

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  04/30/2025
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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844</b></p> <p>Based on observation, interview and document review, the facility failed to follow standards of practice related to medication administration of an inhalation medication for 1 of 3 residents (R26) observed for medication administration.</p> <p>Findings include:</p> <p>R26's quarterly Minimum Data Set (MDS) dated [DATE], indicated R26 was cognitively impaired and had diagnoses which included dementia, anxiety and asthma. Identified R26 required extensive assistance with bed mobility, transfers, toileting and personal hygiene.</p> <p>R26's care plan revised 12/11/23, identified R26 had an activity of daily living (ADL) self-care performance deficit related to weakness. R5's care plan interventions included dependence on staff for bathing, dressing, and personal hygiene. Directed staff to administer medications as ordered.</p> <p>R26's Order Summary Report dated 3/13/25, directed staff to administer Budesonide inhalation suspension 0/5 MG/2 ML via nebulizer twice daily for asthma.</p> <p>During an observation on 4/28/25 at 5:10 p.m., registered nurse (RN)-A entered R26's room and placed the budesonide nebulizer solution in the nebulizer mask. RN-A placed the nebulizer mask on R26's face and informed R26 she would return in 10 minutes to remove the nebulizer mask. At 5:21 p.m., RN-A returned to R26's room, removed the nebulizer mask from R26's face and placed the nebulizer mask on the nebulizer. R26 was not observed to rinse her mouth out and RN-A had not instructed R26 to rinse mouth out after taking the Budesonide nebulizer.</p> <p>During an interview on 4/28/25 at 5:25 p.m., RN-A confirmed she had not instructed R26 to rinse her mouth after the Budesonide nebulizer. RN-A stated she should have instructed R26 to rinse her mouth however, was unsure if R26 was able to rinse and spit. RN-A stated it was important to rinse or swab the mouth after a steroid nebulizer was received to prevent any infections.</p> <p>During an observation of 4/29/25 at 4:06 p.m., nursing assistant (NA)-B placed a glass with water up to R26's mouth and instructed R26 to rinse and spit as NA-B held an empty glass up to R26's mouth. R26 took a drink of water, rinsed mouth and spit the water into the empty glass.</p> <p>(continued on next page)</p>

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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/29/25 at 4:11 p.m., licensed practical nurse (LPN)-A stated R26 had always been able to rinse and spit after receiving the Budesonide nebulizer. LPN-A stated it was important to rinse the mouth after a steroid nebulizer was received to prevent any infections.</p> <p>During an interview on 4/29/25 at 3:51 p.m., pharmacy consultant (PC)-A stated it was important to rinse the mouth after receiving Budesonide nebulizer because it was a steroid. PC-A indicated it could cause thrush, a fungal infection inside the mouth. PC-A stated it was her expectation nursing staff would instruct the resident to rinse their mouth after each use.</p> <p>During an interview on 4/29/25 at 3:51 p.m., director of nursing (DON) stated it was important for residents to rinse their mouth after use to prevent infections in the mouth. DON stated her expectation was nursing staff to instruct R26 to rinse mouth after receiving the Budesonide nebulizer.</p> <p>R26's Budesonide nebulizer box instructions indicated Budesonide was indicated for chronic respiratory conditions. Indicated Patients should rinse the mouth after inhalation of Budesonide inhalation suspension to prevent fungal infections.</p> <p>A facility policy titled Specific Medication Administration Procedures revised 2024, identified all medications would be administered in a safe and effective manner.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48583</p> <p>Based on observation, interview and document review, the facility failed to ensure staff were following fall risk interventions implemented for 1 of 3 (R41) residents identified at risk for falls.</p> <p>Findings include:</p> <p>R41's quarterly Minimum Data Set (MDS) dated [DATE], identified R41 had moderate impaired cognition and had diagnoses which included diabetes mellitus and depression. Indicated R41 required extensive assistance from staff with toileting, transfers, and personal hygiene.</p> <p>R41's care area assessment (CAA) dated 1/14/25, triggered for a risk of falls due to balance problems, use of anti-depression medications and a history of falls.</p> <p>R41's care plan dated 2/17/25, identified R41 was at risk for falls and required assistance from staff with mobility and transfers. R41's care plan indicated the call light should have been within reach. The care plan identified R41 was to have bed in lowest position, mat on floor, door open when in room, call do not fall sign posted, staff were to check on R41 and offered the bathroom between 0200-0400.</p> <p>Review of R41's MHM incident and analysis reports from 11/18/24 to 4/13/25, revealed the following:</p> <ul style="list-style-type: none"> <li>- 11/18/24, R41 had a fall from R41's bed. Interventions included R41's bed to be in the lowest position and fall mat was to be next to the bed.</li> <li>- 12/4/24, R41 was found on the floor. Interventions included R41 was to have the door open at all times for staff to monitor R41 in R41's room.</li> <li>- 2/15/25, R41 was found on the floor. Interventions included to check on R41 during the hours of 2300 and 0500.</li> <li>- 4/13/25, R41 was found on the floor and had a fall from the toilet. Interventions included R41 was to wear gripper socks at night.</li> </ul> <p>Review of Nursing assistant (NA) worksheet undated, identified staff were to check on R41 when he was in his room. However, it lacked any additional fall interventions.</p> <p>During an observation on 4/30/25 at 10:43 a.m., R41 was laying in his is bed with the door closed. R41's eyes were closed and R41 was covered up with a blanket.</p> <p>During an observation on 4/30/25 at 10:56 a.m., R41 continued the same as above.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation/interview on 4/30/25 at 11:18 a.m., registered nurse (RN)-B confirmed the above findings and stated R41's door should have been open when R41 was in the room. RN-B opened R41's door.</p> <p>During an interview on 4/30/25 at 10:23 a.m., NA-C stated NA-C was unaware if R41 had any falls recently. NA-C indicated R41 was to have his bed in low position and his mat on the floor next to the bed. NA-C indicated NA-C was unaware of any other interventions for R41.</p> <p>During an interview on 4/30/25 at 10:32 a.m., RN-C identified R41 as a high fall risk and indicated RN-C was aware of R41's fall history. RN-C stated R41's door was to be open at all times when R41 was in the room. RN-C indicated R41 liked to be in his room throughout the day</p> <p>During an interview on 4/30/25 at 11:29 a.m., director of nursing (DON) confirmed the above findings and stated fall interventions were discussed after the fall during the interdisciplinary team meeting. DON further stated her expectations were staff were to be following the resident's care plans at all times.</p> <p>Facility fall policy requested, however one was not provided.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48583</b></p> <p>Based on interview and document review, the facility failed to implement a system to ensure medications were available to administer as ordered for 1 of 1 residents (R7) reviewed for medication administration.</p> <p>Findings Include:</p> <p>R7's significant change Minimum Data Set (MDS) dated [DATE], identified R7 was cognitively intact and had diagnoses which included: asthma, chronic obstructive pulmonary disorder (COPD) (breathing difficulty) and diabetes mellitus. R7 was dependent on staff for dressing and toileting.</p> <p>R7's care plan dated 4/17/25, identified R7 was at risk for decreased cognition and physical abilities related to diagnosis of COPD and asthma.</p> <p>Review of physician orders placed on 4/17/25, revealed the following order placed:</p> <p>Anoro Ellipta (medication used for COPD) 62.5-25 micrograms (mcg) aerosol powder on puff daily.</p> <p>Review of R7's eMAR dated 4/25, revealed the following:</p> <p>-Umeclidinium Bromide Inhalation Aerosol Powder Breath Activated 62.5 MCG/ACT (Umeclidinium Bromide) 1 puff inhale orally one time a day for COPD Pharmacy Pending Confirmation (Discontinue) 4/18/2025, 08:00.</p> <p>- Anoro Ellipta 62.5-25 MCG/ACT Aerosol Powder, breath activated -</p> <p>INHALE 1 PUFF BY MOUTH ONCE DAILY *THERAPEUTIC INTERCHANGE FOR: UMECLIDINIUM Pharmacy Pending Confirmation 4/17/2025.</p> <p>Review of physician progress notes dated 1/13/25 through 4/17/25, revealed R7 was using Anoro Ellipta 62.5-25 micrograms (mcg) (medication used for COPD) . Further revalued the physician wanted R7 to continue to use the inhaler and it should have been added to R7's electronic medication administration record (eMAR).</p> <p>During an interview on 4/30/25 at 10:11 a.m., registered nursing (RN)-B indicated the order was placed into the system and it needed to be confirmed before the medication could be administered. RN-B was unaware why the medication had not yet been confirmed. RN-B confirmed R7 had not received the medication however, knew the facility had received the medication. RN-B identified the medication was in the medication cart.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/30/25 at 11:37 a.m., director of nursing (DON) revealed a therapeutic interchange for medications was completed by the pharmacy to look for the better priced medication. Once the therapeutic interchange was put to the system and a nurse confirmed it, the previous medication was expected to be discontinued. DON was unaware R7's medication had not been confirmed and R7 had not received the medication since the physician prescribed it on 4/17/25.</p> <p>During an interview on 4/30/25 at 11:56 a.m., medical director (MD) stated anytime a medication was ordered it should have been started right away.</p> <p>During an interview on 4/30/25 at 2:21 p.m., consultant pharmacist (CP) stated R7 received the new medication and it should have been confirmed in the system to be given. CP indicated the confirmation should have taken place on 4/18/25. CP indicated it was best practice to start medications as soon as possible and not to further delay treatment.</p> <p>Review of facility policy titled Medication and Treatment order revised 2/24, orders for medications and treatments would be transcribed accurately and in a timely fashion.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844</b></p> <p>Based on observation, interview and document review, the facility failed to ensure food was served at a palatable and appetizing temperature for 2 of 2 residents (R 11, and R35) who resided on the second floor reviewed for food. This deficient practice had the potential to affect all 24 residents residing on this unit.</p> <p>Findings include:</p> <p>R11's quarterly Minimum Data Set (MDS) dated [DATE], indicated R11 had intact cognition and was able to feed herself after staff set up her tray.</p> <p>R35's quarterly Minimum Data Set (MDS) dated [DATE], indicated R35 had moderate cognitive impairment and was able to feed herself after staff set up her tray.</p> <p>During an interview on 4/28/25 at 1:28 p.m., family member (FM)-A stated R35 usually ate her meals in her room and the food was usually cold by the time it was delivered.</p> <p>During an interview on 4/28/25 at 1:42 p.m., R11 stated she ate in her room and the hot food was not hot and the cold food was not cold by the time the tray was delivered.</p> <p>During an observation 4/28/25 at 6:08 p.m., food was being dished up onto plates and placed on a plate warmer from the steam table in the dining room. The plates were placed on trays and put on a cart. As the last plate was being placed onto the cart, a test tray was requested and placed onto the cart. The meal consisted of chicken, rice, mashed potatoes, and a glass of milk.</p> <p>-at 6:20 p.m., the cart was wheeled into the hallway on the second floor.</p> <p>at 6:30 p.m., as the last tray was being passed nursing assistant (NA)-A tested the food temperatures and the temps were as follows:</p> <p>-Chicken was 106 degrees Fahrenheit (F).</p> <p>-Rice was 119 degrees Fahrenheit (F).</p> <p>-Mashed potatoes were 127 degrees Fahrenheit (F).</p> <p>-Milk was 55 degrees Fahrenheit (F).</p> <p>After temping the meal, the surveyor tasted the food from the tray: the chicken and rice were cold, the mashed potatoes were luke warm and the milk was warm.</p> <p>During an interview on 4/28/25 at 6:27 p.m., NA-A stated she was unsure of what food temperatures food should be held at.</p> <p>(continued on next page)</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 4/28/25 at 6:30 p.m., R11 stated the chicken was cold and the milk was warm.</p> <p>During an interview on 4/28/25 at 6:39 p.m., dietary aide (DA)-C stated he was unsure of what the food temperatures should be held at but would find out.</p> <p>During an interview on 4/28/25 at 6:44 p.m., dietary manager (DM) stated his expectation was food holding temps for hot food would be at least 135 degrees Fahrenheit (F). DM further stated holding temperature for cold food should have been 41 degrees Fahrenheit (F). or lower.</p> <p>Review of a facility policy titled Food Preparation and Service dated revised 2019, identified the danger zone for food temperatures was between 41 and 135 degrees Fahrenheit (F). Identified the longer food remain in the danger zone the greater the risk for the growth of harmful pathogens. Therefore, PHF must be maintained below 41 degrees Fahrenheit (F). or above 135 degrees Fahrenheit (F).</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>22580</p> <p>Based on observation, interview and record review, the facility failed to ensure food items in community refrigerators were properly labeled and dated in 2 of 3 refrigerators where resident's personal food was stored. In addition, the facility failed to ensure food temperatures were maintained according to acceptable standards on 1 of 3 steam tables, and failed to maintain sanitary conditions during food prep.</p> <p><b>REFRIGERATORS</b></p> <p>During an observation on 4/28/25 at 12:52 p.m., the fourth floor refrigerator contained an undated and unlabeled plastic bag, 1/2 plastic pitcher with orange liquid, with no date, and a container of ice cream dated 3/4. The bag contained a Tupperware container. Dietary Manager (DM) verified the containers were for resident consumption and should have been dated. DM stated the juice should have been dated when it was placed in the refrigerator.</p> <p>During an observation on 4/28/25 at 12:54 p.m., the third floor dining room refrigerator contained an unlabeled, undated container of cooked pasta. The Dietary Manager verified the container was unlabeled and undated.</p> <p><b>HOLDING FOOD TEMPERATURES</b></p> <p>During an observation and interview on 4/28/25 at 5:56 p.m., dietary aide (DA)-A completed the temperatures of the food on the steam table on third floor. The chicken was 120 degree Fahrenheit (F). A recheck of the temperature was 120 degrees F. At 6:11 p.m., the dietary manager entered and asked if the temperatures were OK and DA-A answered yes. The surveyor asked the DM to look at the temperatures. The DM verified the chicken was 120 degrees F., and told DA-A that the chicken needed to be at 165 degrees F. The DM took the chicken and indicated he was going to heat it up in the kitchen, and verified that no residents had received any chicken. At 6:18 p.m., the DM returned and took the temperature of the chicken, and it was at 180 degrees F. DA-A proceeded to serve dinner.</p> <p><b>FOOD PREPARATION</b></p> <p>During an observation and interview on 4/29/25 at 10:20 a.m., DA-B was prepping fruit for lunch in the kitchen. DA-B picked up small plastic bowls for fruit and put the empty bowl on a tray. DA-B was not wearing gloves, and was observed touching the inside of every bowl with their thumb while setting on the tray. On 4/29/25 at 10:30 a.m., the DM indicated only the outside of the dish should be touched and touching the inside of the dish would contaminate it.</p> <p>Review of facility's Food Receiving and Storage policy revised 2017, indicated the following:</p> <p>8. All food stored in the refrigerator or freezer would be covered, labeled and dated (use by date).</p> <p>14. Food items and snacks kept on the nursing units must be maintained as indicated below:</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>b. All foods belonging to residents must be labeled with the resident's name, the item and the use by date.</p> <p>d. Beverages must be dated when opened and discarded after twenty-four (24) hours.</p> <p>Review of the facility's Food Preparation and Service policy dated 2019, indicated the following:</p> <p>Food Service/Distribution</p> <ol style="list-style-type: none"> <li>1. Proper hot and cold temperature are maintained during food service.</li> <li>2. The temperature of food held in steam tables are monitored throughout the meal by food and nutrition services staff.</li> </ol> <p>Review of the facility's Food Preparation and Service policy dated 2019, indicated the following:</p> <p>Food Preparation Area</p> <ol style="list-style-type: none"> <li>5. Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of food borne illness.</li> </ol>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>48583</p> <p>Based on observation, interview and document review, the facility failed to ensure soiled facility linens were handled in a manner that prevented potential contamination during the laundry process. This deficient practice had the potential to affect all 65 residents served by the facility laundry.</p> <p>Findings include</p> <p>During an observation and interview on 4/29/25 at 10:09 a.m., with laundry assistant (LA)-A, three towels and a shower curtain were observed not in a bag and laying in the bin located below the laundry chute. LA-A stated some laundry would come down the chute not bagged.</p> <p>During an interview on 4/29/25 at 10:15 a.m., environmental director (ED) confirmed the above findings and indicated soiled linens were to be placed into the bag before sending down the laundry chute. ED stated it could cause contamination and soil the laundry chute.</p> <p>During an interview on 4/29/25 at 4:15 p.m., infection preventionist (IP) stated all soiled linens should be bagged before going down the chute. LA-B further stated soiled linens could contaminate the chute and someone could be exposed to an infection. LA-B indicated she wanted staff to view infection control as a good way to prevent the spread of an infection.</p> <p>Requested facility policy for the laundry chute however, one was not provided.</p>		