

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 07/17/2026
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and document review the facility failed to ensure they had an accurate accounting of controlled substances in 2 of 2 medication carts reviewed for medication storage. Findings include: During an observation on 7/16/26 at 11:57 a.m., of the fourth-floor south medication cart with registered nurse (RN)-A a comparison of the narcotic control book and the narcotic cards was made. Page 81 carisoprodol (a prescription skeletal muscle relaxant used for the short-term relief of acute, painful muscle spasms and injuries) 250 milligrams (mg) showed there should have been one pill left in the card. RN-A was not able to find a matching card with the medication in the locked medication drawer. The last time the medication was dispensed was on 6/1/26. During an interview on 7/16/26 at 12:17 p.m., RN-A verified the count had been incorrect since 6/1/26. During an interview on 7/16/26 at 12:27 p.m., RN-D stated they control the count from the narcotic drawer by calling out the card and page number, then said it would be better to count from the book. RN-D checked the drawer and was not able to find the card to match page 81. During an observation on 7/16/26 at 12:31 p.m., the DON and RN-D performed a narcotic count using the index page to control the count. There were no corresponding cards to match the following pages: 114 Hydromorphone 2 mg (a powerful prescription opioid medication used to treat moderate to severe pain) 115 buprenorphine 2 mg (a partial opioid agonist prescribed to treat opioid disorder and to manage severe chronic or acute pain) 118 alprazolam 1 mg (benzodiazepine used to treat anxiety, panic, and anxiety caused by depression) 120 tramadol 25 mg (opioid pain medicine used to treat moderate to moderately severe pain) 129 tramadol 50 mg 130 buprenorphine 2 mg 131 oxycodone 5 mg (strong opioid pain medicine) 132 oxycodone 5 mg 133 tramadol 50 mg 134 alprazolam 1 mg 139 oxycodone 5 mg 141 butal/APAP 50-30 (prescription medicine used to treat tension headaches) 142 oxycodone/APAP 10-325 mg 143 oxycodone 10 mg 144 carisoprodol 250 mg 146 alprazolam 0.5 mg 152 oxycodone 5 mg 154 oxycodone 5 mg 155 oxycodone 5 mg 156 alprazolam 157 butal/APAP 50-325 mg 159 buprenorphine 2 mg 161 oxycodone 162 alprazolam 0.5 mg 163 buprenorphine 2 mg 165 oxycodone 10 mg 166 alprazolam 1 mg 167 alprazolam 0.5 mg During an interview on 7/16/26 at 12:41 p.m., the DON stated the facility was not following the process for narcotic counts and did not have control of their narcotics. During an observation on 7/16/26 at 12:42 p.m., the DON and licensed practical nurse (LPN)-C completed a narcotic count using the index page and found the same concern, medications listed as still current in the index page but no card to match. The [NAME] stated the narcotics had not been crossed out when they were used or destroyed. During an interview on 7/16/26 at 12:49 p.m., the DON stated narcotics should be signed into the index page and crossed out on the index page when the medication was completed or when the medication was destroyed. During an interview on 7/17/26 at 10:37 a.m., the consultant pharmacist (CP) stated she would expect staff to sign narcotics into the book using the index page. CP also stated she would expect the staff to (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 245417
		If continuation sheet Page 1 of 11

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	perform a narcotic count at each shift change using the index page of the narcotic book and if there were any discrepancies she would expect them to look into the concern immediately and resolve and or report the concern. She stated the purpose of the shift count was to ensure they maintained an accurate accounting of the controlled substances. CP stated staff should log the narcotic into the book, sign the narcotic out of the book when it was dispensed or when the narcotic was destroyed. The policy Medication Storage in the facility - controlled substance storage dated 1/2026, identified at each shift change or when keys were transferred a physical inventory of all controlled substances, including refrigerated items would be conducted by two licensed nurses and would be documented. Any discrepancies would be reported to the DON or designee immediately and every reasonable effort would be made to reconcile the discrepancy.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure the correct physician provider orders for life-sustaining treatment (POLST) were in the correct chart for 1 of 1 resident (R46) reviewed for resuscitation orders. Findings include: R46's Diagnosis Report dated [DATE], identified R46 had diagnoses which included hypo-osmolality and hyponatremia (this state causes water to shift into cells, leading to potentially dangerous cellular swelling, particularly in the brain), cellulitis of left lower limb, anxiety disorder, depressive disorder, and neoplasm of unspecified behavior of endocrine glands and other parts of nervous system. R46's quarterly Minimum Data Set (MDS) dated [DATE], identified R46 was cognitively intact. R46's Order Summary Report identified R46 had an order dated [DATE], for do not resuscitate (DNR). R46's care plan dated [DATE], identified R46 had code status identified as a problem, interventions included to arrange a medical doctor consultation as necessary, review the resident's advance directive as needed per the resident's and/or family's request, and staff were directed to follow the POLST guidelines. R46's POLST dated [DATE], identified she had checked DNR and had signed the documentation of discussion. During a record review on [DATE] at 9:32 a.m., R46's electronic medical record (EMR) banner identified R46 showed DNR. During a record review on [DATE] at 9:33 a.m., R46's EMR record showed R48's POLST had been scanned into R46's record. R48's POLST identified she wished to have cardiopulmonary resuscitation (CPR), and the documentation of discussion was dated [DATE]. During an interview on [DATE] at 9:43 a.m., R46 stated her wishes were to not have CPR. During an interview on [DATE] at 12:23 p.m., licensed practical nurse (LPN)-A reviewed R46's EMR and verified the EMR banner identified R46's was listed as DNR. LPN-A then reviewed the POLST in R46's EMR, she verified R48's POLST was in R46's EMR. LPN-A verified the wrong POLST was in R46's EMR. During an interview on [DATE] at 12:42 p.m., the director of nursing (DON) stated she had heard the wrong POLST was in R46's EMR. The DON stated having the wrong POLST in an EMR could lead to someone receiving CPR who didn't want it and the opposite someone who wanted CPR might not receive it. During an interview on [DATE] at 12:56 p.m., the DON stated the process for the POLST was to go over the resident's wishes upon admission with them, then the POLST would be completed and scanned into the EMR. The DON stated admissions or medical records would scan the document into the medical records. The POLST Documentation Procedure dated 4/2025, identified the wishes of the resident or the resident representative would be discussed and verified, an order would be obtained if needed, the order would be placed in the EMR, and the POLST document would be uploaded into the miscellaneous section of the EMR. The procedure identified a routine audit of the POLST documentation should be completed to ensure consistent and accurate documentation of the POLST form, physician orders, the care plan and entry in PCC (point click care).		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure physician-ordered monitoring for potential adverse effects related to antipsychotic medication use was completed when orthostatic blood pressures (BP) were not obtained as ordered for 1 of 5 residents (R6) reviewed for unnecessary medication use. Findings include: R6's quarterly Minimum Data Set (MDS) dated [DATE], indicated R6 was cognitively intact and required assistance with activities of daily living (ADLs). Diagnoses included dementia, bipolar, sleep apnea, hyperlipidemia, and insomnia. R6's physician orders printed 7/17/26, identified an order for risperidone Oral Tablet 0.5 milligrams (mg) by mouth at bedtime for bipolar disorder. R6's physician orders further identified an order to obtain monthly orthostatic blood pressures (lying, sitting, standing blood pressures) due to antipsychotic medication use, initiated 2/1/26. R6's electronic medical record (EMR) was reviewed from March 2026 through July 2026. May 2026 R6's lying, sitting, and standing blood pressure were all recorded as 116/68, June 2026 R6's lying, sitting, and standing blood pressure were all recorded as 111/68, and July 2026 R6's lying, sitting and standing blood pressure were all recorded as 121/68. When interviewed on 7/16/26 at 10:25 a.m. licensed practical nurse (LPN)-B stated orthostatic blood pressures were done by doing a blood pressure while the resident was lying down, leave the blood pressure cuff on. The resident should be assisted to sit on the edge of the bed with another blood pressure completed while they were sitting. Then have the resident stand up if they were able to and do a third blood pressure. When interviewed on 7/16/26 at 11:09 a.m. registered nurse (RN)-B stated orthostatic blood pressures were expected to be done monthly, RN-B reviewed R6's orthostatic blood pressures and stated there was only one blood pressure that was done and that one reading was recorded for each of the three blood pressures rather than three different readings being done in succession. When interviewed on 7/16/26 at 11:35 a.m. director of nursing (DON) stated the expectation was for the nurses to do orthostatic blood pressures once monthly with lying, sitting, and standing blood pressures being done one after the other as residents receiving antipsychotic medications have a tendency for their blood pressures to drop when they changed positions. DON stated they were not aware that the nurses were not doing the orthostatic blood pressures correctly. Facility policy regarding monitoring orthostatic blood pressures was requested, however, none was provided.		

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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** Based on observation, interview and document review, the facility failed to ensure oxygen orders were followed as written for 1 of 1 resident (R48) reviewed for oxygen therapy. Findings include: R48's admission Minimum Data Set (MDS) dated [DATE], identified R48 had diagnoses which included chronic obstructive pulmonary disease (COPD [a long-term lung condition that blocks airflow and makes it hard to breathe]), chronic pain, hypertension, and rheumatoid arthritis (a long-term autoimmune disease where the immune system attacks the lining of joints). R48's Order Summary Report identified R48 had an order for two liters of oxygen per nasal cannula continuously due to COPD related to hypoxia dated 6/16/26. R48's care plan, reviewed on 7/14/26, identified R48 had an alteration in oxygen/gas exchange, respiratory status related to chronic respiratory failure, and asthma. Interventions included the following: raise the head of the bed for comfort, monitor oxygen levels saturations as ordered and as needed, administer oxygen as ordered, monitor for cyanosis, accessory muscle use, shortness of breath, increased respirations, and difficulty coughing up sputum, and to keep the medical doctor informed of changes. During an observation on 7/13/26 at 2:36 p.m., R48's oxygen was noted to be at three liters per nasal cannula. On 7/16/26 at 8:51 a.m., R48's oxygen was observed at three liters per nasal cannula. Registered nurse (RN)-A verified the oxygen was at three liters and not at two liters as ordered. RN-A stated staff needed to follow the orders to prevent hypercapnia (a medical condition where a person would have too much carbon dioxide in their blood). RN-A stated staff should follow the orders as written and stated the day nurse said they often had to turn the oxygen down from the night shift. During an interview on 7/16/26 at 12:56 p.m., the director of nursing (DON) stated staff were expected to follow the oxygen orders as written and stated it could actually hurt a resident with COPD by giving them too much oxygen. The DON stated staff were expected to call the provider if they thought a resident needed more oxygen. The facility's Medication and Treatment Orders policy, dated 2/2024, identified medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medication in this state.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure tobacco products were maintained in a secured, locked container when not in use for 1 of 1 residents (R53) reviewed for smoking safety. Findings include: R53's quarterly Minimum Data Set (MDS) dated [DATE], indicated R53 refused to answer brief interview for mental status (BIMS) questions and was independent with activities of daily living. A previous BIMS assessment completed on 6/15/26 indicated R53 had severe cognitive impairment. R53's smoking evaluation dated 3/29/26, identified R53 as a smoker and was educated on safety and storage. The resident handled the cigarettes and lighter independently and stored them in a drawer. R53's care plan dated 4/12/26, indicated R53 currently smoked at the facility and was given a metal box for the smoking materials. The goal was R53 would follow the facility smoking policy with an intervention of risk and benefit of smoking violations, smoking assessment as needed for example if there was a change in resident's condition. The care plan also identified R53 used smokeless tobacco. R53 rolled own cigarettes and kept them in a lock box in the room. R53 was given the risks and consequences of inappropriate smoking or storage in the lock box. On 07/13/26 at 2:33 p.m., an open lock box containing loose tobacco was observed sitting on a small table next to the resident's bed. Loose tobacco was also observed on the tabletop. The lock box was wide open. At 2:36 p.m., R53 independently left the nursing unit to smoke. The opened lock box containing tobacco remained on the table next to the resident's bed. At 3:47 p.m. R53 again left the unit to smoke. The lock box remained open with tobacco accessible on the table next to the bed. On 07/14/2026 at 2:54 p.m. R53 independently left the unit, the lock box remained open on the small table with loose tobacco inside. On 07/15/2026 at 7:55 a.m., R53 was out of the room, the lock box was open on the small table next to the bed with loose tobacco inside the box and scattered across the tabletop. At 8:08 a.m. R53 was in the dining room, the lock box remained open with tobacco inside the box and scattered across the tabletop. At 2:41 p.m. R53 left the unit, the lock box remained open on the table with tobacco inside and scattered across the tabletop. On 07/16/2026 at 8:17 a.m., R53's lock box remained open on the small table with tobacco inside and a small amount of tobacco on the tabletop. During an interview on 7/16/26 at 11:00 a.m., registered nurse (RN)-C stated that residents who independently smoked were provided a lock box to store tobacco products. RN-C stated It was up to resident to lock it. RN-C further stated R53 would not allow the staff to lock the box. During an interview on 7/16/26 at 11:35 a.m., director of nursing (DON) stated smoking materials were expected to be stored in a locked drawer or a locked box when it was not in use. DON acknowledged R53 was not safely storing tobacco products and identified the potential risk of other residents accessing the tobacco products if left unsecured. The facility's Resident Smoking policy dated 11/2025, indicated if a resident identified as a current smoker the storage of supplies was determined by the facility based on the resident's smoking assessment.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure they were free of a medication error rate of five percent or greater. The facility had a medication error rate of 7.41% with 2 errors out of 27 opportunities for error involving 1 of 4 residents (R19) who were observed during the medication passes. Findings include: R19's quarterly Minimum Data Set (MDS) dated [DATE], identified R19 had diagnoses which included coronary artery disease, hypertension, diabetes mellitus, hyperlipidemia, and multiple sclerosis. R19's Order Summary Report dated 7/16/26, identified R19 had the following orders: insulin aspart (a fast-acting, man-made insulin) per sliding scale 150-199 = 8 units subcutaneously (sq) 200-249 = 10 units 250-299 = 12 units 300-349 = 14 units 350-399 = 16 units 400-999 = 18 units call provider if over 400 and administer 18 units dated 6/5/26 insulin glargine (a long-acting man-made insulin) 12 units sq two times per day dated 6/5/26 Januvia (an oral agent taken once daily to manage blood sugars) 50 milligrams (mg) by mouth one time a day dated 7/9/26 During an observation on 7/15/26 at 7:49 a.m., licensed practical nurse (LPN)-C scrubbed the hub of the insulin pen, attached an insulin needle and drew up 12 units of insulin aspart. LPN-C did not waste two units of insulin prior to drawing up the 12 units of insulin. Next LPN-C scrubbed the hub of insulin glargine, attached an insulin needle and drew up 12 units of insulin. Again LPN-C failed to waste two units of insulin prior to drawing up the insulin. During an interview on 7/15/26 at 8:06 a.m., LPN-C verified she did not prime the insulin needles prior to drawing up the insulins, stating a prior nurse manager had told her it was not necessary. During an interview on 7/15/26 at 8:38 a.m., the director of nursing (DON) stated she expected nurses to prime the insulin needles with two units of insulin prior to drawing up the insulin dose to ensure the resident received the full dose as ordered. During an interview on 7/15/26 at 9:05 a.m., the consultant pharmacist (CP) stated in general the insulin needle should be primed with two units of insulin to push air out of the needle to ensure the resident received the ordered dose of insulin. The Medication and Treatment Orders policy dated 2/2024, did not address priming insulin needles.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and document review, the facility failed to ensure the medication refrigerators in 2 of 2 medication rooms were at the proper temperature for medication storage. Findings include: During an observation on 7/16/26 at 10:58 a.m., with the director of nursing (DON), the refrigerator in the second-floor medication room had a temperature reading of 30 degrees Fahrenheit (F). A review of the July temperature log identified eight of the recorded temperatures were below 36 degrees F. A copy of the July temperatures was requested but not provided. The refrigerator contained the following: Lantus insulin (a long-acting basal insulin to treat type 1 and type 2 diabetes) Novolog insulin (a rapid-acting insulin used to control high blood sugars) Latanoprost eye drops (used to treat high pressure inside the eye) Timolol eye drops (used to treat high pressure inside the eye) Formoterol (bronchodilator used to treat chronic obstructive pulmonary disease and asthma) Methylprednisolone (corticosteroid used to suppress the immune system and reduce severe inflammation in conditions like arthritis, asthma, severe allergies, and flare-ups of multiple sclerosis) Bisacodyl suppositories (a fast-acting, rectal stimulant laxative to treat occasional constipation). During an observation and interview on 7/16/26 at 11:16 a.m., with the DON of the fourth-floor medication room, the medication temperature reading was 39 degrees F. There were no temperatures recorded for July. A request for the past three months of temperatures was requested but not provided. The refrigerator had insulins, emergency kits and inhalers. A copy of the contents was requested but not provided. The DON stated staff were expected to record the medication refrigerators daily and to report any concerns if the temperature was out of the safe range. During an interview on 7/16/26 at 11:27 a.m., the consultant pharmacist (CP) said the facility needed to check the manufacturer's directions for each medication to determine if it was still viable and would consider the last recorded temperature out of range to be when the medication was no longer considered to be refrigerated. The CP stated they would expect the facility to take corrective action when the temperature was out of the safe temperature range. The facility's Medication Storage policy, dated 1/2026, identified the refrigerator temperature should be maintained between 36 degrees to 46 degrees F.		

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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** Based on observation, interview and document review, the facility failed to ensure staff wore appropriate personal protective equipment (PPE) prior to entering 1 of 1 resident's (R48) room who was in contact precautions. Findings include: R48's admission Minimum Data Set (MDS) dated [DATE], identified R48 had diagnoses which included chronic obstructive pulmonary disease (COPD [a long-term lung condition that blocks airflow and makes it hard to breathe]), chronic pain, hypertension, and rheumatoid arthritis (a long-term autoimmune disease where the immune system attacks the lining of joints). R48's Order Summary Report identified R48 had an order for contact precautions dated 7/14/26. R48's care plan, reviewed on 7/14/26, identified R48 had isolation precautions related to left hand ring finger abscess initiated on 7/14/26. The goal was listed as All staff to follow isolation precautions. Interventions included to follow infection control precautions, and to place a sign on the resident's door. During an observation on 7/14/26 at 2:01 p.m., a staff was observed standing by R48's bed, staff were not wearing any personal protective equipment (PPE). During an observation on 7/15/26 at 12:39 p.m., nursing assistant (NA)-A was observed delivering a meal tray to R48, they were not wearing any PPE. During an interview on 7/15/26 at 12:43 p.m., NA-A stated when someone was in contact isolation staff should wear an isolation gown and gloves whenever they entered the room. NA-A verified they did not do this when they delivered the meal tray and situated R48 for lunch. During an interview on 7/16/26 at 9:41 a.m., the infection preventionist (IP) stated staff were trained on isolation precautions on hire, annually, and when there were changes. IP stated staff were expected to read the isolation sign posted on the door and to follow the directions on the sign. During an interview on 7/16/26 at 12:56 p.m., the director of nursing (DON) stated staff were expected to gown and glove every time they entered a resident's room if the resident was in contact isolation. The DON stated this was important to do to prevent the spread of infection. The sign Contact Precautions, undated, identified staff must put on gloves and gloves before entry into the room. The facility's Infection Prevention and Control - Contact Precautions policy, dated 7/31/23, identified healthcare personnel caring for residents in contact precautions should wear a gown and gloves for all interactions that may involve contact with the resident.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure 2 of 5 residents (R6, R46) reviewed for immunizations were offered and/or provided the pneumococcal vaccination series as recommended by the Centers for Disease Control (CDC) to help reduce the risk of associated infection(s). Findings included: A CDC Pneumococcal Vaccine Timing for Adults feature, dated 3/2025, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over [AGE] years old had received no prior pneumococcal vaccine should receive PCV20 or PCV21, those who had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after [AGE] years old. R6's face sheet dated 7/17/26, indicated R6 was [AGE] years old. The immunization report dated 7/17/26, indicated R6 received a PPSV23 on 8/1/07 followed by PCV13 on 10/17/14. The record lacked evidence of shared clinical decision making with the physician for PCV20 at least 5 years after the last pneumococcal dose. The record lacked evidence that R6 was offered or received PCV20. R46's face sheet dated 7/17/26, indicated R46 was [AGE] years old. The immunization report dated 7/17/26, indicated R46 received a PPSV23 on 10/18/22. The record lacked evidence of shared clinical decision making with the physician for PCV20 at least 5 years after the last pneumococcal dose. The record lacked evidence that R6 was offered or received PCV20. During interview on 7/15/26 at 8:28 a.m. registered nurse (RN)-B stated when a resident admitted they looked at immunizations the resident had already received. If the resident was eligible for a vaccine, the resident was talked to regarding which vaccinations were due and obtained consent or refusal. If consented, the vaccination was administered and documentation of receipt of the vaccination or refusal was indicated in the resident's medical record. RN-B stated annually when it was time for influenza vaccinations all residents were reviewed for other vaccinations, they may be due for and were again offered. When interviewed on 7/16/26 at 11:35 a.m. director of nursing (DON) reviewed R6 and R46 electronic medical records, stated both residents should have been offered the PCV20 and were not. The expectation was for pneumococcal to be offered and administered if they consented when admitted and then vaccinations were to be reviewed and offered if not up to date at least yearly when influenza vaccinations were done. Facility Pneumococcal policy dated 2/24 indicated all residents would be assessed for current immunization status and eligibility to receive the pneumococcal vaccine, within thirty days of admission the resident would be offered the vaccine. The policy further indicated the pneumococcal vaccination would be administered per physician order and CDC recommendations and would be documented in the residents' medical record, if the resident refused vaccination the date of refusal would be documented in the medical record.		

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 07/17/2026
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 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and document review, the facility failed to ensure the Ombudsman was notified of a facility transfer for 1 of 1 resident (R73). Findings include: R73's admission record dated 7/16/26, indicated diagnosis included acute cystitis (medical inflammation of the bladder, usually caused by a bacterial infection) without hematuria (red blood cells in the urine), adult failure to thrive, transient ischemic attack (TIA) and cerebral infarction without residual deficits, other symptoms and signs involving cognitive functions and awareness. R73's provider progress note dated 5/19/26, indicted R73 was being transferred to a memory care center. R73's discharge instructions and summary dated 5/19/26, indicated it was a facility-initiated discharge and must notify the Ombudsman. The facility's Monthly Notice to MN Office for Long-Term Care (LTC) of Emergency Acute Care Transfers and Discharges dated June 2026 lacked R73's name being faxed to the LTC Ombudsman. An interview on 7/14/26 at 2:16 p.m., social services designee (SSD) stated R73 had been transferred. SSD stated R73 was not on the list of transfers and discharges that were faxed to the LTC Ombudsman. SSD stated R73 should have been on the list. SSD stated R73 should have been put on the discharge log that was completed. At 3:27 p.m., SSD stated it was human error on my part. The facility policy Ombudsman Hospital Transfer Report dated 8/2025, indicated the report would be sent monthly, typically within the first 5 days of the month for the previous month. Run the report in PCC (Point Click Care), using the following instructions: go to Admin tab, reports, action summary, ensure your date range is correct, action code-clear it all and the scroll to the bottom and click Transfer out to hospital, discharge date , Discharge/Transfer New Facility. Ensure all payer types are selected, click show to/from description, run report. Then fax the report to the Ombudsman. Once faxed print a fax confirmation.		