



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 3, 2024

Administrator
The Villas At Richfield
7727 Portland Avenue South
Richfield, MN 55423

RE: CCN: 245492
Cycle Start Date: August 21, 2024

Dear Administrator:

On August 21, 2024, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

LeAnn Huseeth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseeth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 November 21, 2024 (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).

In addition, if substantial compliance with the regulations is not verified by February 21, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/ltr_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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

The Villas At Richfield

September 3, 2024

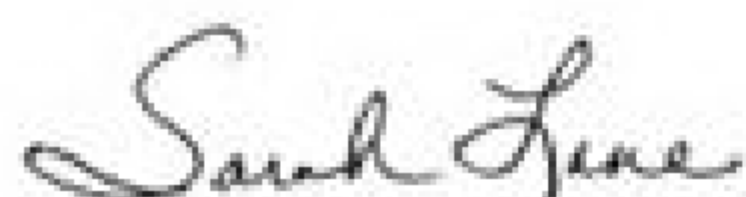
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Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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

PRINTED: 09/10/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245492	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/21/2024
NAME OF PROVIDER OR SUPPLIER THE VILLAS AT RICHFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 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
E 000	Initial Comments On 8/19/24, to 8/21/24 , a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS On 8/19/24 to 8/21/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed The following complaints were reviewed with no deficiency issued: H54926560C (MN00101246). H54926541C (MN00098408). H54926542C (MN00097705). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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.	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/09/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1	F 000			
F 550 SS=D	Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without	F 550			9/24/24

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F 550	Continued From page 2 interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to promote dignity while utilizing a mechanical lift sling for extended periods of time for 1 of 3 residents (R13) reviewed for dignity and who was dependent on staff for activities of daily living (ADL's) and required the use of a mechanical lift for transfers. Findings include: R13's quarterly Minimum Data Set (MDS) dated 6/27/24, identified R13 had moderate cognitive impairment and diagnoses which included: moderate intellectual disabilities, and Parkinsonism (movement symptoms related to Parkinson's disease). Indicated R13 was dependent on staff for chair/bed transfers, dressing, and personal hygiene. R13's Care Area Assessment (CAA) dated 3/18/24, identified R13 needed assistance with ADL's and had decreased mobility and cognition secondary to schizoaffective disorder (mental health condition with symptoms such as hallucinations, delusions, and mood disorders), failure to thrive, and moderate intellectual disabilities. R13 required extensive to total dependence with all ADL's. R13 was not always			F 550	1.R13s plan of care was updated to include residents preference to have sling straps tucked out of sight when up in his wheelchair. 2.All residents have the right to a dignified existence. All residents currently utilizing a mechanical transfer that requires a sling were reviewed for preferences and care plans updated. 3.Policy for resident rights was reviewed and remains the same. Education will be provided to all staff on residents right to a dignified existence. 4.The DON/Admin/designee will audit 4 residents that utilize slings weekly x4 weeks. The results of these observations will be shared with the facility QAPI committee for input on need to increase, decrease, or discontinue audits.		

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F 550	Continued From page 3 able to make his needs known. R13's Care Plan dated 11/2/23, identified R13 was a vulnerable adult and had ADL's self performance deficit with total assistance for bathing, dressing, and personal hygiene. Indicated R13 used an EZ stand (mechanical lift) for transfers as tolerated with assistance of two staff. During an observation on 8/19/24 at 3:27 p.m., R13 was in his wheelchair in his room. R13 had a mechanical lift sling placed under him in his wheelchair. The straps of the sling were observed to be draped over his thighs, approximately each six inches wide, and the sling hung approximately six inches on both sides out the back side of the wheelchair. R13 indicated the fact the sling could be visualized by others while he sat in his wheel chair bothered him. During a phone interview on 8/19/24 at 5:24 p.m., resident representative (RR)-A stated it would bother R13 very much if the mechanical lift sling was visible to others while R13 was in the wheelchair. During an observation on 8/20/24 at 8:32 a.m. R13 was in his wheelchair in the dining room. R13's mechanical lift sling was observed to again be draped over his thighs and hung out the back sides of the wheelchair approximately six inches on both sides. At 11:32 a.m., R14 was again in the dining room in his wheelchair. R13's mechanical lift sling was visible with straps over both thighs, and hung out the back sides of wheelchair approximately six inches on both sides.	F 550			

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F 550	Continued From page 4 During an interview on 8/20/24 at 2:45 p.m., nursing assistant (NA)-C indicated had assisted R13 with transfers in the past and confirmed staff left the mechanical lift sling in R13's wheelchair while R13 was in the wheelchair. NA-C stated if it was difficult to remove the mechanical lift sling while a resident was in their wheelchair, they were supposed to tuck it in so it was not visible for dignity issues. Indicated NA-C had not assisted R13 with transfers that day. During an interview on 8/20/24 at 3:00 p.m., interim care coordinator licensed practical nurse (LPN)-A confirmed R13 used a mechanical lift for transfers and indicated R13's sling should have been taken out of R13's wheelchair while he was in the wheelchair. LPN-A indicated when the mechanical lift was left in residents' wheelchairs while they were in them, it could have been uncomfortable and not dignified. During an interview on 8/21/24 at 8:10 a.m., director of nursing (DON) indicated mechanical lift slings should have been removed from the wheelchairs while residents were in them or hidden if kept in the wheelchair. DON stated this was her expectation to promote privacy and dignity. Review of the facility policy titled Resident Rights Policy dated 1/2024, identified it was the practice of the facility to uphold the rights of all residents.	F 550			
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that	F 554			9/24/24

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F 554	Continued From page 5 this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were administered safely for 3 of 3 residents (R79, R74, R354) who had medications left at the bedside and had not been assessed as safe to self-administer those medications. Findings include: R79 R79's significant change in status Minimum Data Set (MDS) dated 7/15/24, identified R79 was cognitively intact, and had diagnoses which included: cancer, hypertension and diabetes mellitus. Identified R79 was independent with eating, bed mobility, and transfers, and required partial/moderate assistance with dressing. R79's care plan revised 8/7/24, identified R79 was receiving hospice services, and was independent with dressing, personal hygiene, and transfers. R79's care plan lacked instructions for self administration of medications. During an observation on 8/19/24 at 1:29 p.m., R79 was lying in her bed. Next to her bed was a bedside stand with two boxes of antibiotic and pain relief cream and a small tube of antibiotic ointment lying on the floor next to the bed. In addition, on R79's bed side stand, there were facility barrier cream ointments and lotions. Review of R79's Order Summary Report signed 8/21/24, lacked orders for antibiotic and pain relief cream, antibiotic ointment, or orders for self			F 554	1.R74 had self-administration assessment completed, and it was found he cannot self-administer oral and topical medications after set up. R74 had ointments removed from room. n R354 had a self-administration assessment completed and was deemed not safe to self-administer. Medications were removed and room remains free of any medications. R79 had self-administration assessment completed and is not safe to keep topical medications or oral medications at bedside to self-administer. All medications have been removed from R79s room and is stored in the medication cart. Residents identified were not affected by this practice. 2.All residents have the potential to be affected. All residents were interviewed to determine if they want to self-administer medications including topical ointments. If so, self-administration assessment completed, and orders requested if safe to do so. Care plans updated. 3.Self-Administration of Medication policy was reviewed and remains current. Education initiated with nurses and TMAs regarding not leaving medications, including topical medications, at bedside without orders to do so. Education includes what to do if the resident is able to self-administer but does not have an order or self-administration assessment complete. 4.DON or designee will audit the administration of 5 random residents'		

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F 554	Continued From page 6 administration of medications (SAM). R79's medical record lacked documentation of a SAM assessment. During an observation on 8/20/24, at 11:45 a.m., R79 was lying in her bed. The two boxed antibiotic and pain relief cream, and antibiotic ointment were on R79's bedside stand. At 12:56 p.m. R79 was sitting up in her bed, with her meal tray in front of her on the bedside table. The medications continued to be lying on R79's bedside stand. During an interview on 8/20/24 at 2:50 p.m., nursing assistant (NA)-C indicated was unaware if R79 used the antibiotic and pain relief creams or antibiotic ointment independently. Stated NA-C had not applied the ointment or cream on R79. During an interview on 8/20/24 at 3:06 a.m., interim care coordinator licensed practical nurse (LPN)-A confirmed R79's medications were administered by nursing staff and was not aware if R79 had a SAM assessment completed. LPN-A entered R79's room and confirmed R79 had the creams and ointments lying on her bedside table, and removed them from the room. LPN-A indicated R79's family member may have brought the medications. LPN-A confirmed R79 did not have an order for SAM or the creams or ointments. During an interview on 8/21/24 at 8:18 a.m. director of nursing (DON) confirmed had been informed by LPN-A that R79 had medications at bedside that were not ordered, and did not have a SAM assessment or order for SAM. DON stated	F 554	medications per week x 4 weeks. The results of these audits will be shared with facility QAPI committee for input on need to increase, decrease, or discontinue audits.		

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F 554	Continued From page 7 LPN-A had contacted R79's family member who would come in to pick up the medications that were observed in R79's room. DON indicated her expectation and the facility's process was to complete a SAM assessment, then if appropriate, obtain an order for SAM, based on a resident's cognitive and physical abilities. DON stated it was important to follow the SAM process due to risk of overdosing and for other safety reasons, too. R74 R74 admission MDS dated 7/17/24, identified R74 was cognitively intact and had diagnoses which included: hypertension (high blood pressure), anxiety disorder, depression, and respiratory failure. Indicated R74 was independent with bed mobility, transfers, personal hygiene, and dressing. R74's care plan revised on 7/12/24, identified R74 was to take pain medication as ordered by a medical doctor (MD). The care plan lacked documentation of a SAM or order to self-administer medication. During an observation on 8/20/24 at 12:03 p.m., registered nurse (RN)-B checked orders on the electron medication record (EMAR) which identified R74 received Diclofenac Sodium External Gel 1% (Diclofenac Sodium (topical) Apply 4 grams affected joint topically four times a day for joint damage starting 7/11/24 at 8:00 p.m.	F 554			

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F 554	Continued From page 8 RN-B took the Diclofenac Sodium External Gel and verified the medication with the EMR. RN-B took medication into R74's room and had R74 verify his name and date of birth. RN-B went to apply Diclofenac Sodium External Gel 1% to R74 shoulder. R74 opened the dresser drawer and pulled out a medication tube of Diclofenac Sodium External Gel 1%. R74 reported applying it to his shoulder three times a day on his own and would let staff know when the medication became low. R74 placed the medication back in the dresser. RN-B left the room and placed R74's medication that had been removed from the cart back into the medication cart. Review of R74's electronic medication administration record (EMAR) lacked an order for self-administration of medications or a SAM assessment being completed. In addition, the EMAR identified staff signing that Diclofenac Sodium External Gel 1% (Diclofenac Sodium (topical) Apply 4 grams to affected joint topically four times had been applied by staff. During an interview on 8/20/24 at 2:54 p.m., NA-B stated none of the residents had medication in their room according to his knowledge. During an interview on 8/20/24 at 3:23 p.m., RN-C stated she had not received an order for R74 to self-administer medications. During a follow-up interview on 8/21/24 at 10:05 a.m., RN-C stated the process to have a medication left in the room for the resident to self-administer was to inform the provider a SAM had been completed by the facility and then an order for self-administration would be received from the provider.	F 554			

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F 554	Continued From page 9 During an interview on 8/21/24 at 9:46 a.m., RN-B stated some residents came in with a supply of medications. RN-B indicated the process was a nurse would completed a SAM and if the results of the assessment determined the resident could safely self-administer their meds, an order would be obtained from the doctor. During an interview on 8/21/24 at 10:51 a.m. director of nursing (DON) stated the process is to do a self-administration assessment for medication and then requested an order from the physician. DON stated it would be her expectation would be for staff not to leave medication in the room without having done a self-administration of medication assessment and an order from the physician. R354 R354's admission MDS dated 7/15/24, identified R354 was cognitively intact. Diagnoses included orthopedic surgery, arthritis, dementia, anxiety disorder and dependent personality disorder. R354 needed assistance with transfers, dressing, and personal hygiene. R354's care plan dated 8/19/24 lacked information regarding self-administration of medication. The care plan did reveal R354 had a history of substance use disorder with opioids and alcohol. R354 had a goal for staff to make every reasonable attempt to keep the resident safe in the event of an opioid-related overdose. R354's medical record lacked an order for SAM	F 554			

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F 554	Continued From page 10 and lacked evidence a SAM assessment had been completed. During an observation on 8/20/24 at 3:13 p.m., R354 had a cup of medications on his bedside table. R354 stated the cup with medications had been sitting on the bedside table for an hour. R354 was waiting to take the medications until the nurse could tell him what the medications were for. During an interview on 8/20/24 at 3:13 p.m., licensed practical nurse (LPN)-C reported the medications, which included oxycodone (an opioid used for pain) had been sitting on R354 bedside table since 2:38 p.m. R354 was on the phone when LPN-C went to give R354 the medications and left the medications on the bedside table. LPN-C verified that R354 did not have an order to leave medication at the bedside nor for R354 to self-administer his medications. During an interview on 8/20/24 at 3:32 p.m., registered nurse (RN)-C verified R354 did not have a self-administration medication order or a SAM assessment. During an interview on 8/21/24 at 8:18 a.m. director of nursing (DON) indicated her expectation and the facility's process was to complete a SAM assessment, then if appropriate, obtain an order for SAM, based on a resident's cognitive and physical abilities. DON stated it was important to follow the SAM process due to risk of overdosing and for other safety reasons as well. Review of facility policy titled Self-Administration of Medications dated 2/2024, indicated residents had the right to self-administer medications if the	F 554			

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F 554	Continued From page 11	F 554			
F 584 SS=D	interdisciplinary team had determined that it was clinically appropriate and safe for the resident to do so. Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584			9/24/24

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F 584	Continued From page 12 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure housekeeping services for a clean environment for 4 of 4 residents (R79, R2, R81, R19) with a shared bathroom. Findings include: R79's Face Sheet, dated 8/21/24, identified R79 had diagnoses which included; malignant neoplasm of temporal lobe, depression, and diabetes mellitus. R79's care plan revised 8/7/24, identified R79 was independent with a walker for ambulation, transfers, and required assistance of one with toileting. R2's Face Sheet dated 8/21/24, identified R2 had diagnoses which included: Alzheimer's disease, diabetes mellitus, and delusional disorders. R2's care plan revised 6/5/24, identified R2 required two staff for assistance with transfers, wheelchair use for mobility, and required assistance of one with toileting. R81's Face Sheet dated 8/21/24, identified R81 had diagnoses which included: malignant neoplasm of unspecified site of right female	F 584	1.Shared bathroom of R79, R2, R81, and R19 was cleaned. Residents were not affected. 2.All residents have the potential to be affected. All resident rooms with bathrooms were inspected and cleaned. 3.All housekeeping staff have been educated on daily cleaning and disinfectant routine, which includes the bathrooms. 4.Housekeeping manger of designee will audit 5 random bathrooms weekly x4 weeks. The results of these audits will be shared with facility QAPI committee for input on need to increase, decrease, or discontinue audits.		

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F 584	Continued From page 13 breast, muscle weakness, and fracture of unspecified part of neck of the left femur, subsequent encounter for closed fracture with routine healing. R81's care plan revised 6/24/24, identified R81 required two staff for assistance with transfers, one assist with ambulation and required assistance of one with toileting. R19's Face Sheet dated 8/21/24, identified R19 had diagnoses which included: paranoid schizophrenia, generalized anxiety disorder, and difficulty in walking. R19's care plan revised 2/28/24, identified R19 required two staff for assistance with transfers, one staff for locomotion in wheelchair, and check and change every two to three hours for assistance of one with toileting. During an observation on 8/19/24 at 1:29 p.m., shared bathroom of R79, R2, R81, and R19, had an area approximately six to eight inches in diameter of brown substance smeared on the doorframe and wall approximately three feet off the ground, and the floor was very sticky. During an observation on 8/20/24 at 8:23 a.m., the shared bathroom of R79, R2, R81, and R19, continued to have an area approximately six to eight inches in diameter of brown substance smeared on the doorframe and wall approximately three feet off the ground, and the floor was still very sticky. During an observation on 8/20/24 at 11:48 a.m., the shared bathroom of R79, R2, R81, and R19, continued to have an area approximately six to	F 584			

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F 584	Continued From page 14 eight inches in diameter of brown substance smeared on the doorframe and wall approximately three feet off the ground, and the floor was still very sticky. During an interview on 8/20/24 at 11:52 a.m., housekeeper (HSK)-A stated was responsible to clean the resident's rooms and had not cleaned the shared bathroom of R79, R2, R81, and R19 yet that day. In addition, HSK-A had not cleaned the bathroom yesterday either. HSK-A indicated the usual practice was to check the rooms or staff informed the housekeeping staff when cleaning was needed. HSK-A and surveyor entered the shared bathroom of R79, R2, R81, and R19. HSK-A confirmed the bathroom had a brown substance on the wall and doorframe, the floor was sticky and indicated could also see the floor was soiled. HSK-A indicated would have expected someone to have informed housekeeping that the floor and wall needed to be cleaned. During an interview on 8/21/24 at 8:37 a.m., environmental director (ED)-A stated everyday she would complete an inspection of each floor, dining rooms, hallways, break rooms and talk to housekeeping staff to discuss what needed to be done and assist when needed. ED-A indicated she expected housekeeping staff to clean resident bathrooms every day, to check rooms often and clean as soon as possible when soiled. ED-A stated she had instructed housekeeping staff to check the bathrooms more frequently since bathrooms could become soiled more often, even right after they had been cleaned. ED-A stated all staff should check the bathrooms to ensure they are clean and indicated staff could call housekeeping and they would clean it right	F 584			

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F 584	Continued From page 15 away. During an interview on 8/21/24 at 10:17 a.m., director of nursing (DON) indicated an expectation of the resident bathrooms to be cleaned daily, and when soiled, would expect nursing staff to clean it or notify housekeeping to come and clean the bathroom immediately. DON stated this was important for hygiene, infection control, and stated this was the resident's home. Review of the facility policy titled Daily Cleaning Procedures (DCP) undated, included instructions to spot clean walls that were visibly soiled. In addition. the policy included instructions to dust mop, then damp mop the perimeter of the room, including to not forget the restroom.	F 584			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined	F 657			9/24/24

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F 657	Continued From page 16 not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide a care conference for 1 of 1 residents (R68) to review and revise care plan with the interdisciplinary team (IDT), who was reviewed for care planning. R68's quarterly Minimum Data Set (MDS) dated 7/18/24, identified R68 was cognitively intact and had diagnoses which included: malnutrition, anxiety and depression. R68's care plan revised 7/26/24, identified R68 was a vulnerable adult, was at risk for harm related to suicidal thoughts and had started working with relocation services to assist with finding housing. R68 was independent with transfers, ambulation, dressing, bathing, and personal hygiene. R68's Care Conference Form dated 4/1/24, identified it was a quarterly care conference, and resident and family was involved in plan of care. Review of R68's medical record lacked documentation of a care conference completed after R68's quarterly MDS dated 7/18/24, was completed.	F 657	1.R68's quarterly care conference was completed on 8/22/2024, and care plan reviewed and updated accordingly. 2.All residents have the potential to be affected. All-in-house residents were interviewed to determine if they would like to request a care conference. All residents were reviewed and no other quarterly care conferences were found to be missed. 3.Social Services Director and Designee were educated on the expectations for care conferences to be held on admission, quarterly, and as requested by family/resident. They were educated on how to review the MDS schedule for all residents. 4.DON or designee will audit weekly 4 random residents that had a quarterly MDS scheduled and confirm that a quarterly care conference was held/scheduled. The results of these audits will be shared with facility QAPI committee for input on need to increase, decrease, or discontinue audits.		

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F 657	Continued From page 17 During an interview on 8/19/24 at 2:40 p.m., R68 stated had not been offered or attended a care conference to discuss her plan of care for a while, and could not remember when the last care conference was held. During an interview on 8/20/24 at 5:06 p.m., director of social services licensed social worker (LSW)-A stated resident care conferences were held when a resident first arrived then every three months or more frequently if needed. LSW-A confirmed R68's last care conference was held 4/1/24, and confirmed the facility was a month behind for care conferences. LSW-A indicated care conferences with residents or resident representatives were important to ensure the facility was meeting their needs and working through their goals. LSW-A indicated R68 had went to the hospital and one care conference had been canceled, however had not been re-scheduled. During an interview on 8/21/24 at 8:07 a.m., interim administrator stated the expectation was that care conferences followed the resident's MDS calendar, and should have been held after admission, quarterly and when family members requested one. Interim administrator confirmed the facility had two licensed social workers and would have expected R68's care conference to have been rescheduled. Interim administrator indicated care conferences were important so residents could provide input and review their plan of care, any changes could be discussed as well as loved ones could advocate for the residents. A policy was requested, and on 8/21/24 at 2:39 p.m. DON confirmed the facility did not have a	F 657			

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F 657	Continued From page 18			F 657			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with personal hygiene for 2 of 5 residents(R30, R12). In addition the facility failed to provide assistance with dressing for 1 of 5 residents (R66) reviewed for activities of daily living (ADL)'s. Findings include: R30 R30's quarterly Minimum Data Set (MDS) dated 5/14/24, identified R30 had intact cognition and diagnoses which included hypertension, (elevated blood pressure), Renal insufficiency, and Diabetes Mellitus (DM). Identified R30 required physical assistance from staff with personal hygiene. R30's current care plan dated 7/23/23, indicated R30 had deficits with ADL's related to weakness, chronic pain and obesity. R30 required assistance with personal hygiene. R30's Comprehensive Care Area Assessment (CAA) dated 8/15/23, identified R30 had a self care deficit and required assistance with personal			F 677			9/24/24

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F 677	Continued From page 19 hygiene which included shaving facial hair. During an observation on 8/19/24 at 2:37 p.m., R30 was lying in bed and had several gray/white one inch long facial hairs on her chin. During an interview on 8/19/24 at 2:38 p.m., R30 stated she preferred to have her facial hair removed. R30 further stated she was able to shave them herself after staff provide her with the razor however, she preferred the staff help her to remove her facial hair. R30 stated she was unsure of when the last time she received staff assistance to remove her facial hair was. During an observation on 8/20/24 at 9:10 a.m., R30 was lying in bed eating breakfast and continued to have several gray/white one inch facial hairs on her chin. During an interview on 8/20/24 at 9:20 a.m., nursing assistant (NA)-A stated R30 required staff assistance to shave facial hair. NA-A stated she had not offered or assisted R30 with shaving recently and was unsure the last time R30 had been shaved. During an interview on 8/20/24 at 9:22 a.m., registered nurse (RN)-A stated R30 required staff assistance to shave facial hair. RN-A verified R30 had several long facial hairs and was unsure the last time R30 had been shaved. RN-A stated her expectation was R30 would have been shaved when facial hair was present.	F 677	input on need to increase, decrease, or discontinue audits.		

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F 677	Continued From page 20 R12 R12's admission MDS dated 7/17/24 indicated. R12 had short and long-term memory problems and had poor decision making skills requiring guidance from staff. R12 had diagnoses which included Hypertension (high blood pressure), diabetes mellitus, dementia, and seizure disorder. R12 was dependent on staff for personal hygiene, dressing, and mobility. R12's care plan dated 7/12/24, indicated R12's goal was to be dressed, groomed, and bathed per preferences. R12 required assist of two staff for personal hygiene, and assist of two staff for dressing. During an observation on 8/19/24 at 1:51 p.m., R12 was in bed and had facial hair approximately 3 cubic centimeters (cm) long. R12 stated he would like to be shaved and that having long facial hair bothered him. During an observation on 8/20/24 at 9:15 a.m., R12 was in bed and continued to have facial hair approximately 3 cm. long. During an observation on 8/20/24 at 12:00 p.m., R12 was in bed and stated no one had offered to shave him since the previous week. During an observation on 8/21/24 at 8:06 a.m., R12 continued to have facial hair 3 cm in length. During an interview on 8/21/24 at 8:08 a.m., NA-E stated R12 could not shave himself. NA-E confirmed that R12's facial hair was long and should have been shaved off.	F 677			

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F 677	Continued From page 21 During an interview on 8/21/24 at 8:16 a.m., NA-B stated R12 needed assistance with shaving and dressing. NA-B stated staff shaved R12 when needed and R12 would request when he would wanted to be shaved. NA-B confirmed R12's facial hair was long and staff should have asked R12 if he wanted to be shaved. During an interview on 8/21/24 at 9:49 a.m., RN-B stated R12 was able to make his needs known. RN-B confirmed that R12's facial hair was long and staff should have offered shaving care. R66 R66's quarterly MDS dated 6/21/24, identified R66 had severe cognitive impairment and diagnoses which included diabetes, dementia, anxiety, dysphagia (difficulty swallowing) following a cerebrovascular accident (stroke). Indicated R66 required total assistance of two staff with ADL's; personal hygiene, toileting, bathing, bed mobility, transfers. R66's care plan dated 9/21/23, identified R66 had an alteration in communication related to being non-verbal and not interactive. R66's primary language was Somalia. Indicated R66 was unable to use a translator due to cognitive impairment and for staff to speak to R66 in simple to understand terms. Identified R66 would be dressed, groomed and bathed per preferences and was dependent with ADL's. During an observation on 8/19/24 at 2:26 p.m., R66 was sitting in the wheelchair in the dining area wearing a hospital gown and slipper socks.	F 677			

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F 677	Continued From page 22 During an observation on 8/19/24 at 6:17 p.m., R66 was sitting in the wheelchair in the dining area and continued to wear a hospital gown and slipper socks. During an observation on 8/21/24 at 12:11 p.m., R66 was sitting in the wheelchair in the dining area wearing a hospital gown and slipper socks. R66's right hip, thigh and partial buttock area were exposed approximately one foot in length down R66's leg by six inches wide on R66's hip/thigh area. Two other residents were observed to be in the dining room and R66's family member. During an interview on 8/21/24 at 12:53 p.m., with family member (FM)-A utilizing the Somali Burg Translation Service, FM-A stated it bothered her that R66 was not dressed and R66's skin was exposed in the dining room. FM-A stated she had requested staff to put trousers on R66 and to dress R66. FM-A verified R66 was usually wearing a hospital gown and it would bother him. During an interview on 8/21/24 at 1:06 p.m., NA-D verified R66 required total assistance of two staff with personal cares. NA-D stated R66 had clothing available and that staff usually dressed R66. During an interview on 8/21/24 at 1:16 p.m., licensed practical nurse (LPN)-B stated R66 resisted cares at times and it was more appropriate for R66 to wear a hospital gown so R66 was comfortable and staff would not strain themselves. During an interview on 8/20/24 at 4:16 a.m.,	F 677			

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F 677	Continued From page 23 director of nursing (DON) indicated R30 required staff assistance with shaving. DON stated her expectation was R30 would have been shaved at least weekly or when facial hair was present. During a follow-up interview on 8/21/24 at 2:31 p.m., the director of nursing (DON) verified the expectation of staff was to follow the daily ADL's on the care plan for each resident and to document if a resident refused cares, to notify the nurse, attempt ADL's again, and make a note in the resident's chart. The DON confirmed staff were to respect resident/family wishes. Review of a facility policy titled Activities of Daily Living (ADL's) /Maintain Abilities Policy updated 5/9/24, indicated the facility would provide care and services for hygiene, dressing and grooming. Identified a resident who was unable to carry out ADL's would have received the necessary services to maintain grooming and personal hygiene.	F 677			
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812			9/24/24

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F 812	Continued From page 24 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food and beverages stored in the refrigerators, were labeled, dated and discarded properly. This deficient practice had the potential to affect 87 residents who received food and beverages from the refrigerators. Findings include: On 8/19/24 at 12:45 p.m., during the final tour of the kitchen area with the dietary manager(DM), the following concerns were identified.: Kitchen Freezer: -six veggie burgers in an opened plastic bag without notation of a date. Kitchen refrigerator: -large plastic container 1/2 full of Asian salad dressing with black crusty substance around the lid without any notation of the date it had been opened. -plastic carton ¾ full of thickened milk without notation of a date it was opened and a manufacturer's best by date of 3/4/24. -large container ½ full of Orange Marmalade without notation of a date it had been opened. -large plastic container ¾ full of Blue Cheese salad dressing with black crusty particles inside the container without any notation of the date it	F 812	1.Kitchen freezer and fridge were inspected by dietary manager. Containers that had black crusty particles were also discarded. All food containers cold/dry were reviewed for manufacturer use by date, and any items older than manufacturer date were also thrown away. Residents were not affected by this practice. 2.All residents being served meals at the facility have the potential to be affected. All residents will be served meals with only products adhering to facility food storage and shelf-life policy. 3.Cold food storage and shelf-life policy was reviewed and remains current. Education was initiated with all dietary staff members the policy expectations. 4.Dietary Manager or designee will audit fridge, freezer, and dry storage weekly x4 weeks to ensure that all opened items are dated and complete a review of manufacturer use by dates. The results of these audits will be shared with facility QAPI committee for input on need to increase, decrease, or discontinue audits.		

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F 812	Continued From page 25 had been opened. - Large container ½ full of French salad dressing with black crusty particles inside the container without any notation of the date it had been opened. - Large container ½ full of Vinaigrette salad dressing with black crusty particles inside the container and on the outside of the container with an opened date of 5/19/24. -Large container of ½ full container molasses with black crusty particles inside the container and on the outside of the container with an opened date of 6/9/24. During an interview on 8/19/24 at 1:15 p.m., DM confirmed the above findings and indicated the residents had recently been served the above items. DM stated all the above items should have been discarded. DM stated the resident fridge was the responsibility of dietary and was unsure the last time it had been checked for dated or expired items. DM stated they had a water leak a few weeks ago in the kitchen refrigerator which may have been why the above items contained the black substance inside and outside of the containers. DM stated her expectation was all items would have been dated and discarded per facility policy. During an interview on 8/20/24 at 12:06 p.m., registered dietician (RD) stated she was unaware of the items that had not been dated or discarded. DM stated she was aware of the water leak in the refrigerator a few weeks ago and that maintenance had fixed the leak however would have expected staff to review the refrigerator again to ensure the issue had been resolved. RD further stated her expectation was all above items would have been discarded per facility policy.	F 812			

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F 812	Continued From page 26			F 812			
F 880 SS=D	Review of a facility policy titled Food Storage and Shelf Life: Cold Food Storage undated, indicated all opened containers should have had a date opened marked to assure correct rotation. Policy further indicated thickened liquids should have been discarded after manufacturer's use by date. CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or			F 880			9/24/24

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F 880	Continued From page 27 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement appropriate			F 880			
					1.R26 was reviewed and sign and PPE were in place for enhanced barrier		

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F 880	Continued From page 28 donning/doffing of personal protective equipment (PPE) practices to prevent the spread of infection for 1 of 1 residents (R26) observed for enhanced barrier precautions (EBP) (an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities). Findings include: Review of Centers for Disease Control and Prevention(CDC) guidance dated 4/1/24, Implementation of PPE Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) indicated Examples of high-contact resident care activities requiring gown and glove use for EBP included: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing. R26 R26's quarterly Minimum Data Set (MDS) dated 7/31/24, identified R26 had severe cognitive impairment and had diagnoses which included: unspecified intracranial injury, depression, other symptoms and signs involving cognitive functions and awareness, schizoaffective disorder, traumatic brain injury, anxiety, convulsions. Indicated R26 required extensive assistance for activities of daily living (ADL's) which included bed mobility, transfers, toileting, and dressing. Identified R26 had a feeding tube.			F 880	precautions and care planned. Resident was monitored for 1 week to ensure no s/sx of infection began after this incident. Education was completed with the nurse involved. 2.Full house audit completed to identify all residents that require EBP, to ensure they have signage and PPE in place and that this is care planned. 3.Education began with all staff in regard to enhanced barrier precautions including when PPE is to be used. 4.DON or designee will audit 5 residents weekly to ensure enhanced barrier precautions are being followed. The results of these audits will be shared with facility QAPI committee for input on need to increase, decrease, or discontinue audits.		

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F 880	Continued From page 29 R26's care plan dated 9/5/20, identified R26 had a feeding tube. R26's care plan dated 4/3/24, identified R26 was on EBP related to having a feeding tube. The care plan instructed staff to follow EBP and to wear PPE per EBP when providing cares. R26's Order Summary Report dated 8/21/24, identified R26 received medications and feedings through a feeding tube. The order summary report identified the following: staff to follow: enhanced barrier precautions while providing tube feedings including when handling the feeding tube and associated equipment, performing insertion site care and other high contact care activities. During an observation/interview on 8/21/24 at 9:37 a.m., licensed practical nurse (LPN)-B entered R26's room with medications and set the medications on R26's bedside table. LPN-B applied gloves and did not apply a gown, raised the bed using the bed control, filled a basin with water from R26's bathroom, lifted the bedside mat off of the floor, folded the bedside mat and placed the mat next to the foot of R26's bed. LPN-B pulled back the sheets covering R26, lifted the feeding tube and proceeded to give R26 medications through the feeding tube. LPN-B wiped the end of the feeding tube with a 4x4 gauze and threw the used supplies and gloves into the garbage. LPN-B applied gloves, got a mouth swab wet in R26's bathroom and proceeded to clean in and around R26's mouth. LPN-B repeated this step, threw swabs into the garbage, removed Vaseline from the bedside table, squeezed a small amount of Vaseline onto her gloved hand and placed onto R26's lips. LPN-B removed gloves and threw the gloves into			F 880			

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F 880	Continued From page 30 the garbage. LPN-B lowered R26's bed using the bed control, placed the bedside mat onto the floor next to R26's bed, sanitized her hands and exited R26's room. LPN-B stated EBP were required when completing cares for residents. LPN-B confined she had only worn gloves when administering medications via R26's feeding tube. LPN-B stated she was only required to wear gloves when administering medications via the feeding tube and was not required to wear a gown. During an interview on 8/21/24 at 2:25 p.m., director of nursing (DON) confirmed R26 was on EBP related to having a feeding tube and that the expectation of staff was to wear PPE and follow EBP. DON verified it was important to follow EBP to prevent infections from being passed to other residents and staff. Review of a facility policy revised 4/1/24, identified the facility would implement enhanced barrier precautions for prevention of transmission of multidrug-resistant organisms. Indicated EBP employed targeted gown and glove use during high contact resident care activities which included: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, wound care: any skin opening requiring a dressing. Identified the facility would make gowns and gloves available near or outside of the resident's room; PPE for enhanced barrier precautions was necessary when performing high-contact care activities and EBP would be used for the duration of the affected resident's stay in the facility or until the wound heals or indwelling medical device was	F 880			

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F 880	Continued From page 31 removed.			F 880			
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure call lights were accessible for 1 of 1 residents (R27) who were reviewed for call light accessibility. Findings include: R27's quarterly Minimum Data Set (MDS) dated 5/23/24, indicated R27 was cognitively impaired and had diagnoses of depression and schizophrenia (a serious mental health condition). Identified R27 was dependent on staff for activities of daily living (ADL) and mobility. R27's care plan dated 7/19/23, lacked documentation of the use or placement of R27's call light. During an observation on 8/20/24 at 12:18 p.m., R27 was sitting in his wheelchair watching television. R27's call light was laying on a pillow on the nightstand table behind R27. R27 was not able to move his wheelchair or turn around			F 919	1.R27 had call light placed within reach. R27s care plan was reviewed and updated to reflect soft touch call light and preference on call light placement. 2.Full house audit completed ensuring all have functioning call light and their preference in regards to placement. If they prefer something other than keeping it within reach, the preference was updated in care plan and Kardex. 3.Education began with all staff in regards to keeping call light within reach unless their plan of care lists otherwise. Also educated on where to find this information. 4.DON or designee will audit 5 residents weekly to ensure that call light is within reach or that preference for call light placement is being followed. The results of these audits will be shared with facility QAPI committee for input on need to increase, decrease, or discontinue audits.		9/24/24

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NAME OF PROVIDER OR SUPPLIER THE VILLAS AT RICHFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 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 919	Continued From page 32 independently to reach his call light off of the nightstand table. During an observation on 8/20/24 at 12:28 p.m., R27 remained in the same position as above. R27's call light remained laying on a pillow on the nightstand table and was covered with a blanket. R27 continued to not have access to his call light. During an observation on 8/20/24 at 3:52 p.m., R27 had been transferred from this wheelchair to his bed. R27 was laying in his bed covered with a white bed sheet. R27's call light continued to lay on a pillow and the nightstand covered with a blanket. R27 was not able to reach his call light while laying in bed. During an interview on 8/20/24 at 12:37 p.m., R27 stated he could use the flat style call light for staff assistance if it was placed on the right spot on his legs for him to tap it with his left hand. R27 further stated, "I can not hit it unless it is right here (R27 demonstrated where the call light needed to be placed for him to hit it). R27's call light was not within reach for R27 to call for assistance. During an interview on 8/20/24 at 4:02 p.m., nursing assistant (NA)-E stated R27 could use his call light if it was placed next to his head while lying in bed. NA-E further stated call lights should have always been within reach of the residents when they were in their rooms so they could call for assistance. During an interview on 8/20/24 at 4:06 p.m., licensed practical nurse (LPN)-C walked into R27's room and confirmed R27's call light was laying on the nightstand on top of pillows covered with a blanket. LPN-C also confirmed R27 did not	F 919			

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F 919	Continued From page 33 have access to his call light while laying in bed. LPN-C indicated R27 could use his call light to ask for assistance from staff. LPN-C stated R27's call light should have been placed within reach when staff put R27 to bed. LPN-C stated her expectations were for staff to place call lights next to residents and explain to the resident where the call light was so they could call for assistance. During an interview on 8/20/24 at 4:09 p.m., director of nursing (DON) was not aware R27's call light was not within reach. DON stated her expectations were that resident's call lights were within reach at all times so residents could call for assistance when needed. Requested a facility policy on call lights however, it was indicated the facility did not have a call light policy.	F 919			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 3, 2024

Administrator
The Villas At Richfield
7727 Portland Avenue South
Richfield, MN 55423

Re: State Nursing Home Licensing Orders
Event ID: KEKH11

Dear Administrator:

The above facility was surveyed on August 19, 2024 through August 21, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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.

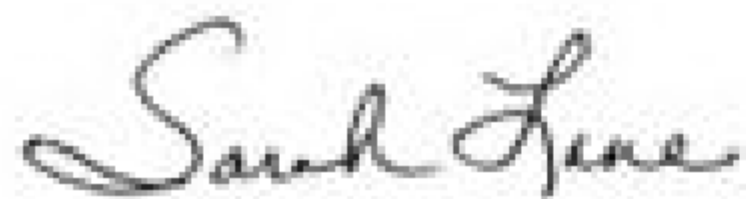
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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:

LeAnn Huseh, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseh@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00253	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/21/2024
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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: On 8/19/24 to 8/21/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

09/09/24

Minnesota Department of Health

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2 000	Continued From page 1 identify the date when they will be completed. In addition, the following complaints were reviewed with no licensing orders issued: H54926560C (MN00101246). H54926541C (MN00098408). H54926542C (MN00097705). 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. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota 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	2 000			

Minnesota Department of Health

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2 000	Continued From page 2 Minnesota Department of Health. 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.	2 000			
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with personal hygiene for 2 of 5 residents(R30, R12). In addition the facility failed to provide assistance with dressing for 1 of 5 residents (R66) reviewed for activities of daily living (ADL)'s. Findings include: R30 R30's quarterly Minimum Data Set (MDS) dated 5/14/24, identified R30 had intact cognition and diagnoses which included hypertension, (elevated	2 920	Corrected.		9/24/24

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2 920	Continued From page 3 blood pressure), Renal insufficiency, and Diabetes Mellitus (DM). Identified R30 required physical assistance from staff with personal hygiene. R30's current care plan dated 7/23/23, indicated R30 had deficits with ADL's related to weakness, chronic pain and obesity. R30 required assistance with personal hygiene. R30's Comprehensive Care Area Assessment (CAA) dated 8/15/23, identified R30 had a self care deficit and required assistance with personal hygiene which included shaving facial hair. During an observation on 8/19/24 at 2:37 p.m., R30 was lying in bed and had several gray/white one inch long facial hairs on her chin. During an interview on 8/19/24 at 2:38 p.m., R30 stated she preferred to have her facial hair removed. R30 further stated she was able to shave them herself after staff provide her with the razor however, she preferred the staff help her to remove her facial hair. R30 stated she was unsure of when the last time she received staff assistance to remove her facial hair was. During an observation on 8/20/24 at 9:10 a.m., R30 was lying in bed eating breakfast and continued to have several gray/white one inch facial hairs on her chin. During an interview on 8/20/24 at 9:20 a.m., nursing assistant (NA)-A stated R30 required staff assistance to shave facial hair. NA-A stated she had not offered or assisted R30 with shaving recently and was unsure the last time R30 had been shaved.	2 920			

Minnesota Department of Health

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2 920	Continued From page 4 During an interview on 8/20/24 at 9:22 a.m., registered nurse (RN)-A stated R30 required staff assistance to shave facial hair. RN-A verified R30 had several long facial hairs and was unsure the last time R30 had been shaved. RN-A stated her expectation was R30 would have been shaved when facial hair was present. R12 R12's admission MDS dated 7/17/24 indicated. R12 had short and long-term memory problems and had poor decision making skills requiring guidance from staff. R12 had diagnoses which included Hypertension (high blood pressure), diabetes mellitus, dementia, and seizure disorder. R12 was dependent on staff for personal hygiene, dressing, and mobility. R12's care plan dated 7/12/24, indicated R12's goal was to be dressed, groomed, and bathed per preferences. R12 required assist of two staff for personal hygiene, and assist of two staff for dressing. During an observation on 8/19/24 at 1:51 p.m., R12 was in bed and had facial hair approximately 3 cubic centimeters (cm) long. R12 stated he would like to be shaved and that having long facial hair bothered him. During an observation on 8/20/24 at 9:15 a.m., R12 was in bed and continued to have facial hair approximately 3 cm. long. During an observation on 8/20/24 at 12:00 p.m., R12 was in bed and stated no one had offered to shave him since the previous week. During an observation on 8/21/24 at 8:06 a.m.,	2 920			

Minnesota Department of Health

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2 920	Continued From page 5 R12 continued to have facial hair 3 cm in length. During an interview on 8/21/24 at 8:08 a.m., NA-E stated R12 could not shave himself. NA-E confirmed that R12's facial hair was long and should have been shaved off. During an interview on 8/21/24 at 8:16 a.m., NA-B stated R12 needed assistance with shaving and dressing. NA-B stated staff shaved R12 when needed and R12 would request when he would wanted to be shaved. NA-B confirmed R12's facial hair was long and staff should have asked R12 if he wanted to be shaved. During an interview on 8/21/24 at 9:49 a.m., RN-B stated R12 was able to make his needs known. RN-B confirmed that R12's facial hair was long and staff should have offered shaving care. R66 R66's quarterly MDS dated 6/21/24, identified R66 had severe cognitive impairment and diagnoses which included diabetes, dementia, anxiety, dysphagia (difficulty swallowing) following a cerebrovascular accident (stroke). Indicated R66 required total assistance of two staff with ADL's; personal hygiene, toileting, bathing, bed mobility, transfers. R66's care plan dated 9/21/23, identified R66 had an alteration in communication related to being non-verbal and not interactive. R66's primary language was Somalia. Indicated R66 was unable to use a translator due to cognitive impairment and for staff to speak to R66 in simple to understand terms. Identified R66 would be dressed, groomed and bathed per preferences and was dependent with ADL's.	2 920			

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2 920	Continued From page 6 During an observation on 8/19/24 at 2:26 p.m., R66 was sitting in the wheelchair in the dining area wearing a hospital gown and slipper socks. During an observation on 8/19/24 at 6:17 p.m., R66 was sitting in the wheelchair in the dining area and continued to wear a hospital gown and slipper socks. During an observation on 8/21/24 at 12:11 p.m., R66 was sitting in the wheelchair in the dining area wearing a hospital gown and slipper socks. R66's right hip, thigh and partial buttock area were exposed approximately one foot in length down R66's leg by six inches wide on R66's hip/thigh area. Two other residents were observed to be in the dining room and R66's family member. During an interview on 8/21/24 at 12:53 p.m., with family member (FM)-A utilizing the Somali Burg Translation Service, FM-A stated it bothered her that R66 was not dressed and R66's skin was exposed in the dining room. FM-A stated she had requested staff to put trousers on R66 and to dress R66. FM-A verified R66 was usually wearing a hospital gown and it would bother him. During an interview on 8/21/24 at 1:06 p.m., NA-D verified R66 required total assistance of two staff with personal cares. NA-D stated R66 had clothing available and that staff usually dressed R66. During an interview on 8/21/24 at 1:16 p.m., licensed practical nurse (LPN)-B stated R66 resisted cares at times and it was more appropriate for R66 to wear a hospital gown so R66 was comfortable and staff would not strain	2 920			

Minnesota Department of Health

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2 920	Continued From page 7 themselves. During an interview on 8/20/24 at 4:16 a.m., director of nursing (DON) indicated R30 required staff assistance with shaving. DON stated her expectation was R30 would have been shaved at least weekly or when facial hair was present. During a follow-up interview on 8/21/24 at 2:31 p.m., the director of nursing (DON) verified the expectation of staff was to follow the daily ADL's on the care plan for each resident and to document if a resident refused cares, to notify the nurse, attempt ADL's again, and make a note in the resident's chart. The DON confirmed staff were to respect resident/family wishes. Review of a facility policy titled Activities of Daily Living (ADL's) /Maintain Abilities Policy updated 5/9/24, indicated the facility would provide care and services for hygiene, dressing and grooming. Identified a resident who was unable to carry out ADL's would have received the necessary services to maintain grooming and personal hygiene. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could monitor for compliance with all direct care staff in providing resident assessed need for personal hygiene cares. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 920			
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary	21015			9/24/24

Minnesota Department of Health

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21015	Continued From page 8 procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food and beverages stored in the refrigerators, were labeled, dated and discarded properly. This deficient practice had the potential to affect 87 residents who received food and beverages from the refrigerators. Findings include: On 8/19/24 at 12:45 p.m., during the final tour of the kitchen area with the dietary manager(DM), the following concerns were identified.: Kitchen Freezer: -six veggie burgers in an opened plastic bag without notation of a date. Kitchen refrigerator: -large plastic container 1/2 full of Asian salad dressing with black crusty substance around the lid without any notation of the date it had been opened. -plastic carton ¾ full of thickened milk without notation of a date it was opened and a manufacturer's best by date of 3/4/24. -large container ½ full of Orange Marmalade without notation of a date it had been opened. -large plastic container ¾ full of Blue Cheese salad dressing with black crusty particles inside the container without any notation of the date it had been opened. - Large container ½ full of French salad dressing	21015	Corrected.		

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21015	Continued From page 9 with black crusty particles inside the container without any notation of the date it had been opened. - Large container ½ full of Vinaigrette salad dressing with black crusty particles inside the container and on the outside of the container with an opened date of 5/19/24. -Large container of ½ full container molasses with black crusty particles inside the container and on the outside of the container with an opened date of 6/9/24. During an interview on 8/19/24 at 1:15 p.m., DM confirmed the above findings and indicated the residents had recently been served the above items. DM stated all the above items should have been discarded. DM stated the resident fridge was the responsibility of dietary and was unsure the last time it had been checked for dated or expired items. DM stated they had a water leak a few weeks ago in the kitchen refrigerator which may have been why the above items contained the black substance inside and outside of the containers. DM stated her expectation was all items would have been dated and discarded per facility policy. During an interview on 8/20/24 at 12:06 p.m., registered dietician (RD) stated she was unaware of the items that had not been dated or discarded. DM stated she was aware of the water leak in the refrigerator a few weeks ago and that maintenance had fixed the leak however would have expected staff to review the refrigerator again to ensure the issue had been resolved. RD further stated her expectation was all above items would have been discarded per facility policy. Review of a facility policy titled Food Storage and Shelf Life: Cold Food Storage undated, indicated	21015			

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21015	Continued From page 10 all opened containers should have had a date opened marked to assure correct rotation. Policy further indicated thickened liquids should have been discarded after manufacturer's use by date. SUGGESTED METHOD OF CORRECTION: The dietary manager, or designee, could ensure appropriate sanitation, storage and proper disposal of food items in the kitchen. The facility could update or create policies and procedures and educate staff on these changes and perform competencies. The dietary manager, or designee could perform audits and report audit findings to the Quality Assurance Performance Improvement (QAPI) for further recommendations or to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015			
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were administered safely for 3 of 3 residents (R79, R74, R354) who had medications left at the bedside and had not been assessed as safe to self-administer those medications.	21565	corrected.		9/24/24

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21565	Continued From page 11 Findings include: R79 R79's significant change in status Minimum Data Set (MDS) dated 7/15/24, identified R79 was cognitively intact, and had diagnoses which included: cancer, hypertension and diabetes mellitus. Identified R79 was independent with eating, bed mobility, and transfers, and required partial/moderate assistance with dressing. R79's care plan revised 8/7/24, identified R79 was receiving hospice services, and was independent with dressing, personal hygiene, and transfers. R79's care plan lacked instructions for self administration of medications. During an observation on 8/19/24 at 1:29 p.m., R79 was lying in her bed. Next to her bed was a bedside stand with two boxes of antibiotic and pain relief cream and a small tube of antibiotic ointment lying on the floor next to the bed. In addition, on R79's bed side stand, there were facility barrier cream ointments and lotions. Review of R79's Order Summary Report signed 8/21/24, lacked orders for antibiotic and pain relief cream, antibiotic ointment, or orders for self administration of medications (SAM). R79's medical record lacked documentation of a SAM assessment. During an observation on 8/20/24, at 11:45 a.m., R79 was lying in her bed. The two boxed antibiotic and pain relief cream, and antibiotic ointment were on R79's bedside stand. At 12:56 p.m. R79 was sitting up in her bed, with her meal tray in front of her on the bedside table. The	21565			

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21565	Continued From page 12 medications continued to be lying on R79's bedside stand. During an interview on 8/20/24 at 2:50 p.m., nursing assistant (NA)-C indicated was unaware if R79 used the antibiotic and pain relief creams or antibiotic ointment independently. Stated NA-C had not applied the ointment or cream on R79. During an interview on 8/20/24 at 3:06 a.m., interim care coordinator licensed practical nurse (LPN)-A confirmed R79's medications were administered by nursing staff and was not aware if R79 had a SAM assessment completed. LPN-A entered R79's room and confirmed R79 had the creams and ointments lying on her bedside table, and removed them from the room. LPN-A indicated R79's family member may have brought the medications. LPN-A confirmed R79 did not have an order for SAM or the creams or ointments. During an interview on 8/21/24 at 8:18 a.m. director of nursing (DON) confirmed had been informed by LPN-A that R79 had medications at bedside that were not ordered, and did not have a SAM assessment or order for SAM. DON stated LPN-A had contacted R79's family member who would come in to pick up the medications that were observed in R79's room. DON indicated her expectation and the facility's process was to complete a SAM assessment, then if appropriate, obtain an order for SAM, based on a resident's cognitive and physical abilities. DON stated it was important to follow the SAM process due to risk of overdosing and for other safety reasons, too. R74	21565			

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21565	Continued From page 13 R74 admission MDS dated 7/17/24, identified R74 was cognitively intact and had diagnoses which included: hypertension (high blood pressure), anxiety disorder, depression, and respiratory failure. Indicated R74 was independent with bed mobility, transfers, personal hygiene, and dressing. R74's care plan revised on 7/12/24, identified R74 was to take pain medication as ordered by a medical doctor (MD). The care plan lacked documentation of a SAM or order to self-administer medication. During an observation on 8/20/24 at 12:03 p.m., registered nurse (RN)-B checked orders on the electron medication record (EMAR) which identified R74 received Diclofenac Sodium External Gel 1% (Diclofenac Sodium (topical) Apply 4 grams affected joint topically four times a day for joint damage starting 7/11/24 at 8:00 p.m. RN-B took the Diclofenac Sodium External Gel and verified the medication with the EMR. RN-B took medication into R74's room and had R74 verify his name and date of birth. RN-B went to apply Diclofenac Sodium External Gel 1% to R74 shoulder. R74 opened the dresser drawer and pulled out a medication tube of Diclofenac Sodium External Gel 1%. R74 reported applying it to his shoulder three times a day on his own and would let staff know when the medication became low. R74 placed the medication back in the dresser. RN-B left the room and placed R74's medication that had been removed from the cart back into the medication cart. Review of R74's electronic medication administration record (EMAR) lacked an order for self-administration of medications or a SAM assessment being completed. In addition, the	21565			

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21565	Continued From page 14 EMAR identified staff signing that Diclofenac Sodium External Gel 1% (Diclofenac Sodium (topical) Apply 4 grams to affected joint topically four times had been applied by staff. During an interview on 8/20/24 at 2:54 p.m., NA-B stated none of the residents had medication in their room according to his knowledge. During an interview on 8/20/24 at 3:23 p.m., RN-C stated she had not received an order for R74 to self-administer medications. During a follow-up interview on 8/21/24 at 10:05 a.m., RN-C stated the process to have a medication left in the room for the resident to self-administer was to inform the provider a SAM had been completed by the facility and then an order for self-administration would be received from the provider. During an interview on 8/21/24 at 9:46 a.m., RN-B stated some residents came in with a supply of medications. RN-B indicated the process was a nurse would completed a SAM and if the results of the assessment determined the resident could safely self-administer their meds, an order would be obtained from the doctor. During an interview on 8/21/24 at 10:51 a.m. director of nursing (DON) stated the process is to do a self-administration assessment for medication and then requested an order from the physician. DON stated it would be her expectation would be for staff not to leave medication in the room without having done a self-administration of medication assessment and an order from the physician.	21565			

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21565	Continued From page 15 R354 R354's admission MDS dated 7/15/24, identified R354 was cognitively intact. Diagnoses included orthopedic surgery, arthritis, dementia, anxiety disorder and dependent personality disorder. R354 needed assistance with transfers, dressing, and personal hygiene. R354's care plan dated 8/19/24 lacked information regarding self-administration of medication. The care plan did reveal R354 had a history of substance use disorder with opioids and alcohol. R354 had a goal for staff to make every reasonable attempt to keep the resident safe in the event of an opioid-related overdose. R354's medical record lacked an order for SAM and lacked evidence a SAM assessment had been completed. During an observation on 8/20/24 at 3:13 p.m., R354 had a cup of medications on his bedside table. R354 stated the cup with medications had been sitting on the bedside table for an hour. R354 was waiting to take the medications until the nurse could tell him what the medications were for. During an interview on 8/20/24 at 3:13 p.m., licensed practical nurse (LPN)-C reported the medications, which included oxycodone (an opioid used for pain) had been sitting on R354 bedside table since 2:38 p.m. R354 was on the phone when LPN-C went to give R354 the medications and left the medications on the bedside table. LPN-C verified that R354 did not have an order to leave medication at the bedside nor for R354 to self-administer his medications.	21565			

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21565	Continued From page 16 During an interview on 8/20/24 at 3:32 p.m., registered nurse (RN)-C verified R354 did not have a self-administration medication order or a SAM assessment. During an interview on 8/21/24 at 8:18 a.m. director of nursing (DON) indicated her expectation and the facility's process was to complete a SAM assessment, then if appropriate, obtain an order for SAM, based on a resident's cognitive and physical abilities. DON stated it was important to follow the SAM process due to risk of overdosing and for other safety reasons as well. Review of facility policy titled Self-Administration of Medications dated 2/2024, indicated residents had the right to self-administer medications if the interdisciplinary team had determined that it was clinically appropriate and safe for the resident to do so. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for self administration of medication according to evidence based practices/procedures. Nursing staff could be educated as necessary to the importance of ensuring the resident is capable of administering their own medications initially, quarterly, annually, or with a change to a resident's physical or mental ability to do so. Nursing staff could also ensure there is a physician's order in place, prior to a nurse/medication aide administering medication. The DON or designee, could audit any/all resident's medical records, to ensure compliance with appropriate medication administration. The DON or designee could take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance.	21565			

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21565	Continued From page 17	21565			
	TIME PERIOD FOR CORRECTION: Twenty one (21) days.				
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure housekeeping services for a clean environment for 4 of 4 residents (R79, R2, R81, R19) with a shared bathroom. Findings include: R79's Face Sheet, dated 8/21/24, identified R79 had diagnoses which included; malignant neoplasm of temporal lobe, depression, and diabetes mellitus. R79's care plan revised 8/7/24, identified R79 was independent with a walker for ambulation, transfers, and required assistance of one with toileting. R2's Face Sheet dated 8/21/24, identified R2 had diagnoses which included: Alzheimer's disease, diabetes mellitus, and delusional disorders.	21695	corrected.	9/24/24	

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21695	Continued From page 18 R2's care plan revised 6/5/24, identified R2 required two staff for assistance with transfers, wheelchair use for mobility, and required assistance of one with toileting. R81's Face Sheet dated 8/21/24, identified R81 had diagnoses which included: malignant neoplasm of unspecified site of right female breast, muscle weakness, and fracture of unspecified part of neck of the left femur, subsequent encounter for closed fracture with routine healing. R81's care plan revised 6/24/24, identified R81 required two staff for assistance with transfers, one assist with ambulation and required assistance of one with toileting. R19's Face Sheet dated 8/21/24, identified R19 had diagnoses which included: paranoid schizophrenia, generalized anxiety disorder, and difficulty in walking. R19's care plan revised 2/28/24, identified R19 required two staff for assistance with transfers, one staff for locomotion in wheelchair, and check and change every two to three hours for assistance of one with toileting. During an observation on 8/19/24 at 1:29 p.m., shared bathroom of R79, R2, R81, and R19, had an area approximately six to eight inches in diameter of brown substance smeared on the doorframe and wall approximately three feet off the ground, and the floor was very sticky. During an observation on 8/20/24 at 8:23 a.m., the shared bathroom of R79, R2, R81, and R19, continued to have an area approximately six to eight inches in diameter of brown substance	21695			

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21695	Continued From page 19 smeared on the doorframe and wall approximately three feet off the ground, and the floor was still very sticky. During an observation on 8/20/24 at 11:48 a.m., the shared bathroom of R79, R2, R81, and R19, continued to have an area approximately six to eight inches in diameter of brown substance smeared on the doorframe and wall approximately three feet off the ground, and the floor was still very sticky. During an interview on 8/20/24 at 11:52 a.m., housekeeper (HSK)-A stated was responsible to clean the resident's rooms and had not cleaned the shared bathroom of R79, R2, R81, and R19 yet that day. In addition, HSK-A had not cleaned the bathroom yesterday either. HSK-A indicated the usual practice was to check the rooms or staff informed the housekeeping staff when cleaning was needed. HSK-A and surveyor entered the shared bathroom of R79, R2, R81, and R19. HSK-A confirmed the bathroom had a brown substance on the wall and doorframe, the floor was sticky and indicated could also see the floor was soiled. HSK-A indicated would have expected someone to have informed housekeeping that the floor and wall needed to be cleaned. During an interview on 8/21/24 at 8:37 a.m., environmental director (ED)-A stated everyday she would complete an inspection of each floor, dining rooms, hallways, break rooms and talk to housekeeping staff to discuss what needed to be done and assist when needed. ED-A indicated she expected housekeeping staff to clean resident bathrooms every day, to check rooms often and clean as soon as possible when soiled. ED-A stated she had instructed housekeeping	21695			

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21695	Continued From page 20 staff to check the bathrooms more frequently since bathrooms could become soiled more often, even right after they had been cleaned. ED-A stated all staff should check the bathrooms to ensure they are clean and indicated staff could call housekeeping and they would clean it right away. During an interview on 8/21/24 at 10:17 a.m., director of nursing (DON) indicated an expectation of the resident bathrooms to be cleaned daily, and when soiled, would expect nursing staff to clean it or notify housekeeping to come and clean the bathroom immediately. DON stated this was important for hygiene, infection control, and stated this was the resident's home. Review of the facility policy titled Daily Cleaning Procedures (DCP) undated, included instructions to spot clean walls that were visibly soiled. In addition. the policy included instructions to dust mop, then damp mop the perimeter of the room, including to not forget the restroom. SUGGESTED METHOD OF CORRECTION: The housekeeping supervisor, or designee could ensure a housekeeping program was developed to ensure ongoing maintenance and preventative housekeeping schedule was completed for the facility and grounds on a routine basis. The housekeeping supervisor or designee could perform audits periodically to ensure maintenance and ongoing housekeeping is adequately completed within the facility and the grounds. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one	21695			

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21695	Continued From page 21 (21) days.	21695	corrected.		9/24/24
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 promote dignity while utilizing a mechanical lift sling for extended periods of time for 1 of 3 residents (R13) reviewed for dignity and who was dependent on staff for activities of daily living (ADL's) and required the use of a mechanical lift for transfers. Findings include: R13's quarterly Minimum Data Set (MDS) dated 6/27/24, identified R13 had moderate cognitive impairment and diagnoses which included: moderate intellectual disabilities, and Parkinsonism (movement symptoms related to Parkinson's disease). Indicated R13 was dependent on staff for chair/bed transfers, dressing, and personal hygiene. R13's Care Area Assessment (CAA) dated 3/18/24, identified R13 needed assistance with ADL's and had decreased mobility and cognition secondary to schizoaffective disorder (mental health condition with symptoms such as hallucinations, delusions, and mood disorders),	21805			

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NAME OF PROVIDER OR SUPPLIER THE VILLAS AT RICHFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 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 22 failure to thrive, and moderate intellectual disabilities. R13 required extensive to total dependence with all ADL's. R13 was not always able to make his needs known. R13's Care Plan dated 11/2/23, identified R13 was a vulnerable adult and had ADL's self performance deficit with total assistance for bathing, dressing, and personal hygiene. Indicated R13 used an EZ stand (mechanical lift) for transfers as tolerated with assistance of two staff. During an observation on 8/19/24 at 3:27 p.m., R13 was in his wheelchair in his room. R13 had a mechanical lift sling placed under him in his wheelchair. The straps of the sling were observed to be draped over his thighs, approximately each six inches wide, and the sling hung approximately six inches on both sides out the back side of the wheelchair. R13 indicated the fact the sling could be visualized by others while he sat in his wheel chair bothered him. During a phone interview on 8/19/24 at 5:24 p.m., resident representative (RR)-A stated it would bother R13 very much if the mechanical lift sling was visible to others while R13 was in the wheelchair. During an observation on 8/20/24 at 8:32 a.m. R13 was in his wheelchair in the dining room. R13's mechanical lift sling was observed to again be draped over his thighs and hung out the back sides of the wheelchair approximately six inches on both sides. At 11:32 a.m., R14 was again in the dining room in his wheelchair. R13's mechanical lift sling was visible with straps over both thighs, and hung out the back sides of wheelchair approximately six inches on both	21805			

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21805	Continued From page 23 sides. During an interview on 8/20/24 at 2:45 p.m., nursing assistant (NA)-C indicated had assisted R13 with transfers in the past and confirmed staff left the mechanical lift sling in R13's wheelchair while R13 was in the wheelchair. NA-C stated if it was difficult to remove the mechanical lift sling while a resident was in their wheelchair, they were supposed to tuck it in so it was not visible for dignity issues. Indicated NA-C had not assisted R13 with transfers that day. During an interview on 8/20/24 at 3:00 p.m., interim care coordinator licensed practical nurse (LPN)-A confirmed R13 used a mechanical lift for transfers and indicated R13's sling should have been taken out of R13's wheelchair while he was in the wheelchair. LPN-A indicated when the mechanical lift was left in residents' wheelchairs while they were in them, it could have been uncomfortable and not dignified. During an interview on 8/21/24 at 8:10 a.m., director of nursing (DON) indicated mechanical lift slings should have been removed from the wheelchairs while residents were in them or hidden if kept in the wheelchair. DON stated this was her expectation to promote privacy and dignity. Review of the facility policy titled Resident Rights Policy dated 1/2024, identified it was the practice of the facility to uphold the rights of all residents. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures related to dignified practices with staff to ensure knowledge, then audit to ensure ongoing	21805			

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21805	Continued From page 24 compliance. TIME FRAME FOR CORRECTION: Twenty one (21) days.	21805			9/24/24
23010	MN Rule 4658.4635 A Nurse Call System; New Construction The nurses' station must be equipped with a communication system designed to receive calls from the resident and nursing service areas required by this part. The communication system, if electrically powered, must be connected to the emergency power supply. Nurse calls and emergency calls must be capable of being inactivated only at the points of origin. A central annunciator must be provided where the door is not visible from the nurses' station. A. A nurse call must be provided for each resident's bed. Call cords, buttons, or other communication devices must be placed where they are within reach of each resident. A call from a resident must register at the nurses' station, activate a light outside the resident bedroom, and activate a duty signal in the medication room, nourishment area, clean utility room, soiled utility room, and sterilizing room. In multi-corridor nursing units, visible signal lights must be provided at corridor intersections. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure call lights were accessible for 1 of 1 residents (R27) who were reviewed for call light accessibility.	23010			

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23010	Continued From page 25 Findings include: R27's quarterly Minimum Data Set (MDS) dated 5/23/24, indicated R27 was cognitively impaired and had diagnoses of depression and schizophrenia (a serious mental health condition). Identified R27 was dependent on staff for activities of daily living (ADL) and mobility. R27's care plan dated 7/19/23, lacked documentation of the use or placement of R27's call light. During an observation on 8/20/24 at 12:18 p.m., R27 was sitting in his wheelchair watching television. R27's call light was laying on a pillow on the nightstand table behind R27. R27 was not able to move his wheelchair or turn around independently to reach his call light off of the nightstand table. During an observation on 8/20/24 at 12:28 p.m., R27 remained in the same position as above. R27's call light remained laying on a pillow on the nightstand table and was covered with a blanket. R27 continued to not have access to his call light. During an observation on 8/20/24 at 3:52 p.m., R27 had been transferred from this wheelchair to his bed. R27 was laying in his bed covered with a white bed sheet. R27's call light continued to lay on a pillow and the nightstand covered with a blanket. R27 was not able to reach his call light while laying in bed. During an interview on 8/20/24 at 12:37 p.m., R27 stated he could use the flat style call light for staff assistance if it was placed on the right spot on his legs for him to tap it with his left hand. R27 further stated, "I can not hit it unless it is right here (R27	23010			

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23010	Continued From page 26 demonstrated where the call light needed to be placed for him to hit it). R27's call light was not within reach for R27 to call for assistance. During an interview on 8/20/24 at 4:02 p.m., nursing assistant (NA)-E stated R27 could use his call light if it was placed next to his head while lying in bed. NA-E further stated call lights should have always been within reach of the residents when they were in their rooms so they could call for assistance. During an interview on 8/20/24 at 4:06 p.m., licensed practical nurse (LPN)-C walked into R27's room and confirmed R27's call light was laying on the nightstand on top of pillows covered with a blanket. LPN-C also confirmed R27 did not have access to his call light while laying in bed. LPN-C indicated R27 could use his call light to ask for assistance from staff. LPN-C stated R27's call light should have been placed within reach when staff put R27 to bed. LPN-C stated her expectations were for staff to place call lights next to residents and explain to the resident where the call light was so they could call for assistance. During an interview on 8/20/24 at 4:09 p.m., director of nursing (DON) was not aware R27's call light was not within reach. DON stated her expectations were that resident's call lights were within reach at all times so residents could call for assistance when needed. Requested a facility policy on call lights however, it was indicated the facility did not have a call light policy. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could development and implement policies and	23010			

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23010	Continued From page 27 procedures to ensure that a resident call light system was implemented and monitored. The director of nursing or designee could then perform audits adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty - one (21) days	23010			

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/20/2024. At the time of this survey, The Villas At Richfield was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

09/10/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Villas At Richfield is a 3 story building with full basement. The building was constructed in 1964 and was determined to be Type II (222) construction. The facility is fully protected throughout by an automatic sprinkler system 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.	K 000			

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K 000	Continued From page 2	K 000			
K 211 SS=E	The facility has a capacity of 105 beds and had a census of 94 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain clear path of egress per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, 19.2.3.4, and 7.1.10.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 08/20/2024 at 10:39 AM, it was revealed by observation that there was a bed, a bench, and 12 kitchen carts being stored in the basement egress corridor. The Facility Maintenance Director stated that the bed had been there for a few days. An interview with the Interim Administrator, Associate Administrator, Facility Maintenance	K 211	1.Basement egress corridor was inspected by Maintenance Director and all items removed from corridor including bench, bed, and all kitchen carts. 2.All staff educated on the expectation that basement corridor always remain free of clutter. 3.Basement corridor to be audited weekly x4 weeks to ensure it remains free of clutter. 4.Maintenance Director 5.09/24/2024	9/24/24	

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K 211	Continued From page 3	K 211			
K 324 SS=D	Director, and Regional Maintenance Director verified this deficient finding at the time of discovery. Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to install the required safety features for cooking equipment and maintain the kitchen hood system per NFPA 101 (2012 edition), Life Safety	K 324		9/24/24	
			1.Maintenance Director scheduled 12-year hydro test and work is completed. Residential stove in physical therapy room was repaired so that it now locks out with timer. East door to kitchen was repaired		

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K 324	Continued From page 4 Code, sections 9.2.3, 19.3.2.5.1, 19.3.2.5.3 and 19.3.2.5.4, and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, sections 4.1.2, 4.1.3.1, 11.2.1 and 11.2.3. These deficient findings could have an isolated impact on the residents within the facility. Findings include: 1. On 08/20/2024 between 09:00 AM and 12:00 PM, it was revealed by a review of available documentation that the kitchen hood inspection reports dated 2/7/2024 and 8/2/2024 both stated "(1) Ansul R-102 3 Gallon System due for 12-year hydro test. Tank date 2012" and the facility did not have documentation showing that the work had been completed. 2. On 08/20/2024 at 10:31 AM, it was revealed by observation that the lockout device that is installed on the residential stove in the physical therapy room does not lock out after the timer times out. During the survey, the timer was tested and there was power going to the timer without having to unlock the power. 3. On 08/20/2024 at 10:46 AM, it was revealed by observation that the east door to the kitchen was held open by a mag hold open device and when the door self-closing was tested the door did not fully close and latch. An interview with the Interim Administrator, Associate Administrator, Facility Maintenance Director, and Regional Maintenance Director verified these deficient findings at the time of			K 324	and now closes seamlessly when released from mag lock. 2.Maintenance director educated on expectations for hydro testing, lock-out of residential ovens, and mag doors. 3.Repaired areas to be audited weekly x4 weeks to ensure repairs remain intact. 4.Maintenance Director 5.09/24/2024		

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K 324	Continued From page 5			K 324			
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1.2, 5.1.1.2, 5.3.2.1, 6.1.4, and 13.8.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include:			K 353	1.Area where FDC check device was located has now been cleared of all items so that it is easily accessible to inspection. Maintenance completed inspection test. 2.Maintenance educated on reviewing inspection reports for errors, barriers, or follow up items that are needed so that they are completed timely. 3.Check device location to be audited weekly x4 weeks to ensure that it remains easily accessible. 4.Maintenance Director		9/24/24

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K 353	Continued From page 6 On 08/20/2024 between 09:00 AM and 12:00 PM, it was revealed by a review of available documentation that the five-year inspection report that the facility provided stated "FDC check not accessible". An interview with the Interim Administrator, Associate Administrator, Facility Maintenance Director, and Regional Maintenance Director verified this deficient finding at the time of discovery.	K 353	5.9/24/2024		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of	K 363		9/24/24	

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(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 363	Continued From page 7 unlimited height are permitted. 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 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.10. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 08/20/2024 at 10:28 AM, it was revealed by observation that the staffing supply room door was being held open with string tied to a shelf. An interview with the Interim Administrator, Associate Administrator, Facility Maintenance Director, and Regional Maintenance Director verified this deficient finding at the time of discovery.	K 363			
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall	K 521	1.Staffing supply room door string has been removed. Door to remain closed at all times. 2.Staffing coordinator is no longer at facility. Maintenance Director will be educated on ensure doors are not propped open. 3.Staffing supply room door to be audited weekly x4 weeks to ensure it remains closed and is not propped. 4.Maintenance Director will be responsible. 5.9/24/2024	9/24/24	

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K 521	Continued From page 8 comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install the facility's heating, ventilation, and air conditioning systems per NFPA 101 (2012 edition), Life Safety Code, sections 19.5.2.1 and 9.2.1, and NFPA 90A (2012 edition), Standard for the Installation of Air-Conditioning and Ventilating Systems, section 4.3.12.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/20/2024 between 09:00 AM and 12:00 PM, it was revealed by observation that the ventilation system for the corridors is utilizing the egress corridor as an exhaust plenum for the ducted make-up air. A hot water system heats the resident rooms, and the corridors are heated by forced air. The resident bathroom fans run continuously and exhaust to the exterior and have dampers located in them. An interview with the Interim Administrator, Associate Administrator, Facility Maintenance Director, and Regional Maintenance Director verified this deficient finding at the time of discovery.	K 521	Waiver has been requested.		
K 711 SS=C	Evacuation and Relocation Plan CFR(s): NFPA 101	K 711		9/24/24	

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K 711	Continued From page 9 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire safety plan per NFPA 101 (2012 edition), Life Safety Code, section 19.7.2.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/20/2024 between 09:00 AM and 12:00 PM, it was revealed by a review of available documentation that the fire safety plan that was provided at the time of the survey did not include Transmission of alarms to fire department. An interview with the Interim Administrator, Associate Administrator, Facility Maintenance Director, and Regional Maintenance Director verified this deficient finding at the time of discovery.	K 711	1.Administrator and Maintenance Director reviewed facility fire plan and updated policy to include that maintenance during drill testing transmission of test is received by fire department and recorded. 2.Maintenance director and IDT Team educated on policy update. 3.Audit emergency preparedness binder weekly x4 weeks that Fire Plan remains up to date. 4.Maintenance Director 5.9/24/2024		
K 920	Electrical Equipment - Power Cords and Extens	K 920			9/24/24

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K 920 SS=D	Continued From page 10 CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include:	K 920	1.Room 219 was inspected by Maintenance Director and resident was supplied with appropriate power strip, and excess devices removed. Resident was educated. 2.Maintenance Director on life safety code expectations for electrical cords. 3.Resident rooms will be audited weekly x4 weeks to ensure power strips meet UL1363A standards and no other devices or extension cords are plugged in to the		

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K 920	Continued From page 11 On 08/20/2024 at 10:56 AM, it was revealed by observation that there were multiple extension cords and power strips plugged into other power strips behind the TV in resident room 219. An interview with the Interim Administrator, Associate Administrator, Facility Maintenance Director, and Regional Maintenance Director verified this deficient finding at the time of discovery.	K 920	power strip. 4.Maintenance Director responsible. 5.9/24/2024		
K 930 SS=D	Gas Equipment - Liquid Oxygen Equipment CFR(s): NFPA 101 Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to safely store liquid oxygen per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.7.4. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 08/20/2024 at 11:06 AM, it was revealed by observation that two liquid oxygen containers were being stored not in use with a third that was being used in resident room 322. An interview with the Interim Administrator, Associate Administrator, Facility Maintenance	K 930	1.Room 322 was inspected and second oxygen tank was removed from resident room and appropriately stored in oxygen room. 2.Nursing staff and leadership will be educated on oxygen storage in residen rooms. 3. Audits will be conducted weekly x 4 weeks in resident rooms who have oxygen orders to ensure oxygen storage is appropriate. 4.Maintenance Director or designee 5.9/24/2024	9/24/24	

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K 930	Continued From page 12 Director, and Regional Maintenance Director verified this deficient finding at the time of discovery.	K 930			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
October 1, 2024

Administrator
The Villas At Richfield
7727 Portland Avenue South
Richfield, MN 55423

RE: CCN: 245492
Cycle Start Date: August 21, 2024

Dear Administrator:

On September 26, 2024, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Your request for a continuing waiver involving the deficiency(ies) cited under K521 - HVAC at the time of the August 21, 2024 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 1, 2024

Administrator
The Villas At Richfield
7727 Portland Avenue South
Richfield, MN 55423

Re: Reinspection Results
Event ID: KEKH12

Dear Administrator:

On September 26, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 21, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us