Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
March 12, 2024

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

RE: CCN: 245417
Cycle Start Date: January 31, 2024

Dear Administrator:

On March 1, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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March 12, 2024

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

Re: Reinspection Results
Event ID: CLJX12

Dear Administrator:

On March 1, 2024 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 January 31, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 7, 2024

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

RE: CCN: 245417
Cycle Start Date: January 31, 2024

Dear Administrator:

On January 31, 2024, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by May 1, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 31, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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Electronically delivered
February 7, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: CLJX11

Dear Administrator:

The above facility was surveyed on January 30, 2024 through January 31, 2024 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:

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

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.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245417	A. BUILDING _____ B. WING _____	C 01/31/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 1/30/24 - 1/31/24 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 H54179392C/MN98529 H54179346C/MN98089 H54179344C/MN96360 H54179345C/MN95474 The following complaints were reviewed H54179347C/MN95437 with deficiencies issued at F684 and F677 Incident findings were found with deficiencies issued at F812, F813 and F842 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 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and	F 677		2/29/24

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

Electronically Signed | 02/14/2024

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

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F 677	Continued From page 1 personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide personal hygiene to 3 of 4 residents (R2, R6, and R7) dependent on staff for activities of daily living (ADL's). The residents did not receive timely showers or weekly skin assessments. Findings include: R2's care plan dated 8/9/22 indicated R2 required the assistance of one staff member to assist with bathing. The care plan did not indicate how often bathing was to be performed. R2's physician order sheet dated 5/22/23 indicated R2 was to receive a weekly shower. 1. Ensure shower/bath was completed, chart refusals. 2. Complete weekly skin inspection. 3. Nurse to ensure aide trims fingernails and toenails. 4. Notify supervisor or nurse manager of any skin alterations. R2's weekly skin inspection reports reviewed from 11/1/23 - 1/31/24 indicated R2 received weekly skin inspections on 11/9/23, 11/27/23, and 1/15/24. R2's nursing progress notes reviewed from 11/1/23 - 1/31/24 did not indicate R2 had refused any weekly showers or skin inspections. R2's quarter Minimum Data Set (MDS) dated 1/19/24 indicated R2 had a Brief Inventory of Mental Status (BIMs) score of 15 indicating R2 was cognitively intact. R2 required assistance of one staff member with toileting and showering.	F 677	Immediate Corrective Action: R2, R6 and R7 bathing has been completed per their preference and their weekly skin assessment has been completed. Corrective Action: as it applies to others: All other residents were asked if their bed bath or shower was not completed and was reoffered. Skin assessment was completed at the time of the bed bath or shower as resident allows. Charted if resident refused. Resident bath schedules were reviewed to ensure weekly tasks are assigned correctly. Education provided to the nursing department regarding the bathing schedule and skin assessment requirements. Date of Compliance: Date all education and personal hygiene and skin checks to be completed by February 29, 2024. Recurrence will be prevented by: Director of Nursing or Designee will complete audit of 5% of residents to ensure bath is completed as scheduled per resident preference and skin assessment completed 2 x weekly for 2 weeks, then weekly x 2 weeks, then monthly x 2 months with a goal of compliance of 90% or greater until determined by QAPI to decrease frequency of audits. Corrections will be monitored by the Director Nursing/ Unit managers or designee.	

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F 677	Continued From page 2	F 677		

R2's pertinent diagnoses were type II diabetes, low back pain, and spondylosis without myopathy, lumbar region (degenerative arthritis of the lower spine).

Upon observation and interview on 1/30/24 at 2:49 p.m. R2 stated she had not received a shower in at least two weeks. She stated, "I smell, I smell, just smell me." R2 stated she does not keep track but would guess she receives a shower approximately once a month, after "begging" for one. R2's hair was matted to her head in the back with an oily appearance. R2 had an odor of perspiration.

R6's skin inspection reports reviewed from 1/13/24 -1/31/24 indicated R6 received an admission skin assessment on 1/18/24 which lacked any documentation and did not receive any other skin inspections.

R6's progress notes reviewed from 1/13/24 - 1/31/24 did not indicate that R6 refused any showers or any skin inspections.

R6's care plan dated 1/16/24 indicated R6 required the assistance with bathing. R6's bathing schedule was every Thursday.

R6's admission MDS dated 1/19/24 indicated R6 had a BIMs score of 15 indicating he was cognitively intact. R6's MDS did not indicate how R6 was to bathe or shower. R6's pertinent diagnoses were left femur (thigh bone) fracture and chronic respiratory failure with hypoxia (low level of oxygen in the body).

Upon interview on 1/31/24 at 10:29 a.m. R6 stated he had not received a shower since he

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F 677	Continued From page 3 was admitted on 1/13/24. He stated he was told he would receive one weekly, however, has not and he would like on. "I am feeling pretty gritty, and it would relax my nerves and help with pain." R7's care plan dated 8/8/19 indicated R7 was to have a shower once a week requiring assistance of one staff member. R7's physician order sheet dated 5/20/23 indicated R7 was to have 1. weekly showers, chart refusals. 2. Completely weekly skin inspection and document. 3. Nurse to trim fingernails and toenails. 4. Notify supervisor or nurse manager of any skin alteration. R7's annual MDS dated 11/17/23 indicated R7 had a BIMs score of 15 indicating R7 was cognitively intact. R7's MDS did not indicate how R7 was to bathe or shower. R7's pertinent diagnoses were difficulty walking, muscle wasting, muscle weakness and morbid obesity. R7's progress notes reviewed 11/1/23 - 1/31/24 did not indicated R7 had refused any showers or skin inspections. R7's weekly skin inspections assessments reviewed 11/1/23 - 1/31/24 indicated R7 received a weekly skin inspection on 11/14/23, 12/2/23, 12/16/23, 1/6/24 and 1/20/24. Upon observation and interview on 1/31/24 R7 stated she was washed-up a few days ago, however, has not received an "actual shower" since the beginning of the month. She stated the staff does not ask her if she wants a shower. She stated that if she does not get a shower, she would at least like her hair washed weekly. R7's	F 677		

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F 677	Continued From page 4 hair was oily and disheveled. Upon interview on 1/30/24 at 12:44 p.m. registered nurse (RN)-B stated the nursing staff is aware when the residents get showered because the nurses must do a skin check the same day. She stated if a resident refuses, the nursing assistants, (NA) are to report the refusal to the nurses so they can still do the skin assessment and document refusal. Upon interview on 1/30/24 at 12:57 p.m. registered nurse (RN)-C stated nurses are aware that the staff are being showered because the nursing staff need to complete a skin assessment. Upon interview on 1/31/24 at 2:12 the director of nursing (DON) stated he can run a report and audit the bathing/showing. He stated he will at times see the care is not being completed. In addition, he stated the Point Click Care system (PCC) (facilities software program) has been pulling something "odd" lately. He stated his expectation is the showers get completed as ordered, if there is a refusal the nursing staff is aware so they can document, try to find a resolution, and complete the skin check. A facility policy titled Activities of Daily Living (ADL's)/Maintain Abilities Policy 3/31/23 indicated a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming and personal or oral hygiene.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		2/29/24

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F 684	Continued From page 5 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 4 residents (R6 and R7) received daily weights as ordered to monitor for heart failure and unexplained weight loss. Findings include: R6's admission MDS dated 1/19/24 indicated R6 had a BIMs score of 15 indicating he was cognitively intact. R6's MDS did not indicate how R6 was to bathe or shower. R6's pertinent diagnoses were left femur (thigh bone) fracture and chronic respiratory failure with hypoxia (low level of oxygen in the body). R6 physician order dated 1/26/24 indicate R7's parameters for Lasix 20 milligram (mg) by mouth everyday prn (as needed); give medication if patient has gained 2 lbs. in 1 day or 5 lbs. in 1 week for significant leg edema; diagnosis diastolic heart failure. R6's Weight summary dated 1/18/24 - 1/31/24 indicated: -1/28/24 his weight was 153.4 and on 1/31/24 his weight was 146.8 lbs. R6's progress notes dated 1/13/24 - 1/31/24	F 684	Immediate Corrective Action R6 weight obtained, and MD updated, no new orders received. R7 weights were obtained, MD updated, new orders received. Corrective Action: as it applies to others. Residents who are to receive daily weights were reviewed and completed as ordered. Education provided to the nursing department regarding daily weights. Date of compliance: Date all education on daily weights to be completed by February 29, 2024. Director of Nursing or Designee will complete audit of 5% of residents to ensure daily weights are completed as ordered 3 x weekly for 2 weeks, then weekly x 2 weeks, then monthly x 2 months with a goal of compliance of 100% or greater until determined by QAPI to decrease frequency of audits. Correction will be monitored by the Director of Nursing/ Unit Managers or designee.	

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F 684	Continued From page 6 indicated: -1/18/24 at 6:00 a.m. R6 refused to be weighed, stating is so early, do later. -1/19/24 at 5:11 a.m. R6 refused weight, stating its very early, later in the day. -1/20/24 at 6:00 a.m. R6 refused weight, refused to get up early and check. -1/21/24 at 5:17 a.m. R6 refused weight, sleeping, please check later. -1/22/24 at 6:14 a.m. R6 refused weight, sleeping -1/23/24 at 2:03 p.m. R6 left early in the a.m. for an appointment. -1/24/24 at 6:16 a.m. R6 sleeping, do not disturb -1/25/24 at 5:55 a.m. R6 sleeping, refused, do not disturb while sleeping -1/29/24 at 5:34 a.m. R6 sleeping, do not disturb R6's electronic treatment administration (TAR) record dated 1/18/24- 1/31/24 indicated: - 1/18/24, 1/20/24 - 1/22/24 and 1/29/24 a number "9" was charted without a weight indicated to see progress notes. -1/19/24 a number "2" was charted without a weight indicating R6 refused -1/23/24 a check mark was charted without a weight and the letters "NA." -1/26/24 - 1/28/24 weights were charted. -1/30/24 a number "7" was charted without a weight chart indicating R6 was sleeping Upon interview on 1/31/24 at 10:29 a.m. R6 stated he is supposed to have his weight taken daily, but it does not get done most days because staff comes in between 5:00 a.m. and 6:00 a.m. He stated, "I don't know why they would wake me up for that, when they have all day?" R6's facilities physician order sheet dated 1/18/24 indicated R6 was to receive daily weights and to	F 684		

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F 684	Continued From page 7	F 684		

update the provider with >2 lbs. in 1 day or >5 lbs. in one week.

R7's progress notes dated 11/1/23 -1/31/24 did not indicate that R7 refused weights at any time.

R7's weight report summary dated 11/1/23 - 1/31/24 indicated:
- 11/3/24 weight was 217 lbs.
- 11/28/24 weight was 180.7 lbs.
- 12/4/24 weight was 190.0 lbs.
- 12/16/24 weight was 192.7 lbs.
- 12/24/24 weight was 191.9 lbs.
- 12/31/24 weight was 191/9 lbs.
- 1/7/24 weight was 192.0 lbs.
- 1/24/24 weight was 192.8 lbs.

R7's annual MDS dated 11/17/23 indicated R7 had a BIMs score of 15 indicating R7 was cognitively intact. R7's MDS did not indicate how R7 was to bathe or shower. R7's pertinent diagnoses were difficulty walking, muscle wasting, muscle weakness and morbid obesity.

R7's physician order dated 11/29/23 indicated to weight R7 and document weight daily for 7 days. Diagnosis: Unexplained weight loss.

R7's electronic medical administration record (MAR) dated 12/1/23 - 12/31/23 indicated R7 was to have daily weights for unexplained weight loss. There was no documentation of any weights on the MAR.

Upon interview on 1/31/24 at 12:50 p.m. registered nurse, RN-C stated the nurses tell the nursing assistants (NAs) who needs to be weighed for the day. The weight order is under the nurses charting, so the nurses need to be

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F 684	Continued From page 8 sure to find out the weights on the residents. Upon interview on 1/31/24 1:21 p.m. R7 stated she was uncertain how often she was to be weighed. She stated, sometimes she gets weighed a few days in a row and then other times she will not get weighed for weeks. Upon interview on 1/31/24 at 2:12 p.m. the director of nursing (DON) indicated he was in the process of looking at all the residents who are daily weights and undo some of them who do not have a medical need. He denied awareness that R6 and R7 had required daily weight that were not completed as ordered. A quality of care policy was requested, however none was received.	F 684		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812		2/29/24

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F 812	Continued From page 9 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure refrigerated food items were disposed of after expiration date and were properly stored, labeled, and dated when the original packaging was opened. This deficient practice had the potential to affect all 70 residents who resided in the facility. Findings include: Upon observation on 1/30/24 at 10:22 a.m. the refrigerator in the facility's main kitchen. The following items were expired and still in the refrigerator: -one gallon size container of potato salad with a manufacture use by date of 12/8/23, -one opened half-gallon of buttermilk with a manufacture use by date of 12/23/23. - A block of cream cheese in a cardboard box with the inner foil torn. Approximately 1/3 of the cream cheese had been used and mold was found covering the cheese where the inner foil had been opened, the manufacture use by date was 11/4/23. The following items were opened without any dates: -Three one-gallon size salad dressings - One plastic container of Dijon mustard - One tin can of caramel syrup, - one plastic bottle of soy sauce - one plastic container of relish - one plastic container of cherries - five slices of a white cheese wrapped in saran wrap	F 812	Immediate Corrective Action All items in the refrigerator that were identified in the survey were discarded. Corrective Action: as it applies to others. All shared refrigerators audited and items in the refrigerator that were identified in the survey were discarded. Education was provided to the dietary department regarding dating of food and discarding food when indicated by the date. Date of compliance: Completion of education on food storage to be completed by February 29, 2024. Director of Dietary or Designee will complete audit of 100% of Kitchen and shared refrigerators that food items are labeled/dated with use by date and discarded on used by date 2 x weekly for 2 weeks, then weekly x 2 weeks, then monthly x 2 months with a goal of compliance of 100% or greater until determined by QAPI to decrease frequency of audits. Correction will be monitored by the Director of Dietary/ or designee.	

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F 812	Continued From page 10 - a metal container with shredded cheese covered with saran wrap - one box lined with a plastic bag full of raisins unsealed -a gallon size plastic bottle of bar-b-que sauce, and two loaves of white bread. -one box of processed fully thawed turkey bundles individually wrapped in plastic The following items were open, had manufactures dates, but were undated by the facility staff upon opening: -one box filled with plastic wrapped ground beef, completely thawed with a manufacture date of 1/26/24. -one round rump roast in a cardboard box wrapped in manufacture plastic, completely thawed with a manufacture date of 1/23/24. -two dozen eggs with a manufacture date of 1/13/24. -two plastic containers of sour cream with a manufacture date of 1/13/24. Upon interview on 1/30/24 at 11:01 the dietary manager stated that all opened food in the refrigerator required a date in which the facility opened the item. He stated he "fixed" all the items that were not dated with the dates the products were opened "to the best of his knowledge" after he saw the surveyor in the refrigerator. Upon observation and interview on 1/30/24 at 1:30 p.m. the Dietician stated the staff should be putting an open date on any food immediately when opening. She stated the dietary manager should not have gone back and dated items that he was uncertain opened dates. The Dietician went into the refrigerator and pulled out the moldy	F 812		

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F 812	Continued From page 11 cream cheese, the expired butter milk, the expiated potato salad, and some hard-boiled eggs in a metal container covered in plastic with a date of 1/26/24. She stated hard boiled eggs need to be disposed of within three days of use. She was uncertain about the of the box of opened raises, the thawed ground beef, the thawed roast, and the processed turkey. The Dietician was going to do a "little research" and dispose of those items if need be. She stated all the other undated items should have been dated upon opening. She stated she has always taught staff to use the date they open a package. She was unaware that the facility policy indicated all storage items should have a "use by" date. She stated she always makes sure a form is posted on the bullet board directly outside of the refrigerator which indicated when the food products were to be disposed of. An undated facility form titled Food storage and shelf life indicated: - prepared food was to be used by three days after placing in the refrigerator -foods in original form was to be used within seven days of placing in the refrigerator -dairy products were to be used within the manufactures date or seven days after sell by date -margarine was to be used eight months or by expiration date - cheese was to be used within thirty days if opened and six months if unopened -salad dressing, mayo, BBQ sauce, and soup bases were to be used within three months after opening -mustard, ketchup, relish, soy sauce, vinegar and jelly were to be used within six months after opening.	F 812		

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F 812	Continued From page 12 -Luncheon meal was to be used by manufactures use by date or seven days after sell date. -Fresh fruit was to be used with 14 days after receiving or before quality is compromised. -Prepackaged salads are to be used by manufacturers use by date or seven days after sell by date. -Pasteurized eggs to be used within 60 days after Julian date (the date the product was packaged). Upon interview on 1/30/24 at 1:48 p.m. dietary aid (DA)-A stated she "thought" whoever opens a food item and places it in the refrigerator is supposed to the date the opened food when it was opened. She stated ground hamburger was not to be in the refrigerator for more than a day after it was moved from the freezer and that any salad dressing were to be disposed of with thirty days after the date of opening. DA-A stated she was not aware of a facility chart indicating when food was to be disposed of. Upon interview on 1/30/24 at 2:02 p.m. dietary aid (DA)-B stated he is uncertain how and when food stored in the refrigerator are dated. He stated when he sees open salad dressing it must be used up with two days. DA-B stated if he has a question about the food, he will call the supervisor. DA-B was unare of the food chart on the bullet board. A facility policy titled Food Receiving and Storage revised 10/17 indicated all foods stored in the refrigerator or freezer will be covered, labeled, and dated ("use by" date). Such foods will be rotated using a "first in- first out" system.	F 812		
F 813 SS=E	Personal Food Policy CFR(s): 483.60(i)(3)	F 813		2/29/24

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F 813	Continued From page 13 §483.60(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the food a residents brought in from the outside was dated and labeled the transitional care unit. This had the potential to affect all 20 residents who resided on that floor. In addition, the facility was unable to provide documentation that the residents communal refrigerator temperatures were being monitored. Findings include: Upon observation on 1/30/24 at 12:46 p.m. the resident floor refrigerator was found to have six plastic grocery bags that were tied bags with deli-style boxes of food inside, none of these bags were labeled with a name or a date. There was a bag of rotisserie chicken in the manufacturers bag that stated "keep frozen" in the refrigerator with thawed meat unlabeled with a name or date. There was a package of opened half-eaten Colby jack cheese slices with no name, it had a use by date of 10/12/23. In addition, there was an opened jar of salsa with mold inside with a use by date of 9/21/22. The refrigerator had a thermometer in it reading 40 degrees. There was a foul odor upon opening the door. Upon interview on 1/30/24 at 12:55 p.m. licensed practical nurse (LPN)-A stated the refrigerator is for all the residents who reside on the fourth floor. She stated resident bring back food when they	F 813	Immediate Correction Action Resident community refrigerators were cleaned, and items removed that were not dated or labeled and temperature log put into place. Corrective Action: as it applies to others. All items in the resident community refrigerator were cleaned, and items removed that were not dated or labeled and the temperature log put into place. Education was provided to the dietary department regarding monitoring of resident refrigerator for proper dating, labeling and temperature taking. Director of Dietary or Designee will complete audit of 100% of Kitchen and shared refrigerators for temperature, and dating of food placed in refrigerator 2 x weekly for 2 weeks, then weekly x 2 weeks, then monthly x 2 months with a goal of compliance of 100% or greater until determined by QAPI to decrease frequency of audits. Correction will be monitored by the Director of Dietary or designee.	

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F 813	Continued From page 14 have gone out or family brings in food for them. She stated the food needs be labeled with the resident's name and the date it was brought it. LPN-A was uncertain who monitored the food in the refrigerator. Upon observation and interview on 1/30/24 the Dietician was observed taking the plastic grocery bags out of the refrigerator and placing them on the floor. She stated, she thought the bags belonged to a new lady at the facility but wasn't certain. She stated the bags needed to be disposed of because of no name and no date. She stated she was going to immediately clean out the refrigerator and tell the residents of anything disposed of. She stated any staff can be responsible for the refrigerator monitoring, including nursing, dietary and activities. She was unaware of any audits being done of the products in the refrigerator. She looked for a record of the temperature monitoring however was unable to provide one. The facility policy titled Food Receiving and Storage dated 10/2017 indicated all foods belonging to residents must be labeled with the resident's name, the items and the "use by" date. Refrigerators must have working thermometers and be monitored for temperature according to state specific guidelines. Partially eaten foods may not be kept in the refrigerator.	F 813		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is	F 842		2/29/24

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F 842	Continued From page 15 resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.	F 842		

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F 842	Continued From page 16 §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to maintain a medical record that was accurately documented for 1 of 1 resident (R1), when Registered Nurse (RN)-A documented a completed treatment that had not been completed. Findings include: R1's quarter Minimum Data Set (MDS) dated 12/1/23 indicated R1 had a Brief Inventory of Mental Status (BIMs) score of 15 indicating R1 was cognitively intact. R1 was dependent with toileting, showering, and lower body dressing requiring two staff members. R1 required maximum assistance with rolling in bed and	F 842	Immediate Correction Action R1 treatment was immediately completed. Education provided to nurse immediately. Correction Action: as it applies to others. All residents that receive wound care have been reviewed by wound provider and orders remain current. Education provided to the nursing department regarding treatment completion. Director of Nursing or Designee will complete audit of 5% of residents with wounds to ensure they have their treatment completed prior to documentation in the EMar 2 x weekly for 2 weeks, then weekly x 2 weeks, then	

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F 842	Continued From page 17 hygiene. R1's diagnoses were calculus in bladder (bladder stones), moderate protein calorie deficiency and chronic pain. R1's physician order sheet dated 12/5/23 indicated wound care to left great toe every a.m. shift. 1. Clean wound with moist 4x4 gauze. 2. Paint wound with iodine swab. 3. Cover with gauze and tape. R1's electronic treatment administration record printed 1/31/24 at 11:34 indicated registered nurse (RN)-A had completed the wound treatment for R1. Upon observation and interview on 1/31/24 at 12:57 p.m. R1 was in bed turned slightly to the right side, her feet were positioned on a pillow sticking out from under the covers. R1's left great toe was not wrapped with gauze and there was no sign that betadine had been applied to the toe, the toenail was overgrown, and the toenail base was green. R1 stated she rarely has a dressing applied, as staff just do not do it. She stated the toe was painful and it could be because her toenails were so grown out or the infection was still present. Upon interview on 1/31/24 at 1:04 registered nurse, RN-A stated he did chart that the wound treatment had been completed, but he was going to do it closer to 2:00 p.m. Upon interview on 1/31/24 at 1:08 p.m. registered nurse, RN-B the unit manager stated she had just observed R1's wound and it had not been treated yet. She stated staff is supposed to complete medications passing or treatments before they chart it was done.	F 842	monthly x 2 months with a goal of compliance of 90% or greater until determined by QAPI to decrease frequency of audits. Correction will be monitored by the Director of Nursing/ Unit Manager or designee.	

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F 842	Continued From page 18 Upon interview on 1/31/24 at 2:12 p.m. the director of nursing, DON stated cares need to be completed before they are charted. A policy on medication documentation was requested, however none was provided.	F 842		

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	00122	A. BUILDING: _____ B. WING _____	C 01/31/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 1/30/24 - 1/31/24 , 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 orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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

Electronically Signed | 02/14/24

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed with no deficiency issued: H54179392C/MN98529 H54179346C/MN98089 H54179344C/MN96360 H54179345C/MN95474 The following complaints were reviewed. H54179347C/MN95437 with a licensing order issued at ST0920 Incidental findings with licensing orders were issued at ST625 and ST1080 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	2 000		

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2 000	Continued From page 2 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 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		
2 625	MN Rule 4658.0450 Subp. 1 A-P Clinical Record Contents; In General Subpart 1. In general. Each resident's clinical record, including nursing notes, must include: A. the condition of the resident at the time of admission; B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I; C. the resident's height and weight, according to part 4658.0520, subpart 2, item J; D. the resident's general condition, actions, and attitudes; E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel;	2 625		2/29/24

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2 625	Continued From page 3 F. significant observations on, for example, behavior, orientation, adjustment to the nursing home, judgment, or moods; G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication; H. a report of a tuberculin test within the three months prior to admission, as described in part 4658.0810; I. reports of laboratory examinations; J. dates and times of all treatments and dressings; K. dates and times of visits by all licensed health care practitioners; L. visits to clinics or hospitals; M. any orders or instructions relative to the comprehensive plan of care; N. any change in the resident's sleeping habits or appetite; O. pertinent factors regarding changes in the resident's general conditions; and P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part 4658.0400. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to maintain a medical record that was accurately documented for 1 of 1 resident (R1), when Registered Nurse (RN)-A documented a completed treated which had not been completed. Findings include:	2 625	completed	

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2 625	Continued From page 4 R1's quarter Minimum Data Set (MDS) dated 12/1/23 indicated R1 had a Brief Inventory of Mental Status (BIMs) score of 15 indicating R1 was cognitively intact. R1 was dependent with toileting, showering, and lower body dressing requiring two staff members. R1 required maximum assistance with rolling in bed and hygiene. R1's diagnoses were calculus in bladder (bladder stones), moderate protein calorie deficiency and chronic pain. R1's physician order sheet dated 12/5/23 indicated wound care to left great toe every a.m. shift. 1. Clean wound with moist 4x4 gauze. 2. Paint wound with iodine swab. 3. Cover with gauze and tape. R1's electronic treatment administration record printed 1/31/24 at 11:34 indicated registered nurse (RN)-A had completed the wound treatment for R1. Upon observation and interview on 1/31/24 at 12:57 p.m. R1 was in bed turned slightly to the right side, her feet were positioned on a pillow sticking out from under the covers. R1's left great toe was not wrapped with gauze and there was no sign that betadine had been applied to the toe, the toenail was overgrown, and the toenail base was green. R1 stated she rarely has a dressing applied, as staff just don't do it. She stated the toe was painful and it could be because her toenails were so grown out or the infection was still present. Upon interview on 1/31/24 at 1:04 registered nurse, RN-A stated he did chart that the wound treatment had been completed, but he was going to do it closer to 2:00 p.m.	2 625		

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2 625	Continued From page 5 Upon interview on 1/31/24 at 1:08 p.m. registered nurse, RN-B the unit manager stated she had just observed R1's wound and it had not been treated yet. She stated staff is supposed to complete medications passing or treatments before they chart it was done. Upon interview on 1/31/24 at 2:12 p.m. the director of nursing, DON stated cares need to be completed before they are charted. A policy on medication documentation was requested, however none was provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 625		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide personal	2 920	completed	2/29/24

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2 920	Continued From page 6 hygiene to 3 of 4 residents (R2, R6, and R7) dependent on staff for activities of daily living (ADL's). The residents did not receive timely showers or weekly skin assessments. Findings include: R2's care plan dated 8/9/22 indicated R2 required the assistance of one staff member to assist with bathing. The care plan did not indicate how often bathing was to be performed. R2's physician order sheet dated 5/22/23 indicated R2 was to receive a weekly shower. 1. Ensure shower/bath was completed, chart refusals. 2. Complete weekly skin inspection. 3. Nurse to ensure aide trims fingernails and toenails. 4. Notify supervisor or nurse manager of any skin alterations. R2's weekly skin inspection reports reviewed from 11/1/23 - 1/31/24 indicated R2 received weekly skin inspections on 11/9/23, 11/27/23, and 1/15/24. R2's nursing progress notes reviewed from 11/1/23 - 1/31/24 did not indicate R2 had refused any weekly showers or skin inspections. R2's quarter Minimum Data Set (MDS) dated 1/19/24 indicated R2 had a Brief Inventory of Mental Status (BIMs) score of 15 indicating R2 was cognitively intact. R2 required assistance of one staff member with toileting and showering. R2's pertinent diagnoses were type II diabetes, low back pain, and spondylosis without myopathy, lumbar region (degenerative arthritis of the lower spine). Upon observation and interview on 1/30/24 at	2 920		

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2 920	Continued From page 7 2:49 p.m. R2 stated she had not received a shower in at least two weeks. She stated, "I smell, I smell, just smell me." R2 stated she does not keep track but would guess she receives a shower approximately once a month, after "begging" for one. R2's hair was matted to her head in the back with an oily appearance. R2 had an odor of perspiration. R6's skin inspection reports reviewed from 1/13/24 -1/31/24 indicated R6 received an admission skin assessment on 1/18/24 which lacked any documentation and did not receive any other skin inspections. R6's progress notes reviewed from 1/13/24 - 1/31/24 did not indicate that R6 refused any showers or any skin inspections. R6's care plan dated 1/16/24 indicated R6 required the assistance with bathing. R6's bathing schedule was every Thursday. R6's admission MDS dated 1/19/24 indicated R6 had a BIMs score of 15 indicating he was cognitively intact. R6's MDS did not indicate how R6 was to bathe or shower. R6's pertinent diagnoses were left femur (thigh bone) fracture and chronic respiratory failure with hypoxia (low level of oxygen in the body). Upon interview on 1/31/24 at 10:29 a.m. R6 stated he had not received a shower since he was admitted on 1/13/24. He stated he was told he would receive one weekly, however, has not and he would like on. "I am feeling pretty gritty, and it would relax my nerves and help with pain." R7's care plan dated 8/8/19 indicated R7 was to have a shower once a week requiring assistance	2 920		

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2 920	Continued From page 8 of one staff member. R7's physician order sheet dated 5/20/23 indicated R7 was to have 1. weekly showers, chart refusals. 2. Completely weekly skin inspection and document. 3. Nurse to trim fingernails and toenails. 4. Notify supervisor or nurse manager of any skin alteration. R7's annual MDS dated 11/17/23 indicated R7 had a BIMs score of 15 indicating R7 was cognitively intact. R7's MDS did not indicate how R7 was to bathe or shower. R7's pertinent diagnoses were difficulty walking, muscle wasting, muscle weakness and morbid obesity. R7's progress notes reviewed 11/1/23 - 1/31/24 did not indicated R7 had refused any showers or skin inspections. R7's weekly skin inspections assessments reviewed 11/1/23 - 1/31/24 indicated R7 received a weekly skin inspection on 11/14/23, 12/2/23, 12/16/23, 1/6/24 and 1/20/24. Upon observation and interview on 1/31/24 R7 stated she was washed-up a few days ago, however, has not received an "actual shower" since the beginning of the month. She stated the staff does not ask her if she wants a shower. She stated that if she does not get a shower, she would at least like her hair washed weekly. R7's hair was oily and disheveled. Upon interview on 1/30/24 at 12:44 p.m. registered nurse (RN)-B stated the nursing staff is aware when the residents get showered because the nurses must do a skin check the same day. She stated if a resident refuses, the nursing assistants, (NA) are to report the refusal to the	2 920		

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2 920	Continued From page 9 nurses so they can still do the skin assessment and document refusal. Upon interview on 1/30/24 at 12:57 p.m. registered nurse (RN)-C stated nurses are aware that the staff are being showered because the nursing staff need to complete a skin assessment. Upon interview on 1/31/24 at 2:12 the director of nursing (DON) stated he can run a report and audit the bathing/showing. He stated he will at times see the care is not being completed. In addition, he stated the Point Click Care system (PCC) (facilities software program) has been pulling something "odd" lately. He stated his expectation is the showers get completed as ordered, if there is a refusal the nursing staff is aware so they can document, try to find a resolution, and complete the skin check. A facility policy titled Activities of Daily Living (ADL's)/Maintain Abilities Policy 3/31/23 indicated a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming and personal or oral hygiene. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 920		

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21080	Continued From page 10	21080		
21080	MN Rule 4658.0650 Subp. 1 Food Supplies; Clean,free from spoilage Subpart 1. Food. All food must be clean, wholesome, free from spoilage, free from adulteration and misbranding, and safe for human consumption. Canned or preserved food which has been processed in a place other than a commercial food-processing establishment is prohibited for use by nursing homes. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure refrigerated food items were disposed of after expiration date and were properly stored, labeled, and dated when the original packaging was opened. This deficient practice had the potential to affect all 70 residents who resided in the facility. Findings include: Upon observation on 1/30/24 at 10:22 a.m. the refrigerator in the facility's main kitchen. The following items were expired and still in the refrigerator: -one gallon size container of potato salad with a manufacture use by date of 12/8/23, -one opened half-gallon of buttermilk with a manufacture use by date of 12/23/23. - A block of cream cheese in a cardboard box with the inner foil torn. Approximately 1/3 of the cream cheese had been used and mold was found covering the cheese where the inner foil had been opened, the manufacture use by date was 11/4/23. The following items were opened without any	21080	completed	2/29/24

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21080	Continued From page 11 dates: -Three one-gallon size salad dressings - One plastic container of Dijon mustard - One tin can of caramel syrup, - one plastic bottle of soy sauce - one plastic container of relish - one plastic container of cherries - five slices of a white cheese wrapped in saran wrap - a metal container with shredded cheese covered with saran wrap - one box lined with a plastic bag full of raisins unsealed -a gallon size plastic bottle of bar-b-que sauce, and two loaves of white bread. -one box of processed fully thawed turkey bundles individually wrapped in plastic The following items were open, had manufactures dates, but were undated by the facility staff upon opening: -one box filled with plastic wrapped ground beef, completely thawed with a manufacture date of 1/26/24. -one round rump roast in a cardboard box wrapped in manufacture plastic, completely thawed with a manufacture date of 1/23/24. -two dozen eggs with a manufacture date of 1/13/24. -two plastic containers of sour cream with a manufacture date of 1/13/24. Upon interview on 1/30/24 at 11:01 the dietary manager stated that all opened food in the refrigerator required a date in which the facility opened the item. He stated he "fixed" all the items that were not dated with the dates the products were opened "to the best of his knowledge" after he saw the surveyor in the refrigerator.	21080		

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21080	Continued From page 12 Upon observation and interview on 1/30/24 at 1:30 p.m. the Dietician stated the staff should be putting an open date on any food immediately when opening. She stated the dietary manager should not have gone back and dated items that he was uncertain opened dates. The Dietician went into the refrigerator and pulled out the moldy cream cheese, the expired butter milk, the expiated potato salad, and some hard-boiled eggs in a metal container covered in plastic with a date of 1/26/24. She stated hard boiled eggs need to be disposed of within three days of use. She was uncertain about the of the box of opened raises, the thawed ground beef, the thawed roast, and the processed turkey. The Dietician was going to do a "little research" and dispose of those items if need be. She stated all the other undated items should have been dated upon opening. She stated she has always taught staff to use the date they open a package. She was unaware that the facility policy indicated all storage items should have a "use by" date. She stated she always makes sure a form is posted on the bullet board directly outside of the refrigerator which indicated when the food products were to be disposed of. An undated facility form titled Food storage and shelf life indicated: - prepared food was to be used by three days after placing in the refrigerator -foods in original form was to be used within seven days of placing in the refrigerator -dairy products were to be used within the manufactures date or seven days after sell by date -margarine was to be used eight months or by expiration date - cheese was to be used within thirty days if	21080		

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21080	Continued From page 13 opened and six months if unopened -salad dressing, mayo, BBQ sauce, and soup bases were to be used within three months after opening -mustard, ketchup, relish, soy sauce, vinegar and jelly were to be used within six months after opening. -Luncheon meal was to be used by manufactures use by date or seven days after sell date. -Fresh fruit was to be used with 14 days after receiving or before quality is compromised. -Prepackaged salads are to be used by manufacturers use by date or seven days after sell by date. -Pasteurized eggs to be used within 60 days after Julian date (the date the product was packaged). Upon interview on 1/30/24 at 1:48 p.m. dietary aid (DA)-A stated she "thought" whoever opens a food item and places it in the refrigerator is supposed to the date the opened food when it was opened. She stated ground hamburger was not to be in the refrigerator for more than a day after it was moved from the freezer and that any salad dressing were to be disposed of with thirty days after the date of opening. DA-A stated she was not aware of a facility chart indicating when food was to be disposed of. Upon interview on 1/30/24 at 2:02 p.m. dietary aid (DA)-B stated he is uncertain how and when food stored in the refrigerator are dated. He stated when he sees open salad dressing it must be used up with two days. DA-B stated if he has a question about the food, he will call the supervisor. DA-B was unare of the food chart on the bullet board. A facility policy titled Food Receiving and Storage revised 10/17 indicated all foods stored in the refrigerator or freezer will be covered, labeled,	21080		

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 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21080	Continued From page 14 and dated ("use by" date). Such foods will be rotated using a "first in- first out" system. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21080		