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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3D7Z

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) **07/01/2015**

6. DATE OF SURVEY **05/20/2016** (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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (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):

17. SURVEYOR SIGNATURE Date :
Douglas Stevens, HFE NEII 06/02/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 07/08/2016 (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.
06301 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
05/18/2016 (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245492

July 8, 2016

Ms. Jo Ann Buytendorp, Administrator
Richfield Health Center
7727 Portland Avenue South
Richfield, Minnesota 55423

Dear Ms. Buytendorp:

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 May 13, 2016 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.

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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 2, 2016

Ms. Jo Ann Buytendorp, Administrator
Richfield Health Center
7727 Portland Avenue South
Richfield, Minnesota 55423

RE: Project Number S5492026

Dear Ms. Buytendorp:

On April 13, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 31, 2016. 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 May 20, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on May 2, 2016 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 March 31, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 13, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 31, 2016, effective May 13, 2016 and therefore remedies outlined in our letter to you dated April 13, 2016, 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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245492 Y1	A. Building B. Wing Y2	5/20/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0241	Correction	ID Prefix F0246	Correction	ID Prefix F0280	Correction
Reg. # 483.15(a)	Completed	Reg. # 483.15(e)(1)	Completed	Reg. # 483.20(d)(3), 483.10(k)(2)	Completed
LSC	05/13/2016	LSC	05/13/2016	LSC	05/13/2016
ID Prefix F0282	Correction	ID Prefix F0309	Correction	ID Prefix F0329	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed	Reg. # 483.25(l)	Completed
LSC	05/13/2016	LSC	05/13/2016	LSC	05/13/2016
ID Prefix F0356	Correction	ID Prefix F0441	Correction	ID Prefix F0465	Correction
Reg. # 483.30(e)	Completed	Reg. # 483.65	Completed	Reg. # 483.70(h)	Completed
LSC	05/13/2016	LSC	05/13/2016	LSC	04/29/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	GL/mm	06/02/2016	32976	05/20/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 3/31/2016

☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245492 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	5/2/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0018	04/01/2016	LSC K0038	04/29/2016	LSC K0050	04/29/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0051	04/20/2016	LSC K0056	04/19/2016	LSC K0064	04/01/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0067	04/20/2016	LSC K0130	04/05/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	TL/mm	06/02/2016	27200	05/02/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/30/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

June 2, 2016

Ms. Jo Ann Buytendorp, Administrator
Richfield Health Center
7727 Portland Avenue South
Richfield, Minnesota 55423

Re: Reinspection Results - Project Number S5492026

Dear Ms. Buytendorp:

On May 20, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 15, 2016. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00253 Y1	A. Building B. Wing Y2	5/20/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20565	Correction	ID Prefix 20570	Correction	ID Prefix 20830	Correction
Reg. # MN Rule 4658.0405 Subp. 3	Completed	Reg. # MN Rule 4658.0405 Subp. 4	Completed	Reg. # MN Rule 4658.0520 Subp. 1	Completed
LSC	05/20/2016	LSC	05/20/2016	LSC	05/20/2016
ID Prefix 21390	Correction	ID Prefix 21426	Correction	ID Prefix 21540	Correction
Reg. # MN Rule 4658.0800 Subp. 4 A-I	Completed	Reg. # MN St. Statute 144A.04 Subd. 3	Completed	Reg. # MN Rule 4658.1315 Subp. 2	Completed
LSC	05/20/2016	LSC	05/20/2016	LSC	05/20/2016
ID Prefix 21685	Correction	ID Prefix 21805	Correction	ID Prefix 21810	Correction
Reg. # MN Rule 4658.1415 Subp. 2	Completed	Reg. # MN St. Statute 144.651 Subd. 5	Completed	Reg. # MN St. Statute 144.651 Subd. 6	Completed
LSC	05/20/2016	LSC	05/20/2016	LSC	05/20/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	GA/mm	06/02/2016	32976	05/02/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/31/2016

[ ] 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: 3D7Z

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) **07/01/2015**
6. DATE OF SURVEY **03/31/2016** (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
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (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):

17. SURVEYOR SIGNATURE — Date :
Jane Teipel, HFE NEII — 04/25/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 05/10/2016 (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.
06301
(L31)

30. REMARKS
Posted 05/18/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 13, 2016

Ms. Jo Ann Buytendorp, Administrator
Richfield Health Center
7727 Portland Avenue South
Richfield, Minnesota 55423

RE: Project Number S5492026

Dear Ms. Buytendorp:

On March 31, 2016, 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.

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.

.

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:

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - 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;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - 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
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: gayle.lantto@state.mn.us
Phone: (651) 201-3794 Fax: (651) 215-9697

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 May 10, 2016, 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 May 10, 2016 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC 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 ePoC 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 ePoC 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 ePoC 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 ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 July 1, 2016 (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 October 1, 2016 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC 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 electronic 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

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 _____	03/31/2016

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. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic 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.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dignified dining was provided for 3 of 4 residents (R51, R101, R112) who were fed by staff. Findings include: The evening meal service was observed on 3/28/16, at 6:03 p.m. Three residents, R51, R101 and R112 were seated at the same table. A licensed practical nurse (LPN)-A assisted R51 and R101 to eat, standing throughout the entire meal. Multiple times during the meal LPN-A	F 241	Preparation, submission and implementation of this plan of correction do not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and fedueral regulatory requirements. 1. R51, R101, and R112, have been provided care in a manner and in an	5/13/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/22/2016

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 _____	03/31/2016

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 241	Continued From page 1 walked away from the table to check on other residents throughout the dining room and a resident in the hallway. LPN-A returned back to the table, stood above R51 and R101 to continued assisting R51 and R101 to finish their meal. In addition, a nursing assistant (NA)-A stood at the same table to feed R112 the first part of his meal, and then sat to feed him the remainder of his meal. At the end of the meal service at 6:47 p.m. LPN-A confirmed he stood while assisting R51 and R101 to eat. LPN-A explained that if residents required assistance to eat, staff had been instructed to sit next to the resident until they had finished eating. LPN-A explained the reason why he stood was so he could visualize all the residents in the dining room, which was difficult to do while seated. LPN-A furthered explained that R51 and R101 usually only needed verbal cues for eating, but "For some reason tonight both residents required assistance with their meals from me." NA-A verified she was standing while assisting R112 with his meal. NA-A stated she worked at this facility for many years and had received training on how to properly assist residents with their meals during dining. NA-A stated, "We are told we can either stand or sit while feeding." R51's Minimum Data Set (MDS) dated 1/1/16, indicated the resident required assistance of one staff for eating. R51's care plan dated 1/1/16, indicated the resident had cognitive impairment and was at risk for dehydration due to advanced dementia, and the resident had a visual loss, as well. Interventions directed staff to monitor position to promote adequate nutritional intake, weigh the resident, monitor for signs of	F 241	environment that maintains and enhances their dignity and respect in full recognition of their individuality. 2. All residents at Richfield Health Center who need assistance with meals have the potential to be affected by this by this practice. All residents who need assistance with meals have been provided care in a manner and environment that promotes dignity. 3. Licensed/unlicensed nurses and IDT have been educated on dignity and respect while providing meal service to the residents. 4. The Dietary Manager/designee will observe the dining room during meals and audit weekly for 4 weeks and then 1 time per month times 3 months to ensure staff is seated when assisting residents during meals. 5. All results will be brought to the monthly Quality Assurance Performance Improvement meetings and reviewed for trends.	

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 _____	03/31/2016

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 241	Continued From page 2 dehydration and encourage fluids, and assist with meals and anticipate needs. R101's care plan dated 3/10/16, indicated the resident was receiving comfort cares, had cognitive impairment and diagnoses of dementia and anxiety, and was resistive with cares. R101's care plan dated 6/10/14, indicated staff was to assist with meals and monitor for signs of dehydration and to weigh the resident monthly. R112's care plan dated 12/31/15, indicated the resident had a potential risk for dehydration. R112 was receiving hospice care and had dementia and anxiety, was non-verbal and displayed behavioral issues. R112's care plan dated 10/26/15, indicated severe cognitive impairment with a significant weight loss within 30 day. Staff interventions included monitoring intake at mealtime and for signs of dehydration, encourage fluids, and weigh the resident monthly. During an interview on 3/28/16, at 6:48 p.m. a registered nurse (RN)-A explained, "I expect staff to serve one table at a time. If food is placed in front of a resident, staff was to help get that resident started with the mea. Those residents who required assistance to eat would be fed last and staff would then sit while assisting those residents to eat. Dining and assisting residents with meals is an ongoing education with staff." RN-A said if R51, R101 and R112 required needed help with their meals staff should have sat next to the residents and assisted them. RN-A verified that R112 required total assistance to eat. RN-A explained that staff received an inservice East and West dining room set up and Serving Trays training on 12/11/15. The inservice included step by step instruction for staff "when	F 241		

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 _____	03/31/2016

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 241	Continued From page 3 putting a tray in front of a resident that needs to be fed you need to sit down and start to feed." Both LPN-A and NA-A attended the inservice and signed the attendance sheet. The facility's 7/15, Dining Goals and Objectives directed the staff to ensure the residents' dining environment would be an pleasant experience which will encourage socialization and nutritional intake.	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accommodate bathing preferences for 2 of 3 residents (R85, R14) reviewed for choices. Findings include: R85 stated on 3/28/16, at 2:44 p.m. she received one shower a week, but wanted at least two showers a week, preferably three. R85 stated staff had informed her there was not enough help at the facility to have additional showers. R85's quarterly Minimum Data Set (MDS) dated 3/5/16, indicated the resident cognition was intact, and	F 246	1. R85 and R14 were interviewed and accommodations have been made per the individual's needs and preferences related to showers and/or bathing. Resident choice and perference will be reviewed quarterly and as needed to accommodate related to bathing/showers. Care plans have been updated with preferences. 2. All residents at Richfield Health Center have the potential to be affected by this practice. All residents were interviewed and accommodations have been made per the individual's needs and preferences related to showers and/or bathing.	5/13/16

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 _____	03/31/2016

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 246	Continued From page 4 the resident required physical help from staff with part of the bathing activity. R14 stated on 3/28/16, at 5:13 p.m. she received one shower a week, but would like more and stated, "Sometimes I smell." Again on 3/30/16, R14 stated she preferred more than one shower a week and again stated, "I think I smell." R14 stated she had never been asked by anyone at the facility if she wanted more than one shower weekly. R14's quarterly MDS dated 1/3/16, indicated R14's cognition was moderately impaired. R14's MDS also indicated R14 was total dependent on staff for bathing and rejected no cares. During an interview on 3/29/16, at 1:55 p.m. a nursing assistant (NA)-C stated residents would tell the staff if they want more than one shower a week. At 2:17 p.m. NA-D stated residents could choose to have more than one shower a week. The following morning at 8:09 a.m. a registered nurse (RN)-D stated if a resident stated a preference how often they wanted a shower they could, and in fact some residents did get two showers a week. RN-D stated the residents were asked upon admission about bathing and that if their preference varied from one shower a week it would be scheduled and care planned accordingly. On 3/30/16, at 8:25 a.m. a licensed social worker (LSW)-B stated she did not ask residents or families about bathing preferences. LSW-B stated she only got involved with bathing when family members asked her to make sure the	F 246	Resident choices and preference will be reviewed quarterly and as needed to accommodate. Care plans will be updated as needed. 3. Social Services department, licensed/unlicensed staff, and IDT received education regarding resident choices and preferences with bathing. 4. Caring partners will meet with and audit resident's choices and preferences 1 time per week times 4 weeks, then monthly times 3 months. 5. All results will be brought to the monthly Quality Assurance Performance Improvement meeting and reviewed for trends.	

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 _____	03/31/2016

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 246	Continued From page 5 resident got a shower if the resident smelled really badly. At 9:10 a.m. the life enrichment director stated residents were asked bathing preferences upon admission and if the resident's preference was for more than one shower weekly, nursing staff was informed. On 3/30/16, at 10:48 a.m. RN-D stated nursing staff did not ask bathing preferences of a resident, nor their family or guardian after their admission. RN-D stated she had not been notified R14 or R85 wanted an additional shower each week. On 3/31/16, at 10:20 a.m. RN-G stated residents received at least one shower weekly and if they requested, could have a second shower. RN-G stated it was not appropriate to tell a resident they would only get a shower is staff had time, and it needed to be scheduled or it would not get completed. At 1:16 p.m. on 3/31/16, the director of nursing stated residents could have one shower a week and if they asked for more than one shower a week it was then added to the bathing schedule. The 2ND Floor Bath List indicated R14 and R85 received one shower weekly. R14 and R85's care plans did not address additional bathing frequency. A bathing policy was requested on 3/31/16, but was not provided by the facility.	F 246		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		5/13/16

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 _____	03/31/2016

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 280	Continued From page 6 The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide opportunities to participate in care planning for 2 of 3 residents (R14, R85) reviewed for choices. Findings include: R14's care conferences were not held quarterly. On 3/30/16, at 8:09 a.m. a registered nurse (RN)-D stated care conferences held were charted in the progress notes by the licensed social workers (LSWs). RN-D also stated R14's guardian had been invited to the care conferences and R14's care conferences had	F 280	1. R14 has been provided the opportunity to participate in planning care, treatment, or changes in cares and treatment. R14 declined to attend the care conference. 2. All residents at Richfield Health Center have the potential to be affected by this practice. All residents, as appropriate, have been provided the opportunity to participate in planning care, treatment, or changes in cares and treatment. 3. Licensed staff, Social Service department, and IDT have been educated on providing residents the opportunity to	

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 _____	03/31/2016

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 280	Continued From page 7 been canceled a couple of times. RN-D stated care conferences were to be held quarterly. At 8:25 a.m. LSW-B stated R14's care conference was canceled early January as the guardian did not show up and was also canceled for "tomorrow" as it had been a busy week. On 3/30/16, at 10:29 a.m. R14 stated she would like more than one shower a week. R14 also stated that her teeth were "not good"--she was missing some top teeth and her front teeth ached sometimes, and had for "awhile." R14 stated she was supposed to have seen the dentist six months to a year after her last visit, but that it had been awhile. R14 re-stated that her top front teeth hurt and that she did not think that the facility had made her a dental appointment. R14's quarterly Minimum Data Set (MDS) dated 1/3/16, indicated R14's cognition was moderately impaired and rejected no cares. At 10:36 a.m. a nursing assistant (NA)-E said R14 had not said anything to her about her teeth hurting in morning cares, but she would tell the nurse and medical records person about it as she scheduled the dental appointments. Following the interview, a registered nurse (RN)-D stated R14 had seen the dentist 10/8/15, and that she had not heard about R14's teeth hurting. At 10:41 a.m. the medical records staff person (MR) stated she had not known about R14's teeth hurting but she would ensure she was placed on the list to see the dentist. At 2:05 p.m. the MR while looking through R14's chart stated R14 s last actual care conference had been held	F 280	participate in planning care, treatment, or changes in care and treatment. 4. Director of Social Services/designee will audit care conferences with resident participation weekly times 4 weeks, then monthly times 3 months. 5. All results will be brought to the monthly Quality Assurance Performance Improvement meeting and reviewed for trends.	

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 _____	03/31/2016

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 280	Continued From page 8	F 280		

3/24/15, with the resident, social services and therapy present. MR stated R14's guardian had been invited, but had not answered.

At 2:13 p.m. RN-D explained a care conference for R14 had been planned for 3/31/16, but was canceled due to being a busy week.

On 3/31/16, at 12:05 p.m. LSW-B stated if a resident or guardian declined a care conference one was not held. LSW-B stated she was new to the position and the previous LSW had been behind on care conferences at the time he left the position. LSW-B verified there had not been a care conference held for R14 since 3/15. On 3/31/16, at 12:05 p.m. LSW-B also verified there was no documentation indicating R14 refused a care conference.

R85 had stated to surveyor on 3/28/16, at 2:44 p.m. that she would like at least two showers a week, preferably three, but presently only received one shower a week. R85's quarterly MDS dated 3/5/16, indicated R85's cognition was intact.

R85's care conferences were not held quarterly. On 3/31/16, at 12:05 p.m. LSW-B verified there was no documented evidence R85 had a care conference or declined a care conference.

At 1:38 p.m. on 3/31/16, the director of social services (DSS) stated resident care conferences were held upon admission and held quarterly after that. The DSS stated residents and guardians were both invited to the care conferences. The DSS stated care conferences would be rescheduled if needed and would let the resident know because of resident choice. The

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 _____	03/31/2016

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 280	Continued From page 9 DSS stated care plans were reviewed at care conferences. The facility's 7/15, Resident/Family Conference policy indicated, "The center will encourage the resident and/or family/legal representative to attend the Resident Care Conference, which will be scheduled with the appropriate Interdisciplinary Team (IDT) members. The conferences will be scheduled based on identified needs and regulatory standards..Discuss the Plan of Care goals with the resident/family/responsible party to express their preferences about care. a. Respect and incorporate their preferences in the care decisions. 6. Summarize the outcome of the meeting and document attendance."	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: ` Based on interview and record review, the facility failed to adequately monitor the dialysis access site for 2 of 3 residents (R77, R99) as directed in the care plan. Findings include: R77's care plan directed staff to monitor a dialysis access site for proper functioning by feeling the site for evidence of blood flow and listening with	F 282	1. R77 and R99 treatment records have been updated to adequately monitor the dialysis access sites and reflects in the resident's plan of care. 2. All residents at Richfield Health Center who receive dialysis services have the potential to be affected by this practice. All treatment records and care plans have been updated for residents receiving dialysis services to reflect adequate monitoring of the dialysis acces sites.	5/13/16

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 _____	03/31/2016

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 282	Continued From page 10 a stethoscope for evidence of blood flow. On 3/31/16, at 8:46 a.m. a registered nurse (RN)-B verified there was no documentation to indicate completion of R77's access site for proper function. RN-B explained the site was supposed to have been monitored daily. At 9:19 a.m. RN-E produced a treatment documentation sheet dated 3/9/16, that directed staff to monitor the access site. The sheet did not indicate when the monitoring was to be completed, but rather had "all" written in under the hours column. RN-E explained when the sheet indicated, "all" the staff was not required to sign off that the treatment had indeed been completed. RN-E verified the sheet should have instead indicated a shift where documentation would be recorded. RN-E produced a new sheet where shifts would be initiated. R99 had a dialysis venous access site (AV graft) on the left side of his chest. R99 was also prescribed medication to reduce the clotting time of his blood, making him more susceptible to bleeding. The care plan for R99 (dated as reviewed 2/16), included a goal for the access site to be free from signs and symptoms of infection daily. Interventions included staff to monitor for signs and symptoms of infection such as pain, swelling, warmth, drainage and report problems to R99's physician. The dialysis care plan did not provide specific instruction on monitoring an AV graft. The care plan for risk of bleeding indicated staff was to monitor and report signs and symptoms of bleeding. The treatment record for R99 lacked directions for nursing staff to monitor the AV graft for bleeding and lacked directions as to how to proceed if bleeding did occur. Documentation in R99's progress notes	F 282	3. Unit managers and licensed nurses have been educated on care planning, documenting, and assessing dialysis access sites as appropriate. 4. Nurse managers will conmplete audits on 3 dialysis residents per week to ensure appropriate care plan in place as well as daily documentation for 4 weeks, then every month times 3 months. 5. All results will be brought to the monthly Quality Assurance Performance Improvement meeting and reviewed for trends.	

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 _____	03/31/2016

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 282	Continued From page 11	F 282		

did indicate "no bleeding at access site" after each return from dialysis.

On 3/31/16, at 9:50 a.m. RN-F verified the treatment record lacked documentation for monitoring the AV graft and lacked instructions for staff should bleeding at access site occur. RN-F said he would call nurse practitioner (NP) and 9-1-1 would most likely be called.

At 9:56 a.m. RN-D said she believed the treatment record had a place to record daily monitoring of R99's access site. RN-D explained the procedure for bleeding would have been to apply pressure and call the NP for direction for severe bleeding. RN-D reviewed the treatment record and verified the lack of monitoring and documentation. The physician orders were also reviewed and lacked specific direction related to potential bleeding from the AV graft site.

On 3/31/16, at 10:09 a.m. the director of nursing (DON) explained the normal procedure for monitoring a dialysis access sites would be to monitor the site daily to check for infection or bleeding and for evidence of blood flow. The DON said she would expect the monitoring be documented on a treatment sheet.

A Dialysis Cheat Sheet used to coordinate proper care and services for a resident on dialysis was provided. The form indicated assessment and documentation of the access site was to be performed daily.

A 7/15, Dialysis Management policy included instructions to assure completion of daily assessment and documentation of the access site. The policy included a sample hemodialysis

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 _____	03/31/2016

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 282	Continued From page 12 care plan. The sample plan included a place to mark which type of access site the resident utilized. The goal was for a working site, free from signs and symptoms of infection. Interventions included "AV fistula/graft site care and monitoring as ordered; check graft site for bleeding post dialysis procedure; apply direct pressure to graft site for 15 minutes or longer for bleeding after dialysis; and notify physician immediately for graft site bleeding." In addition, staff was directed to check for proper blood flow for a fistula access site and document on the treatment record.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to adequately monitor dialysis access sites for 2 of 3 residents (R77, R99) who received dialysis. Findings include: R77 required hemodialysis due to kidney disease and had a vascular access site (a fistula), on the inside of his arm. The care plan for R77 directed staff to monitor the access site for proper functioning by feeling the site for evidence of	F 309	1. R77 and R99 treatment records have been updated to adequately monitor the dialysis access sites and reflects in the plan of care. 2. All residents at Richfield Health Center who receive dialysis services have the potential to be affected by this practice. All treatment records and care plans have been updated for resident receiving dialysis services to reflect adequate monitoring of the dialysis access sites. 3. Unit Managers and licensed nurses	5/13/16

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 _____	03/31/2016

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 309	Continued From page 13 blood flow and listening with a stethoscope for evidence of blood flow. The treatment record for R77 lacked documented evidence the nursing staff had completed the monitoring. On 3/31/16, at 8:46 a.m. a registered nurse (RN)-B verified there was no documentation to indicate completion of R77's access site for proper function. RN-B explained the site was supposed to have been monitored daily. At 9:19 a.m. RN-E produced a treatment documentation sheet dated 3/9/16, that directed staff to monitor the access site. The sheet did not indicate when the monitoring was to be completed, but rather had "all" written in under the hours column. RN-E explained when the sheet indicated, "all" the staff was not required to sign off that the treatment had indeed been completed. RN-E verified the sheet should have instead indicated a shift where documentation would be recorded. RN-E produced a new sheet where shifts would be initiated. R99 had a dialysis venous access site (AV graft) on the left side of his chest. R99 was also prescribed medication to reduce the clotting time of his blood, making him more susceptible to bleeding. The care plan for R99 (dated as reviewed 2/16), included a goal for the access site to be free from signs and symptoms of infection daily. Interventions included staff to monitor for signs and symptoms of infection such as pain, swelling, warmth, drainage and report problems to R99's physician. The dialysis care plan did not provide specific instruction on monitoring an AV graft. The care plan for risk of bleeding indicated staff was to monitor and report signs and symptoms of bleeding. The treatment record for R99 lacked directions for nursing staff	F 309	have been educated on care planning, documenting and assessing dialysis access sites. 4. Nurse Managers will complete audits on 3 dialysis residents per week to ensure appropiate care plan in place as well as daily documentation for 4 weeks, then every month times 3 months. 5. All results will be brought to the monthly Quality Assurance Performance Improvement meeting and reviewed for trends.	

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 _____	03/31/2016

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 309	Continued From page 14	F 309		

to monitor the AV graft for bleeding and lacked directions as to how to proceed if bleeding did occur. Documentation in R99's progress notes did indicate "no bleeding at access site" after each return from dialysis.

On 3/31/16, at 9:50 a.m. RN-F verified the treatment record lacked documentation for monitoring the AV graft and lacked instructions for staff should bleeding at access site occur. RN-F said he would call nurse practitioner (NP) and 9-1-1 would most likely be called.

At 9:56 a.m. RN-D said she believed the treatment record had a place to record daily monitoring of R99's access site. RN-D explained the procedure for bleeding would have been to apply pressure and call the NP for direction for severe bleeding. RN-D reviewed the treatment record and verified the lack of monitoring and documentation. The physician orders were also reviewed and lacked specific direction related to potential bleeding from the AV graft site.

On 3/31/16, at 10:09 a.m. the director of nursing (DON) explained the normal procedure for monitoring a dialysis access sites would be to monitor the site daily to check for infection or bleeding and for evidence of blood flow. The DON said she would expect the monitoring be documented on a treatment sheet.

A Dialysis Cheat Sheet used to coordinate proper care and services for a resident on dialysis was provided. The form indicated assessment and documentation of the access site was to be performed daily.

A 7/15, Dialysis Management policy included

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 _____	03/31/2016

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 309	Continued From page 15 instructions to assure completion of daily assessment and documentation of the access site. The policy included a sample hemodialysis care plan. The sample plan included a place to mark which type of access site the resident utilized. The goal was for a working site, free from signs and symptoms of infection. Interventions included "AV fistula/graft site care and monitoring as ordered; check graft site for bleeding post dialysis procedure; apply direct pressure to graft site for 15 minutes or longer for bleeding after dialysis; and notify physician immediately for graft site bleeding." In addition, staff was directed to check for proper blood flow for a fistula access site and document on the treatment record.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329		5/13/16

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 _____	03/31/2016

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 329	Continued From page 16 drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide proper medication monitoring for 1 of 5 residents (R14) reviewed for unnecessary medications. Findings include: SIDE EFFECT MONITORING: R14 stated on 3/30/16, at 7:53 a.m. stated she did not know what medications she was prescribed. She thought she was taking the antipsychotic Haldol, but was unaware of any potential medication side effects. R14 reported she had felt "a little dizzy the other day." R14's quarterly Minimum Data Set (MDS) indicated the resident had diagnoses including schizophrenia (mental illness) and the resident had moderately impaired cognition. The MDS also noted R14 had received antipsychotic and antidepressant medications daily in the one week assessment period. Physician orders dated 3/16, revealed R14 was prescribed clonazepam for anxiety, Celexa and Paxil for depression, and Zyprexa and Risperdal both antipsychotic medications. On 3/29/16, at 3:26 p.m. a licensed practical nurse (LPN)-C verified R14's last DISCUS assessment to monitor for potential tardive dyskinesia (or TD--a potential abnormal	F 329	1. R14 has had DISCUS completed. R14 has had labs completed per order. 2. All residents who receive a psychoactive medication at Richfield Health Center have the potential to be affected by this practice. All residents who receive a psychoactive medication have had DISCUS completed. Resident's lab orders in the past 30 days have been reveiwed and all labs have been drawn per order. 3. Licensed nurses, social service department, and IDT have been educated on psychoactive medication monitoring to include DISCUS completion as needed. Licensed nursing staff have been educated on the lab tracking and processing policy and procedure. Lab tracking binder will be reviewed daily M-F in the DON/UM meeting to ensure labs are drawn per orders. 4. Unit Managers/designee to audit 3 charts per week times 4 weeks, then 1 chart per month times 3 months. 5. All results will be brought to the monthly Quality Assurance Performance Improvement meeting and reviewed for trends.	

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 _____	03/31/2016

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 329	Continued From page 17	F 329		

movement disorder from antipsychotic use) had been completed on 9/9/15. The score was one indicating no TD, and the next assessment should have been completed six months later on 2/28/16. LPN-C said the nurse managers were responsible for competing the assessment, and she verified there was no other DISCUS available in R14's medical record.

A registered nurse (RN)-D then stated at 3:34 p.m. registered nurse (RN)-D she completed the DISCUS assessments. RN-D verified there was not a recent DISCUS for R14 completed in the chart nor in the nurse practitioner's (NP's) mailbox for review. RN-D verified R14's DISCUS was past due, and said she had been trying to align the assessments with each resident's quarterly assessment. RN-D reported she would complete the DISCUS next week with R14's quarterly MDS assessment. RN-D explained she thought she had competed the assessment at the time of R14's last quarterly assessment at the beginning of 1/16. At 4:22 p.m. RN-D said she had received a pile of papers on 3/17/16, including the pharmacist's recommendation a DISCUS be completed, however, she had not yet followed through on the recommendation. The following morning at 8:09 a.m. RN-D reported the TD assessments were supposed to have been competed semi-annually.

At 7:32 a.m. on 3/30/16, the director of nursing (DON) stated a new DISCUS book had been created for nurse managers on each floor so they would be able to identify when the assessments were due. The intention was to help the managers complete the assessments in a timely manner. The DON explained residents were to have a DISCUS when antipsychotic medicaiton

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 _____	03/31/2016

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 329	Continued From page 18 was imitated, and then every three to six months, depending on the medicaiton prescribed. LABORATORY TESTING On 3/29/16, at 3:19 p.m. RN-D verified R14's laboratory (lab) testing order from the nephrologist's visit had not been ordered. RN-D instructed LPN-C to call the NP or the nephrologist and see if R14's lab was still required, as the testing had not been completed as ordered. LPN-C called the nephrologist's office and then instructed RN-D the basic metabolic profile (or BMP consisting of eight commonly ordered lab tests) was still needed, as it was required as part of the standing orders when initiating the multivitamin with minerals, TheraLith. At 4:22 p.m. The DON was asked about the missing lab work and stated, "I have to educate--re-educate on lab procedures." The DON explained lab results were faxed to the facility and she would check with the NP to see if she had reviewed it. On 3/31/16, at 10:20 a.m. RN-G stated she recalled when R14's TheraLith came in, she first dated it 3/8/16, and then opened it. RN-G stated the medication was started the following day, and the next time she worked was 3/10/16, and she administered the TheraLith to R14 that day. RN-G verified the lab work for R14 had been missed, and should have been drawn on 3/16/16. RN-G said she had transcribed the order for the lab draw, but the lab work was inadvertently drawn in February, although the physician's order read to draw the lab work one week after starting the medicaiton (3/9/16). RN-G stated R14's BMP had been drawn yesterday and the results faxed to the physician and put on the facility's 24-hour report. At 1:16 p.m. on 3/31/16, the DON reported the	F 329		

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 _____	03/31/2016

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 329	Continued From page 19 NP and physicians had since been updated with R14's laboratory results, and the results had been filed in the resident's medical record.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced	F 356		5/13/16

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 _____	03/31/2016

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 356	Continued From page 20 by: Based on observation, interview and document review, the facility failed to post accurate staff postings. This had the potential to affect all residents and visitors to the facility. Findings include: During interview with the staffing coordinator (SC) on 3/30/16, at 2:24 p.m. she stated she posted the staff posting when she left the facility at 5:00 p.m. Monday through Friday. The night nurse on third floor posted the information when she came in on Saturday and Sunday nights. The SC stated the posting reflected the day starting with the night shift at 10:00 p.m. on the top of the form. When visitors came in to the facility in the evening Monday through Friday they would have been unable to see the nursing hours and census for that evening as the posting had already been switched to the next day starting with night shift when she left for the day. The SC stated she was responsible for the scheduling when she was in the facility which included replacements for staff call ins. The SC stated sometimes licensed practical nurses (LPNs) were replaced with trained medication assistants (TMAs) and sometimes LPNs were replaced with registered nurses (RNs) and only seldom was she unable to replace a staff person on a shift. She did not update the information if the census had changed. The SC stated the staff postings were not always accurate as posted, and she had not been trained to make changes to the posting after it was made posted the previous evening. The SC stated the facility did not have a policy related to staff posting. The January through March 2016 nursing	F 356	1. Daily nurse staff posting was immediately corrected/updated after identification. 2. Staffing coordinator, facility nursing supervisors and IDT will be educated on the facility's Daily Nurse Staffing policy by the Executive Director or designee. 3. ED/Designee will audit Daily Nurse Staffing form 2 times per week for one month, then 1 time per week for an additional 2 months. 4. All results will be brought to the monthly Quality Assurance performance Improvement meeting and reviewed for trends.	

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 _____	03/31/2016

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 356	Continued From page 21 schedules indicated changes in nursing disciplines and length of the nursing shift worked. The nursing schedule same time frame reviewed also indicated occasional not replacing a nursing staff with call ins. The corresponding January through March 2016 daily staffing postings indicated no updates had been made to nursing disciplines, length of shift worked nor census changes. The facility's 7/15, Daily Nurse Staffing policy directed staff as follows: "The Daily Nurse Staffing (Copy Form) is completed at the beginning at each shift to post nurse--staffing data for the licensed and unlicensed staff directly responsible for resident care in the facility ... Centers must post the information daily at the beginning of each shift. Any changes to the posted information must be made as soon as possible...Initiate the Daily Nurse Staffing (Copy Form) at the start of the Night shift...Post each shift staff numbers very close to the beginning of the shift in order to ensure that the posted numbers are actual staff working the shift. If any changes to the information posted are needed, they must be made as soon as possible. "	F 356		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441		5/13/16

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 _____	03/31/2016

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 441	Continued From page 22 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement procedures to minimize the spread of infection during blood glucose monitoring for 1 of 1 resident (R102). In addition, the facility failed to properly sanitize a shared glucometer after use, having the potential to affect six other first floor residents who shared the glucometer.	F 441	1. The facility's infection control policy and procedures were reviewed. The facility has implemented procedures to assist in minimizing the spread of infection during blood glucose monitoring per our policy and procedure. 2. All diabetic residents at Richfield Health Center receiving blood glucose monitoring have the protential to be	

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 _____	03/31/2016

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 441	Continued From page 23 Findings include: During observation on 3/28/16, at 5:48 p.m. a licensed practical nurse (LPN)-B retrieved a blood glucose machine from the medication cart, entered R102's room and proceeded to check his blood sugar without donning gloves. LPN-B then left R102's room, returned to medication cart and disposed off the used lancets in the sharps container (used to safely store used sharps). LPN-B then donned gloves, took a sanitizing wipe from the cart and wrapped the glucometer machine. Without wearing gloves, LPN-B then prepared R102's insulin (used to lower blood sugar) and administered it to the resident. R102's physician's orders signed on 2/23/16, indicated an order for Insulin-Novolog 100 u/ml to be injected subcutaneous three times daily and at bedtime per sliding scale for diabetes. LPN-B explained at 5:55 p.m. that wearing gloves during glucose monitoring or insulin injection was optional. LPN-B stated, "We can either use gloves or not--it's optional." LPN-B explained that after using the glucometer machine, the procedure was to to wipe the machine down with a sanitizing wipes, throw away the wipe, get another wipe and wrap the machine for about two minutes "to kill germs." LPN-B confirmed she did not wipe the machine prior to wrapping it with the sanitizing wipe. LPN-B stated, "I was supposed to wipe it before wrapping it. I guess I forgot." A registered nurse (RN)-E was interviewed later at 6:01 p.m. and explained the expectations were for staff to wear gloves when measuring a resident's blood glucose. RN-E explained that glucometer machines were supposed to be wiped	F 441	affected by this practice. The facility has implemented procedures to assist in minimizing the spread of infection during blood glucose monitoring. 3. License nurses have been educated on the policy and procedure in relation to the process for cleaning and sanitizing glucometers. 4. DON/Designee to audit the process for cleaning/sanitizing glucometers 1 times per week for 4 weeks, then 1 time a month for 3 months. 5. All results will be brought to the monthly Quality Assurance Performance Improvement meeting and reviewed for trends.	

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 _____	03/31/2016

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 441	Continued From page 24 with sanitizing wipes after use and then wrapped for "couple of minutes" with a sanitizing wipe to kill germs. On 3/30/16, at 2:42 p.m. the director of nursing (DON) was interviewed, and explained staff was supposed to have wear gloves when obtaining blood glucose "but not necessarily when administering shots." The DON explained her expectation was for staff to sanitize the glucometer machines per facility policy. A facility's 7/15, Glucose Monitoring Equipment: Disinfect/Decontaminate policy directed, "Don gloves to perform test. Perform blood glucose test according to manufacturer's recommendation as required." Under the Cleaning the Glucometer the policy directed, "Use the disinfectant wipe to clean all external parts of the glucometer with gloves on. Remove gloves. Perform hand hygiene. Don clean gloves. Obtain a second wipe and fresh paper towel. Use the wipe to clean all external parts of the glucometer for the second cleaning. Allow the meter to remain wet for the contact time required by manufacturer's recommendation before completing another glucose test."	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by:	F 465		5/13/16

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 _____	03/31/2016

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 465	Continued From page 25 Based on observation, interview, and document review, the facility failed to ensure the environment was maintained in a clean manner and in good repair. This had the potential to affect the sixteen residents who resided in the identified rooms. Findings include: An environmental tour was completed on 3/31/16, at 10:07 a.m. with the maintenance assistant (MA), director of housing and laundry (DHL) and the executive director (ED). The following issues were identified and were confirmed by both the MA, DHL and the ED: 1) The floor on the shared room 112 on the first floor was observed to be stained with black and brown sticky stains throughout the floor. Shades were missing on the lights in the bathroom. The DHL confirmed that floor was dirty and stated, "I think we can do better than this." The MA confirmed the lights in bathroom did not have shades and explained they "were probably taken off when the resident complained of the bathroom being too dark." When asked if the current residents in room had requested they be removed the MA replied, "I'm not sure." 2) The heat register in the shared room 118 was off the wall and hanging loose. The shared bathroom floor was covered with black stains, and there was a sticky brown/black stain around the toilet base. The MA explained that nursing staff was supposed to fill out work orders for any environmental issues. The ED explained the register needed to be repaired and stated, "That should have been caught by now." The DHL confirmed that bathroom was dirty and stated, "We can do better cleaning than that."	F 465	1. The floor in room 112 was stripped and waxed on 4/7/16 and the bathroom light was replaced. 2. The heat register in room 118 was repaired and the floor in the bathroom was cleaned on 4/1/16. 3. The wall by the head of the bed in room 124 is scheduled to be repaired on 4/29/16. 4. The heat register in room 201 was repaired on 4/1/16. 5. R25's rube feeding pole was cleaned on 4/1/16. 6. The bathroom door in room 209 was repaired on 4/1/16. 7. The bathroom door in room 219 and the heat register were repaired on 4/1/16. All residents have potential to be affected. Staff were re-educated on the facility's policy and procedure on communication of needed repairs using the maintenance forms. Maintenance and housekeeping personnel will complete preventative maintenance rounds and observations of rooms per policy. Caring Partners during weekly visits will observe rooms for cleanliness and repairs and report findings to Executive Director. Issues will be corrected as needed. Trend of reviews and audits will be forwarded to the Quality Assurance Performance Improvement Meeting. Maintenance Director, Housekeeping Director and the Executive Director will complete daily rounds to ensure future	

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 _____	03/31/2016

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 465	Continued From page 26 3) The wall by the head of bed in room 124 near the door had scraped plaster in many places from the bed down. The MA explained it had been caused by the bed in the room, and stated it would be repaired. 4) The heat register behind the head of the bed by the window in room 201 had a large crack along the wall. The heat register was also scraped. The ED and MA confirmed the register needed repairs. 5) The base of R25's tube feeding pole was covered with brown sticky stain and had a brown substance dripping from the top to bottom of the pole. The DHL explained that house keeping was responsible for wiping down resident equipment. The DHL touched the pole and stated, "This can come off. It just needs a little more scrubbing." The DHL explained housekeeping staff was supposed to let him know about such issues so he could thoroughly clean it. 6) The shared bathroom door in room 209 had two large holes on the lower part of the door. The MA explained it should have been reported via maintenance slip. The MA explained staff were supposed to fill the maintenance slip with any environmental issues "and I check them periodically throughout the day." The MA stated, "We can fix this with a metal plate." 7) The shared bathroom door in room 219 had two large holes; one at the top and another in the middle. The heat register by the window had a large rusted area by the edge. The MA explained that the bathroom door "will need to be replaced and the register will be painted." During a follow-up interview with the DHL at 12:41 p.m. it was explained the staff was supposed to have followed a checklist. The DHL also explained there was always a housekeeper on	F 465	compliance.	

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 _____	03/31/2016

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 465	Continued From page 27 each floor during the day, but not on the evening shift. The MA was interviewed at 1:10 p.m. explained the facility utilized a preventive maintenance plan that "We go through each month and check off what we have done." The MA said additionally, staff was supposed to also fill out the maintenance slips "that are located on each floor" if they observed any environmental concerns. A facility's Cleaning Principles (Housekeeping) dated 7/15, directed, "The center strives to ensure that the worksite is maintained in a clean and sanitary condition. Each center will determine and implement an appropriate written schedule for cleaning and method of decontamination based upon the location within the center, type of surface to be cleaned, type of soil present, and tasks or procedures being performed in the area."	F 465		

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 _____	**03/30/2016**

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
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 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 Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Richfield Health 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: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/22/2016

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 _____	**03/30/2016**

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
K 000	Continued From page 1 By e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@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 Richfield Health Center is a 3-story building was constructed in 1971 and was determined to be of Type II (222) construction. It has a full basement. The facility is fully fire sprinklered protected and 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 104 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 018 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than	K 018		4/1/16

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 _____	**03/30/2016**

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
K 018	Continued From page 2 required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility had 1 of several corridor doors that did not meet the requirements of NFPA 101 LSC (00) section 19.3.6.3.2. This deficient practice could affect 20 of 104 residents, as well as an undetermined number of staff, and visitors if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On facility tour between 9:30 AM and 1:30 PM on 03/30/16, it was observed that the corridor door leading to the conference room on the main level of the facility did not completely close and latch into the frame under normal efforts and required an inordinate amount of effort to force the door to latch into the frame. This deficient condition was verified by the	K 018	The corridor door leading to the conference room on the main level was repaired on 4/1/16 and it does latch. All doors within the facility are checked on a regular basis to ensure they have a positive latch. Maintenance will audit quarterly to ensure future compliance.	

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 _____	**03/30/2016**

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
K 018	Continued From page 3 Maintenance Supervisor.	K 018		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a means of egress in accordance with the following requirements of the NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 19.2.1 and 7.2.1.5.1 and the 2007 MN State Fire Code, Appendix I. This deficient practice could affect 104 of 104 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 9:30 AM and 1:30 PM on 03/30/16, Observation revealed that the doors to exit stairwells have a coded keypad used to unlock the doors to the stairwells, but did not have a the code or instructions on how to open the door posted at the location of the keypad. This deficient condition was verified by the Maintenance Supervisor.	K 038	A 2-push button release station will be installed with a sounding cover to both 3rd floor stairwell doors to ensure a means of egress for staff and visitors. A vendor has ordered the parts and installation is scheduled for 4/29/16. Maintenance will monitor during daily rounds to ensure future compliance.	4/29/16
K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership.	K 050		4/29/16

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 _____	**03/30/2016**

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
K 050	Continued From page 4 Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct fire drills in accordance with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.7.1.2, during the last 12-month period. This deficient practice could affect 104 of 104 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 9:30 AM and 1:30 PM on 03/30/16, during the review of all available fire drill documentation and interview with the Maintenance Supervisor it was revealed that the facility had conducted 3 fire drills in the 4 AM hour thus failing to vary the times of the fire drills. This deficient condition was verified by the Maintenance Supervisor.	K 050	The facility conducted Fire Drill training with the NOC nursing staff on 4/20/16. The NOC fire drills will be conducted at various times during the shift each month. The maintenance director will monitor and audit monthly to ensure compliance.	
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of	K 051		4/20/16

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 _____	**03/30/2016**

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
K 051	Continued From page 5 egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observation and staff interview it was revealed that the facility failed to correctly install manually actuated alarm-initiating devices throughout the facility in accordance with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 19.3.4.2 and 9.6.2, NFPA 72 National Fire Alarm Code (99), Sections 2-8.1 and 2-8.2, and the MN State Fire Code 907.3.3.1. This deficient condition could adversely affect the ability to initiate the fire alarm system and delay emergency actions, and emergency forces notification in the event of an emergency, thus negatively affecting 104 of 104 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 9:30 AM and 1:30 PM on 03/30/16, observation revealed that the Manual fire alarm boxes located at the main entrance, 3 west stairwell and in the 3 west nurses station are mounted at 59 inches above the floor level which is higher than the maximum 54 inches as stated in NFPA 72 (99)	K 051	The manual fire alarm boxes located at the main entrance, 3 west stairwell and 3 west nurses station have been mounted to the proper height. Maintenance will monitor for future compliance.	

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 _____	**03/30/2016**

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
K 051	Continued From page 6 This deficient condition was verified by the Maintenance Supervisor.	K 051		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NAPA 13 the Standard for the Installation of Sprinkler Systems 1999 edition. The failure to maintain the sprinkler system in compliance with NAPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect 104 of 104 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 9:30 AM and 1:30 PM on 03/30/16, observations reveled that in the mechanical room that contains the fire sprinkler riser it was found that the sprinkler riser and auxiliary components are not clearly labeled or identified.	K 056	The sprinkler riser and auxiliary components have been clearly labled in accordance with NAPA 13. The maintenance director will monitor for future compliance.	4/19/16

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 _____	**03/30/2016**

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
K 056	Continued From page 7 This deficient condition was verified by the Maintenance Supervisor.	K 056		
K 064 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, it was determined that the facility failed to maintain portable fire extinguishers in accordance with NFPA 101-2000 edition and NFPA 10. This deficient practice could affect 10 of 104 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 9:30 AM and 1:30 PM on 03/30/16, observations revealed that the K-Class fire extinguisher which is located in the kitchen is mounted 67 inches from the floor level which is higher than 5 feet above the floor level maximum as specified in NFPA 10. This deficient condition was verified by the Maintenance Supervisor.	K 064	The K-class fire extinguisher located in the kitchen has been mounted to the proper height as specified in NFPA 10. The maintenance director will monitor for future compliance.	4/1/16
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		4/20/16

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 _____	**03/30/2016**

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
K 067	Continued From page 8 This STANDARD is not met as evidenced by: Based on observations and an interview, it was revealed that the facility is using the corridors as part of the air distribution system to provide make-up air for the sleeping rooms' bathroom exhaust, throughout the building which is not in accordance with NFPA 90A. This deficient practice could allow the products of combustion to travel far from the fire origin and negatively affect 104 of 104 residents, as well as an undetermined number of staff, and visitors by restricting their means of egress in a fire situation.. Findings include: On facility tour between 9:30 AM and 1:30 PM on 03/30/16, 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. This deficient condition was verified by the Maintenance Supervisor.	K 067	The center is requesting an annual waiver. Please see attached Annual Waiver Request.	
K 130 SS=C	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility had combustibles to close to the fuel-fired equipment. This deficient practice is in violation of the Minnesota State Fire Code (07) 315.2.3.1 and	K 130	All combustible items have been removed from the mechanical room on the lower level. Maintenenace director will monitor on a weekly basis to ensure future	4/5/16

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 _____	**03/30/2016**

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
K 130	Continued From page 9 315.2.3.2 Miscellaneous combustible materials storage and clearance. A working space of not less than 36 inches from fuel-fired equipment or appliances. Not maintaining neat and orderly storage and allowing the combustible storage to be placed up to and against fuel-fired equipment or appliances could negatively affect 20 of 104 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 9:30 AM and 1:30 PM on 03/30/16, it was observed in the mechanical room on the lower level of the facility containing fuel-fired hot water heaters had excessive amounts of combustible storage placed next to, and against, the water heaters. This deficient condition was verified by the Maintenance Supervisor.	K 130	compliance.	

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 13, 2016

Ms. Jo Ann Buytendorp, Administrator
Richfield Health Center
7727 Portland Avenue South
Richfield, Minnesota 55423

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5492026

Dear Ms. Buytendorp:

The above facility was surveyed on March 28, 2016 through March 31, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the

statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Gayle Lantto at (651) 201-3794**.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING: _____ B. WING _____	03/31/2016

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING: _____ B. WING _____	03/31/2016

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) COMPLETE DATE
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On March 28, 29, 30, and 31, 2016, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING: _____ B. WING _____	03/31/2016

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) COMPLETE DATE
2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to adequately monitor dialysis access sites for 2 of 3 residents (R77, R99) who received dialysis. Findings include: R77 required hemodialysis due to kidney disease and had a vascular access site (a fistula), on the inside of his arm. The care plan for R77 directed staff to monitor the access site for proper functioning by feeling the site for evidence of blood flow and listening with a stethoscope for evidence of blood flow. The treatment record for R77 lacked documented evidence the nursing staff had completed the monitoring. On 3/31/16, at 8:46 a.m. a registered nurse (RN)-B verified there was no documentation to indicate completion of R77's access site for proper function. RN-B explained the site was supposed to have been monitored daily. At 9:19	2 565	Correct	4/27/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING: _____ B. WING _____	03/31/2016

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) COMPLETE DATE
2 565	Continued From page 3	2 565		

a.m. RN-E produced a treatment documentation sheet dated 3/9/16, that directed staff to monitor the access site. The sheet did not indicate when the monitoring was to be completed, but rather had "all" written in under the hours column. RN-E explained when the sheet indicated, "all" the staff was not required to sign off that the treatment had indeed been completed. RN-E verified the sheet should have instead indicated a shift where documentation would be recorded. RN-E produced a new sheet where shifts would be initiated.

R99 had a dialysis venous access site (AV graft) on the left side of his chest. R99 was also prescribed medication to reduce the clotting time of his blood, making him more susceptible to bleeding. The care plan for R99 (dated as reviewed 2/16), included a goal for the access site to be free from signs and symptoms of infection daily. Interventions included staff to monitor for signs and symptoms of infection such as pain, swelling, warmth, drainage and report problems to R99's physician. The dialysis care plan did not provide specific instruction on monitoring an AV graft. The care plan for risk of bleeding indicated staff was to monitor and report signs and symptoms of bleeding. The treatment record for R99 lacked directions for nursing staff to monitor the AV graft for bleeding and lacked directions as to how to proceed if bleeding did occur. Documentation in R99's progress notes did indicate "no bleeding at access site" after each return from dialysis.

On 3/31/16, at 9:50 a.m. RN-F verified the treatment record lacked documentation for monitoring the AV graft and lacked instructions for staff should bleeding at access site occur. RN-F said he would call nurse practitioner (NP) and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING: _____ B. WING _____	03/31/2016

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) COMPLETE DATE
2 565	Continued From page 4 9-1-1 would most likely be called. At 9:56 a.m. RN-D said she believed the treatment record had a place to record daily monitoring of R99's access site. RN-D explained the procedure for bleeding would have been to apply pressure and call the NP for direction for severe bleeding. RN-D reviewed the treatment record and verified the lack of monitoring and documentation. The physician orders were also reviewed and lacked specific direction related to potential bleeding from the AV graft site. On 3/31/16, at 10:09 a.m. the director of nursing (DON) explained the normal procedure for monitoring a dialysis access sites would be to monitor the site daily to check for infection or bleeding and for evidence of blood flow. The DON said she would expect the monitoring be documented on a treatment sheet. A Dialysis Cheat Sheet used to coordinate proper care and services for a resident on dialysis was provided. The form indicated assessment and documentation of the access site was to be performed daily. A 7/15, Dialysis Management policy included instructions to assure completion of daily assessment and documentation of the access site. The policy included a sample hemodialysis care plan. The sample plan included a place to mark which type of access site the resident utilized. The goal was for a working site, free from signs and symptoms of infection. Interventions included "AV fistula/graft site care and monitoring as ordered; check graft site for bleeding post dialysis procedure; apply direct pressure to graft site for 15 minutes or longer for bleeding after dialysis; and notify physician immediately for graft	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING: _____ B. WING _____	03/31/2016

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) COMPLETE DATE
2 565	Continued From page 5 site bleeding." In addition, staff was directed to check for proper blood flow for a fistula access site and document on the treatment record. SUGGESTED METHOD OF CORRECTION: The director of nursing could develop, review, and/or revise policies and procedures to ensure the facility followed care plan interventions according to the resident's individualized needs. The director of nursing could educate all appropriate staff on the policies and procedures to follow care plan interventions. The director of nursing could monitor to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide opportunities to	2 570	Corrected	5/13/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING: _____ B. WING _____	03/31/2016

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) COMPLETE DATE
2 570	Continued From page 6 participate in care planning for 2 of 3 residents (R14, R85) reviewed for choices. Findings include: R14's care conferences were not held quarterly. On 3/30/16, at 8:09 a.m. a registered nurse (RN)-D stated care conferences held were charted in the progress notes by the licensed social workers (LSWs). RN-D also stated R14's guardian had been invited to the care conferences and R14's care conferences had been canceled a couple of times. RN-D stated care conferences were to be held quarterly. At 8:25 a.m. LSW-B stated R14's care conference was canceled early January as the guardian did not show up and was also canceled for "tomorrow" as it had been a busy week. On 3/30/16, at 10:29 a.m. R14 stated she would like more than one shower a week. R14 also stated that her teeth were "not good"--she was missing some top teeth and her front teeth ached sometimes, and had for "awhile." R14 stated she was supposed to have seen the dentist six months to a year after her last visit, but that it had been awhile. R14 re-stated that her top front teeth hurt and that she did not think that the facility had made her a dental appointment. R14's quarterly Minimum Data Set (MDS) dated 1/3/16, indicated R14's cognition was moderately impaired and rejected no cares. At 10:36 a.m. a nursing assistant (NA)-E said R14 had not said anything to her about her teeth hurting in morning cares, but she would tell the nurse and medical records person about it as she scheduled the dental appointments.	2 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING: _____ B. WING _____	03/31/2016

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) COMPLETE DATE
2 570	Continued From page 7 Following the interview, a registered nurse (RN)-D stated R14 had seen the dentist 10/8/15, and that she had not heard about R14's teeth hurting. At 10:41 a.m. the medical records staff person (MR) stated she had not known about R14's teeth hurting but she would ensure she was placed on the list to see the dentist. At 2:05 p.m. the MR while looking through R14's chart stated R14 s last actual care conference had been held 3/24/15, with the resident, social services and therapy present. MR stated R14's guardian had been invited, but had not answered. At 2:13 p.m. RN-D explained a care conference for R14 had been planned for 3/31/16, but was canceled due to being a busy week. On 3/31/16, at 12:05 p.m. LSW-B stated if a resident or guardian declined a care conference one was not held. LSW-B stated she was new to the position and the previous LSW had been behind on care conferences at the time he left the position. LSW-B verified there had not been a care conference held for R14 since 3/15. On 3/31/16, at 12:05 p.m. LSW-B also verified there was no documentation indicating R14 refused a care conference. R85 had stated to surveyor on 3/28/16, at 2:44 p.m. that she would like at least two showers a week, preferably three, but presently only received one shower a week. R85's quarterly MDS dated 3/5/16, indicated R85's cognition was intact. R85's care conferences were not held quarterly. On 3/31/16, at 12:05 p.m. LSW-B verified there was no documented evidence R85 had a care	2 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING: _____ B. WING _____	03/31/2016

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) COMPLETE DATE
2 570	Continued From page 8 conference or declined a care conference. At 1:38 p.m. on 3/31/16, the director of social services (DSS) stated resident care conferences were held upon admission and held quarterly after that. The DSS stated residents and guardians were both invited to the care conferences. The DSS stated care conferences would be rescheduled if needed and would let the resident know because of resident choice. The DSS stated care plans were reviewed at care conferences. The facility's 7/15, Resident/Family Conference policy indicated, "The center will encourage the resident and/or family/legal representative to attend the Resident Care Conference, which will be scheduled with the appropriate Interdisciplinary Team (IDT) members. The conferences will be scheduled based on identified needs and regulatory standards..Discuss the Plan of Care goals with the resident/family/responsible party to express their preferences about care. a. Respect and incorporate their preferences in the care decisions. 6. Summarize the outcome of the meeting and document attendance." SUGGESTED METHOD OF CORRECTION: The licensed social workers (LSWs) could develop and implement policies and procedures related to timely care conferences. The LSWs could provide training for all nursing staff related to the timeliness of care conference. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING: _____ B. WING _____	03/31/2016

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) COMPLETE DATE
2 830	Continued From page 9	2 830		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to adequately monitor dialysis access sites for 2 of 3 residents (R77, R99) who received dialysis. Findings include: R77 required hemodialysis due to kidney disease and had a vascular access site (a fistula), on the inside of his arm. The care plan for R77 directed staff to monitor the access site for proper functioning by feeling the site for evidence of blood flow and listening with a stethoscope for evidence of blood flow. The treatment record for R77 lacked documented evidence the nursing staff had completed the monitoring. On 3/31/16, at 8:46 a.m. a registered nurse (RN)-B verified there was no documentation to indicate completion of R77's access site for	2 830	corrected	4/27/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING: _____ B. WING _____	03/31/2016

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) COMPLETE DATE
2 830	Continued From page 10 proper function. RN-B explained the site was supposed to have been monitored daily. At 9:19 a.m. RN-E produced a treatment documentation sheet dated 3/9/16, that directed staff to monitor the access site. The sheet did not indicate when the monitoring was to be completed, but rather had "all" written in under the hours column. RN-E explained when the sheet indicated, "all" the staff was not required to sign off that the treatment had indeed been completed. RN-E verified the sheet should have instead indicated a shift where documentation would be recorded. RN-E produced a new sheet where shifts would be initiated. R99 had a dialysis venous access site (AV graft) on the left side of his chest. R99 was also prescribed medication to reduce the clotting time of his blood, making him more susceptible to bleeding. The care plan for R99 (dated as reviewed 2/16), included a goal for the access site to be free from signs and symptoms of infection daily. Interventions included staff to monitor for signs and symptoms of infection such as pain, swelling, warmth, drainage and report problems to R99's physician. The dialysis care plan did not provide specific instruction on monitoring an AV graft. The care plan for risk of bleeding indicated staff was to monitor and report signs and symptoms of bleeding. The treatment record for R99 lacked directions for nursing staff to monitor the AV graft for bleeding and lacked directions as to how to proceed if bleeding did occur. Documentation in R99's progress notes did indicate "no bleeding at access site" after each return from dialysis. On 3/31/16, at 9:50 a.m. RN-F verified the treatment record lacked documentation for monitoring the AV graft and lacked instructions for	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING: _____ B. WING _____	03/31/2016

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) COMPLETE DATE
2 830	Continued From page 11 staff should bleeding at access site occur. RN-F said he would call nurse practitioner (NP) and 9-1-1 would most likely be called. At 9:56 a.m. RN-D said she believed the treatment record had a place to record daily monitoring of R99's access site. RN-D explained the procedure for bleeding would have been to apply pressure and call the NP for direction for severe bleeding. RN-D reviewed the treatment record and verified the lack of monitoring and documentation. The physician orders were also reviewed and lacked specific direction related to potential bleeding from the AV graft site. On 3/31/16, at 10:09 a.m. the director of nursing (DON) explained the normal procedure for monitoring a dialysis access sites would be to monitor the site daily to check for infection or bleeding and for evidence of blood flow. The DON said she would expect the monitoring be documented on a treatment sheet. A Dialysis Cheat Sheet used to coordinate proper care and services for a resident on dialysis was provided. The form indicated assessment and documentation of the access site was to be performed daily. A 7/15, Dialysis Management policy included instructions to assure completion of daily assessment and documentation of the access site. The policy included a sample hemodialysis care plan. The sample plan included a place to mark which type of access site the resident utilized. The goal was for a working site, free from signs and symptoms of infection. Interventions included "AV fistula/graft site care and monitoring as ordered; check graft site for bleeding post dialysis procedure; apply direct pressure to graft	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING: _____ B. WING _____	03/31/2016

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) COMPLETE DATE
2 830	Continued From page 12 site for 15 minutes or longer for bleeding after dialysis; and notify physician immediately for graft site bleeding." In addition, staff was directed to check for proper blood flow for a fistula access site and document on the treatment record. SUGGESTED METHOD OF CORRECTION: The director of nurses could educate staff on the current dialysis policies and expectations of proper assessment and timely interventions related to dialysis access site. An audit could be completed to ensure compliance and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 830		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as	21390		5/13/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING: _____ B. WING _____	03/31/2016

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) COMPLETE DATE
21390	Continued From page 13 defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement procedures to minimize the spread of infection during blood glucose monitoring for 1 of 1 resident (R102). In addition, the facility failed to properly sanitize a shared glucometer after use, having the potential to affect six other first floor residents who shared the glucometer. Findings include: During observation on 3/28/16, at 5:48 p.m. a licensed practical nurse (LPN)-B retrieved a blood glucose machine from the medication cart, entered R102's room and proceeded to check his blood sugar without donning gloves. LPN-B then left R102's room, returned to medication cart and disposed off the used lancets in the sharps container (used to safely store used sharps). LPN-B then donned gloves, took a sanitizing wipe from the cart and wrapped the glucometer machine. Without wearing gloves, LPN-B then prepared R102's insulin (used to lower blood sugar) and administered it to the resident. R102's physician's orders signed on 2/23/16, indicated an order for Insulin-Novolog 100 u/ml to be injected subcutaneous three times daily and at	21390	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING: _____ B. WING _____	03/31/2016

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) COMPLETE DATE
21390	Continued From page 14 bedtime per sliding scale for diabetes. LPN-B explained at 5:55 p.m. that wearing gloves during glucose monitoring or insulin injection was optional. LPN-B stated, "We can either use gloves or not--it's optional." LPN-B explained that after using the glucometer machine, the procedure was to to wipe the machine down with a sanitizing wipes, throw away the wipe, get another wipe and wrap the machine for about two minutes "to kill germs." LPN-B confirmed she did not wipe the machine prior to wrapping it with the sanitizing wipe. LPN-B stated, "I was supposed to wipe it before wrapping it. I guess I forgot." A registered nurse (RN)-E was interviewed later at 6:01 p.m. and explained the expectations were for staff to wear gloves when measuring a resident's blood glucose. RN-E explained that glucometer machines were supposed to be wiped with sanitizing wipes after use and then wrapped for "couple of minutes" with a sanitizing wipe to kill germs. On 3/30/16, at 2:42 p.m. the director of nursing (DON) was interviewed, and explained staff was supposed to have wear gloves when obtaining blood glucose "but not necessarily when administering shots." The DON explained her expectation was for staff to sanitize the glucometer machines per facility policy. A facility's 7/15, Glucose Monitoring Equipment: Disinfect/Decontaminate policy directed, "Don gloves to perform test. Perform blood glucose test according to manufacturer's recommendation as required." Under the Cleaning the Glucometer the policy directed, "Use the disinfectant wipe to clean all external parts of the glucometer with gloves on. Remove gloves. Perform hand	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING: _____ B. WING _____	03/31/2016

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) COMPLETE DATE
21390	Continued From page 15 hygiene. Don clean gloves. Obtain a second wipe and fresh paper towel. Use the wipe to clean all external parts of the glucometer for the second cleaning. Allow the meter to remain wet for the contact time required by manufacturer's recommendation before completing another glucose test." SUGGESTED METHOD OF CORRECTION: The infection control nurse could review policies and procedures to ensure proper infection control techniques regarding cleaning of blood glucose equipment are followed. The director of nursing could ensure the staff were educated on the importance to minimize the potential spread of infections. An audit could be completed to ensure compliance, and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.	21426		5/13/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING: _____ B. WING _____	03/31/2016

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) COMPLETE DATE
21426	Continued From page 16 (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure Employee Tuberculosis (TB) Screening, Tuberculin Skin Test (TST) and medical evaluations for 3 of 5 employees (E1, E2, E3) was completed prior to working with residents as required. In addition, the facility failed to ensure 2 of 5 residents (R115, R159) had TB Screening, TST and medical evaluations completed. Findings include: A review of employee files was conducted on 3/29/16, at approximately 2:00 p.m. The review revealed E1 had a start date of 1/26/16. A TB symptom screen was completed on 1/26/16 and a first-step TST completed on 1/24/16. A second TST, a blood test or a chest x-ray was not completed. E-2 had a start date of 12/14/15. A TB symptoms screen was not completed. A negative chest X-ray dated 9/3/15 was on file. E3 had a start date of 12/4/15. A TB symptom screen and first-step TST was done on 12/14/15. A second TST, a blood test or a chest x-ray was not completed. A review of resident medical records was conducted on 3/29/16, at approximately 3:00 p.m. The review revealed R159 was admitted on	21426	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING: _____ B. WING _____	03/31/2016

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) COMPLETE DATE
21426	Continued From page 17	21426		

2/11/16. A TB symptom screen was completed on 2/11/16. A first-step TST was completed on 2/12/16, but lacked the mm of induration/ interpretation of reading as required. A 2nd-step was completed on 2/26/16, but there were again no results documented. R115 was admitted on 6/1/15. A symptoms screen and first-step TST was completed on 6/1/15. A negative interpretation of reading was document but no number of mm of induration documented. A second-step TST was completed on 6/10/15, but there were no results documented.

An interview was conducted with the director of nursing (DON) on 3/30/16, at 2:32 p.m. The DON verified staff TST were not completed as per the facility's policy. DON explained that the development staff responsible for tracking TB screening and testing for staff had moved to different position and responsibility was handed to her. The DON acknowledged that "I know we have a problem with that [staffs' Mantoux]." The DON explained staff and residents are supposed to have had a two-step TST completed. The DON explained the TST testing would be repeated.

A facility's Tuberculosis Exposure Control Plan dated 7/15, directed, "The center will administer the two-step Mantoux Purified Protein Derivative (PPD) Test to all new residents as required by State Regulations on admission unless they have documented evidence of previous positive skin test which includes millimeters (mm) of induration."

SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service the staff responsible for completing and monitoring the TB program to ensure it is consistent with current TB requirements. Audits could be conducted and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING: _____ B. WING _____	03/31/2016

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) COMPLETE DATE
21426	Continued From page 18 results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days	21426		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide proper medication monitoring for 1 of 5 residents (R14) reviewed for unnecessary medications.	21540	Correct	5/13/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING: _____ B. WING _____	03/31/2016

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) COMPLETE DATE
21540	Continued From page 19 Findings include: SIDE EFFECT MONITORING: R14 stated on 3/30/16, at 7:53 a.m. stated she did not know what medications she was prescribed. She thought she was taking the antipsychotic Haldol, but was unaware of any potential medication side effects. R14 reported she had felt "a little dizzy the other day." R14's quarterly Minimum Data Set (MDS) indicated the resident had diagnoses including schizophrenia (mental illness) and the resident had moderately impaired cognition. The MDS also noted R14 had received antipsychotic and antidepressant medications daily in the one week assessment period. Physician orders dated 3/16, revealed R14 was prescribed clonazepam for anxiety, Celexa and Paxil for depression, and Zyprexa and Risperdal both antipsychotic medications. On 3/29/16, at 3:26 p.m. a licensed practical nurse (LPN)-C verified R14's last DISCUS assessment to monitor for potential tardive dyskinesia (or TD--a potential abnormal movement disorder from antipsychotic use) had been completed on 9/9/15. The score was one indicating no TD, and the next assessment should have been completed six months later on 2/28/16. LPN-C said the nurse managers were responsible for competing the assessment, and she verified there was no other DISCUS available in R14's medical record. A registered nurse (RN)-D then stated at 3:34 p.m. registered nurse (RN)-D she completed the DISCUS assessments. RN-D verified there was not a recent DISCUS for R14 completed in the	21540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING: _____ B. WING _____	03/31/2016

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) COMPLETE DATE
21540	Continued From page 20	21540		

chart nor in the nurse practitioner's (NP's) mailbox for review. RN-D verified R14's DISCUS was past due, and said she had been trying to align the assessments with each resident's quarterly assessment. RN-D reported she would complete the DISCUS next week with R14's quarterly MDS assessment. RN-D explained she thought she had competed the assessment at the time of R14's last quarterly assessment at the beginning of 1/16. At 4:22 p.m. RN-D said she had received a pile of papers on 3/17/16, including the pharmacist's recommendation a DISCUS be completed, however, she had not yet followed through on the recommendation. The following morning at 8:09 a.m. RN-D reported the TD assessments were supposed to have been competed semi-annually.

At 7:32 a.m. on 3/30/16, the director of nursing (DON) stated a new DISCUS book had been created for nurse managers on each floor so they would be able to identify when the assessments were due. The intention was to help the managers complete the assessments in a timely manner. The DON explained residents were to have a DISCUS when antipsychotic medicaiton was imitated, and then every three to six months, depending on the medicaiton prescribed.

LABORATORY TESTING
On 3/29/16, at 3:19 p.m. RN-D verified R14's laboratory (lab) testing order from the nephrologist's visit had not been ordered. RN-D instructed LPN-C to call the NP or the nephrologist and see if R14's lab was still required, as the testing had not been completed as ordered. LPN-C called the nephrologist's office and then instructed RN-D the basic metabolic profile (or BMP consisting of eight commonly ordered lab tests) was still needed, as it was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING: _____ B. WING _____	03/31/2016

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) COMPLETE DATE
21540	Continued From page 21 required as part of the standing orders when initiating the multivitamin with minerals, TheraLith. At 4:22 p.m. The DON was asked about the missing lab work and stated, "I have to educate--re-educate on lab procedures." The DON explained lab results were faxed to the facility and she would check with the NP to see if she had reviewed it. On 3/31/16, at 10:20 a.m. RN-G stated she recalled when R14's TheraLith came in, she first dated it 3/8/16, and then opened it. RN-G stated the medication was started the following day, and the next time she worked was 3/10/16, and she administered the TheraLith to R14 that day. RN-G verified the lab work for R14 had been missed, and should have been drawn on 3/16/16. RN-G said she had transcribed the order for the lab draw, but the lab work was inadvertently drawn in February, although the physician's order read to draw the lab work one week after starting the medicaiton (3/9/16). RN-G stated R14's BMP had been drawn yesterday and the results faxed to the physician and put on the facility's 24-hour report. At 1:16 p.m. on 3/31/16, the DON reported the NP and physicians had since been updated with R14's laboratory results, and the results had been filed in the resident's medical record. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring the side effects of psychotropic medication . The nurse manager or designee, along with the pharmacist, could complete audits to ensure testing system to monitor the side effects of psychotropic medication are being completed timely.	21540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING: _____ B. WING _____	03/31/2016

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) COMPLETE DATE
21540	Continued From page 22 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the environment was maintained in a clean manner and in good repair. This had the potential to affect the sixteen residents who resided in the identified rooms. Findings include: An environmental tour was completed on 3/31/16, at 10:07 a.m. with the maintenance assistant (MA), director of housing and laundry (DHL) and the executive director (ED). The following issues were identified and were confirmed by both the MA, DHL and the ED: 1) The floor on the shared room 112 on the first floor was observed to be stained with black and brown sticky stains throughout the floor. Shades were missing on the lights in the bathroom. The DHL confirmed that floor was dirty and stated, "I think we can do better than this." The MA	21685	Corrected	5/13/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING: _____ B. WING _____	03/31/2016

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) COMPLETE DATE
21685	Continued From page 23 confirmed the lights in bathroom did not have shades and explained they "were probably taken off when the resident complained of the bathroom being too dark." When asked if the current residents in room had requested they be removed the MA replied, "I'm not sure." 2) The heat register in the shared room 118 was off the wall and hanging loose. The shared bathroom floor was covered with black stains, and there was a sticky brown/black stain around the toilet base. The MA explained that nursing staff was supposed to fill out work orders for any environmental issues. The ED explained the register needed to be repaired and stated, "That should have been caught by now." The DHL confirmed that bathroom was dirty and stated, "We can do better cleaning than that." 3) The wall by the head of bed in room 124 near the door had scraped plaster in many places from the bed down. The MA explained it had been caused by the bed in the room, and stated it would be repaired. 4) The heat register behind the head of the bed by the window in room 201 had a large crack along the wall. The heat register was also scraped. The ED and MA confirmed the register needed repairs. 5) The base of R25's tube feeding pole was covered with brown sticky stain and had a brown substance dripping from the top to bottom of the pole. The DHL explained that house keeping was responsible for wiping down resident equipment. The DHL touched the pole and stated, "This can come off. It just needs a little more scrubbing." The DHL explained housekeeping staff was supposed to let him know about such issues so he could thoroughly clean it. 6) The shared bathroom door in room 209 had two large holes on the lower part of the door. The MA explained it should have been reported via	21685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING: _____ B. WING _____	03/31/2016

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) COMPLETE DATE
21685	Continued From page 24	21685		

maintenance slip. The MA explained staff were supposed to fill the maintenance slip with any environmental issues "and I check them periodically throughout the day." The MA stated, "We can fix this with a metal plate."
7) The shared bathroom door in room 219 had two large holes; one at the top and another in the middle. The heat register by the window had a large rusted area by the edge. The MA explained that the bathroom door "will need to be replaced and the register will be painted."

During a follow-up interview with the DHL at 12:41 p.m. it was explained the staff was supposed to have followed a checklist. The DHL also explained there was always a housekeeper on each floor during the day, but not on the evening shift.

The MA was interviewed at 1:10 p.m. explained the facility utilized a preventive maintenance plan that "We go through each month and check off what we have done." The MA said additionally, staff was supposed to also fill out the maintenance slips "that are located on each floor" if they observed any environmental concerns.

A facility's Cleaning Principles (Housekeeping) dated 7/15, directed, "The center strives to ensure that the worksite is maintained in a clean and sanitary condition. Each center will determine and implement an appropriate written schedule for cleaning and method of decontamination based upon the location within the center, type of surface to be cleaned, type of soil present, and tasks or procedures being performed in the area."

SUGGESTED METHOD OF CORRECTION:
The maintenance director could develop a maintenance program to ensure damaged walls

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING: _____ B. WING _____	03/31/2016

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) COMPLETE DATE
21685	Continued From page 25 and clean living areas are repaired to maintain a safe, clean, homelike environment. The director could ensure appropriate staff are educated, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dignified dining was provided for 3 of 4 residents (R51, R101, R112) who were fed by staff. Findings include: The evening meal service was observed on 3/28/16, at 6:03 p.m. Three residents, R51, R101 and R112 were seated at the same table. A licensed practical nurse (LPN)-A assisted R51 and R101 to eat, standing throughout the entire meal. Multiple times during the meal LPN-A walked away from the table to check on other residents throughout the dining room and a resident in the hallway. LPN-A returned back to the table, stood above R51 and R101 to continued assisting R51 and R101 to finish their	21805	Corrected	5/13/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING: _____ B. WING _____	03/31/2016

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) COMPLETE DATE
21805	Continued From page 26	21805		

meal. In addition, a nursing assistant (NA)-A stood at the same table to feed R112 the first part of his meal, and then sat to feed him the remainder of his meal.

At the end of the meal service at 6:47 p.m. LPN-A confirmed he stood while assisting R51 and R101 to eat. LPN-A explained that if residents required assistance to eat, staff had been instructed to sit next to the resident until they had finished eating. LPN-A explained the reason why he stood was so he could visualize all the residents in the dining room, which was difficult to do while seated. LPN-A furthered explained that R51 and R101 usually only needed verbal cues for eating, but "For some reason tonight both residents required assistance with their meals from me."

NA-A verified she was standing while assisting R112 with his meal. NA-A stated she worked at this facility for many years and had received training on how to properly assist residents with their meals during dining. NA-A stated, "We are told we can either stand or sit while feeding."

R51's Minimum Data Set (MDS) dated 1/1/16, indicated the resident required assistance of one staff for eating. R51's care plan dated 1/1/16, indicated the resident had cognitive impairment and was at risk for dehydration due to advanced dementia, and the resident had a visual loss, as well. Interventions directed staff to monitor position to promote adequate nutritional intake, weigh the resident, monitor for signs of dehydration and encourage fluids, and assist with meals and anticipate needs.

R101's care plan dated 3/10/16, indicated the resident was receiving comfort cares, had cognitive impairment and diagnoses of dementia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING: _____ B. WING _____	03/31/2016

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) COMPLETE DATE
21805	Continued From page 27 and anxiety, and was resistive with cares. R101's care plan dated 6/10/14, indicated staff was to assist with meals and monitor for signs of dehydration and to weigh the resident monthly. R112's care plan dated 12/31/15, indicated the resident had a potential risk for dehydration. R112 was receiving hospice care and had dementia and anxiety, was non-verbal and displayed behavioral issues. R112's care plan dated 10/26/15, indicated severe cognitive impairment with a significant weight loss within 30 day. Staff interventions included monitoring intake at mealtime and for signs of dehydration, encourage fluids, and weigh the resident monthly. During an interview on 3/28/16, at 6:48 p.m. a registered nurse (RN)-A explained, "I expect staff to serve one table at a time. If food is placed in front of a resident, staff was to help get that resident started with the mea. Those residents who required assistance to eat would be fed last and staff would then sit while assisting those residents to eat. Dining and assisting residents with meals is an ongoing education with staff." RN-A said if R51, R101 and R112 required needed help with their meals staff should have sat next to the residents and assisted them. RN-A verified that R112 required total assistance to eat. RN-A explained that staff received an inservice East and West dining room set up and Serving Trays training on 12/11/15. The inservice included step by step instruction for staff "when putting a tray in front of a resident that needs to be fed you need to sit down and start to feed." Both LPN-A and NA-A attended the inservice and signed the attendance sheet. The facility's 7/15, Dining Goals and Objectives directed the staff to ensure the residents' dining	21805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING: _____ B. WING _____	03/31/2016

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) COMPLETE DATE
21805	Continued From page 28 environment would be an pleasant experience which will encourage socialization and nutritional intake. SUGGESTED METHOD OF CORRECTION: The nurse manager or designee could review and revise policies and procedures related to ensuring residents are treated with dignity and respect during dining. The nurse manager or designee could complete audits to ensure residents are treated in a dignified and respectful manner while dining. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21805		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to accommodate bathing preferences for 2 of 3 residents (R85, R14) reviewed for choices. Findings include:	21810	Corrected	5/13/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING: _____ B. WING _____	03/31/2016

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) COMPLETE DATE
21810	Continued From page 29 R85 stated on 3/28/16, at 2:44 p.m. she received one shower a week, but wanted at least two showers a week, preferably three. R85 stated staff had informed her there was not enough help at the facility to have additional showers. R85's quarterly Minimum Data Set (MDS) dated 3/5/16, indicated the resident cognition was intact, and the resident required physical help from staff with part of the bathing activity. R14 stated on 3/28/16, at 5:13 p.m. she received one shower a week, but would like more and stated, "Sometimes I smell." Again on 3/30/16, R14 stated she preferred more than one shower a week and again stated, "I think I smell." R14 stated she had never been asked by anyone at the facility if she wanted more than one shower weekly. R14's quarterly MDS dated 1/3/16, indicated R14's cognition was moderately impaired. R14's MDS also indicated R14 was total dependent on staff for bathing and rejected no cares. During an interview on 3/29/16, at 1:55 p.m. a nursing assistant (NA)-C stated residents would tell the staff if they want more than one shower a week. At 2:17 p.m. NA-D stated residents could choose to have more than one shower a week. The following morning at 8:09 a.m. a registered nurse (RN)-D stated if a resident stated a preference how often they wanted a shower they could, and in fact some residents did get two showers a week. RN-D stated the residents were asked upon admission about bathing and that if their preference varied from one shower a week it would be scheduled and care planned accordingly.	21810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING: _____ B. WING _____	03/31/2016

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) COMPLETE DATE
21810	Continued From page 30 On 3/30/16, at 8:25 a.m. a licensed social worker (LSW)-B stated she did not ask residents or families about bathing preferences. LSW-B stated she only got involved with bathing when family members asked her to make sure the resident got a shower if the resident smelled really badly. At 9:10 a.m. the life enrichment director stated residents were asked bathing preferences upon admission and if the resident's preference was for more than one shower weekly, nursing staff was informed. On 3/30/16, at 10:48 a.m. RN-D stated nursing staff did not ask bathing preferences of a resident, nor their family or guardian after their admission. RN-D stated she had not been notified R14 or R85 wanted an additional shower each week. On 3/31/16, at 10:20 a.m. RN-G stated residents received at least one shower weekly and if they requested, could have a second shower. RN-G stated it was not appropriate to tell a resident they would only get a shower is staff had time, and it needed to be scheduled or it would not get completed. At 1:16 p.m. on 3/31/16, the director of nursing stated residents could have one shower a week and if they asked for more than one shower a week it was then added to the bathing schedule. The 2ND Floor Bath List indicated R14 and R85 received one shower weekly. R14 and R85's care plans did not address additional bathing frequency.	21810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING: _____ B. WING _____	03/31/2016

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) COMPLETE DATE
21810	Continued From page 31 A bathing policy was requested on 3/31/16, but was not provided by the facility. SUGGESTED METHOD OF CORRECTION: The director of nursing and LSWs could ensure resident preferences were honored regarding bathing. Training could be provided as necessary, audits could be compelted, and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		