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 07/28/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44651 Based on observation, interview, and document review, the facility failed to ensure timely assistance with incontinence care when requested to promote dignity for 1 of 1 residents (R41) reviewed for dignity. Findings include: R41's quarterly Minimum Data Set, dated dated dated [DATE], indicated R41 was cognitively intact, had diagnoses of kidney failure, anxiety, and depression, was frequently incontinent of urine and bowel, and fully dependent on staff for toileting needs. R41 was able to understand and was easily understood. R41's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 3/18/24, identified R41 as incontinent of bowel and bladder, dependent on staff for toileting, did not transfer to the toilet, and wore a brief on check and change due to mobility. R41 was at risk for skin breakdown. R41's care plan dated 4/11/24, included R41 was incontinent of bladder, used disposable briefs, and instructed staff to offer R41 assistance to check and change upon rising, before and after meals, at night, and as needed for incontinence. The care plan identified staff were to provide CARES IN PAIRS ONLY, assist of two staff with checking and changing, and R41 will let staff know when [they] need to be changed. During continuous observation on 7/24/24, the following occurred: -At 11:05 a.m., R41 stated staff had not yet changed their incontinent brief that morning and they were wet. R41 turned on their call light for assistance. -At 11:06 a.m., trained medication aide (TMA)-A entered R41's room and R41 stated they needed to be changed. TMA-A left the room and walked toward the nursing desk. -At 11:08 a.m., TMA-A returned to R41's room, told R41 another person was coming, turned off the call light, and left the room. -At 11:37 a.m., two aides began transporting residents to the dining room for lunch. (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

Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

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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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 12:05 p.m., nursing assistant (NA)-A and NA-B approached R41's room and then stepped away. They returned at 12:08 p.m., donned gowns and gloves, knocked on R41's door, and entered the room to change R41's incontinence brief. During interview on 7/24/24 at 12:29 p.m., NA-A stated they did the best they could to attend to everyone's needs timely. During interview on 7/24/24, at 12:35 a.m., TMA-A stated they told NA-B R41 needed to be changed, however NA-B was working with another resident and two NAs were on break. During interview on 7/24/24 at 12:39 p.m., NA-B stated they were with other residents when TMA-A told then R41 needed to be changed and could not attend to R41 right away. During interview on 7/24/24 at 12:45 p.m., R41 stated it made them feel hot and forgotten when they had to wait so long for help, and it happened often. During subsequent interview on 7/24/24 at 1:33 p.m., TMA-A stated R41 required two staff to provide cares and TMA-A could not care for R41 alone, which delayed care. They stated they tried to put themselves in the residents' place and would feel 'really bad' if they had to wait an hour to be changed out of a wet brief like R41 did. During interview on 7/24/24 at 1:50 p.m., registered nurse (RN)-A stated any staff person could respond to call lights, and if they could not provide what the resident needed, they were expected to leave the light on and pass a message to someone who could appropriately addressed the resident's concern. The light should not be turned off until the resident's needs were met. They indicated staff should respond as soon as possible and did not identify an acceptable response time, however indicated an hour wait to have a brief change could impact a resident's sense of dignity and was not good. During interview on 7/25/24 at 10:51 a.m., director of nursing (DON) stated staff should respond to call lights in under 15 minutes, depending upon the situation, and the light should be left on until the resident's needs have been met. They stated waiting for care was challenging for the resident and the staff did everything possible to provide care, however DON would not like to be left for that extended period from a dignity perspective. The Resident Rights Policy dated 1/24, included it is the practice of the facility to uphold the rights of all residents as outlined in the Combined Federal and State [NAME] of Rights. The Combined Federal and State Resident [NAME] of Rights dated 6/18/19, included the resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. The resident has a right to be treated with respect and dignity.

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44651 Based on observation, interview, and document review, the facility failed to comprehensively re-assess for ability or safety, document resident education regarding risks, and care plan the self-administration of medications for 1 of 1 resident (R41) known to obtain their own medication from outside sources, who was observed to have such medications at bedside. Findings include: R41's quarterly Minimum Data Set (MDS) dated [DATE], included R41 was cognitively intact, had diagnoses of dysphasia (difficulty swallowing), malnutrition, attention deficit hyperactivity disorder, depression, and anxiety, and required set-up or clean-up for eating. R41's care plan dated 4/10/24, included R41 completed a risk/benefit form due to their desire to continue and inappropriate diet and unwillingness to elevate the head of the bed to prevent aspiration. A care plan intervention dated 12/6/22, indicated R41 required assistance to eat but refused. R41's MHM Self Adminsitration of Medication Evaluation dated 10/2/23, indicated R41 was capable of self-administering oral, topical, and opthalmic medications. R41's medical record lacked additional assessments. R41's Order Summary Report dated 7/25/24, included: *Guaifenesin Extended Release (ER) Tablet (and expectorant), 600 milligram(mg), give 600 mg by mouth two times per day for abnormal amount of sputum starting 5/31/24. *DO NOT LEAVE MEDICATION IN ROOM!! Every shift for Medication safety starting 7/9/24. During observation on 7/22/24 at 4:22 p.m., two staff entered R41's room to assist with cares. They emerged at 4:37 p.m. During observation and interview on 7/22/24 at 5:10 p.m., R41 was lying in bed with a tray table over their bed covered in various items. On the front side closest to the resident was a bottle of guaifenesin 400 mg, and a bottle of eye drops. In a container toward the center of the table was a nearly empty bottle of nystatin powder, and a bottle of ear wax remover. R41 indicated they were kept there for her use. The eye drops, ear wax remover, and nystatin bottle labels appeared older and slightly worn. The guaifenesin bottle appeared to be less so. During interview on 7/24/24 at 10:29 a.m., registered nurse (RN)-B stated a resident needed to be assessed for safety and have a provider order prior to being able to keep medications at bedside to ensure they knew when and how to use them and avoid potential complications. During observation on 7/24/24 at 10:59 a.m., one bottle of guaifenesin, one bottle of eye drops, and one bottle of ear wax remover and one bottle of nystatin remained situated on the top of R41's bedside table. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 7/24/24 at 11:06 a.m., trained medication aide (TMA)-A entered R41's room to respond to their call light. TMA-A stood next to R41's bed and tray table, with R41's medications within sight approximately 12 inches from where TMA-A was standing. TMA-A left the room and returned, once again standing next to the medications on R41's table. During observation on 7/24/24 at 12:08 p.m., nursing assistant (NA)-A and NA-B entered R41's room to assist with cares. NA-A stood next to R41's bed and moved the table containing the medications to the side. Cares were provided, and at approximately 12:25 p.m., the table with the medications was moved back within reach of R41. During interview on 7/24/24 at 1:50 p.m., registered nurse (RN)-A stated if a resident wished to self-administer medications, staff completed an assessment, observed the resident taking the medications to ensure they were safe, educated the resident, and informed the provider to obtain an order. The resident would be reassessed annually or with a significant change. R41 kept nystatin and a mentholated ointment in their room for their use. When asked about the instructions to not leave medications in R41's room, RN-A stated it was to direct the nursing staff to ensure R41 took their prescribed oral medications while the nurse was in the room because R41 could choke on them since she preferred to lay in bed and not sit upright. RN-A stated R41 should not have anything like Tylenol or other pills sitting around for safety purposes, however R41 had a track record of ordering her own medications, or having friends bring them in. They indicated staff, including nurses and social services, were in R41's room quite often, and RN-A expected staff to notice if there were bottles of pills on the table. RN-A walked to R41's room and verified the presence of the bottle of guaifenesin and removed it from the room. The bottle had been opened and was approximately 3/4 full of large white pills approximately 1/2 inch long. RN-A confirmed they were a potential choking hazard for R41, however was not concerned with the other medications in R41's possession. During interview on 7/25/24 at 10:51 a.m., director of nursing (DON) stated if a resident wanted to self-administer medications or was found to have outside medications in their possession, a nurse completed the self-administration assessment, watched the resident demonstrate their ability to take them safely, and if successful, informed nurse practitioner so they could place an order. The care plan would then be updated to indicate which medications the resident could self-administer. DON stated the instructions to ensure medications were not left in R41's room were to ensure the nurses watched R41 take them and did not apply to creams or powders. DON stated sometimes R41 ordered her own medication from outside sources, and their personal assistant also brought items in. They indicated it was within R41's rights, and the DON was not authorized to see what R41 had in their possession. While R41 tended to hoard items in their room, DON stated if they noticed medications out in plain view, they would ask the resident if they could take it. The stated R41 would likely tell them it was none of their business and kick staff out of the room. DON stated they were not aware R41 had the guaifenesin in their room. They confirmed R41 had not been recently assessed for safe self-administration of medications, did not have a risk/benefit discussion documented regarding outside medications, and expressed concern regarding possible interactions between the prescribed medication given by staff and those obtained by the resident and self-administered. (continued on next page)

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	245417	A. Building B. Wing	07/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Self-Administration of Medications policy dated 2/24, included, as part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. The decision that a resident can safely self-administer medications is re-assessed periodically based on changes in the resident's medical and/or decision-making status. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party.

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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** 44651 Based on observation, interview, and document review, the facility failed to comprehensively assess and monitor non-pressure related skin conditions for 1 of 2 residents (R40) reviewed for skin concerns, and failed to monitor resident weights for 1 of 1 residents (R40) reviewed who took a diuretic and had a history of weight fluctuations. Findings include: R40's quarterly Minimum Data Set (MDS) dated [DATE], identified R40 was cognitively impaired, had a diagnoses of alcohol use disorder, depression, and cellulitis, was incontinent of bowel and bladder, and required supervision for walking and toileting. R40's hospital discharge note dated 6/11/24, identified R40 was admitted to the hospital through the emergency department on 5/31/24, with severe dehydration, nausea, vomiting, diarrhea, shortness of breath, low blood pressure and high heart rate. Their weight at hospital admission on 5/31/24 was approximately 188. 5 pounds. R40's hospital nutrition assessment date 6/5/24, included R40 weighed approximately 188.5 pounds on 5/31/24, and 246 pounds on 6/4/24, with the increase due to fluid gains. The note identified open abrasions to the right knee and both right and left cheeks. R40's care plan dated 6/11/24, included R40 had an alteration in skin integrity and instructed staff to monitor skin integrity daily during cares, complete a weekly skin inspection by nurse, treat open areas per order, and perform weekly measurements and assessments of wound(s). R40's nutritional care plan included a goal to maintain adequate nutritional status. R40's Nutrition Care Area Assessment (CAA) dated 6/18/24, identified refer to nutrition evaluation. The Pressure Ulcer/Injury CAA included R40 was at risk for skin injury with contributing factors of weakness, pain, decreased mobility, and weight loss complicated by incontinence. R40's MHM Clinical Nutrition Evaluation V-5 dated 7/18/24, indicated R40's most recent weight was 188 pounds, and usual body weight was 220 pounds. R40 lost 5 percent (%) or more in the past month or 10% or more during the past six months and was not on a prescribed weight loss regimen. The evaluation included R40 had no skin conditions, and staff were to monitor and document meal intakes and obtain weight per policy, and dietician to follow up as needed with changes in meal intakes, weights, and skin. R40's Order Summary Report dated 7/25/24, included: Furosemide (a water pill) 40 milligrams (mg) daily for congestive heart failure starting 6/11/24 Obtain admission weight on 6/11/24 Weekly skin inspection by licensed nurse every Tuesday starting 6/11/24 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hydrocortisone External Cream 1%, apply to skin as needed for skin rash, Apply to perineum affected area starting 7/15/24 Hydrocortisone External Cream 1%, apply to skin two times per day for skin rash for 10 days, Apply to the perineum affected area of the skin two or three times per day as needed. The report lacked orders for R40's weight monitoring. R40's Weight Summary identified they weighed 188.5 pounds on 6/11/24 and 201.4 pounds on 7/24/24. There was no other evidence of weights in the medical record. R40's MHM Weekly Skin Inspection V-4 forms included the following: 6/11/24 and 6/18/24, lacked identification of open sores and/or scabs. 7/2/24 at 2:13 p.m., included R40 had scarring on their face, arms, and legs from picking themselves, and lacked further assessment of those areas. 7/2/24 at 5:35 p.m., included R40 had Rashes all over the body. 7/16/24, lacked identification of sores. 7/17, included R40 minimized picking their skin. 7/23/24, lacked identification of sores. During observation and interview on 7/22/24 at 2:07 p.m., R40 was seated on the side of their bed wearing a T-shirt and incontinence brief. R40 had numerous scabs and open sores on both arms, both legs, and their face, with a large one approximately 1 centimeter (cm) by 1 cm on their right cheek. R40 stated they had always had skin issues their whole life and had a nervous thing with picking, but it had gotten ten times worse due to anxiety. They indicated they had some prescription medication to help with it. During interview on 7/24/24 at 10:18 a.m., nursing assistant (NA)-C stated the aides informed the nurses of any new or concerning skin issues and the nurse would come to assess and measure the area of concern. NA-C indicated R40 picked at their skin and had numerous scabs and thought it might be improving but was unsure. During interview on 7/24/24 at 10:29 a.m., registered nurse (RN)-B stated the nurses completed weekly skin checks, and if new skin concerns were identified, including sores, scabs, and scratches, they completed a risk management form, measured the area, wrote a note in the chart, and let the nurse manager know so they could take photos and monitor. They indicated they did not work at the facility often and didn't know anything about R40's open sores other than they apply a cream. and indicated if wound documentation was not in the chart, they were not sure if it was being monitored. They stated if they noticed a new skin concerns, they would monitor it to identify if it was getting bigger and determine if a new treatment was required or identify any infection. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 7/25/24 at 8:39 a.m., RN-C stated the facility had a lot of agency staff, and the residents saw different staff every day. They indicated R40's wounds were in the process of healing. Upon review of R40's medical record, RN-C confirmed there was no documentation regarding the sores on R40's face, arms, and legs, and when asked how they determined if they were improving or getting worse, they stated they just knew by observing them and passed the information to other staff through report. RN-C was not sure how agency staff would be able to determine if they were new, improving, or becoming worse without any previous documentation. Regarding weights, (RN)-C stated staff did not obtain R40's weight at admission and afterward because R40 could not sit in a chair or stand when they first arrived. They confirmed R40 should have been weighed weekly or monthly, however R40 was admitted by agency staff who did not enter the order for weights, which did not trigger staff to obtain them. They stated if nothing else, staff should have documented a reason for the lack of weights. During interview on 7/25/24 at 8:47 a.m., nurse practitioner (NP) stated the dieticians followed the resident weights closely and they provided updates about weight gain or loss. NP indicated R40 was taking furosemide, confirmed there was no specific order for weights, and stated it was important to monitor weights for R40 due to diagnoses and medications. In addition, NP stated it was important to regularly assess skin and document findings regularly. During interview on 7/25/24 at 9:31 a.m., dietician (D) stated residents were expected to be weighed according to provider orders, but at least monthly. If a resident triggered for significant weight gain or loss their name would appear on a list and the dietician would complete an assessment and document interventions. They indicated if a resident refused to be weighed the staff used the most recent hospital weight until another could be obtained. Upon review of R40's medical record, D confirmed R40 should have been weighed at least monthly, however since there was one recorded early in June and again late July, they would consider that adequate. They verified R40 had a weight increase of 13 pounds and were unable to find evidence the dietary department had been informed. They indicated they needed to assess R40 to determine the cause and implement appropriate interventions based upon their medical status, but assumed if R40 needed to be weighed more often there would have been an order for it. During interview on 7/25/24 at 10:51 a.m., director of nursing (DON) stated staff obtained resident weights based upon provider orders, but at least monthly, but more often if a resident took a diuretic or had a history of weight gain or loss. They indicated monitoring was important to determine if action needed to be taken. DON stated staff completed resident skin assessments weekly and documented any scratched, sores, bruise, or other skin concerns on the medical record so they could follow up and discuss with the interdisciplinary team. DON confirmed R40 had multiple sores on their body, the NP was aware, and R40 had a prescription cream to treat them, however the medical record lacked documentation. They indicated it was important to monitor to determine if they needed to change the treatment course. The Skin Assessment and Wound Management policy dated 3/124, included when a significant alteration in skin integrity is noted staff would initiate skin and wound evaluation and update the care plan. The Weight Protocol policy (undated) indicated all residents are weighed by nursing staff at a minimum of daily upon admission for three days, then weekly for four weeks, then monthly thereafter.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Based on observation, interviews and document review, the facility failed to ensure that residents received proper follow-up recommendation for hearing assistive devices to maintain hearing abilities for 1 of 1 residents (R12) reviewed for hearing services. Findings include: R12's quarterly Minimum Data Set (MDS) dated [DATE], indicated she had intact cognition, had no rejections of care or rejections of evaluation of care, and had diagnoses of Alzheimer's dementia, anxiety, and high blood pressure. R12's Care Area Assessment (CAA) for communication dated 7/21/23, identified R12 appeared hard of hearing but did not wear hearing aids. The CAA indicated R12 was at risk for mixed messages. A hearing and vision assessment dated [DATE], identified R12 had adequate hearing and did not wear hearing aids. R12's care plan lacked documentation of communication needs. An audiology (hearing) provider progress note dated 2/12/24, identified an order for a medical consult to obtain medical clearance for hearing aids. A provider progress note dated 3/4/24, identified under the assessment and plan header for health maintenance, audiology exam on February 12, 2024 revealed mild to severe sensorineural hearing loss in the right ear and moderate to profound sensorineural hearing loss in the left era. Hearing aids were recommended, and are currently pending. A provider progress note dated 4/29/24, indicated under the assessment and plan header for health maintenance, audiology exam on February 12, 2024 revealed mild to severe sensorineural hearing loss in the right ear and moderate to profound sensorineural hearing loss in the left era. Hearing aids were recommended, and are currently pending. A provider progress note dated 5/23/24, indicated under the assessment and plan header for health maintenance, audiology exam on February 12, 2024 revealed mild to severe sensorineural hearing loss in the right ear and moderate to profound sensorineural hearing loss in the left era. Hearing aids were recommended, and are currently pending. On 7/22/24 at 2:32 p.m., R12 stated she saw an in-house audiologist quite some time ago and they recommended hearing aids. R12 stated those had not been delivered. R12 was observed turning her head so her ear was towards the surveyor's mouth when the surveyor was asking questions as well as watching the surveyor's mouth. R12 stated she's had a more difficult time hearing people as she's aged. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 7/24/24 at 12:41 p.m., the medical records (MR) staff explained if a resident received an order for hearing devices that required medical clearance, a medical doctor needed to sign off on the order first. The MR staff stated the audiology staff typically emailed the list of residents that required medical clearance about a month after the appointment. The MR staff stated R12's family member called social services (SS) and inquired about the hearing aids, and SS reached out to MR. When asked when the notification for R12's medical clearance request came in, the MR staff stated, they must have missed it in between when they sent the email and when R12's family reached out to SS. The MR staff stated R12's medical clearance request was sent to her provider on 7/16/24 and routed to her medical doctor on 7/18/24. The MR staff stated the communication between the audiology staff and the facility was problematic and stated they could improve their process. The MR staff stated nurse managers reviewed all progress notes for further recommendations and to ensure there were no missed orders. During interview on 7/25/24 at 9:54, SS confirmed R12's family member called to ask about the status of her hearing aids. SS could not remember what date the family member called, but stated the information was passed along to MR. During interview on 7/25/24 at 11:15 a.m., registered nurse (RN)-A confirmed nurse managers reviewed progress notes to ensure there were no missed orders. RN-A stated MR would be responsible for taking care of in-house provider orders, such as audiology. RN-A stated when staff received new orders from a provider, it was expected to be acted upon immediately. RN-A stated the audiology staff typically worked directly with the MR staff during and after visits, and if a progress note or after-visit summary (AVS) was uploaded into a resident's electronic health record (EHR), the implication was the orders had been reviewed. RN-A verbalized being unsure what the delay was between R12's audiology visit and requesting medical clearance for the recommended hearing devices, but stated the expectation would be to document the delay, and what was being done and to update the provider, resident, and representative(s). RN-A stated the clinical significance was that R12 may not be able to hear, and her hearing loss could worsen. During interview on 7/25/24 at 11:39 a.m., the director of nursing (DON) stated in-house providers would send new orders and recommendations to the MR staff from their office after the visit. The DON stated if an order doesn't have a specific start time, the order should be processed as soon as it was received. The DON was unsure what the delay was between the order for R12's hearing aids and the request for medical clearance being sent to her medical doctor, but stated it was the facility's responsibility to ensure she could hear. A request for a facility policy pertaining to appointment follow-up or hearing and communication was requested but not received.

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 07/28/2024
NAME OF PROVIDER OR SUPPLIER The Villas at Robbinsdale		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48299 Based on observation, interview, and document review, the facility failed to ensure 1 of 3 ice dispensing machines were clean and free of excess mineral build up and cleaned on a regular schedule. This had potential to affect all residents of the nursing home, staff, and visitors who consumed food from the main production kitchen and/or ice and water from the fourth floor dining room ice machine. Findings include: During observation on 7/25/24 at 9:28 a.m., the fourth floor dining room ice and water dispenser had white, speckled, crust residue on the inside of the dispenser chutes, the drip tray, and other surfaces. During interview on 7/25/24 at 11:27 a.m., maintenance director (DOM) stated the third floor water and ice dispenser in the dining room was out of commission, and they worked on the fourth floor water and ice machine last night because the light came on which indicated it was time to complete maintenance, so DOM ordered the chemical cleaners and sanitizer to complete the cleaning. DOM stated the facility's system reminded them every month or every other month to check if the light of the water and ice dispenser was on that indicated a need for maintenance and cleaning. DOM stated they started working with the facility in March 2024, and this was the first time they would be cleaning and sanitizing the water and ice dispenser. Cleaning and sanitizing supplies were ordered and scheduled to come on 7/29/24. The machine also had a filter which needed replacement yearly to prevent sediment build-up. DOM stated staff still use the ice and water dispenser while waiting for the cleaning and sanitizing supplies and has observed the staff looking at the water which comes from the machine to make sure it is clear. During interview on 7/25/24 at 12:49 p.m., nursing assistant (NA)-C stated staff used the ice and water machine on the fourth floor today and had a cup of ice in a paper cup to give to a resident during meal service. During interview on 7/25/24 at 12:52 p.m., NA-A stated the ice and water dispenser on the third floor was not in operation and obtained ice and water from the fourth or second floor or the main kitchen brought up ice. During observation and interview on 7/25/24 at 1:44 p.m., the administrator expected maintenance to clean the water and ice machine when triggered in TELs (the facility communication system) and anytime in between when sediment visible. Administrator stated the fourth floor water and ice dispensing machine had two filters to counter the facility's hard water which caused sediment build-up every few days. One of the filters was dated 3/28/24. Admin confirmed the sediment on the fourth floor ice and water dispenser machine. It was important to clean and sanitize the machine for its appearance and cleanliness, and there were infection control concerns if not cleaned and sanitized. (continued on next page)

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	07/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at Robbinsdale	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Scotsman Ice Systems Installation and User's Manual for Meridian Ice Maker-Dispensers models dated July 2018, recommended the ice making and ice dispensing system to be cleaned at a minimum of every 6 months and a Time to Clean Light glowed after 6 months of power time. Cleaning the machine would reset the light and timer controls. More frequent cleanings were required based on mineral content of the water, run time, and airborne contamination. A work history report undated, indicated ice machines and ice bins were cleaned 5/31/24. The facility policy Sanitization dated October 2008, directed staff to wash all equipment to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions. Ice machines and ice storage containers would be drained, cleaned and sanitized per manufacturer's instructions and facility policy.