| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245417 | A. Building<br>B. Wing | 11/20/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Villas at Robbinsdale | 3130 Grimes Avenue North<br>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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to timely report an allegation of physical abuse to the state agency (SA) for 1 of 3 residents (R1) reviewed for abusefindings includeR1's quarterly Minimum Data Set (MDS) dated [DATE], indicated she was independent with all activities of daily living. R1's undated admission Record identified R1 admitted to the facility on [DATE]. Diagnosis included fracture of vertebrae, diabetes, depression and hypertension.R1's care plan dated 11/14/25, identified an alteration in mobility and staff were to assist with transfers and bed mobility. R1's Associated Clinic of Psychology (ACP) visit note dated 11/13/25, indicated a visit was requested due to an increase in confusion and falls. R1 expressed concern for how a staff person moved her around the previous day and spoke of people being in her bed with her. Staff was consulted after session to report psychotic symptoms and clients care concern. The visit note indicated R1's appearance was unkempt, lying in bed in a facility gown. Head was craned to the left and R1 lied still during the visit. R1 endorsed pain in the left leg that she said was new. On 11/20/25 at 11:50 a.m., licensed social worker (SW)-A and the administrator were interviewed. SW-A stated R1 told her a staff member had picked her up and threw her on the floor, then picked her up and threw her back on the bed. SW-A stated R1 reported the allegation Friday morning on 11/14/25, when family member (FM)-A was present. SW-A said she reported the incident to the SA later that evening. SW-A said abuse allegations should have been reported to the SA within two hours but said R1's FM-A said R1 was confused. The administrator said she felt the problem was that FM-A was insistent R1 was confused but said abuse allegations should have been reported within two hours.During interview on 11/20/25 at 1:53 p.m., the ACP- social worker (SW) stated she had been onsite at the facility and was asked to see R1. The ACP-SW said R1 had presented as delusional. She said R1 was in bed during the visit and had been pretty still and reported pain in her leg which she had attributed to the way staff had moved her around the previous day. The ACP-SW said she reported the care concern and to LSW-A.During interview on 11/20/25 at 2:40 p.m., LSW-A stated she had spoken to the ACP-SW after her session with R1. LSW-A said she did not report the concern about pain to anyone because the ACP-SW said she had talked to someone.The facility Abuse Prohibition/Vulnerable Adult Policy dated 4/2025, indicated the policy was intended to protect residents against abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends or other individuals, or self-abuse and to promptly report, document and investigate all incidents of alleged or suspected abuse/neglect. Incidents to be reported included abuse and indicated suspected abuse shall be reported to the SA no later than two hours after forming the suspicion of abuse. |

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 |
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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to provide evidence of ongoing clinical assessments following a fall for 1 of 3 residents (R1) reviewed for falls. Findings include:R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated she was independent with all activities of daily living and required supervision to walk 50 feet.R1's undated admission Record indicated R1 admitted to the facility on [DATE]. Diagnosis included fracture of vertebrae, diabetes, depression and hypertension.R1's care plan dated 11/14/25, identified a risk for falls and included the following interventions: use of a concave mattress, signs in room to remind R1 to call for assistance and use of a reacher. The care plan identified an alteration in mobility and staff to assist with transfers and bed mobility. R1's Progress Notes identified the following:11/11/25, Writer was conducting routine rounds and heard someone calling for help. When writer approached R1's room, she was found seated on the floor. Bruising was observed to right elbow and R1 was assisted back to bed.11/12/25, Writer went to room and found R1 on the floor with her head facing the window. When asked, R1 stated she wanted to get out of bed and go home. Assessment was completed, range of motion done to both upper and lower extremities. R1 denied pain or discomfort. No visible bruises or bleeding noted.11/14/25, Neurological flow sheet for fall follow-up, vital signs within normal range. No concerns noted at this time. Hourly checks performed.11/14/25, Social Worker (SW) was called to R1's room secondary to R1 not wanting to get dressed or changed. R1 was weepy and said her legs hurt and she did not want to get up. Family member (FM) was present and asked to have R1 sent to the emergency department for confusion and pain secondary to the two falls.11/14/25. R1 was transferred to the hospital due to weakness, confusion and lethargy. 11/16/25, R1 was discharge from the facility.R1's Associated Clinic of Psychology (ACP) visit note dated 11/13/25, indicated visit was requested due to increase in confusion and falls. R1 expressed concern for how a staff person had moved her around the previous day and spoke of people being in her bed with her. Staff was consulted after session to report psychotic symptoms and clients care concern. The visit note indicated R1's appearance was unkempt, lying in bed in a facility gown. Head was craned to the left and R1 lied still during the visit. R1 endorsed pain in the left leg that she said was new. The note indicated, Seems most likely that client is experiencing delirium - important to rule out underlying medical issue. R1's Physical Therapy Treatment Encounter Notes indicated the following:11/11/25, R1 was approached and not agreeable to therapy. Therapist attempted to discuss fall that occurred that morning. R1 stated, I don't know to all questions Increased time was spent locating registered nurse (RN), R1 was shaking, twitching and unable to lift head off the bed or keep her eyes open. Located RN who stated she thought R1 was just tired but agreed she did not look well. Response to session indicated; limited by fall, RN had no increased insight on incident, R1 had been found sitting on the floor in her room with no recollection of what had happened. R1 shaky and unable to stay alert through conversation.11/13/25. R1 was approached for therapy and not agreeable. Stated she had a fall the previous night reaching for something on the floor. Response to session indicated limited by not feeling well after fall, still looked unwell. R1's medical record lacked evidence the following was completed: neurological checks with vital signs as directed; assessment related to a change in condition.During interview on 11/20/25 at 8:48 a.m., FM-B said a few weeks prior, he received a call that R1 had an unwitnessed fall and there were no injuries. FM-B said the previous week he received another call to inform him R1 had a fall with no injuries. FM-B said he got another call later that R1 again had fallen 4-5 hours earlier. FM-B said FM-A went to the facility on [DATE], at about 8:20 a.m. and R1 was curled up on the bed in the fetal position, in dirty sheets and there was blood on the floor in the room. FM-A told FM-B R1 had not responded when she called to her from the door. When R1 got up she was in so much pain, FM-A had asked the SW to call an ambulance. FM-B said R1 had been and R1 was found to have bruising on one whole side of her body, a broken hip, fractured ribs and a urinary tract infection.FM-B said R1 had<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | been at the facility for two days with a broken hip and was still in the hospital and had surgery to repair her hip. During interview on 11/20/25 at 12:04 p.m., nursing assistant (NA)-B stated she met R1 when she transitioned to the third floor. NA-B said R1 had been very independent and staff typically just checked on her. NA-B said before the two falls, R1 walked but afterward had been staying in her wheelchair.During interview on 11/20/25 at 12:09 p.m., NA-A stated on Friday morning (11/14/25), she asked R1 if she needed anything. NA-A said she attempted to change R1 due to incontinence and R1 did not want to put clothes on. NA-A said when she changed R1's incontinent brief she rolled a little to one side but could not roll onto the opposite side. NA-A said she did not recall if she saw any bruising.During interview on 11/20/25 at 12:47 p.m., the director of nursing (DON) stated R1 had a past medical history of falls and fractures and said any little thing would probably fracture her. The DON said after a fall, staff should perform and assessment, completed neurological checks for 72 hours and if an obvious injury was noted, send the resident to the hospital. The DON said he had been told a neurological flow sheet had been completed but he had not seen it and did not know where it was. The DON said he had been told after R1 went to the hospital she had a fracture.During interview on 11/20/25 at 1:53 p.m., the ACP-SW stated she had been onsite at the facility and was asked to see R1. The ACP-SW said R1 had presented as delusional. She said R1 was in bed during the visit and had been pretty still and reported pain in her leg which she had attributed to staff care. The ACP-SW said she reported the care concern and the report of pain to LSW-A.During interview on 11/13/25 at 2:01 p.m., the therapy director (TD) stated R1 had been doing better and was using a walker prior to her falls. The TD said after the falls R1 had not made much progress. The TD said she reviewed R1's therapy notes and she had not been wanting to walk. During interview on 11/20/25 at 2:40 p.m., LSW-A stated she had spoken to the ACP-SW after her session with R1. LSW-A said she did not report the concern about pain to anyone because the ACP-SW said she had talked to someone.During interview on 11/20/25 at 2:44 p.m., the DON stated he expected staff to perform ongoing monitoring of vital signs, any pain and/or injury. The DON stated if bruising was present staff were to put an order in the medication administration record to monitor. A policy related to ongoing assessment after a fall was requested but not received. |