



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered  
January 9, 2026

Administrator

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

RE: CCN: 245417

Cycle Start Date: November 20, 2025

Dear Administrator:

On November 20, 2025, 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.

A handwritten signature in black ink that reads 'Holly Zahler'.

Holly Zahler, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
Freeman Building | HRD-OLF 3B  
625 Robert St. N.  
P.O. Box 64975  
St. Paul, MN 55164-0899  
Office: 651-201-4384 | Email: [holly.zahler@state.mn.us](mailto:holly.zahler@state.mn.us)



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 15, 2025

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

RE: CCN:245417

Cycle Start Date: November 20, 2025

Dear Administrator:

On November 20, 2025, a survey was completed at your facility by the Minnesota Department of Health 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:

Susie Haben, Regional Operations Supervisor, Rapid Response  
Health Regulation Division  
Minnesota Department of Health  
4140 Thielman Lane  
Saint Cloud, Minnesota 56301-4557  
Email: [susie.haben@state.mn.us](mailto:susie.haben@state.mn.us)  
Office: (320) 223-7356 Mobile: (651) 230-2334

#### **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 February 20, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by May 20, 2026 (six months after the identification of noncompliance), your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

### **INFORMAL DISPUTE RESOLUTION (IDR)**

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: [https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\\_8.html](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html)

## INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,



Holly Zahler, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
Freeman Building | HRD-OLF 3B  
625 Robert St. N.  
P.O. Box 64975  
St. Paul, MN 55164-0899  
Office: 651-201-4384 | Email: [holly.zahler@state.mn.us](mailto:holly.zahler@state.mn.us)



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December 15, 2025

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

Re: Event ID: 1DBF15-H1

Dear Administrator:

The above facility survey was completed on November 20, 2025, 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,

A handwritten signature in black ink that reads 'H. Zahler'.

Holly Zahler, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
Office: 651-201-4384  
Email: [holly.zahler@state.mn.us](mailto:holly.zahler@state.mn.us)

Minnesota State Department of Health

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>11/20/2025</b>
NAME OF PROVIDER OR SUPPLIER <b>THE VILLAS AT ROBBINSDALE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3130 GRIMES AVENUE NORTH , ROBBINSDALE, Minnesota, 55422</b>	
(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
20000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.</p> <p>INITIAL COMMENTS:</p> <p>On 11/19/25 through 11/20/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was in compliance with the MN State Licensure.</p> <p>The following complaints were reviewed during the survey: H54177802C (2669711) and H54177803C (2669756).</p> <p>Minnesota Department of Health is documenting the State</p>	20000		12/15/2025

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota State Department of Health

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20000	Continued from page 1 Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		

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F0000	<p>INITIAL COMMENTS</p> <p>On 11/19/25 through 11/20/25, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was not in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.</p> <p>The following complaint was reviewed. H54177802C (2669711) with a deficiency issued at F684; and H54177803C (2669756).</p> <p>As a result of the investigation a deficiency was issued at F609.</p> <p>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.</p> <p>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.</p>	F0000		12/15/2025
F0609 SS = D	<p>Reporting of Alleged Violations</p> <p>CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)</p> <p>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown 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</p>	F0609	<p>Immediate corrective action: Immediate training was completed on timely reporting with the individual that received the statement of concern.</p> <p>Corrective action as it applies to others: All residents have the potential to be affected by this practice.</p> <p>All staff were re-educated on the vulnerable adult reporting policy and procedure. Staff were educated on the time requirements of reporting any allegation of abuse or neglect.</p> <p>Reoccurrence will be prevented by: the Administrator or designee will audit reportable incidents for timely reporting weekly x 4 weeks, then monthly x 2 months until determined by QAPI to decrease frequency of audits.</p>	01/05/2026

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0609 SS = D	<p>Continued from page 1 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.</p> <p>§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.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review the facility failed to timely report an allegation of physical abuse to the state agency (SA) for 1 of 3 residents (R1) reviewed for abuse</p> <p>findings include"</p> <p>R1's quarterly Minimum Data Set (MDS) dated 11/3/25, indicated she was independent with all activities of daily living.</p> <p>R1's undated Admission Record identified R1 admitted to the facility on 5/22/25. Diagnosis included fracture of vertebrae, diabetes, depression and hypertension.</p> <p>R1's care plan dated 11/14/25, identified an alteration in mobility and staff were to assist with transfers and bed mobility.</p> <p>R1's Associated Clinic of Psychology (ACP) visit note dated 11/13/25, indicated a visit was requested due to an increase in confusion and falls. R1 expressed concern for how a staff person moved her around the previous day and spoke of people being in her bed with her. " Staff was consulted after session to report psychotic symptoms and clients care concern." The visit note indicated R1's appearance was "unkempt," lying in bed in a facility gown. Head was craned to the left and R1 lied still during the visit. R1 endorsed pain in the left leg that she said was new.</p> <p>On 11/20/25 at 11:50 a.m., licensed social worker (SW)-A and the administrator were interviewed. SW-A stated R1 told her a staff member had picked her up and threw her on the floor, then picked her up and threw her back on the bed. SW-A stated R1 reported the allegation Friday morning on 11/14/25, when family</p>	F0609	<p>Continued from page 1</p> <p>Date of compliance: All education regarding abuse reporting will be put in place and completed by January 5, 2026.</p>	

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F0609 SS = D	<p>Continued from page 2</p> <p>member (FM)-A was present. SW-A said she reported the incident to the SA later that evening. SW-A said abuse allegations should have been reported to the SA within two hours but said R1's FM-A said R1 was confused. The administrator said she felt the problem was that FM-A was insistent R1 was confused but said abuse allegations should have been reported within two hours.</p> <p>During interview on 11/20/25 at 1:53 p.m., the ACP-social worker (SW) stated she had been onsite at the facility and was asked to see R1. The ACP-SW said R1 had presented as delusional. She said R1 was in bed during the visit and had been pretty still and reported pain in her leg which she had attributed to the way staff had moved her around the previous day. The ACP-SW said she reported the care concern and to LSW-A.</p> <p>During interview on 11/20/25 at 2:40 p.m., LSW-A stated she had spoken to the ACP-SW after her session with R1. LSW-A said she did not report the concern about pain to anyone because the ACP-SW said she had talked to someone.</p> <p>The facility Abuse Prohibition/Vulnerable Adult Policy dated 4/2025, indicated the policy was intended to protect residents against abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends or other individuals, or self-abuse and to promptly report, document and investigate all incidents of alleged or suspected abuse/neglect. Incidents to be reported included abuse and indicated suspected abuse shall be reported to the SA no later than two hours after forming the suspicion of abuse.</p>	F0609		
F0684 SS = D	<p>Quality of Care</p> <p>CFR(s): 483.25</p> <p>§ 483.25 Quality of care</p> <p>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.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review the facility failed to provide evidence of ongoing clinical</p>	F0684	<p>Immediate corrective action: R1 has been discharged from the facility.</p> <p>Corrective action as it applies to others: All residents who sustain a fall have the potential to be affected by this practice.</p> <p>Education provided to all nurses to utilize fall batch orders that include monitoring for signs and symptoms of an injury post fall, effectiveness of the implemented intervention, post fall vital signs, neuro checks as needed, and entering a post fall follow up note for 72 hours post fall.</p> <p>Reoccurrence will be prevented by the Director of Nursing or designee will audit post fall batch orders to ensure they are all active in PCC following a fall. The falls will be audited 2 x weekly, then monthly x 2</p>	01/05/2026

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F0684 SS = D	<p>Continued from page 3 assessments following a fall for 1 of 3 residents (R1) reviewed for falls.</p> <p>Findings include:</p> <p>R1's quarterly Minimum Data Set (MDS) dated 11/3/25, indicated she was independent with all activities of daily living and required supervision to walk 50 feet.</p> <p>R1's undated Admission Record indicated R1 admitted to the facility on 5/22/25. Diagnosis included fracture of vertebrae, diabetes, depression and hypertension.</p> <p>R1's care plan dated 11/14/25, identified a risk for falls and included the following interventions: use of a concave mattress, signs in room to remind R1 to call for assistance and use of a reacher. The care plan identified an alteration in mobility and staff to assist with transfers and bed mobility.</p> <p>R1's Progress Notes identified the following: 11/11/25, Writer was conducting routine rounds and heard someone calling for help. When writer approached R1's room, she was found seated on the floor. Bruising was observed to right elbow and R1 was assisted back to bed. 11/12/25, Writer went to room and found R1 on the floor with her head facing the window. When asked, R1 stated she wanted to get out of bed and go home. Assessment was completed, range of motion done to both upper and lower extremities. R1 denied pain or discomfort. No visible bruises or bleeding noted. 11/14/25, Neurological flow sheet for fall follow-up, vital signs within normal range. No concerns noted at this time. Hourly checks performed. 11/14/25, Social Worker (SW) was called to R1's room secondary to R1 not wanting to get dressed or changed. R1 was weepy and said her legs hurt and she did not want to get up. Family member (FM) was present and asked to have R1 sent to the emergency department for confusion and pain secondary to the two falls. 11/14/25. R1 was transferred to the hospital due to weakness, confusion and lethargy. 11/16/25, R1 was discharge from the facility. R1's Associated Clinic of Psychology (ACP) visit note dated 11/13/25, indicated visit was requested due to increase in confusion and falls. R1 expressed concern for how a staff person had moved her around the previous day and spoke of people being in her bed with her. " Staff was consulted after session to report psychotic symptoms and clients care concern. The visit note indicated R1's appearance was "unkempt," lying in bed in a facility gown. Head was craned to the left and R1 lied still during the visit. R1 endorsed pain in the left leg that she said was new. The note indicated, "Seems most likely that client is experiencing delirium - important to rule out</p>	F0684	<p>Continued from page 3 until determined by QAPI to decrease frequency of audits.</p> <p>Date of compliance: All education and monitoring were put in place and will be completed by January 5, 2026.</p>	

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NAME OF PROVIDER OR SUPPLIER <b>THE VILLAS AT ROBBINSDALE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3130 GRIMES AVENUE NORTH , ROBBINSDALE, Minnesota, 55422</b>	
(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
F0684 SS = D	<p>Continued from page 4 underlying medical issue."</p> <p>R1's Physical Therapy Treatment Encounter Notes indicated the following:11/11/25, R1 was approached and not agreeable to therapy. Therapist attempted to discuss fall that occurred that morning. R1 stated, "I don't know" to all questions Increased time was spent locating registered nurse (RN), R1 was shaking, twitching and unable to lift head off the bed or keep her eyes open. Located RN who stated she thought R1 was just tired but agreed she did not look well. Response to session indicated; limited by fall, RN had no increased insight on incident, R1 had been found sitting on the floor in her room with no recollection of what had happened. R1 shaky and unable to stay alert through conversation.11/13/25. R1 was approached for therapy and not agreeable. Stated she had a fall the previous night reaching for something on the floor. Response to session indicated limited by not feeling well after fall, still looked unwell. R1's medical record lacked evidence the following was completed: neurological checks with vital signs as directed; assessment related to a change in condition.</p> <p>During interview on 11/20/25 at 8:48 a.m., FM-B said a few weeks prior, he received a call that R1 had an unwitnessed fall and there were no injuries. FM-B said the previous week he received another call to inform him R1 had a fall with no injuries. FM-B said he got another call later that R1 again had fallen 4-5 hours earlier. FM-B said FM-A went to the facility on 11/14/25, at about 8:20 a.m. and R1 was curled up on the bed in the fetal position, in dirty sheets and there was blood on the floor in the room. FM-A told FM-B R1 had not responded when she called to her from the door. When R1 got up she was in so much pain, FM-A had asked the SW to call an ambulance. FM-B said R1 had been and R1 was found to have bruising on one whole side of her body, a broken hip, fractured ribs and a urinary tract infection.FM-B said R1 had been at the facility for two days with a broken hip and was still in the hospital and had surgery to repair her hip.</p> <p>During interview on 11/20/25 at 12:04 p.m., nursing assistant (NA)-B stated she met R1 when she transitioned to the third floor. NA-B said R1 had been very independent and staff typically just checked on her. NA-B said before the two falls, R1 walked but afterward had been staying in her wheelchair.</p> <p>During interview on 11/20/25 at 12:09 p.m., NA-A stated on Friday morning (11/14/25), she asked R1 if she needed anything. NA-A said she attempted to change R1</p>	F0684		

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>245417</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>11/20/2025</b>
NAME OF PROVIDER OR SUPPLIER <b>THE VILLAS AT ROBBINSDALE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3130 GRIMES AVENUE NORTH , ROBBINSDALE, Minnesota, 55422</b>	
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F0684 SS = D	<p>Continued from page 5 due to incontinence and R1 did not want to put clothes on. NA-A said when she changed R1's incontinent brief she rolled a little to one side but could not roll onto the opposite side. NA-A said she did not recall if she saw any bruising.</p> <p>During interview on 11/20/25 at 12:47 p.m., the director of nursing (DON) stated R1 had a past medical history of falls and fractures and said "any little thing would probably fracture her." The DON said after a fall, staff should perform and assessment, completed neurological checks for 72 hours and if an obvious injury was noted, send the resident to the hospital. The DON said he had been told a neurological flow sheet had been completed but he had not seen it and did not know where it was. The DON said he had been told after R1 went to the hospital she had a fracture.</p> <p>During interview on 11/20/25 at 1:53 p.m., the ACP-SW stated she had been onsite at the facility and was asked to see R1. The ACP-SW said R1 had presented as delusional. She said R1 was in bed during the visit and had been pretty still and reported pain in her leg which she had attributed to staff care. The ACP-SW said she reported the care concern and the report of pain to LSW-A.</p> <p>During interview on 11/13/25 at 2:01 p.m., the therapy director (TD) stated R1 had been doing better and was using a walker prior to her falls. The TD said after the falls R1 had not made much progress. The TD said she reviewed R1's therapy notes and she had not been wanting to walk.</p> <p>During interview on 11/20/25 at 2:40 p.m., LSW-A stated she had spoken to the ACP-SW after her session with R1. LSW-A said she did not report the concern about pain to anyone because the ACP-SW said she had talked to someone.</p> <p>During interview on 11/20/25 at 2:44 p.m., the DON stated he expected staff to perform ongoing monitoring of vital signs, any pain and/or injury. The DON stated if bruising was present staff were to put an order in the medication administration record to monitor.</p> <p>A policy related to ongoing assessment after a fall was requested but not received.</p>	F0684		