| 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 | 03/17/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 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) |
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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to provide supervision and care planned individualized interventions resulting in the risk for serious harm, injury impairment or death for 1 of 5 residents (R1) who was an elopement risk, was actively attempting to leave the facility, and succeeded with eloping on 3/7/26. R1 was located one hour and 20 minutes later, by the police, about 5 blocks from the facility. In addition, to R1 in immediate jeopardy, the facility failed to develop supervision and care planned individualized interventions with the potential for harm that is not immediate jeopardy for 3 of 3, residents (R3, R4, R5) reviewed for elopement risks. The immediate jeopardy began on 3/7/26 when the facility failure to provide adequate supervision resulted in R1's elopement and was identified on 3/13/26. The administrator and director of nursing were notified of the immediate jeopardy at 12:05 p.m. on 3/13/26. The immediate jeopardy was removed on 3/17/26, but noncompliance remained at a lower scope and severity level 2, D isolated scope, and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.Findings include: R1's admission minimum data set (MDS), dated [DATE], indicated she had a diagnosis of malnutrition, severe cognitive impairment, did not exhibit wandering, and was completely dependent on staff for all personal care and mobility. R1's elopement assessment, dated 3/3/26, indicated R1 was an elopement risk, displayed agitation and wanted to go home. She had cognitive impairment, was able to self-propel her wheelchair, and was actively exit-seeking. R1's care plan, dated 3/3/26, indicated R1 was at risk for elopement. The care plan directed wander device in place, wander device will be monitored for proper functioning and door alarms would be answered promptly. The care plan lacked staff supervision and individualized interventions. A progress note dated 3/3/26 at 4:06 p.m., indicated R1 was exit-seeking, pushing on the exit door and was expressing she wanted to go home. R1 was going up and down the hallway in her wheelchair. She was cognitively impaired, and her elopement assessment indicated she was at risk for elopement. A wander device was placed on her right wrist. A progress note dated 3/3/26 at 5:56 p.m., indicated R1 was wandering around the unit all day long and had tried to leave. R1 was confused, disoriented, and walking around against nurse advice. She had tried to leave a few times. Continue to monitor for confusion and elopement. A progress note dated 3/6/26 at 1:07 p.m., indicated R1 was wandering up and down the hallway, was confused and disoriented. R1 was wandering against nurse advice and attempted to leave a few times. Continue to monitor for confusion and elopement. A progress note dated 3/7/26 at 11:15 a.m., indicated R1 was confused, disoriented, and very agitated. R1 was wandering into other residents' rooms and called the police. R1 stated staff were holding her hostage and attempted to leave the facility multiple times despite redirection. A progress note dated 3/8/26 at 3:12 a.m., indicated R1 wandered out of the facility through the fourth-floor door. R1 was found 5 blocks away, by the police. R1 was sent to the hospital for assessment and returned to the facility. Review of the facility's video surveillance of the fourth-floor door, on 3/7/26, showed the following activity by R1, without her walker:At 8:17 p.m., R1 attempted to open the stairwell door immediately to the right of the fourth-floor door. Nursing assistant (NA)-B was observed to redirect R1 and reset<br>(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 |
|---|---|---|

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | the alarm.At 8:20 p.m., R1 turned the doorknob for the stairwell door. NA-B redirected R1 from the door and reset the door code.At 9:06 p.m., R1 pushed on the fourth-floor door and was redirected from the door.At 9:19 p.m., R1 pushed on the fourth-floor door and was redirected by NA-B. NA-B reset the alarm.At 10:29 p.m., R1 pushed both exit doors. RN-B reset the alarm and staff redirected her.At 10:45 p.m., R1 walked out the fourth-floor door. No staff were present. A police report indicated the initial call to 911 was at 11:58 p.m., on 3/7/26. The report indicated R1 was not dressed for the weather and was wearing all black. The police report indicated another caller from a home approximately 5 blocks from the facility reported a person matching R1's description was knocking on the door, yelling please help, and attempting to pull on the door latch. The police located R1 at the residence at 12:06 a.m., on 3/8/26. R1 appeared confused and was sent to the hospital for evaluation. Hospital documentation from the emergency department, dated 3/8/26, indicated R1 was admitted to the emergency department at 12:51 a.m., and was discharged in stable condition at 6:05 a.m., without injuries or medical concerns. Weather report on 3/12/26 from wunderground.com indicated the temperature was 32 degrees Fahrenheit with eight mile per hour winds at 10:45 p.m. R3's elopement assessment, dated 2/10/26, indicated she was an elopement risk, was confused and asked to go home. R3's care plan, dated 2/10/26, indicated she was exit-seeking upon admission, and she was disoriented to time, place, and person. She had a wander device on her left wrist. The care plan lacked staff supervision and individualized interventions. The care plan directed staff to monitor and document for exit seeking behavior, wander device in place, door alarms answered promptly and invite resident to activities. The facility NA care sheet did not indicate R3 was an elopement risk and lacked interventions to prevent elopement. R4's quarterly MDS, dated [DATE], indicated he had a diagnosis of dementia and severe cognitive impairment. He required supervision to walk with his walker for ambulation. R4's elopement assessment, dated 1/26/25, indicated he was at risk for elopement. R4's care plan, dated 9/22/25 indicated he was an elopement risk and had a wander device on his right hand. The care plan lacked staff supervision and individualized interventions. The care plan directed staff to monitor and document for exit seeking behavior, wander device in place, door alarms answered promptly and invite resident to activities. The NA care sheet indicated R4 had a wander device but lacked interventions to prevent elopement. R5's quarterly MDS, dated [DATE], indicated she had diagnoses of breast cancer, dementia, and moderate cognitive impairment. She could ambulate with supervision. R5's elopement assessment, dated 1/26/26 indicate R5 was at risk for elopement. R5's care plan, dated 10/28/24 indicated she was at risk for elopement due to acute encephalopathy and confusion. She had a wander device in use. The care plan lacked staff supervision and individualized interventions. Staff were to monitor and document for exit seeking behavior, wander device in place, door alarms answered promptly and invite resident to activities. The facility NA care sheet did not indicate R5 was an elopement risk and lacked interventions to prevent elopement. During an interview on 3/12/26 at 11:46 a.m., nursing assistant (NA)-A, an agency NA, stated it was her first shift at the facility. She was not alerted to any residents who were at risk to wander or elope. NA-A stated she had a sheet to reference each residents' needs, but the sheet did not indicate elopement risks. During an interview on 3/12/26, at 12:00 p.m., NA-B, an agency NA, stated it was her first shift at the facility. She was not alerted to any residents who were at risk to wander or elope. NA-B stated her care sheet did not indicate any residents at risk for elopement. During an interview on 3/12/26, at 12:05 p.m., the social service designee (SSD) stated R1's physical condition improved quickly. The elopement assessment on 3/3/26 was conducted when R1 was observed halfway out the door, stating she wanted to go home, and the wander device was initiated at that time. SSD stated R1 also made attempts to leave via the elevator as well, stating she wanted to go home. During an interview on 3/12/26, at 12:25 p.m., licensed practical nurse (LPN)-A stated he was aware of the residents who were at risk for elopement. He was responsible to ensure the wander device was in place and check the expiration date every day but was not responsible for checking the functionality of the device. He stated the nurse managers (NM) were responsible for determining whether the device was working<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | correctly. During an interview on 3/12/26, at 12:38 p.m., NM-A stated the nurses on the floor were responsible to test the wander device by bringing the test box to the resident every day on the day shift. She was responsible for replacing the device before the expiration date. NM-A stated the NA's received a care sheet at the start of their shift that indicated which residents were an elopement risk and how to care for them. During an interview on 3/12/26, at 1:05 p.m., NA-C, an agency NA stated it was her first shift at the facility. She received an orientation to the facility; it did not include which residents were at risk for elopement. She stated she received a care sheet indicating what each resident requires, but it did not include elopement risks. During an interview on 3/12/26, at 1:37 p.m., registered nurse (RN)-A stated she worked 3/7/26 in the evening before R1 eloped. RN-A stated the staff watched R1 closely and redirected her but did not implement any formal interventions, other than the wander device. During an interview on 3/12/26, at 2:31 p.m., RN-B stated she was working when R1 eloped and realized R1 was missing as she was giving report to the nurse for the night shift. R1 was wandering earlier in the evening and attempted to elope twice through the door and through the elevator during her shift. RN-B stated, it wasn't any problem, as R1 was able to be redirected. She did not implement additional interventions for R1 as she had a wander device in place and only the NM or director of nursing (DON) could make care plan changes. RN-B stated she was not advised that R1 had multiple attempts to leave the facility that evening. During an interview on 3/12/26, at 2:25 p.m., NM-B stated R1 had been escalating in the days prior to her elopement and was much more agitated and confused, setting off the wander alert system several times on 3/7/26 from approximately 10:00 a.m. to 2:00 p.m. NM-B stated additional supervision for residents should have been added to the care plan. She stated residents at risk for elopement should be noted on the care sheets provided to the NA's. NM-B stated R3's elopement risk was not indicated on the care sheet. NM-B also stated the nurses were expected to ensure placement of the wander device each shift and test the device on the day shift. During an interview on 3/12/26, at 3:10 p.m., the DON stated R1's physical condition progressed quickly, from being non-ambulatory to walking independently. R1 had not been exit-seeking prior to her elopement incident on 3/7/26. R1's wander device alerted when she walked too close to the sensors on the elevator as her friends left. The DON stated she expected the nurse would have called her that evening, when R1 made multiple attempts to exit the facility and interventions would have been established. There was a list of residents identified as elopement risks at each nursing station. The NA care sheets should have indicated which residents were at risk to elope. All nurses could make changes to the care plan. The wander device was expected to be checked for proper function daily. Immediately following the elopement incident, the code alert system and automatic locking doors were tested. The DON stated education related to the elopement policy and one-to-one resident supervision was reviewed with all staff. During an interview on 3/12/26, the administrator stated the code alert system and automatic locking doors were tested multiple times following R1's elopement incident and a technician came to the facility but was unable to determine why the system did not alert when R1 eloped. She stated she was unaware of R1's increased exit-seeking behaviors prior to her elopement. During an interview on 3/13/26, at 9:28 a.m., NA-D stated he was working directly with R1 on the evening of 3/7/26. R1 was acting differently on 3/7/26, as she wandered room to room, called the police, and was trying to get out. He stated he redirected her away from the doors multiple times and notified RN-B of this. The immediate jeopardy that began on 3/7/26 was removed on 3/17/26, when the facility audited the care plans of residents identified as elopement risks, provided education to staff regarding the elopement policy, elopement assessments, one-to-one supervision, every 15-minute safety checks, wander device management, development and implementation of individualized care plans with interventions including supervision for residents at risk for elopement but noncompliance remained at a lower scope and severity level 2, D isolated scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy because removed the likelihood of serious harm, injury, impairment, or death. A facility document, Elopement Policy, dated 11/2025, directed staff to<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | establish a process to check the bracelet alarm/device batteries according to the manufacturer's directions. The Code Alert Wander Management Transmitters User Guide directed transmitters must be tested at least weekly to verify proper operation. |

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| F 0729<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining.<br><br>Based on interview and document review the facility failed to ensure competency evaluation on the Minnesota Nursing Assistant Register for 1 of 1 nursing assistants (NA)-A) reviewed for registry verification. This had the potential to affect all 71 residents at the facility.Findings include: On 3/12/26 at 11:46 a.m., (nursing assistant) NA-A stated it was her first shift at the facility. The facility schedule, dated 3/12/26, indicated NA-A was assigned to work the day shift on the third floor, for 7.5 hours. The facility resident list indicated 26 residents were living on the third floor and a total of 71 residents in the facility, as of 3/12/26. The Minnesota Nurse Aide Registry Search, dated 3/13/26 at 11:45 a.m., provided by the facility, indicated NA-A was inactive since 12/7/24. On 3/12/26 at 3:30 p.m., the director of nursing (DON) stated she trusted the staffing agency sent them only staff on the registry. Further, she stated the facility did not verify an active status for agency staff. On 3/12/26 at 3:32 p.m., the administrator stated their process did not include verifying current certification of agency aide. She stated she expected only currently certified NA's would be sent. A facility policy was requested but not provided. |

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| F 0838<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.<br><br>Based on interview and document review the facility failed to ensure the facility assessment included the required components of a plan for recruitment and retention of staff. This had the opportunity to affect all 71 residents.Findings include: Review of the facility assessment, dated 12/17/25, failed to include a plan to maximize recruitment and retention of direct care staff. It also lacked a contingency plan for events that did not require activation of the facility's emergency plan, but had the potential to affect resident care, such as availability of direct care nurse staffing or other resources for resident care. On 3/13/26 at 3:32 p.m., the administrator stated they had a plan to recruit staff; however, it was not included in the facility assessment document. She stated the facility assessment did not include a plan for staff retention or a plan to address direct care staffing outside of the facility's emergency plan. A policy regarding the facility assessment was requested but not received. |