DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 11, 2025

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

RE: CCN: 245417
Cycle Start Date: February 26, 2025

Dear Administrator:

On April 10, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

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

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Electronically delivered

April 11, 2025

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

Re: Reinspection Results
Event ID: V4RG12

Dear Administrator:

On April 10, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 26, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

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

Electronically delivered
March 6, 2025

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

RE: CCN: 245417
Cycle Start Date: February 26, 2025

Dear Administrator:

On February 26, 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:

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 May 26, 2025 (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 August 26, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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)

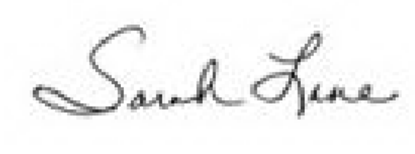
In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments 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,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
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Electronically delivered
March 6, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: V4RG11

Dear Administrator:

The above facility was surveyed on February 25, 2025 through February 26, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245417	A. BUILDING _____ B. WING _____	C 02/26/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 2/25/25 and 2/26/25, 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: H54178581C (MN00110910) and H54178502C (MN00110906) with deficiencies issued at F580, F684, and F880. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	F 580		3/25/25

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

Electronically Signed | 03/11/2025

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

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F 580	Continued From page 1 status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 580	Immediate corrective action: R2 MD was	

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F 580	Continued From page 2 facility failed to update the provider of a medication refusal of Lovenox (medication used to prevent blood clots following surgery) for 1 of 3 residents (R2) reviewed for medication administration. Findings include: R2's admission Minimum Data Set (MDS) dated 2/12/25, indicated R2 was cognitively intact, had a surgical wound, and required non-surgical dressings. R2's diagnoses list printed 2/25/25, included fistula of intestine. R2's hospital discharge orders dated 2/5/25, indicated enoxaparin (Lovenox) (anticoagulation therapy-used to prevent blood clotting after surgery) 40 milligrams (mg)/0.4 milliliters (ml) injection, inject 0.4 ml daily subcutaneously (subq) (under the skin). R2's orders dated 2/5/25, indicated enoxaparin sodium solution 40 mg/0.4 ml, inject 40 mg subcutaneously one time a day for prevent[ion] blood clotting, to start 2/6/25. R2's February 2025 Medication Administration Record (MAR) indicated R2 refused Lovenox injections 2/6/25 through 2/8/25 and 2/11/25 through 2/16/25, R2 was in the hospital on 2/17/25 and 2/18/25, and indicated see progress notes for 2/9/25 and 2/10/25. R2's progress note dated 2/9/25 at 8:36 p.m., indicated staff administered the Lovenox injection.	F 580	notified that R2 had refused her Lovenox. After review with the doctor the medication was discontinued. Corrective action as it applies to others: all other residents who use Lovenox (medication used to prevent blood clots following surgery) were reviewed and no medication administration was refused. Education provided to nursing staff regarding accuracy of notifying MD of any refusal of Lovenox (medication used to prevent blood clots following surgery) medication administration. Recurrence will be prevented by: Director of Nursing or designee will audit the administration of Lovenox. Audits will consist of Lovenox medication administration refusals 2 x weekly for 2 weeks, once weekly x 2 weeks, then monthly x 2 months until determined by QAPI decreased frequency of audits. Corrections will be monitored by the Director of Nursing or designee.	

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F 580	Continued From page 3 R2's progress note dated 2/10/25 at 7:21 p.m., indicated R2 refused the Lovenox injection. The progress note lacked indication R2's medical provider was notified. R2's care plan lacked mention of anticoagulation therapy. On 2/26/25 at 12:04 p.m., during an interview registered nurse (RN)-A stated when a resident refused Lovenox, the nurse should notify the provider and ask for instructions. RN-A further stated when R2 refused her first dose, the provider should have been notified right away because R2 could get blood clots without the medication. On 2/26/25 at 3:02 p.m., during an interview the director of nursing stated the facility expectation was to notify a medical provider when a resident refused medication and document the refusal in a progress note. The DON acknowledged the provider was not notified of the refusal. The DON stated Lovenox is a blood thinner and was utilized after surgery to prevent blood clotting. The Specific Medication Administration Procedure dated 5/2022, indicated when a resident refused a medication, document the refusal on the Mar or TAR [Treatment Administration Record]. Notify physician/ prescriber of persistent refusals.	F 580		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	F 684		3/25/25

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F 684	Continued From page 4 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review the facility failed to provide wound care as ordered for 1 of 3 residents (R2) reviewed for wound care. Additionally, the facility failed to ensure R2's care plan indicated wound care and pouch changes for the fistula. Findings include: R2's admission Minimum Data Set (MDS) dated 2/12/25, indicated R2 was cognitively intact, had a surgical wound, and required non-surgical dressings. R2's diagnoses list printed 2/25/25, included fistula of intestine. R2's hospital discharge orders dated 2/5/25, indicated the following: Wound care management 1. Remove pouch with adhesive spray. 2. Cleanse surrounding skin with Vashe [wound cleaner]and pat dry. 3. Use 3M Advanced Care Wand to raw skin. Let dry one minute. 4. Offer Lidocaine spray (prevents pain caused by some procedures). 5. Measure and cut out opening of Convatec Eakin Fistula Manager ((square) or Coloplast Post op pouch 18681/18691 (round)- (pouches designed to protect skin and contain drainage from wounds and fistulas) both have a	F 684	Immediate corrective action: R2 wound care orders were reviewed per doctors orders. R2 care plan was updated to indicate wound care and pouch changes for the fistula. Corrective action as it applies to others: All other residents who have wound care or fistula could be affected. The resident care plans were reviewed for those who have wound care to ensure correct orders were being followed and care planned. The residents who have fistulas their care plans were reviewed and updated as needed. Education provided to nursing staff on the policy regarding medication and treatment orders. Recurrence will be prevented by: Director of Nursing or designee will audit wound treatment orders and care plans to ensure they are correct. Audits will consist of 2 x a week for 2 weeks, once weekly x 2 weeks, then monthly x2 months until determined by QAPI decreased frequency of audits. Corrections will be monitored by the Director of Nursing or designee.	

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F 684	Continued From page 5 peek-a-boo plastic window for dressing packing. 6. Border window opening with ostomy barrier rings (cut ring in half and stretch ring around one-half of the wound forming a half-moon shape for each side). 7. Apply pouch. Add tape or elastic barrier strips for extra security. 8. Open plastic peek-a-boo window downward for dressing packs every 6 hours. Change 1-2 times a week and as needed (PRN) for leakage or dressing failure. May apply 3M Cavilon spray (used to protect skin around the fistula from damage) to irritated/ burning skin BID (twice daily) surrounding fistula manager. Let dry one minute. Coloplast Post Op Pouch acting as fistula manager to be changed 2x weekly. Pack wound every six hours, wet to dry with normal saline. However, R2's provider orders reviewed 2/25/25, lacked orders for the wound care as indicated in the hospital discharge orders dated 2/5/25. R2's care plan dated 2/7/25, indicated R2 had an alteration in elimination related to fistula manager care and indicated R2 was able to direct her stoma care treatment with staff. The care plan indicated R2 would tell staff how to do her stoma care in a step-by-step direction, and staff would monitor for skin breakdown. The care plan also indicated a self-care deficit related to fistula manager care dated 2/7/25, with a goal that R2 would accept assistance with self-cares. The interventions for the care deficit lacked mention of assistance with pouch changes and wound dressings. R2's Skin and Wound Evaluation dated 2/13/25, indicated the wound was present on admission, the wound was new, measured 10.9 centimeters	F 684		

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

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F 684	Continued From page 6 (cm) x 7.6 cm, and the practitioner was notified. The wound evaluation lacked indication of the type of wound, assessment or description of the wound bed, assessment or description of drainage, assessment or description of the surrounding tissue, a pain assessment, or the treatment administered. There were no additional wound assessments documented between 2/13/25 and discharge to the hospital on 2/17/25. R2's wound provider progress note dated 2/13/25, indicated R2 had an enteroatmospheric fistula (EAF) (an abnormal connection between the gastrointestinal tract and the open atmosphere - a hole in the bowel that directly opens to the outside of the body) which allowed intestinal contents to leak out freely. The progress note further stated, "There was a treatment error and pt [patient] had not been receiving dressing changes q [every] 6 hours to ostomy. Ostomy was irritated and bleeding because of this. Pt reported emptying the pouch daily but never adding wet gauze to the ostomy. Pt attempted to change wound pouch last night [2/4/25] on her own with assistance of staff. Pt made the cutting area too large, so exposed skin was present in the wound pouch. Pt did not have another wound pouch for the situation to be rectified. Instructed nurse manager to order wound pouches asap [as soon as possible]. Educated pt and staff on the importance of keeping the skin around the site dry and unexposed and the importance of keeping the ostomy viable and moist by packing with wet gauze." R2's progress note dated 2/14/25 at 5:50 a.m., indicated ostomy site intact. Ostomy care provided. Treatment to wound performed on shift as ordered. The progress note lacked indication	F 684		

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	245417	A. BUILDING _____ B. WING _____	C 02/26/2025

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F 684	Continued From page 7 of what ostomy cares were provided and which wound treatment was provided. R2's progress note dated 2/14/25 at 3:50 p.m., indicated ostomy was intact. R2's progress note dated 2/14/25 at 7:20 p.m., indicated no surgical wounds noted. R2's progress note dated 2/15/25 at 6:25 a.m., indicated surgical wound present: abdomen has open wounds present; abdomen dressing to wounds remains clean, dry, and intact. Wound not visualized. The progress note lacked mention of the ostomy. R2's progress note dated 2/16/25 at 6:17 a.m., indicated loose stools noted. Has colostomy. Ostomy site intact. Surgical wound present: abdomen has open wounds present: abdomen dressing remains clean, dry, and intact. Wound not visualized. R2's progress note dated 2/16/25 at 5:25 p.m., indicated stool was formed, ostomy site intact, ostomy care provided, but lacked indication what care was provided. The progress note indicated surgical wound present: abdomen, no open wounds noted. Dressing to wound remains clean, dry, and intact. Wound not visualized. R2's progress note dated 2/17/25 at 6:52 a.m., indicated loose stools noted. Has colostomy. Ostomy site intact. Ostomy care provided. The progress note lacked indication of what ostomy care was provided. R2's progress note dated 2/17/25 at 3:39 p.m., indicated R2 transferred to the emergency room	F 684		

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F 684	Continued From page 8 because the tracheostomy tube was out and, "There is inflammation of her ostomy". R2's progress notes dated 2/17/25, indicated R2 was sent to ER and subsequently admitted to the hospital for an infection not related to her ostomy. R2's February 2025 Treatment Administration Record indicated the orders from the wound provider were added on 2/19/25. On 2/26/25 at 12:04 p.m., during an interview registered nurse (RN)-A stated the process for resident hospital orders was a nurse entered the orders upon resident admission to the facility to start care for the resident. RN-A acknowledged the orders for R2's wound care were not entered when R2 was admitted on 2/5/25, and was not sure why. RN-A stated if wound care orders were not followed the resident could get an infection or have skin breakdown. On 2/26/25 at 12:34 p.m., RN-B stated R2's fistula pouch was not changed twice weekly as ordered, and when RN-B assessed R2's skin on 2/13/25, and described it as, "Fire engine red, macerated, and raw." RN-B further stated if the wound care had been done correctly, the dressing could have progressed to once weekly changes but have to continue twice weekly to repair the skin. On 2/26/25 at 2:19 p.m., during an interview physician assistant (PA)-A stated it was important for R2 to have good wound care to ensure the skin was protected. The PA-A stated the wound care orders were not followed for changing the ostomy/fistula bags or performing the wound packing. PA-A further stated R2 had a high fistula	F 684		

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F 684	Continued From page 9 output, the fluid was leaking around the ostomy bag, and fluid was sitting on R2's skin, causing skin breakdown. PA-A stated, "If they [facility staff] had taken better care of her skin she wouldn't have the erosive injury on her skin." On 2/26/25 at 3:02 p.m., during an interview the director of nursing (DON) stated the process for entering resident orders after hospitalization was the admitting nurse entered the orders, another nurse checked the orders, and a nurse manager verified the orders. The DON acknowledged R2's admission wound care orders were not entered into the medical record and staff did not perform the care as ordered. The DON further acknowledged the nurse did not perform the wound assessment completely on 2/13/25, to assess R2's wound/ fistula. The Skin Assessment and Wound Management policy dated 2/2025, indicated the facility would follow treatments per provider order and update the care plan as needed.	F 684		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		3/25/25

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F 880	Continued From page 10 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 11 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review the facility failed to conduct appropriate hand hygiene during wound care for 1 of 3 residents (R2) reviewed for wound care. Findings include: R2's admission Minimum Data Set (MDS) dated 2/12/25, indicated R2 was cognitively intact, had a surgical wound, and required non-surgical dressings. R2's diagnoses list printed 2/25/25, included fistula of intestine. On 2/26/25 at 11:04 a.m., R2's wound care was observed. Licensed practical nurse (LPN)-A washed his hands with soap and water prior to performing wound care. LPN-A donned gloves, opened R2's fistula collection bag that contained stool, removed a soiled dressing saturated with stool from inside bag, placed the soiled dressing in the garbage, and drained the bag into a plastic receptacle to measure R2's stool output. LPN-A	F 880	Immediate corrective action: the nurse was educated on the steps of hand hygiene during wound care. Corrective action as it applies to others: all other nurses were educated in the steps of hand hygiene during wound care. Recurrence will be prevented by: Infection Control Coordinator, Director of Nursing or designee will audit wound treatment hand hygiene to ensure no steps are missed. Audits will consist of 2 x a week for 2 weeks, once weekly x 2 weeks, then monthly x 2 months until determined by QAPI decreased frequency of audits. Corrections will be monitored by the Director of Nursing or designee.	

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F 880	Continued From page 12 doffed his gloves, and donned clean gloves. LPN-A did not perform hand hygiene between glove changes. LPN-A used a Sani wipe to clean stool from R2's legs, discarded the Sani wipe in the garbage, doffed his gloves, and again donned clean gloves without performing hand hygiene between glove changes. LPN-A opened a clean gauze dressing, cut it to size, put it in a cup, poured saline over the dressing, and put the dressing in the collection bag. LPN-A removed his gloves, did not perform hand hygiene, and picked up the wound care supplies and put them away in the supply bin in the room. LPN-A donned clean gloves, picked up the receptacle with the stool, measured it, and flushed it down the toilet. LPN-A washed the receptacle with water, dried it with a paper towel, and set in the on counter next to the sink. LPN-A doffed his gloves, touched the top of the receptacle that previously held stool with his bare hands, and moved R2's tray table closer to the bed. LPN-A donned clean gloves, again without performing hand hygiene after touching the dirty receptacle, picked up the garbage bag, touched the door handle to open the door, and then doffed his gloves. LPN-A took the garbage to the room where is was disposed. LPN-A did not perform hand hygiene when he left the room, but did after he disposed of the garbage. On 2/26/25 at 11:23 a.m., during an interview, LPN-A acknowledged he had not performed hand hygiene while performing wound care, except prior to performing the wound care. LPN-A further acknowledged he should have performed hand hygiene between each glove change, after touching the collection receptacle, and after leaving the room. LPN-A stated he could spread germs if he did not perform hand hygiene correctly.	F 880		

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F 880	Continued From page 13 On 2/26/25 at 3:37 p.m., during an interview the director of nursing stated she had provided staff education about hand hygiene in the last month or two. The DON stated she expected staff to follow the hand hygiene policy, and all staff had been taught how to correctly perform hand hygiene to prevent spread of infection. The Handwashing policy dated 2/2024, indicated proper handwashing techniques should be used to protect the spread of infection. The policy indicated hand washing would be completed before and after treating a wound, after cleaning up someone who has used the toilet, and after touching garbage. The policy further indicated when conducting a procedure requiring the use of gloves, proper hand washing would be performed before donning gloves and after removing gloves.	F 880		

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2 000	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 2/25/25 and 2/26/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. The following complaints were reviewed: H54178581C (MN00110910) and H54178502C (MN00110906) with licensing orders issued at 0265 and 1426. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is	2 000		

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2 000	Continued From page 2 not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment;	2 265		3/25/25

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2 265	Continued From page 3 D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to update the provider of a medication refusal of Lovenox (medication used to prevent blood clots following surgery) for 1 of 3 residents (R2) reviewed for medication administration. Findings include: R2's admission Minimum Data Set (MDS) dated 2/12/25, indicated R2 was cognitively intact, had a surgical wound, and required non-surgical dressings. R2's diagnoses list printed 2/25/25, included fistula of intestine. R2's hospital discharge orders dated 2/5/25, indicated enoxaparin (Lovenox) (anticoagulation therapy-used to prevent blood clotting after surgery) 40 milligrams (mg)/0.4 milliliters (ml) injection, inject 0.4 ml daily subcutaneously (subq) (under the skin). R2's orders dated 2/5/25, indicated enoxaparin sodium solution 40 mg/0.4 ml, inject 40 mg subcutaneously one time a day for prevent[ion] blood clotting, to start 2/6/25. R2's February 2025 Medication Administration Record (MAR) indicated R2 refused Lovenox	2 265	Corrected	

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2 265	Continued From page 4 injections 2/6/25 through 2/8/25 and 2/11/25 through 2/16/25, R2 was in the hospital on 2/17/25 and 2/18/25, and indicated see progress notes for 2/9/25 and 2/10/25. R2's progress note dated 2/9/25 at 8:36 p.m., indicated staff administered the Lovenox injection. R2's progress note dated 2/10/25 at 7:21 p.m., indicated R2 refused the Lovenox injection. The progress note lacked indication R2's medical provider was notified. R2's care plan lacked mention of anticoagulation therapy. On 2/26/25 at 12:04 p.m., during an interview registered nurse (RN)-A stated when a resident refused Lovenox, the nurse should notify the provider and ask for instructions. RN-A further stated when R2 refused her first dose, the provider should have been notified right away because R2 could get blood clots without the medication. On 2/26/25 at 3:02 p.m., during an interview the director of nursing stated the facility expectation was to notify a medical provider when a resident refused medication and document the refusal in a progress note. The DON acknowledged the provider was not notified of the refusal. The DON stated Lovenox is a blood thinner and was utilized after surgery to prevent blood clotting. The Specific Medication Administration Procedure dated 5/2022, indicated when a resident refused a medication, document the refusal on the Mar or TAR [Treatment Administration Record]. Notify physician/ prescriber of persistent refusals.	2 265		

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2 265	Continued From page 5 Suggested Method of Correction: The director of nursing (DON) or designee could work with the medical director to update policies and procedures for when to notify the physician of medication refusals. The DON or designee could educate staff about the policies and procedures. The DON or designee could perform audits to determine if the physician had been notified as appropriate, and bring the results of the audits to the QA committee. Time Period for Correction: Twenty-one (21) days.	2 265		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		3/25/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00122	A. BUILDING: _____ B. WING _____	C 02/26/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 6 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 residents (R2) completed a required tuberculosis (TB) screening and two-step tuberculin skin test (TST). This had the potential to affect all 69 residents who reside in the facility, staff, and visitors. Findings include: The CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Settings, 2005, (MMWR) directed all residents must receive a baseline TB screening within 72 hours of admission or within 3 months prior to admission. The screening must include an assessment of the resident's risk factors for TB, and any current TB symptoms. R2 was admitted to the facility on 2/12/25, R2's medical record lacked evidence TB test had been completed. R2's progress note dated 2/9/25 at 9:42 p.m., indicated, "No TB screening is noted in PCC [Point Click Care - electronic medical record], unable to read results. On 2/26/25 at 9:51 a.m., during an interview the infection preventionist (IP) stated when R2 refused the TB test on 2/6/25, the facility should have performed a chest X-Ray to complete TB screening but had not. On 2/26/25 at 3:02 p.m., during an interview the director of nursing (DON) confirmed R2's TB test was not completed, and stated, "I missed her."	21426	corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21426	Continued From page 7 The Tuberculosis Screening and Prevention-Residents policy dated 7/31/23, indicated resident Tuberculosis screening will be performed within 90 days prior to admission or within 72 hours of admission, to include a TB risk assessment, system evaluation, and TB testing. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could review and/or revise the current TB policies and procedures to ensure all residents are screened for physical signs and symptoms of active TB disease on admission. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21426		