioid for 1 of 3 residents (R2) reviewed for medications. The misadministration of medication was caused by a transcription error when R2 was given 100 mg (milligrams) of morphine sulfate on two days. Findings include: R2's quarterly Minimum Data Set (MDS) dated 7/12/22, noted R2 had intact cognition and his diagnoses included: malignant neoplasm of sigmoid colon (colon cancer), congestive heart failure, atrial fibrillation, major depressive	F 609	The submission of this Plan of Correction is not an admission by the provider of any fact or conclusion set forth in the Statement of Deficiency. This Plan of Correction is being submitted because it is required by law. However, evidencing Robbinsdale A Villa Center good faith, the facility offers the following Plan of Correction. 1.R2 remains at the facility, medication record has been reviewed for accuracy of orders. 2.All residents that reside at Robbinsdale a Villa Center have the potential to be	

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F 609	Continued From page 2 disorder, and generalized anxiety disorder. R2's Medication Administration Record (MAR) for September 2022 indicated Morphine Sulfate solution 20 milligrams (mg) / 5 ml (milliliters). Give 5 mL by mouth every 4 hours as needed for pain/SOB (shortness of breath) to begin on 9/27/22. The MAR indicated R2 received the transcribed dose of Morphine Sulfate on 9/27/2022 at 7:40 p.m. and 9/28/22 at 4:50 p.m. There was no noted administration of Morphine Sulfate on 9/29/22. R2's incident report dated 9/28/22 indicated on 9/28/22 at 8:10 p.m. it was identified R2 was administered 5 ml of Morphine Sulfate solution when the ordered dose was 0.5 ml of Morphine Sulfate 20 mg/0.5 ml every 4 hours as needed. R2 was administered the incorrect amount of medication when the staff administering the medication did not look at the bottle and compare the dosing instructions to the medication administration record. R2's vital signs were temperature 98.5, blood pressure 110/76, respirations 18, pulse 85, and oxygen saturations 96% on room air. The investigative note indicated R2 had a "feeling of being in the clouds". R2 was monitored in the facility throughout the night. R2 did become more lethargic in the morning on 9/29/22 after 12 hours post administration of the medication and was give Narcan, responded, and was sent to the hospital returning the same day. R2's physician and family had been notified of the misadministration. The incident note also indicated R2 was again lethargic and unresponsive the morning of 9/30/22 and Narcan was given. There were no doses of morphine given for the past 24 hours. A room search was	F 609	affected by this practice. Medication misadministration of an opioid that has the potential to have resulted in an adverse consequence to the resident. All medication errors be reviewed by the DON and reported per State and Federal regulation. 3.Education has been provided to the DON and reviewed policy on reporting significant medication errors. 4.Regional Director of Clinical operations will review all occurrences of incorrect dosing of an opioid medication. Audits will be completed x 4 weeks. Audits will be reviewed at QAPI for continued Quality improvements.	

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F 609	Continued From page 3 conducted and multiple bottles of alcohol were found and removed. R2 was educated on the use of alcohol with medications. The misadministration of Morphine Sulfate was attributed to a transcription error. Hospital documentation uploaded to R2's electronic medical record (EMR) dated 9/29/22, noted R2 was in the emergency department (ED) for 6 hours for observation due to receiving 100 mg of Morphine Sulfate instead of the ordered dose of 10 mg, he was found obtunded and hypoxic. The hospital documentation noted R2 was without any notable events during his time in the ED, did not receive any medications, endorsed feeling unsettled after learning of what occurred and was discharged back to the facility after he was assessed to able to ambulate and tolerate food. During an interview on 10/5/22, at 1:25 p.m. R2's hospice nurse (HN) stated she was the nurse that found R2 unresponsive, administered the Narcan and gave orders to send him to the hospital. HN stated she spoke with R2 regarding the overdose and that he told her he was concerned about getting the wrong dose, that it could have been fatal, that he had to have Narcan and that he had to go to the hospital. During an interview on 10/5/22, at 4:31 p.m. the director of nursing (DON) stated she stopped by to see R2 on 9/29/22, and he was ok at that time. The DON stated when hospice came in around 9:30 or 10:00 a.m. R2 was "starting to drift". The DON stated she had discussed reporting the incident to the SA with the facility ' s regional team but since there was no adverse outcome, it was decided that it was not a reportable event. The	F 609		

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F 609	Continued From page 4 DON stated she was not sure if there had been any psychological evaluations or assessments completed in regards to his feelings towards taking medication and that anytime she had asked hospice staff how R2 was doing they reported he was ok. The DON stated she did not have a discussion of the effects on overdose with R2 but noted she saw in the hospital paperwork that he reported being a little scared to the hospital staff. A facility policy titled Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property effective as of 11/28/2017, noted the facility will ensure that all alleged violations of abuse, neglect, exploitation or mistreatment including injuries of unknown origin and misappropriation of property are reported immediately but no later than 2 hours.	F 609		