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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44654 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 [DATE], 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. 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. (continued on next page)

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.

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

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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NAME OF PROVIDER OR SUPPLIER The Villas at Robbinsdale		STREET ADDRESS, CITY, STATE, ZIP CODE 3130 Grimes Avenue North Robbinsdale, MN 55422	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate treatment and care according to orders, resident's preferences and goals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44654

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 [DATE], 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 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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 (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 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 [DATE], 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 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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44654 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 [DATE], 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 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. 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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.