DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 285I

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00253

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245492**
2.STATE VENDOR OR MEDICAID NO.
(L2) **080343000**

3. NAME AND ADDRESS OF FACILITY
(L3) **RICHFIELD HEALTH CENTER**
(L4) **7727 PORTLAND AVENUE SOUTH**
(L5) **RICHFIELD, MN** (L6) **55423**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY 03/06/2014 (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **118** (L18)

13.Total Certified Beds **118** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
X 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	118			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Susan Miller, HFE NEII 03/11/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 04/25/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
01/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00450
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/12/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5492

Post Certification Revisit completed on March 6, 2014, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective February 17, 2014, the facility is certified for 118 skilled nursing facility beds.

The facility's request for a continuing waiver involving the deficiency cited at K67 is recommended for approval.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5492

April 25, 2014

Ms. Lynn Sauerer, Administrator
Richfield Health Center
7727 Portland Avenue South
Richfield, Minnesota 55423

Dear Ms. Sauerer:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective February 17, 2014 the above facility is certified for:

118 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 118 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

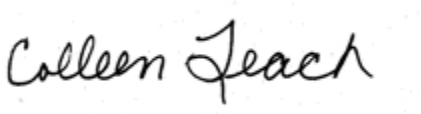
We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K67.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for this deficiency or renew your request for waiver in order to continue your participation in the Medicare Program.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,



Colleen B. Leach, Program Specialist
Program Assurance Unit
Licensing and Certification Program

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 11, 2014

Ms. Lynn Sauerer, Administrator
Richfield Health Center
7727 Portland Avenue South
Richfield, MN 55423

RE: Project Number S5492024

Dear Ms. Sauerer:

On February 3, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 9, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 6, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on February 28, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 9, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 17, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 9, 2014, effective February 17, 2014 and therefore remedies outlined in our letter to you dated February 3, 2014, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245492	A. Building B. Wing	3/6/2014

Name of Facility	Street Address, City, State, Zip Code
RICHFIELD HEALTH CENTER	7727 PORTLAND AVENUE SOUTH RICHFIELD, MN 55423

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **02/17/2014**	ID Prefix **F0332** Reg. # **483.25(m)(1)** LSC	Correction Completed **02/17/2014**	ID Prefix **F0412** Reg. # **483.55(b)** LSC	Correction Completed **02/17/2014**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **02/17/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SM/AK	03/11/2014	03023	03/06/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/9/2014			

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00253	A. Building B. Wing	3/6/2014

Name of Facility	Street Address, City, State, Zip Code
RICHFIELD HEALTH CENTER	7727 PORTLAND AVENUE SOUTH RICHFIELD, MN 55423

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20900** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **02/17/2014**	ID Prefix **21330** Reg. # **MN Rule 4658.0725 Subp.** LSC	Correction Completed **02/17/2014**	ID Prefix **21545** Reg. # **MN Rule 4658.1320 A.B.C** LSC	Correction Completed **02/17/2014**
ID Prefix **21580** Reg. # **MN Rule 4658.1325 Subp.** LSC	Correction Completed **02/17/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SM/AK	03/11/2014	03023	03/06/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/9/2014			

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245492	A. Building / B. Wing: **01 - MAIN BUILDING 01**	2/28/2014

Name of Facility	Street Address, City, State, Zip Code
RICHFIELD HEALTH CENTER	7727 PORTLAND AVENUE SOUTH RICHFIELD, MN 55423

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0052	**02/17/2014**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	PS/AK	03/11/2014	19251	02/28/2014
Reviewed By CMS RO				

Followup to Survey Completed on: 1/16/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 285I

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00253

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245492**
2.STATE VENDOR OR MEDICAID NO.
(L2) **080343000**

3. NAME AND ADDRESS OF FACILITY
(L3) **RICHFIELD HEALTH CENTER**
(L4) **7727 PORTLAND AVENUE SOUTH**
(L5) **RICHFIELD, MN** (L6) **55423**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/09/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **118** (L18)

13.Total Certified Beds **118** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
X 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	118			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Elizabeth Nelson, HFE NE II 02/18/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 02/26/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION **01/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
00450 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN 24-5492
On January 9, 2014 a health survey was conducted and January 16, 2014 a Life Safety Code survey was conducted at Richfield Health Center which was not in substantial compliance with Federal participation requirements.This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. Please refer to the CMS-2567 along with the facility's plan of correction. Post Certification Revisit to follow.

The facility's request for a continuing waiver involving the deficiency cited at K67 is recommended for approval. Documentation supporting the waiver request is attached.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8040

February 3, 2014

Ms. Lynn Sauerer, Administrator
Richfield Health Center
7727 Portland Avenue South
Richfield, Minnesota 55423

RE: Project Number S5492024 and Complaint Number H5492091

Dear Ms. Sauerer:

On January 16, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the January 16, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5492091.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the January 16, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5492091 that was found to be unsubstantiated.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gayle Lantto, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3794
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 18, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by February 18, 2014 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and

sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by April 9, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 9, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution

policies are posted on the MDH Information Bulletin website at:
http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245492	A. BUILDING _____ B. WING _____	01/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER	7727 PORTLAND AVENUE SOUTH RICHFIELD, MN 55423

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verifcation of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. Complaint investigation was completed at the time of the standard recertification survey. Complaint H5492091 was unsubstantiated.	F 000	Disclaimer For Plan of Correction: Richfield Health Center objects to the allegation of non-compliance. Submits of this response and plan of correction is NOT a legal admission that a deficiency exists or, that this statement of deficiency was correctly cited, and is also NOT to be construed as an admission against interest by the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in the response and plan of correction. In addition, preparation and submission of this plan of correction does NOT constitute	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess a new pressure sore for 1 of 1 resident (46) who developed a new pressure sore. Findings include:	F 314		2/17/14

POC accepted 2/10/14 M Rantto

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lynn Laureen	LNHA	2/5/14

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.

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F 314	Continued From page 1 R46 developed a pressure sore on the sacrum (bony structure located at the base of the lower spine); however, a comprehensive assessment was not completed to address the potential contributing factors to develop an appropriate plan of care. An interview conducted on 1/6/14, at 6:54 p.m. a licensed practical nurse (LPN)-A stated R46 developed an open area on the coccyx from moisture not pressure on 1/2/14, and the ulcer measured 3 centimeters (cm) x 0.5 cm. LPN-A also stated R46 had unstageable pressure ulcers on both heels. On 1/9/14, at 8:16 a.m. R46 was observed in his room sitting up in a wheelchair on a cushion. R46 was wearing bilateral boots on both feet. On 1/9/14, 9:55 a.m. LPN-B and LPN-A was observed completing a pressure ulcer treatment for R46. LPN-B wash both hands and donned gloves. LPN-A assisted R46 to roll onto the left side. LPN-B removed Allevyn (adhesive hydrocellular dressing) from the crease of R46's buttocks. LPN- B changed gloves and proceeded to clean wound with dermal wound cleaner and applied Santyl (cleans wounds to promote healthy tissue) ointment. LPN-B then reapplied Allevyn dressing. After the treatment, R46 was positioned on right side, and pillows placed behind back. LPN-B stated the wound developed a week or so ago. R46's quarterly Minimum Data Set (MDS) dated 11/22/13, revealed diagnoses including cerebral vascular accident (stroke), dementia, and diabetes, and the need for extensive assistance	F 314	an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Richfield Health Center respectfully makes its allegation of compliance on all areas and has written these plans of correction to constitute the allegation. F314 R46 pressure sore has been re-assessed and a comprehensive assessment and plan of care have been completed and updated. All Residents in facility with identified pressure sores have been assessed and reviewed. Plan of care updated as needed.	2/17/14 per DON 2/10/14

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F 314	Continued From page 2 with bed mobility and transferring. The resident was unable to walk, was always incontinent of bladder and bowel and had severely impaired decision making skills. The most recent Braden assessment (used to predict pressure ulcer development) dated 11/23/13, identified R46 as being at moderate risk for pressure sore development. A positioning assessment was also completed on 11/23/13, which included the skin's ability to withstand prolonged pressure. The Wound Monitoring Flow Sheet dated 1/2/14, identified a "open area" measuring 3 x 0.5 cm x 0.1 (depth) on the sacrum and on 1/7/14, the area measured 4.5 cm x 1.1 cm x 0.4 cm and was identified as "unstageable." The progress notes dated 1/6/14, indicated R46 had an open area in the gluteal fold 3 cm x 0.8 cm with macerated edges and physician orders included dimethicone cream (topical used to treat and prevent dry, rough skin, minor irritation) to peri area every shift after incontinence. Also a new order was obtained for a "cushion J3 with gel" for the resident's wheelchair. The family of R46 was notified and asked by the nurse practitioner (NP) if they were interested in pursuing hospice care. The wound physician progress notes the following day revealed the wound on the "sacrum" measured 4.5 cm x 1 x 2.5 cm and was unstageable with etiology identified as "pressure." The undated care plan noted the resident had an open area on the gluteal fold--sacrum, and interventions included gel cushion to wheelchair (1/6/14) and Santyl and Allevyn to sacrum	F 314	All Licensed staff have been re-educated regarding pressure sore assessment, documentation and monitoring. DON/Designee will audit all residents in facility with identified pressure sores weekly. Audit results will be reviewed by QA&A. Person responsible: Director of Nursing/Designee	

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F 314	Continued From page 3 (1/8/14). An interview on 1/9/14, at 2:15 p.m. LPN-A stated the area on R46's sacrum developed on 1/2/14, LPN-A thought the area was initially caused by yeast and would clear up with dimethicone treatment. When the LPN returned to work on 1/6/14, the area had not improved so the NP and family were notified. LPN-A verified the last skin/positioning assessment had been completed on 11/23/13. The facility policy revised on 4/09, on Pressure Ulcer Prevention/Treatment indicated all residents will be assessed on admission and weekly for four weeks, quarterly, and with a significant change in condition using the Braden Risk Assessment, and Skin Integrity Assessment Prevention and Treatment Care Plan.	F 314		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to administer medications according to manufacturer's recommendations for 1 of 7 residents (R168) observed for medication administration. This resulted in a medication error rate of 9%. Findings include:	F 332	F332 R168 has been assessed for any adverse effects related to medication. All Licensed staff have been re-educated regarding medication administration. DON/Designee will audit/observe 5 Licensed staff weekly regarding medication administration.	2/17/14

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F 332	Continued From page 4 On 1/7/14, at 4:10 p.m. a registered nurse (RN)-A administered three medications to R168: Prilosec (for heartburn) with instructions to give thirty minutes prior to meal, Ziprasidone HCL (for bipolar disorder) and Meloxicam (for arthritis) as these medications were not given with food. After administering the medication RN-A explained that residents ate supper at 5:30 p.m. and snacks were given at 2:00 and 8:00 p.m. R168's physician orders dated 12/4/13, indicated Meloxicam 7.5 milligrams (mg) twice daily with meals; Omeprazole 20 mg twice daily, take 30 minutes before a meal; and Ziprasidone HCL 80 mg twice daily with meals. On 1/9/14, at 3:35 p.m. the director of nursing (DON) stated medications given prior to meals should have been administered closer to the mealtime and medications with instructions to administer with food should have been given with food. The policy and procedure Medication Administration, revised 11/12, indicated the licensed nurse would administer medication according to manufacturer guidelines as it related to food intake.	F 332	Audit results will be reviewed by QA&A. Person responsible: Directory of Nursing/ Designee	
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for	F 412	F412 R84 and R128 have been offered dental Services.	2/17/14

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F 412	Continued From page 5 transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document, review the facility failed to provide routine dental services for 2 of 2 residents (R84, R128) observed with chipped/broken teeth. Findings include: R84 was observed on 1/6/14, at 5:10 p.m. and several broken teeth throughout the mouth were seen. In an interview conducted on 1/8/14, at 1:10 p.m. R84 stated his teeth had broken off and did not cause much pain. R84 was unsure of the last time had seen a dentist. R84's Face Sheet indicated was admitted to the facility in 2012. R84's Minimum Data Set (MDS) dated 8/30/13, indicated R84 was cognitively impaired and required extensive assist of oral care needs. R84's oral status indicated there were obvious cavities or broken teeth. The Care Area Assessment (CAA) indicated R84 was able to perform oral cares after set up by staff. The CAA indicated R84 had multiple missing teeth and some broken teeth and the resident was unable to tell the last time saw a dentist. The CAA also indicated R84 was able to eat without problems, consumed 50 to 100% at meal times and was at risk for oral carries and infection. The MDS 3.0 Oral/Dental assessment form dated 1/3/12, completed by a registered dental hygienist indicated R84 had a cavity and broken teeth with	F 412	An audit of all residents in facility has been completed to ensure each resident receives annual dental services. Unit Managers, Social Workers and Medical Record staff have been re-educated on routine and emergency dental services. LNHA/Designee will audit all resident charts quarterly to determine last dental service offered or provided. Audit results will Be reviewed by QA&A. Person responsible: LNHA/Designee	

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root tips showing. The oral/dental assessment indicated R84 required direct staff assistance with tooth brushing and soft tissue care after brushing, and routine dental referral. The "Notes to Nursing Staff for follow up/Care Conference: would benefit from dental tx [treatment]."

On 1/9/14, at 3:30 p.m. the director of nursing (DON) stated medical records staff set up dental appointments and follow up. The DON stated social service staff tracked the dental appointments and follow through quarterly. At 4:00 p.m. the staff in charge of medical records (MR)-A stated when residents were at the facility for at least thirty days, the MDS triggered the oral assessment to be completed, and the dental hygienist from contracted dental service completes the oral assessment. The MR-A had the resident sign a consent form for the dental service to take place and then scheduled the first visit. Afterward the dental service would inform the MR-A how often a resident should be seen. Although R84 had an oral assessment completed there were no follow up appointments.

Social service progress notes reviewed since R84's admission included an area for documentation of appointments, however, no dental appointments were noted.

R84's undated care plan indicated interventions as, "Provide oral care daily and prn [as needed] and provide set-up, cue, and physical assist...Own teeth only 3 present."
R128 was not provided routine dental services related to a chipped right front upper tooth.

R128 was observed during an interview on 1/6/14, at 4:31 p.m. with a chipped right front

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upper tooth. R128 said had wanted an in-house exam for the chipped tooth for about a year (since admission in 12/12). R128 indicated the condition did cause eating problems, "I have to watch where in my mouth I chew what I eat." The resident had been trying to see a dentist outside the facility, but said there was a problem with the wheelchair width, "so I have not seen anyone yet." The resident reported waiting more than a year to see the in-house dentist and when an inquiry as to the status R128 reported, "They say I'm on the waiting list."

In an interview on 1/9/14, at 9:42 a.m. the administrator verified an appointment had been made with a Health Partners Dental Clinic, but said R128 was unable to go, because Metro Mobility transport had a weight limit for riders and wheelchairs, which R128 exceeded. The administrator said they had just now discussed with R128 having a dental exam on-site, and R128 agreed.

A follow up interview on 1/9/14, at 2:57 p.m. R128 reported being seen at the bedside indicated was seen at bedside by a "dentist" in 12/12 during an oral screening exam. R128 had asked and, "They said they had put me on a list for an exam by the in-house dentist." R128 said nothing ever came of the request despite asking the nurses, physician, and nurse practitioner at intervals throughout the year, as well as the "social worker [name] at my quarterly care conferences." R128 reported going out in the electric w/c to dentists in the neighborhood, but said they could not accommodate the width of his w/c. "I was seen again this fall and they scheduled me for Health Partners [for a dental exam], but the van couldn't take me there." R128 added it was because the

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combined weight of himself and the electric w/c exceeded the van's maximum carry capacity.

During an interview on 1/9/14, at 3:05 p.m. the licensed social worker ((LSW)-A, when asked about R128's comment about alleging the raising of dental concerns at care conferences the (LSW)-A was aware of the resident's most recent request, during a Caring Partner visit between the resident and (LSW)-A. The (LSW)-A stated, "I put that in my notes, I always do that for all of his questions/issues."

An interview was conducted on 1/9/14, at approximately 3:15 p.m. MR-A reported being in charge of scheduling dental evaluations and follow-up appointments. The MR-A stated the person R128 was seen by in 12/12 at the bedside was a dental hygienist, who did oral screenings for Apple Tree Dental. The MR-A added the hygienist did the screening, and then MR-A obtained consent for an in-house dental visit. R128 would be scheduled at the time of the next dental visit. The MR-A said Apple Tree Dental visited approximately monthly, indicating residents were seen for oral care/procedures in the activities room in the basement. MR-A added R128 was unable to be seen at that first scheduled exam because of issues with the wheelchair and no way to get the resident to the basement level at the time.

On 1/9/14, at 5:19 p.m. MR-A stated a hygienist would not have examined R128 at the time of the resident's admission, as they never saw a resident until they had resided in the facility for at least 30 days. MR-A added a physician had talked with R128 about oral hygiene near the time of admission, and speculated R128 might be

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F 412	Continued From page 9 confusing timelines. R128's medical record there was an Apple Tree Dental Oral Health Plan & Consent Form present, with signature of R128 dated 1/6/14. A social worker progress note dated 12/5/13, indicated R128, "Stated concerns with need for dental care...added to both dental and podiatry list." There was no initiation of dental care on/near admission, and no subsequent action taken regarding routine dental care or R128's expressed concern for over six months after admission, despite the facility's policy indicating a chipped tooth fell into a category requiring "emergency" dental services. The facility's Dental Services procedure dated 4/00, indicated to "Identify those residents that need emergency dental services including, but not limited to the following: Acute pain in teeth, gums or palate; broken or otherwise damaged teeth; any problem requiring immediate attention of a dentist. Schedule an appointment and arrange transportation as needed." The document, PROCEDURE Dental Services--Referral to, included item numbered: "4. Identify residents that need emergency dental services including, but not limited to, the following:...Broken or otherwise damaged teeth...."	F 412		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431	F431 Residents (R15, R18, R24, R55, R107, R123) insulin medications have been removed from medication cart.	2/17/14

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F 431	Continued From page 10 of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure insulin ready for use was discarded after 28 days for 6 residents (R15, R18, R24, R55, R107, R123) on 1 of 3 units on second floor during medication	F 431	An audit of all medication carts in the facility has been completed to ensure no expired medications are retained in medication cart. All Licensed staff have been re-educated on medication storage. DON/Designee will audit all medication carts in building weekly. Audit results will be reviewed by QA&A. Person responsible: Director of Nursing/ Designee	

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F 431	Continued From page 11 storage review. Findings include: Medication storage was reviewed on 1/7/14, at 1:15 p.m. with a trained medication assistant (TMA)-A and registered nurse (RN)-B. There was a vial of Lantus and Humalog (medications used to control blood sugar) dated opened 12/9/13, for R15; one vial of Novolog (medication used to control blood sugar) dated 12/8/13, opened for R18 and one vial of Lantus opened 12/9/13; one vial of Lantus dated opened 12/9/13, for R24; one vial of Lantus and one vial of Humalog for R55 dated opened 12/9/13; one vial of Humalog opened 12/9/13, for R107; and one vial of Novolog opened 12/9/13, for R123. These findings were verified by TMA-A and RN-B. RN-B stated the insulin for the above mentioned residents should have been removed after 28 days from the date the vials were opened. R15's Physician Orders dated 12/4/13, indicated Humalog 100 units/milliliter (u/ml) at bedtime per sliding scale for blood sugars: 201-250=3 units, 251-300=4 units, 301 or greater=6 units. Also, there was an order for Lantus 100u/ml-inject 5 units every morning. R18's Physician Orders dated 12/4/13, indicated Lantus 100u/ml, 55 units every morning; 70 units every evening; 15 units before each meal. Novolog 100u/ml 15 units four times daily per sliding scale: less than 150=0, 150-200=5 units, 201-250=10 units, 251-300=15 units, 301-350=20 units. R24's Physician Orders dated 12/4/13, indicated Lantus inject 5 units every morning.	F 431		

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	245492	A. BUILDING _____ B. WING _____	01/09/2014

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F 431	Continued From page 12 R55's Physician Orders dated 11/6/13, indicated Lantus inject 8 units every morning and every bedtime; Novolog inject before meals and at bedtime per sliding scale: 140-189=1 unit, 190-239=2 units, 240-289=3 units, 290-339=4 units, and greater than 340=5 units. R107's Physician Orders dated 12/4/13, indicated Humalog 100u/ml, inject three times daily per sliding scale: 150-200=1 unit, 201-250=2 units, 251-300=3 units, 301-350=4 units, greater than 350=5 units. R123's Physician Orders dated 11/29/13, indicated Lantus inject 10 units every morning and evening; Novolog inject 3 units at meal times. The facility's policy and procedure Storage and Expiration of Medications, Biological's, Syringes and Needles revised 1/1/13, indicated the facility should ensure medications and biological's were not retained longer than recommended by manufacturer or supplier guidelines. The Lantus Patient Package Insert dated 2007, noted the following for "Open (In-Use) vial: Once a vial is opened, you can keep it in a refrigerator or at room temperature (below 86°F [30°C]) but away from direct heat and light. Opened vial, either kept in a refrigerator or at room temperature, should be discarded 28 days after the first use even if it still contains LANTUS. Do not leave your insulin in a car on a summer day." Humalog: Package Insert and Label Information dated 2011, noted the following for vials: - "Keep in the refrigerator or at room temperature below 86°F (30°C) for up to 28 days.	F 431		

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F 431	Continued From page 13 - Keep vials away from direct heat or light. - Throw away an opened vial after 28 days of use, even if there is insulin left in the vial. - Unopened vials can be used until the expiration date on the HUMALOG carton and label, if the medicine has been stored in a refrigerator." The Novolog Patient Package Insert dated 10/13, noted the following: "Vials: After initial use a vial may be kept at temperatures below 30°C (86°F) for up to 28 days, but should not be exposed to excessive heat or light. Opened vials may be refrigerated."	F 431		

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	245492	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/16/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER	**7727 PORTLAND AVENUE SOUTH** **RICHFIELD, MN 55423**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on January 16, 2014. At the time of this survey, Richfield Healthcare Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K 000	POC ok W/A W for K67 JS 2-18-14 RECEIVED FEB 10 2014 PUBLIC SAFETY AL DIVISION	

Dc: 2-18-14

Exit: 1-9-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lynn Anderson	LNHA	2/5/14

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245492	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/16/2014**

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RICHFIELD HEALTH CENTER	**7727 PORTLAND AVENUE SOUTH** **RICHFIELD, MN 55423**

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This 3-story building was constructed in 1971 and was determined to be of Type II (222) construction. It has a full basement and is fully fire sprinklered. The facility has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 118 beds and had a census of 103 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052	K052 The facility will complete an annual fire alarm test. Maintenance Director has been re-educated regarding annual fire alarm test regulations.	2/17/14

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K 052	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation, documentation review and interview, the facility failed to maintain the fire alarm system in accordance with the requirement 1999 NFPA 72, Section 5-4.2.1, 3-8.4.4.2.2. The deficient practice could affect all 103 residents, visitors, and staff. Findings include: On facility tour between 9:00 AM and 12:00 PM on 1/16/2014, 1. In review of the 2014 yearly fire alarm documentation, revealed the annual fire alarm test had not been conducted the system was last tested on 1/03/2013. This deficient practice was confirmed by the Maintenace Supervisor.	K 052	Maintenance Director will assure facility annual fire alarm test is completed. Results of annual fire Alarm test will be Reviewed by QA&A. Person responsible: Maintenance Director/ Designee	
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067	AW K067 Facility is requesting an annual/ continuing waiver. See K067 waiver request.	

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K 067	Continued From page 3 This STANDARD is not met as evidenced by: Based on observations and interviews, it could not be verified that the facility's general ventilating and air conditioning system (HVAC) is installed in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 2-3.11. A noncompliant HVAC system could affect all residents. Findings include: During the facility tour between 9:00 AM and 2:00 PM on 1/16/2014, observation revealed that the ventilation system for the corridors are utilizing the egress corridor as an air plenum for the resident rooms. The resident rooms are heated by hot water register. The corridors are heated by forced air. No return duct could be located in the corridors. The resident bathroom fans run continuously and exhaust to the exterior and draw their supply from the corridors through the resident rooms.	K 067		

Name of Facility **2000 CODE**

Richfield Health Center 7727 Portland Avenue South Richfield MN 55423

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 K067 The building Heating, Ventilation & Air Conditioning Equipment (HVAC) does not comply with LSC (00) Section 9.2, and NFPA 90A, 1999 ED., because the corridors are being used as a plenum. 1 of 2	An annual/continuing waiver is being requested for K067. A. Compliance with this provision will cause an unreasonable hardship because: 1. The most recent cost estimate dated 12/07/2012 for a complying ducted HVAC systems is $1,030,000. 2. Efforts to obtain an estimate for a ducted system regarding the above estimate does not include duct work, electrical connections, roofing changes, insulation, drawings, engineering fees, permit fees or taxes. 3. The ducted system would decrease the corridor headroom to less than that required by the LSC. 4. The building electrical system would need to be upgraded to support a new ducted system. 5. the ducted system would need to penetrate load bearing walls, decreasing building structural integrity. 6. Installation of a ducted system would require asbestos abatement which would increase the cost. 7. Existing non-complying HVAC systems can be allowed to continue in use. B. There will be no adverse effect on the building occupant's safety because: 1. The building is protected by a complete fire sprinkler system that complies with NFPA 13, 1999 Edition. 2. The existing HVAC system ventilation fans do automatically shut down upon activation of the fire alarm system, or detection of smoke in the HVAC system. 3. Resident rooms have smoke detectors in addition to fire sprinklers. 4. The corridors are wquipped with a complying smoke detection system. 5. Richfield Health Center is 45 years old with a usable life of 30 plus years. 6. The facility fire alarm system is monitored to provide automatic fire alarm notification to the fire department.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title Fire Safety Supervisor	Office State Fire Marshal	Date 2-18-14

Form CMS-2786R (03/04) Previous Versions Obsolete Lynn Sauerer LNHA 2/18/14

Name of Facility **2000 CODE**

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PROVISION NUMBER(S)	JUSTIFICATION
K84 K067 The building Heating, Ventilation & Air Conditioning Equipment (HVAC) does not comply with LSC (00) Section 9.2, and NFPA 90A, 1999 Ed., because the corridors are being used as a plenum. 2 of 2	7. Fire safety training is provided for all employees on an annual basis and during orientation for all new hires. 8. Fire drills are conducted monthly on each shift. 9. This annual/continuing waiver has been approved in the past.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date 2-18-14