Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 17, 2026

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

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

Dear Administrator:

On March 30, 2026, we notified you a remedy was imposed.

On April 7, 2026, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 4, 2026.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective April 14, 2026, did not go into effect. (42 CFR 488.417 (b))

In our letter of March 30, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 17, 2026. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted

March 30, 2026

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

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

Dear Administrator:

On March 17, 2026, 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both **substandard quality of care** and **immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On March 17, 2026, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 14, 2026.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 14, 2026, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 14, 2026, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective March 17, 2026. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, THE VILLAS AT ROBBINSDALE is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective March 17, 2026. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing

Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Annette Winters, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
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 their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 17, 2026 (six months after the identification of noncompliance), if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
St. Paul, MN 55164-0899
Office: 651-201-4384 | Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245417	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/17/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 3/12/26 through 3/17/26, a standard abbreviated survey was conducted at your facility. 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. H54178280C (2798564) and H54175262C (2733214) with a deficiencies issued at F689, F729, F838. 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. The survey resulted in an Immediate Jeopardy (IJ) at F689 when the facility failed to provide adequate interventions including supervision to a resident (R1), with a known elopement risk and was actively exit-seeking. This resulted in R1 eloping from the building. The IJ began on 3/7/26, and the immediacy was removed on 3/17/26. The above findings constituted substandard quality of care, and an extended survey was conducted from 3/13/26 to 3/17/26.	F0000		
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F0689		

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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F0689 SS = SQC-J	Continued from page 1 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to provide supervision and care planned individualized interventions resulting in the risk for serious harm, injury impairment or death for 1 of 5 residents (R1) who was an elopement risk, was actively attempting to leave the facility, and succeeded with eloping on 3/7/26. R1 was located one hour and 20 minutes later, by the police, about 5 blocks from the facility. In addition, to R1 in immediate jeopardy, the facility failed to develop supervision and care planned individualized interventions with the potential for harm that is not immediate jeopardy for 3 of 3, residents (R3, R4, R5) reviewed for elopement risks. The immediate jeopardy began on 3/7/26 when the facility failure to provide adequate supervision resulted in R1's elopement and was identified on 3/13/26. The administrator and director of nursing were notified of the immediate jeopardy at 12:05 p.m. on 3/13/26. The immediate jeopardy was removed on 3/17/26, but noncompliance remained at a lower scope and severity level 2, D isolated scope, and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's admission minimum data set (MDS), dated 2/16/26, indicated she had a diagnosis of malnutrition, severe cognitive impairment, did not exhibit wandering, and was completely dependent on staff for all personal care and mobility. R1's elopement assessment, dated 3/3/26, indicated R1 was an elopement risk, displayed agitation and wanted to go home. She had cognitive impairment, was able to self-propel her wheelchair, and was actively exit-seeking. R1's care plan, dated 3/3/26, indicated R1 was at risk for elopement. The care plan directed wander device in place, wander device will be monitored for proper functioning and door alarms would be answered promptly.	F0689		

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F0689 SS = SQC-J	Continued from page 2 The care plan lacked staff supervision and individualized interventions. A progress note dated 3/3/26 at 4:06 p.m., indicated R1 was exit-seeking, pushing on the exit door and was expressing she wanted to go home. R1 was going up and down the hallway in her wheelchair. She was cognitively impaired, and her elopement assessment indicated she was at risk for elopement. A wander device was placed on her right wrist. A progress note dated 3/3/26 at 5:56 p.m., indicated R1 was wandering around the unit all day long and had tried to leave. R1 was confused, disoriented, and walking around against nurse advice. She had tried to leave a few times. Continue to monitor for confusion and elopement. A progress note dated 3/6/26 at 1:07 p.m., indicated R1 was wandering up and down the hallway, was confused and disoriented. R1 was wandering against nurse advice and attempted to leave a few times. Continue to monitor for confusion and elopement. A progress note dated 3/7/26 at 11:15 a.m., indicated R1 was confused, disoriented, and very agitated. R1 was wandering into other residents' rooms and called the police. R1 stated staff were holding her hostage and attempted to leave the facility multiple times despite redirection. A progress note dated 3/8/26 at 3:12 a.m., indicated R1 wandered out of the facility through the fourth-floor door. R1 was found 5 blocks away, by the police. R1 was sent to the hospital for assessment and returned to the facility. Review of the facility's video surveillance of the fourth-floor door, on 3/7/26, showed the following activity by R1, without her walker:At 8:17 p.m., R1 attempted to open the stairwell door immediately to the right of the fourth-floor door. Nursing assistant (NA)-B was observed to redirect R1 and reset the alarm.At 8:20 p.m., R1 turned the doorknob for the stairwell door. NA-B redirected R1 from the door and reset the door code.At 9:06 p.m., R1 pushed on the fourth-floor door and was redirected from the door.At 9:19 p.m., R1 pushed on the fourth-floor door and was	F0689		

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F0689 SS = SQC-J	Continued from page 3 redirected by NA-B. NA-B reset the alarm.At 10:29 p.m., R1 pushed both exit doors. RN-B reset the alarm and staff redirected her.At 10:45 p.m., R1 walked out the fourth-floor door. No staff were present. A police report indicated the initial call to 911 was at 11:58 p.m., on 3/7/26. The report indicated R1 was not dressed for the weather and was wearing all black. The police report indicated another caller from a home approximately 5 blocks from the facility reported a person matching R1's description was knocking on the door, yelling "please help", and attempting to pull on the door latch. The police located R1 at the residence at 12:06 a.m., on 3/8/26. R1 appeared confused and was sent to the hospital for evaluation. Hospital documentation from the emergency department, dated 3/8/26, indicated R1 was admitted to the emergency department at 12:51 a.m., and was discharged in stable condition at 6:05 a.m., without injuries or medical concerns. Weather report on 3/12/26 from wunderground.com indicated the temperature was 32 degrees Fahrenheit with eight mile per hour winds at 10:45 p.m. R3's elopement assessment, dated 2/10/26, indicated she was an elopement risk, was confused and asked to go home. R3's care plan, dated 2/10/26, indicated she was exit-seeking upon admission, and she was disoriented to time, place, and person. She had a wander device on her left wrist. The care plan lacked staff supervision and individualized interventions. The care plan directed staff to monitor and document for exit seeking behavior, wander device in place, door alarms answered promptly and invite resident to activities. The facility NA care sheet did not indicate R3 was an elopement risk and lacked interventions to prevent elopement. R4's quarterly MDS, dated 1/17/26, indicated he had a diagnosis of dementia and severe cognitive impairment. He required supervision to walk with his walker for ambulation.	F0689		

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F0689 SS = SQC-J	Continued from page 4 R4's elopement assessment, dated 1/26/25, indicated he was at risk for elopement. R4's care plan, dated 9/22/25 indicated he was an elopement risk and had a wander device on his right hand. The care plan lacked staff supervision and individualized interventions. The care plan directed staff to monitor and document for exit seeking behavior, wander device in place, door alarms answered promptly and invite resident to activities. The NA care sheet indicated R4 had a wander device but lacked interventions to prevent elopement. R5's quarterly MDS, dated 1/12/26, indicated she had diagnoses of breast cancer, dementia, and moderate cognitive impairment. She could ambulate with supervision. R5's elopement assessment, dated 1/26/26 indicate R5 was at risk for elopement. R5's care plan, dated 10/28/24 indicated she was at risk for elopement due to acute encephalopathy and confusion. She had a wander device in use. The care plan lacked staff supervision and individualized interventions. Staff were to monitor and document for exit seeking behavior, wander device in place, door alarms answered promptly and invite resident to activities. The facility NA care sheet did not indicate R5 was an elopement risk and lacked interventions to prevent elopement. During an interview on 3/12/26 at 11:46 a.m., nursing assistant (NA)-A, an agency NA, stated it was her first shift at the facility. She was not alerted to any residents who were at risk to wander or elope. NA-A stated she had a sheet to reference each residents' needs, but the sheet did not indicate elopement risks. During an interview on 3/12/26, at 12:00 p.m., NA-B, an agency NA, stated it was her first shift at the facility. She was not alerted to any residents who were	F0689		

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F0689 SS = SQC-J	Continued from page 5 at risk to wander or elope. NA-B stated her care sheet did not indicate any residents at risk for elopement. During an interview on 3/12/26, at 12:05 p.m., the social service designee (SSD) stated R1's physical condition improved quickly. The elopement assessment on 3/3/26 was conducted when R1 was observed "halfway out the door", stating she wanted to go home, and the wander device was initiated at that time. SSD stated R1 also made attempts to leave via the elevator as well, stating she wanted to go home. During an interview on 3/12/26, at 12:25 p.m., licensed practical nurse (LPN)-A stated he was aware of the residents who were at risk for elopement. He was responsible to ensure the wander device was in place and check the expiration date every day but was not responsible for checking the functionality of the device. He stated the nurse managers (NM) were responsible for determining whether the device was working correctly. During an interview on 3/12/26, at 12:38 p.m., NM-A stated the nurses on the floor were responsible to test the wander device by bringing the test box to the resident every day on the day shift. She was responsible for replacing the device before the expiration date. NM-A stated the NA's received a care sheet at the start of their shift that indicated which residents were an elopement risk and how to care for them. During an interview on 3/12/26, at 1:05 p.m., NA-C, an agency NA stated it was her first shift at the facility. She received an orientation to the facility; it did not include which residents were at risk for elopement. She stated she received a care sheet indicating what each resident requires, but it did not include elopement risks. During an interview on 3/12/26, at 1:37 p.m., registered nurse (RN)-A stated she worked 3/7/26 in the evening before R1 eloped. RN-A stated the staff watched R1 closely and redirected her but did not implement any formal interventions, other than the wander device. During an interview on 3/12/26, at 2:31 p.m., RN-B stated she was working when R1 eloped and realized R1	F0689		

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F0689 SS = SQC-J	Continued from page 6 was missing as she was giving report to the nurse for the night shift. R1 was wandering earlier in the evening and attempted to elope twice through the door and through the elevator during her shift. RN-B stated, “it wasn’t any problem”, as R1 was able to be redirected. She did not implement additional interventions for R1 as she had a wander device in place and only the NM or director of nursing (DON) could make care plan changes. RN-B stated she was not advised that R1 had multiple attempts to leave the facility that evening. During an interview on 3/12/26, at 2:25 p.m., NM-B stated R1 had been escalating in the days prior to her elopement and was much more agitated and confused, setting off the wander alert system several times on 3/7/26 from approximately 10:00 a.m. to 2:00 p.m. NM-B stated additional supervision for residents should have been added to the care plan. She stated residents at risk for elopement should be noted on the care sheets provided to the NA’s. NM-B stated R3’s elopement risk was not indicated on the care sheet. NM-B also stated the nurses were expected to ensure placement of the wander device each shift and test the device on the day shift. During an interview on 3/12/26, at 3:10 p.m., the DON stated R1’s physical condition progressed quickly, from being non-ambulatory to walking independently. R1 had not been exit-seeking prior to her elopement incident on 3/7/26. R1’s wander device alerted when she walked too close to the sensors on the elevator as her friends left. The DON stated she expected the nurse would have called her that evening, when R1 made multiple attempts to exit the facility and interventions would have been established. There was a list of residents identified as elopement risks at each nursing station. The NA care sheets should have indicated which residents were at risk to elope. All nurses could make changes to the care plan. The wander device was expected to be checked for proper function daily. Immediately following the elopement incident, the code alert system and automatic locking doors were tested. The DON stated education related to the elopement policy and one-to-one resident supervision was reviewed with all staff. During an interview on 3/12/26, the administrator stated the code alert system and automatic locking doors were tested multiple times following R1’s elopement incident and a technician came to the facility but was unable to determine why the system did	F0689		

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F0689 SS = SQC-J	Continued from page 7 not alert when R1 eloped. She stated she was unaware of R1's increased exit-seeking behaviors prior to her elopement. During an interview on 3/13/26, at 9:28 a.m., NA-D stated he was working directly with R1 on the evening of 3/7/26. R1 was acting differently on 3/7/26, as she wandered room to room, called the police, and was trying to get out. He stated he redirected her away from the doors multiple times and notified RN-B of this. The immediate jeopardy that began on 3/7/26 was removed on 3/17/26, when the facility audited the care plans of residents identified as elopement risks, provided education to staff regarding the elopement policy, elopement assessments, one-to-one supervision, every 15-minute safety checks, wander device management, development and implementation of individualized care plans with interventions including supervision for residents at risk for elopement but noncompliance remained at a lower scope and severity level 2, D isolated scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy because removed the likelihood of serious harm, injury, impairment, or death. . A facility document, Elopement Policy, dated 11/2025, directed staff to establish a process to check the bracelet alarm/device batteries according to the manufacturer's directions. The Code Alert Wander Management Transmitters User Guide directed transmitters must be tested at least weekly to verify proper operation.	F0689		
F0729 SS = C	Nurse Aide Registry Verification, Retraining CFR(s): §483.35(d)(4)-(6) §483.35(d)(4) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless—	F0729		

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F0729 SS = C	Continued from page 8 (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or (ii) The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. §483.35(e)(5) Multi-State registry verification Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual. §483.35(e)(6) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure competency evaluation on the Minnesota Nursing Assistant Register for 1 of 1 nursing assistants (NA)-A) reviewed for registry verification. This had the potential to affect all 71 residents at the facility. Findings include: On 3/12/26 at 11:46 a.m., (nursing assistant) NA-A stated it was her first shift at the facility. The facility schedule, dated 3/12/26, indicated NA-A was assigned to work the day shift on the third floor,	F0729		

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F0729 SS = C	Continued from page 9 for 7.5 hours. The facility resident list indicated 26 residents were living on the third floor and a total of 71 residents in the facility, as of 3/12/26. The Minnesota Nurse Aide Registry Search, dated 3/13/26 at 11:45 a.m., provided by the facility, indicated NA-A was inactive since 12/7/24. On 3/12/26 at 3:30 p.m., the director of nursing (DON) stated she trusted the staffing agency sent them only staff on the registry. Further, she stated the facility did not verify an active status for agency staff. On 3/12/26 at 3:32 p.m., the administrator stated their process did not include verifying current certification of agency aide. She stated she expected only currently certified NA's would be sent. A facility policy was requested but not provided.	F0729		
F0838 SS = F	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity;	F0838		

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F0838 SS = F	Continued from page 10 (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as	F0838		

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F0838 SS = F	Continued from page 11 required in §483.73(a)(1). § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other	F0838		

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F0838 SS = F	Continued from page 12 resources needed for resident care. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure the facility assessment included the required components of a plan for recruitment and retention of staff. This had the opportunity to affect all 71 residents. Findings include: Review of the facility assessment, dated 12/17/25, failed to include a plan to maximize recruitment and retention of direct care staff. It also lacked a contingency plan for events that did not require activation of the facility's emergency plan, but had the potential to affect resident care, such as availability of direct care nurse staffing or other resources for resident care. On 3/13/26 at 3:32 p.m., the administrator stated they had a plan to recruit staff; however, it was not included in the facility assessment document. She stated the facility assessment did not include a plan for staff retention or a plan to address direct care staffing outside of the facility's emergency plan. A policy regarding the facility assessment was requested but not received.	F0838		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 30, 2026

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

Re: Event ID 1F3657-H1

Dear Administrator:

The above facility survey was completed on March 17, 2026, 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,

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

Minnesota State Department of Health

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER 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. 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. 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. INITIAL COMMENTS: On 3/12/26 through 3/17/26, 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 The following complaints were reviewed during the survey. H54175262C (2733214), H54178280C (2798564)	20000		

Office of Primary Care and Health Systems Management

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

Minnesota State Department of Health

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20000	Continued from page 1 Minnesota Department of Health is documenting the State 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	INITIAL COMMENTS On 3/12/26 through 3/17/26, a standard abbreviated survey was conducted at your facility. 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. H54178280C (2798564) and H54175262C (2733214) with a deficiencies issued at F689, F729, F838. 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. The survey resulted in an Immediate Jeopardy (IJ) at F689 when the facility failed to provide adequate interventions including supervision to a resident (R1), with a known elopement risk and was actively exit-seeking. This resulted in R1 eloping from the building. The IJ began on 3/7/26, and the immediacy was removed on 3/17/26. The above findings constituted substandard quality of care, and an extended survey was conducted from 3/13/26 to 3/17/26.	F0000		04/03/2026
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F0689	Immediate Corrective action: R1 was discharged to a secure unit. An audit was completed on the other identified residents (R3, R4 and R5) to ensure elopement risk evaluations were completed, wander guards were put into place, orders for checking function and placement were in place, care guides and care plans were updated with individualized interventions. Corrective action as it applies to others: A full house audit was completed to identify any additional	04/04/2026

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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F0689 SS = SQC-J	Continued from page 1 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to provide supervision and care planned individualized interventions resulting in the risk for serious harm, injury impairment or death for 1 of 5 residents (R1) who was an elopement risk, was actively attempting to leave the facility, and succeeded with eloping on 3/7/26. R1 was located one hour and 20 minutes later, by the police, about 5 blocks from the facility. In addition, to R1 in immediate jeopardy, the facility failed to develop supervision and care planned individualized interventions with the potential for harm that is not immediate jeopardy for 3 of 3, residents (R3, R4, R5) reviewed for elopement risks. The immediate jeopardy began on 3/7/26 when the facility failure to provide adequate supervision resulted in R1's elopement and was identified on 3/13/26. The administrator and director of nursing were notified of the immediate jeopardy at 12:05 p.m. on 3/13/26. The immediate jeopardy was removed on 3/17/26, but noncompliance remained at a lower scope and severity level 2, D isolated scope, and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's admission minimum data set (MDS), dated 2/16/26, indicated she had a diagnosis of malnutrition, severe cognitive impairment, did not exhibit wandering, and was completely dependent on staff for all personal care and mobility. R1's elopement assessment, dated 3/3/26, indicated R1 was an elopement risk, displayed agitation and wanted to go home. She had cognitive impairment, was able to self-propel her wheelchair, and was actively exit-seeking. R1's care plan, dated 3/3/26, indicated R1 was at risk for elopement. The care plan directed wander device in place, wander device will be monitored for proper functioning and door alarms would be answered promptly.	F0689	Continued from page 1 residents at risk for elopement, with no additional residents identified at the time. If a resident is identified as an elopement risk per the elopement risk assessment, the IDT will meet to develop and implement individualized interventions to mitigate the risk of elopement, including supervision. The resident's care plan will be updated to reflect the interventions." Education provided to all staff included training on which residents are at risk for elopement, where to find the information about an elopement risk and interventions for residents who are at risk for elopement and harm. Staff were asked to repeat back who is identified as at risk for elopement and where to find the information. The nursing staff were trained in elopement assessment and when a resident triggers 4 or higher, individualized interventions must be put in place. The interventions will be on the care plan and nursing assistant guides sheets. Nurses were trained in placing a wander guard, checking the function and placement, and interventions that can be used when a resident is actively exit seeking. Staff were asked to repeat back who is identified as at risk for elopement and where to find the information. Follow up quizzes were completed to ensure staff retained education that was provided. Nurse Managers were provided education on individualizing care plans for residents who are at risk for elopement. The resident care plan will be personalized per resident for specific interventions. The elopement risk assessment will be completed on admission or as needed to determine the resident's risk level of elopement and potential harm. If the resident is actively exit seeking or triggered due to assessment, the level of supervision will be reviewed for the resident's individualized care plan to prevent harm. Resident care plans and care guides will reflect the supervision determined to ensure communication for necessary supervision of residents at risk for elopement. Reoccurrence will be prevented by: Director of Nursing or the designee will audit 5 residents weekly to determine elopement risk, to ensure interventions are in place and resident care plan and care guide indicate interventions. The audits will be reviewed at QAPI to determine the frequency to decrease audits.	

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F0689 SS = SQC-J	Continued from page 2 The care plan lacked staff supervision and individualized interventions. A progress note dated 3/3/26 at 4:06 p.m., indicated R1 was exit-seeking, pushing on the exit door and was expressing she wanted to go home. R1 was going up and down the hallway in her wheelchair. She was cognitively impaired, and her elopement assessment indicated she was at risk for elopement. A wander device was placed on her right wrist. A progress note dated 3/3/26 at 5:56 p.m., indicated R1 was wandering around the unit all day long and had tried to leave. R1 was confused, disoriented, and walking around against nurse advice. She had tried to leave a few times. Continue to monitor for confusion and elopement. A progress note dated 3/6/26 at 1:07 p.m., indicated R1 was wandering up and down the hallway, was confused and disoriented. R1 was wandering against nurse advice and attempted to leave a few times. Continue to monitor for confusion and elopement. A progress note dated 3/7/26 at 11:15 a.m., indicated R1 was confused, disoriented, and very agitated. R1 was wandering into other residents' rooms and called the police. R1 stated staff were holding her hostage and attempted to leave the facility multiple times despite redirection. A progress note dated 3/8/26 at 3:12 a.m., indicated R1 wandered out of the facility through the fourth-floor door. R1 was found 5 blocks away, by the police. R1 was sent to the hospital for assessment and returned to the facility. Review of the facility's video surveillance of the fourth-floor door, on 3/7/26, showed the following activity by R1, without her walker:At 8:17 p.m., R1 attempted to open the stairwell door immediately to the right of the fourth-floor door. Nursing assistant (NA)-B was observed to redirect R1 and reset the alarm.At 8:20 p.m., R1 turned the doorknob for the stairwell door. NA-B redirected R1 from the door and reset the door code.At 9:06 p.m., R1 pushed on the fourth-floor door and was redirected from the door.At 9:19 p.m., R1 pushed on the fourth-floor door and was	F0689		

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F0689 SS = SQC-J	Continued from page 3 redirected by NA-B. NA-B reset the alarm.At 10:29 p.m., R1 pushed both exit doors. RN-B reset the alarm and staff redirected her.At 10:45 p.m., R1 walked out the fourth-floor door. No staff were present. A police report indicated the initial call to 911 was at 11:58 p.m., on 3/7/26. The report indicated R1 was not dressed for the weather and was wearing all black. The police report indicated another caller from a home approximately 5 blocks from the facility reported a person matching R1's description was knocking on the door, yelling "please help", and attempting to pull on the door latch. The police located R1 at the residence at 12:06 a.m., on 3/8/26. R1 appeared confused and was sent to the hospital for evaluation. Hospital documentation from the emergency department, dated 3/8/26, indicated R1 was admitted to the emergency department at 12:51 a.m., and was discharged in stable condition at 6:05 a.m., without injuries or medical concerns. Weather report on 3/12/26 from wunderground.com indicated the temperature was 32 degrees Fahrenheit with eight mile per hour winds at 10:45 p.m. R3's elopement assessment, dated 2/10/26, indicated she was an elopement risk, was confused and asked to go home. R3's care plan, dated 2/10/26, indicated she was exit-seeking upon admission, and she was disoriented to time, place, and person. She had a wander device on her left wrist. The care plan lacked staff supervision and individualized interventions. The care plan directed staff to monitor and document for exit seeking behavior, wander device in place, door alarms answered promptly and invite resident to activities. The facility NA care sheet did not indicate R3 was an elopement risk and lacked interventions to prevent elopement. R4's quarterly MDS, dated 1/17/26, indicated he had a diagnosis of dementia and severe cognitive impairment. He required supervision to walk with his walker for ambulation.	F0689		

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F0689 SS = SQC-J	Continued from page 4 R4's elopement assessment, dated 1/26/25, indicated he was at risk for elopement. R4's care plan, dated 9/22/25 indicated he was an elopement risk and had a wander device on his right hand. The care plan lacked staff supervision and individualized interventions. The care plan directed staff to monitor and document for exit seeking behavior, wander device in place, door alarms answered promptly and invite resident to activities. The NA care sheet indicated R4 had a wander device but lacked interventions to prevent elopement. R5's quarterly MDS, dated 1/12/26, indicated she had diagnoses of breast cancer, dementia, and moderate cognitive impairment. She could ambulate with supervision. R5's elopement assessment, dated 1/26/26 indicate R5 was at risk for elopement. R5's care plan, dated 10/28/24 indicated she was at risk for elopement due to acute encephalopathy and confusion. She had a wander device in use. The care plan lacked staff supervision and individualized interventions. Staff were to monitor and document for exit seeking behavior, wander device in place, door alarms answered promptly and invite resident to activities. The facility NA care sheet did not indicate R5 was an elopement risk and lacked interventions to prevent elopement. During an interview on 3/12/26 at 11:46 a.m., nursing assistant (NA)-A, an agency NA, stated it was her first shift at the facility. She was not alerted to any residents who were at risk to wander or elope. NA-A stated she had a sheet to reference each residents' needs, but the sheet did not indicate elopement risks. During an interview on 3/12/26, at 12:00 p.m., NA-B, an agency NA, stated it was her first shift at the facility. She was not alerted to any residents who were	F0689		

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F0689 SS = SQC-J	Continued from page 5 at risk to wander or elope. NA-B stated her care sheet did not indicate any residents at risk for elopement. During an interview on 3/12/26, at 12:05 p.m., the social service designee (SSD) stated R1's physical condition improved quickly. The elopement assessment on 3/3/26 was conducted when R1 was observed "halfway out the door", stating she wanted to go home, and the wander device was initiated at that time. SSD stated R1 also made attempts to leave via the elevator as well, stating she wanted to go home. During an interview on 3/12/26, at 12:25 p.m., licensed practical nurse (LPN)-A stated he was aware of the residents who were at risk for elopement. He was responsible to ensure the wander device was in place and check the expiration date every day but was not responsible for checking the functionality of the device. He stated the nurse managers (NM) were responsible for determining whether the device was working correctly. During an interview on 3/12/26, at 12:38 p.m., NM-A stated the nurses on the floor were responsible to test the wander device by bringing the test box to the resident every day on the day shift. She was responsible for replacing the device before the expiration date. NM-A stated the NA's received a care sheet at the start of their shift that indicated which residents were an elopement risk and how to care for them. During an interview on 3/12/26, at 1:05 p.m., NA-C, an agency NA stated it was her first shift at the facility. She received an orientation to the facility; it did not include which residents were at risk for elopement. She stated she received a care sheet indicating what each resident requires, but it did not include elopement risks. During an interview on 3/12/26, at 1:37 p.m., registered nurse (RN)-A stated she worked 3/7/26 in the evening before R1 eloped. RN-A stated the staff watched R1 closely and redirected her but did not implement any formal interventions, other than the wander device. During an interview on 3/12/26, at 2:31 p.m., RN-B stated she was working when R1 eloped and realized R1	F0689		

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F0689 SS = SQC-J	Continued from page 6 was missing as she was giving report to the nurse for the night shift. R1 was wandering earlier in the evening and attempted to elope twice through the door and through the elevator during her shift. RN-B stated, “it wasn’t any problem”, as R1 was able to be redirected. She did not implement additional interventions for R1 as she had a wander device in place and only the NM or director of nursing (DON) could make care plan changes. RN-B stated she was not advised that R1 had multiple attempts to leave the facility that evening. During an interview on 3/12/26, at 2:25 p.m., NM-B stated R1 had been escalating in the days prior to her elopement and was much more agitated and confused, setting off the wander alert system several times on 3/7/26 from approximately 10:00 a.m. to 2:00 p.m. NM-B stated additional supervision for residents should have been added to the care plan. She stated residents at risk for elopement should be noted on the care sheets provided to the NA’s. NM-B stated R3’s elopement risk was not indicated on the care sheet. NM-B also stated the nurses were expected to ensure placement of the wander device each shift and test the device on the day shift. During an interview on 3/12/26, at 3:10 p.m., the DON stated R1’s physical condition progressed quickly, from being non-ambulatory to walking independently. R1 had not been exit-seeking prior to her elopement incident on 3/7/26. R1’s wander device alerted when she walked too close to the sensors on the elevator as her friends left. The DON stated she expected the nurse would have called her that evening, when R1 made multiple attempts to exit the facility and interventions would have been established. There was a list of residents identified as elopement risks at each nursing station. The NA care sheets should have indicated which residents were at risk to elope. All nurses could make changes to the care plan. The wander device was expected to be checked for proper function daily. Immediately following the elopement incident, the code alert system and automatic locking doors were tested. The DON stated education related to the elopement policy and one-to-one resident supervision was reviewed with all staff. During an interview on 3/12/26, the administrator stated the code alert system and automatic locking doors were tested multiple times following R1’s elopement incident and a technician came to the facility but was unable to determine why the system did	F0689		

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F0689 SS = SQC-J	Continued from page 7 not alert when R1 eloped. She stated she was unaware of R1's increased exit-seeking behaviors prior to her elopement. During an interview on 3/13/26, at 9:28 a.m., NA-D stated he was working directly with R1 on the evening of 3/7/26. R1 was acting differently on 3/7/26, as she wandered room to room, called the police, and was trying to get out. He stated he redirected her away from the doors multiple times and notified RN-B of this. The immediate jeopardy that began on 3/7/26 was removed on 3/17/26, when the facility audited the care plans of residents identified as elopement risks, provided education to staff regarding the elopement policy, elopement assessments, one-to-one supervision, every 15-minute safety checks, wander device management, development and implementation of individualized care plans with interventions including supervision for residents at risk for elopement but noncompliance remained at a lower scope and severity level 2, D isolated scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy because removed the likelihood of serious harm, injury, impairment, or death. . A facility document, Elopement Policy, dated 11/2025, directed staff to establish a process to check the bracelet alarm/device batteries according to the manufacturer's directions. The Code Alert Wander Management Transmitters User Guide directed transmitters must be tested at least weekly to verify proper operation.	F0689		
F0729 SS = C	Nurse Aide Registry Verification, Retraining CFR(s): §483.35(d)(4)-(6) §483.35(d)(4) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless—	F0729	Immediate Corrective action: The agency in question was notified and (NA-A) was put on do not return to facility. The agency in question also informed the facility that they have removed her from their schedule. Corrective action as it applies to others: all agencies currently used were informed about what occurred, and they were asked to check their records. We currently request proof of licensure and/or certificate before they can work a shift. Education was provided to all on-call nurse managers	04/04/2026

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F0729 SS = C	Continued from page 8 (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or (ii) The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. §483.35(e)(5) Multi-State registry verification Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual. §483.35(e)(6) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure competency evaluation on the Minnesota Nursing Assistant Register for 1 of 1 nursing assistants (NA)-A) reviewed for registry verification. This had the potential to affect all 71 residents at the facility. Findings include: On 3/12/26 at 11:46 a.m., (nursing assistant) NA-A stated it was her first shift at the facility. The facility schedule, dated 3/12/26, indicated NA-A was assigned to work the day shift on the third floor,	F0729	Continued from page 8 and DON that if they request an agency employee to fill a shift, they must have proof of licensure and/or certificate. Reoccurrence will be prevented by: All licenses and/or certificates for agency staff are verified before they work a shift with us. All agencies are assisting with compliance with this review. Facility will audit 3 agency records for 4 weeks then 2 agency records a week x 2 weeks until determined by QAPI to decrease frequency of audits.	

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F0729 SS = C	Continued from page 9 for 7.5 hours. The facility resident list indicated 26 residents were living on the third floor and a total of 71 residents in the facility, as of 3/12/26. The Minnesota Nurse Aide Registry Search, dated 3/13/26 at 11:45 a.m., provided by the facility, indicated NA-A was inactive since 12/7/24. On 3/12/26 at 3:30 p.m., the director of nursing (DON) stated she trusted the staffing agency sent them only staff on the registry. Further, she stated the facility did not verify an active status for agency staff. On 3/12/26 at 3:32 p.m., the administrator stated their process did not include verifying current certification of agency aide. She stated she expected only currently certified NA's would be sent. A facility policy was requested but not provided.	F0729		
F0838 SS = F	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity;	F0838	Immediate Corrective action: The facility assessment was updated to include a plan for recruitment and retention of staff. The facility assessment includes the staffing levels needed to competently care for residents during both day-to-day operations on all shifts including weekends and emergencies. The contingency plan includes measures for staffing levels for events that do not require activation of the facility's emergency plan but do have the potential to affect resident care. Education was provided to the administrator on the required component that was missing from the facility assessment. Reoccurrence will be prevented by: The administrator will ensure that all new requirements will be included in the facility assessment. The facility assessment will continue to be reviewed annually and/or if any changes in the operation occur during our QAPI meeting.	04/04/2026

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F0838 SS = F	Continued from page 10 (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as	F0838		

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F0838 SS = F	Continued from page 11 required in §483.73(a)(1). § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other	F0838		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245417	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/17/2026

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

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F0838 SS = F	Continued from page 12 resources needed for resident care. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure the facility assessment included the required components of a plan for recruitment and retention of staff. This had the opportunity to affect all 71 residents. Findings include: Review of the facility assessment, dated 12/17/25, failed to include a plan to maximize recruitment and retention of direct care staff. It also lacked a contingency plan for events that did not require activation of the facility's emergency plan, but had the potential to affect resident care, such as availability of direct care nurse staffing or other resources for resident care. On 3/13/26 at 3:32 p.m., the administrator stated they had a plan to recruit staff; however, it was not included in the facility assessment document. She stated the facility assessment did not include a plan for staff retention or a plan to address direct care staffing outside of the facility's emergency plan. A policy regarding the facility assessment was requested but not received.	F0838		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/17/2026**

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER 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. 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. 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. INITIAL COMMENTS: On 3/12/26 through 3/17/26, 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 The following complaints were reviewed during the survey. H54175262C (2733214), H54178280C (2798564)	20000		04/03/2026

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

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/17/2026**

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20000	Continued from page 1 Minnesota Department of Health is documenting the State 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		