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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: KN3W

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00253

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **12/01/2017**
6. DATE OF SURVEY **10/09/2019** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **112** (L18)
13.Total Certified Beds **112** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	112			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Nicole Osterloh, Unit Supervisor — 11/13/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Douglas Larson, Enforcement Specialist — 11/13/2019 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06301
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/24/2019
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 13, 2019

CMS Certification Number (CCN): 245492

Administrator
Richfield A Villa Center
7727 Portland Avenue South
Richfield, MN 55423

Dear Administrator:

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

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

Effective October 9, 2019 the above facility is certified for:

112 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 112 skilled nursing facility beds.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K 521.

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit

Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Electronically delivered
November 13, 2019

Administrator
Richfield A Villa Center
7727 Portland Avenue South
Richfield, MN 55423

RE: CCN: 245492
Cycle Start Date: August 29, 2019

Dear Administrator:

On September 25, 2019, we notified you a remedy was imposed. On October 9, 2019 the Minnesota Department(s) of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 9, 2019.

As a result of the revisit findings:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 17, 2019 be rescinded as of October 9, 2019. (42 CFR 488.417 (b))

In our letter of September 25, 2019, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 17, 2019 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 9, 2019, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Your request for a continuing waiver involving the deficiency(ies) cited under K521 at the time of the August 29, 2019 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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KN3W

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00253

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(L4) **7727 PORTLAND AVENUE SOUTH**
(L5) **RICHFIELD, MN** (L6) **55423**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**

8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **12/01/2017**

6. DATE OF SURVEY **08/29/2019** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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From (a) :
To (b) :

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A. In Compliance With Program Requirements Compliance Based On:
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X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B, 5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	112			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Julie Serbus, HFE NE II 10/18/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 10/18/2019 (L20)

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

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____ 2. Facility is not Eligible
(L21)

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3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
01/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06301
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered

September 18, 2019

Administrator
Richfield A Villa Center
7727 Portland Avenue South
Richfield, MN 55423

RE: Project Numbers S5492030, H5492125C, H5492126C, H5492127C, H5492131C

Dear Administrator:

On August 29, 2019, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the August 29, 2019 standard survey the Minnesota Department of Health, completed an investigation of complaint number(s) H5492125C, H5492126C, H5492127C, H5492131C.

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.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is October 8, 2019.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable plan of correction (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 a 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:

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

- Civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement (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" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Nicole Osterloh, Unit Supervisor
Marshall District Office
Health Regulation Division
Licensing and Certification
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083
Fax: 507-537-7194

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 29, 2019 (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 29, 2020 (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/ltc_idr.cfm

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245492	A. BUILDING _____ B. WING _____	C 08/29/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 08/26/19 through 08/29/19, during a recertification survey. The facility was found to be IN COMPLIANCE with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 8/26/19 through 8/29/19, a standard survey was completed at your facility by the Minnesota Department of Health. Richfield A Villa Center was found NOT in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. Additionally, a complaint investigation was conducted on 8/26/19 through 8/29/19, at your facility. Your facility was found NOT to be in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5492126C and H5492127C. However, no deficiencies were cited. The following complaints were found to be SUBSTANTIATED: H5492125C with deficiencies citied at current noncompliance at F580. The following complaints were found to be UNSUBSTANTIATED: H5492131C. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are	F 000		

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

Electronically Signed | 09/25/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245492	A. BUILDING _____ B. WING _____	C 08/29/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.	F 580		10/7/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245492	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 580	Continued From page 2 (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the primary care provider regarding weight gain, complaints of shortness of breath, chest pain, and continued decline in health status for 1 of 1 resident (R259) reviewed for hospitalization. Findings include: R259 was reviewed as a closed record. Family member (FM)-B was interviewed via telephone on 8/27/19, at 12:47 p.m. and stated she was worried about R259 due to not hearing from him for since 8/8/19, and explained normally	F 580	1. Resident R259 has been discharged. 2. Residents on increased weight monitoring have potential to be affected by this practice. Providers will be updated appropriately on parameters and/or change in condition. 3. Nursing staff have been re-educated on the Villa Notification of Changes Guideline. Residents who have a change in condition will have their physicians and responsible parties notified. 4. The DON/Designee will audit during the clinical start up meeting to ensure compliance. The audits will continue for 3 months. All results will be brought to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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RICHFIELD A VILLA CENTER	**7727 PORTLAND AVENUE SOUTH RICHFIELD, MN 55423**

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F 580	Continued From page 3 R259 would call her and the other FM daily. FM-B stated she arrived to the facility on 8/12/19, at 12:30 p.m. and found R259 slumped over in his wheelchair (w/c) disorientated. FM-B stated she went to notify the nurse who agreed R259 did not look well. FM-B stated the nurse took R259's vital signs, however could not get a blood pressure reading and then asked the nurse to call the provider. FM-B stated the nurse returned and said the provider ordered a chest x-ray. FM-B stated after waiting a while R259 seemed to be worse and was hunched over with his head hanging down not talking. FM-B then requested R259 be sent to the hospital and stated R259 was admitted to the hospital and diagnosed with dehydration, acute kidney failure, cardiac issues and hypotension (low blood pressure). R259's care plan dated 4/27/19, identified R259 had altered cardiovascular status related to coronary artery disease and directed staff to encourage low fat and salt intake. R259's Dehydration care plan dated 5/1/19, identified a risk for dehydration related to nausea and poor oral intake and directed staff to monitor and record fluid intake at each meal, monitor vital signs and notify provider of significant abnormalities, monitor bowel sounds and frequency, monitor and document any signs and/ or symptoms of dehydration decreased or no urine output, new onset confusion, dizziness on sitting/ standing, increased pulse, headache, fatigue/ weakness, fever and thirst. R259's Dehydration/ Fluid Maintenance Care Area Assessment dated 5/7/19, indicated R259 was at risk for dehydration and directed staff to monitor laboratory results and observe oral intake.	F 580	monthly Quality Assurance performance Improvement meetings and reviewed for trends in quality improvement.	

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F 580	Continued From page 4 R259's Order Summary Report dated 7/7/19, included daily weight, update provider if more than 2 pounds (lbs) gain in one day or 5 pounds gain in one week. R259's quarterly Minimum Data Set (MDS) dated 7/13/19, identified intact cognition and diagnoses that included anemia and heart failure. The MDS indicated R259 required extensive assistance with activities of daily living. R259's Progress Notes (PN) and weight summary were reviewed 8/1/19, through 8/15/19, and revealed the following: -R259's weight summary lacked weights for 8/1/19, and 8/2/19; -R259's weight dated 8/3/19, was recorded as 155.6 lbs; -R259's weight dated 8/4/19, was recorded as 153 lbs; -R259's weight dated 8/5/19, was recorded as 153 lbs; -R259's weight dated 8/6/19, was recorded as 161.2 lbs, however R259's medical record lacked evidence the medical provider was updated per orders if more than 2 lbs gain in one day or 5 lbs gain in one week; -R259's weight record lacked evidence of recorded weights for 8/7/19, 8/8/19, and 8/9/19; -R259's weight dated 8/10/19, was recorded as 161.3 lbs, however R259's medical record lacked evidence the medical provider was updated per orders if more than 5 lbs gain in one week; -The PN dated 8/10/19, indicated at 7:00 p.m. R259 complained of shortness of breath and chest pain. Vital signs taken and "everything was normal" as needed albuterol was administered. Report was given to night nurse R259 was doing	F 580		

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fine. R259's medical record lacked evidence of updating the medical provider regarding shortness of breath, new onset of chest pain and weight gain. In addition, R259's medical record lacked evidence of comprehensive assessment following complaints of shortness of breath and new onset of chest pain and ongoing monitoring of R259's change in condition;
-The PN dated 8/12/19, indicated "writer noticed significant change of condition this morning. pt. [patient] was groggy, disoriented and appeared pale in color. Upon assessment, vitals assessed and stable re assessed in 2 hours. res [resident] appeared to be declining. Saturation would be in 90% one min [minute] and dip down to low 70%. Res appeared much more lethargic and confused. Was not able to tell me person, place or situation. Writer phoned NP [nurse practitioner] NP gave orders to send pt [patient].

Registered nurse (RN)-H was interviewed on 8/27/19, at 2:08 p.m. and stated she was the nurse whom sent R259 to the hospital on 8/12/19, and indicated she had worked with R259 on 8/9/19, and noted R259 seemed tired and kept to himself more than normal. RN-H explained R259 would "normally" come find the nurse for his medications and/ or to have a conversation, however on 8/9/19, R259 did not do these things. RN-H stated she did not work again until 8/12/19, and when she administered R259's morning medications she noted "he was not himself." RN-H explained R259 did not eat much and stated he wanted to rest. RN-H stated around 11:00 a.m. she checked on R259 and his oxygen saturation was 86% she directed him to cough and his saturation came up to 92% with complaints of shortness of breath. RN-H stated R259's FM-B arrived to the facility and expressed

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concern regarding R259's disorientation. RN-H indicated she updated the provider who ordered a stat chest x-ray. RN-H stated she went to notify FM-B of the chest x-ray orders, however RN-H stated at that time R259's oxygen saturation dropped between 70 to 80% and he was almost tumbling out of his w/c. RN-H indicated she called the provider back and sent R259 to the hospital. RN-H reviewed R259's electronic medical record (EMR) confirmed she did not document R259's vital signs and entire assessment on 8/12/19. RN-H stated she reported to the evening nurse on 8/9/19, that R259 had not been himself during the day shift.

RN-A was interviewed on 8/29/19, at 8:47 a.m. and reviewed R259's EMR and stated the provider should have been called regarding a weight gain and complaints of shortness of breath and chest pain. RN-A stated there should have been additional monitoring which would include vital signs and assessment following R259's complaints of shortness of breath and chest pain on 8/10/19. RN-A verified R259's weights were not obtained daily for 8/2019, and blood pressure and pulse were not recorded since 7/28/19.

R259's Nurse Practitioner (NP) was interviewed via telephone on 8/29/19, at 10:11 a.m. and stated she had not been notified of R259's weight gain, complaints of shortness of breath and chest pain. The NP stated R259 had not had complaints of chest pain that she was aware of. The NP stated she would expect to be notified of weight gain per orders and complaints of shortness of breath and chest pain immediately.

The director of nursing (DON) was interviewed on 8/29/19, at 11:05 a.m. and stated it was her

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F 580	Continued From page 7 expectation staff obtain daily weights and update the provider per orders. The DON indicated she would expect the provider to be updated when a resident had a change in condition and monitor vital signs every shift. The facility Notification of Changes Guideline dated 11/28/17, indicated it was the practice of the facility that changes in a resident's condition or treatment were immediately shared with the resident's attending physician or delegate. The guideline directed staff to notify the resident's physician when a significant change in health status occurred. The guideline further indicated the nurse would document the notification and record any new orders in the resident's medical record, update the resident's care plan, communicate the changes to the rest of the care team and oncoming shift and inform the supervisor.	F 580		
F 584 SS=E	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.	F 584		10/7/19

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F 584	Continued From page 8 (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; §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 and interview, the facility failed to ensure fans and air conditioners were maintained clean of heavy dust-like debris for 12 of 110 resident (R4, R9, R12, R31, R34, R44, R57, R77, R86, R88, R102, and R461) rooms. The facility also failed to maintain a homelike environment for 2 of 8 residents (R49 and R96) with missing paint and scratches on room walls. Findings include: During observation on 8/27/19 at 2:50 p.m. R31's oscillating fan was circulating and blowing heavy	F 584	1. R4,R9,R12,R31,R34,R44,R57,R77,R86,R88,R102 and R461 have had their fans and air conditioners cleaned. R49 and R96 have had their walls repaired and painted. 2. All residents who reside at Richfield a Villa Center have the potential to be affected by this practice. All fans and A/C units have been checked and cleaned as necessary. Resident rooms have been checked for necessary wall/paint repair. 3. Maintenance, Housekeeping and	

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F 584	Continued From page 9 dust debris was visible and falling out of the fan onto the floor. Observations on 8/28/19 from 10:22 a.m. to 11:00 a.m. of the following resident's rooms identified: 1. R88 and R57's rooms had a wall mounted oscillating fan that contained a thick layer of dust on the grates and blades. The window air conditioner that had thick layers of dust on the filter and vents. 2. R102 and R77's wall mounted fan contained a thick layer of dust-like debris hanging off the fan. 3. R461's wall fan was noted to have thick layer of dust-like debris. The window air conditioner also had dust-like debris. 4. R9 was laying in bed with the oscillating fan mounted to the wall above the head of the bed. That fan had heavy dust-like debris, which was falling out of the fan onto the resident. 5. R243's wall mounted oscillating fan had a thick layer of dust-like debris blowing above where she was seated. 6. R86's wall mounted air conditioner contained a very thick layer of dust-like debris on the vent which reduced air flow. 7. R44, R4 and R12's air conditioner and oscillating fan had a thick layer of dust-like debris. Interview on 8/28/19 at 11:02 a.m., with housekeeper (H)-A identified she was unaware when the fans were to be cleaned, or who was responsible to clean them. On 8/28/19, at 11:48 a.m. the administrator identified facility housekeeping services were a contracted service. His expectation was fans were to be cleaned once per month by housekeeping.	F 584	department heads have been re-educated regarding communication on needed repairs using TELS program located in PCC. Maintenance and housekeeping personnel will complete preventive maintenance checklists daily. 4. Maintenance Director, Housekeeping Director and Administrator will complete weekly audits to ensure compliance and will log results into the TELS system. All results will be brought to the monthly Quality Assurance performance Improvement meetings and reviewed for trends in quality improvement.	

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F 584	Continued From page 10 During interview and facility tour on 8/28/19, at 11:53 a.m., with the contracted certified training manager (CTM) agreed the fans, air conditioner, and vents were heavily soiled with dust-like debris. The outside surface of the fans and air conditioners should be dusted and cleaned daily. The fans and vents should be taken apart and thoroughly cleaned once per month. Contract staff had not had any cleaning tracking logs, and the CTM was unaware when they had been cleaned last. The CTM agreed staff had not maintained the resident's fans and air conditioners to ensure they were free of dust and debris. There was no policy related to environmental fan cleaning provided at the time of survey.	F 584		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		10/7/19

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F 656	Continued From page 11 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate supervision to ensure continuous use of oxygen for 1 of 1 resident (R80). Findings include: R80's significant change minimum data set (MDS) on 7/23/19, identified moderately impaired cognition, and severe depression, with thoughts of harming himself daily. R80 had no behaviors or refusal of care. R80 required extensive assistance of 1 staff for bed mobility, transfers, personal hygiene, dressing, and toileting, and limited assistance of 1 staff for eating. R80's	F 656	1. Resident R80 has been discharged. 2. Residents on oxygen who reside at Richfield a Villa Center have the potential to be affected by this practice. 3. Licensed nurses will be re-educated on oxygen monitoring per care plans. Licensed nurses will be re-educated on the Careplan Standard Guideline. 4. The DON/Designee will ensure accurate care plans through weekly audits. Audits will continue weekly for 3 months. All results will be brought to the monthly Quality Assurance performance Improvement meetings and reviewed for trends in quality improvement.	

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diagnoses included chronic obstructive pulmonary disease (COPD), and depression. R80 had shortness of breath when lying flat, and required oxygen therapy. R80 received hospice care and had diagnoses that my result in life expectancy of less than 6 months.

R80's physician orders dated 8/29/19, included to receive oxygen continuously through a nasal canula at 2 liters per minute to keep oxygen saturation above 89 percent (%) or greater. Staff were to check R80 every hour to ensure his nasal canula was in his nose and to monitor shortness of breath. Staff were to check R80 every 15 minutes to identify R80's whereabouts, and condition, R80 had suicidal ideation (discontinued 8/29/19). Staff were to check oxygen saturation every shift due to full code status if start dropping into low oxygen levels, send 911 to the emergency room despite hospice status.

During observation on 8/26/19, at 4:00 p.m., R80's nasal canula was not on. R80 had slightly labored breathing but denied difficulty breathing. R80 shook his head yes when asked if he removed his oxygen. R80 verified he was supposed to wear oxygen all the time. R80 spoke with a soft quiet voice during the interview and used short sentences.

On 08/27/19, at 2:45 p.m., R80's nasal canula was off and he had labored breathing. R80 indicated he needed help putting his oxygen back on. R80's liquid oxygen canister was set at 2 liter per minute. Licensed practical nurse (LPN)-C was called to the room. LPN-C replaced R80's oxygen and did not check R80's oxygen saturation. She verified R80 was supposed to wear his oxygen continuously and said he often

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removed his nasal canula and required assistance to put it back on. At 3:16 p.m., LPN-C entered R80's room and assessed his vital signs. At 3:33 p.m., unidentified nursing assistants (NA)s walked past R80's room, but did not look into R80's room. NAs were talking to each other and were looking in the opposite direction of his room when they passed by.

On 8/28/19 at 7:12 a.m., R80 was lying in bed on his right side. His nasal canula was off and he was short of breath. R80 had labored breathing and requested the nurse. Trained medication aid (TMA)-A entered the room TMA-A asked R80 if he needed help and R80 shook his head yes. TMA-A did not observed R80's oxygen was off. TMA-A was asked if R80 needed oxygen at all times and stated R80 wore oxygen sometimes. R80's oxygen saturation level was requested. TMA-C exited the room and summoned the LPN-A. TMA-A returned to the room without an oximeter to measure R80's oxygen level. R80 continued to be short of breath. TMA-C replaced R80's nasal canula, and exited the room to get an oximeter. R80's oxygen saturation (SpO2) was 95% at 3 liters per minute. TMA-A was unsure what R80's oxygen flow rate was supposed to be. TMA-A did not check R80's orders to identify what R80's oxygen tank settings were and did not check to see if R80 was supposed to wear oxygen continuously. LPN-A instructed TMA-A to check R80's medication administration record. TMA-A did not check the record to find out what R80's orders were and did not adjust R80's oxygen to 2 liter per minute according to the physician orders.

On 8/28/19 at 8:54 a.m., an interview with TMA-A identified he had been assigned to work as a

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TMA on the second floor because they were short. He stated he worked the second floor infrequently, and when he was assigned to the second floor, he usually worked as an NA. TMA-A stated R80 frequently removed his oxygen and required staff to assist him to replace it. He confirmed he did not check the orders to verify what R80's orders.

During interview with on 8/28/19, at 10:45 a.m .unit manager, LPN-A indicated TMA-A was expected to monitor R80's oxygen if he was short of breath and not wearing his nasal canula and stated R80 frequently removed his oxygen and was short of breath. R80 was full code, even though he was on hospice because he refused to change his code status. Hospice was working with him to change is code status, but until he did, staff were to monitor R80's oxygen levels to keep them above 90%. If R80 were to have respiratory distress, nursing staff were to transport him to the emergency department and contact hospice. R80 was not supposed to have 15 minute checks any longer, because 15 minute checks were not realistic, but staff were to check R80 when they passed by his room on routine rounding because he removed frequently removed his oxygen. R80's room was at the end of the hallway farthest from the nurse desk. LPN-A was unsure sure how frequently staff checked R80's nasal canula for placement and said R80 was not a reliable call light user, but would yell for help if needed.

On 8/28/19, at 10:50 a.m. the director of nursing (DON) stated staff were expected to know R80's care plan, and if staff were unsure of the care plan and physician orders, they were expected to look in the residents electronic medical record, electronic care plan, and medication

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F 656	Continued From page 15 administration records to identify R80's needs for oxygen use. The DON stated R80's care plan should reflect his current status and identify interventions that were individualized and relevant to his needs. The DON stated R80 frequently removed his oxygen that was ordered to be used continuous and staff would be expected to evaluate his needs, adapt his care plan accordingly, and ensure R80's oxygen saturation levels remained as prescribed. Review of the facility's Careplan Standard Guideline dated 11/28/17, indicated care plan interventions should be specific to reflect the specific goal and should be individualized to the resident, and should be revised to reflect the current status of the resident.	F 656		
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		10/7/19

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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 observation, interview and document review, the facility failed to update and revise the care plan for 1 of 1 resident (R53) with physical sexual behaviors. Findings include: R53's quarterly Bladder Evaluation dated 6/20/19, indicated he was incontinent of bladder related to diagnosis of dementia and medications which included antidepressant and antipsychotic. The evaluation indicated R53 had functional urinary incontinence and treatment plan was staff were provide a check and change. R53's annual Minimum Data Set (MDS) dated 6/26/19, indicated he had severe cognitive impairment and diagnoses which included dementia and depression. The MDS indicated R53 required extensive assist of two for activities of daily living which included dressing and toileting. The MDS indicated R53 had no behavior symptoms, no change in behaviors and no rejection of cares during look back period. R53's Urinary Incontinence Care Area Assessment (CAA) dated 7/2/19, identified R53 was always incontinent of bladder and required	F 657	1. R53's care plan has been updated and revised. 2. Residents who reside at Richfield a Villa Center have the potential to be affected by this practice. All resident's Kardex have been reviewed and modified if needed. 3. Licensed nurses will be re-educated on the care plan policy and resident Kardex. Nursing assistants will be re-educated on reviewing the Kardex prior to starting shift. 4. The DON/Designee will ensure accurate care plans and Kardex through weekly audits. Audits will continue weekly for 3 months. All results will be brought to the monthly Quality Assurance performance Improvement meetings and reviewed for trends in quality improvement.	

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F 657	Continued From page 17 extensive staff assist with incontinence cares related to dementia with behaviors and indicated proceed to care plan to keep R53 clean and dry. R53's care plan dated 7/10/18, identified behavior problems related to resisting cares, urinating on the floor, wandering in the hallway, spitting on the floor and hitting staff. The care plan directed staff to anticipate and meet needs, approach in a calm manner, approach from the front, give verbal cues, use the hand under hand approach, move to the side and get down to eye level, positive interaction, stop and talk to R53 when passing by and document behaviors and response to interventions. The care plan identified target behaviors which included urinating inappropriately outside of toilet and directed staff to offer toileting, check and change as needed and redirect. R53's care plan did not identify the use of overalls and lacked evidence of information related to chronic masturbation. R53's guardian was interviewed via telephone on 8/28/19, at 8:47 a.m. and stated in 3/2019, the facility social worker asked her to purchase overalls for R53 due to masturbation in public areas. R53's guardian explained the overalls were to keep R53 from accessing his penis easily while in the public areas and indicated they had tried sweat pants and jeans, however these were not successful and R53 continued to masturbate in public areas. R53's guardian stated she had witnessed R53 masturbating around the time she was asked to purchase the overalls. She stated R53 was standing at the window in the public area when she arrived to visit and was facing the window while masturbating with his penis showing.	F 657		

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R53 was interviewed on 8/28/19, at 1:50 p.m. and unable to answer questions. R53 was observed to have been calm wearing jean overalls while seated on a chair in the common area.

Nursing assistant (NA)-C was interviewed at 8/28/19, at 1:55 p.m. and stated R53 wore overalls due to urinating "everywhere." NA-C indicated R53 would urinate in the public areas in the corners and on the floor when he was not wearing the overalls. However, NA-C stated he was not aware of R53 masturbating in public areas. NA-C stated R53's overalls were removed at bedtime and put back on upon rising in the morning.

Social services (SS)-A was interviewed on 8/28/19, at 2:03 p.m. and verified R53's overalls were worn due to his chronic masturbating in the public dining room. SS-A stated the overalls were to prevent R53 from being able to touch his penis in public areas. SS-A indicated R53 had not masturbated in public areas since he began to wear the overalls.

R53 was observed on 8/29/19, at 9:14 a.m. to have been seated in the dining room wearing overalls with eyes closed.

Registered nurse (RN)-F was interviewed on 8/29/19, at 10:58 a.m. and stated she was not aware why R53 wore overalls. RN-F indicated she reviewed R53's current care plan and verified it lacked evidence of R53 masturbating or the overall use intervention.

The director of nursing (DON) was interviewed on 8/29/19, at 11:21 a.m. and stated she was not aware R53 had to wear overalls. R53 had a

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F 657	Continued From page 19 history of urinating in the dining room corners when wearing regular pants. The DON stated it was her expectation staff were to have updated the care plan for any interventions used. There was no policy regarding revision of care plan provided.	F 657		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the	F 660		10/7/19

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discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.
(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or

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F 660	Continued From page 21 resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide effective discharge planning to facilitate finding an alternative placement in a timely manner for 1 of 2 resident (R67) reviewed for discharge planning. Findings include: Family member (FM)-A was interviewed via telephone on 8/28/19, at 9:16 a.m. and stated R67 and FM-A wanted to transfer R67 to a different facility since R67 had first been admitted in May 2019. FM-A stated she had spoken to the facility social worker who indicated the surrounding facilities were full and R67 would need to go on a waiting list. FM-A explained the facility social worker sent FM-A a list of facilities in the beginning July 2019, and had indicated for FM-A to call, however since then FM-A stated she had not heard anything further from the facility. FM-A indicated R67 would need to apply for community county assistance and FM-A was unsure of next steps or how to apply. FM-A stated she needed help and felt the facility should be following up and providing placement updates. Social service (SS)-A was interviewed on 8/28/19, at 10:35 a.m. and stated she had spoken to FM-A "today" due to R67 mentioning to the medical provider last week that he did not know why he was here and wanted to move. SS-A indicated R67 would need to apply for an elderly waiver and	F 660	1. R67's discharge plan has been established and is in progress. Social services are working with county to open Elderly Waiver. Social services is working with R67's family to determine best placement. 2. All Residents who reside at Richfield a Villa Center who desire to discharge have the potential to be affected by this practice. Residents will be re-interviewed with discharge plans updated per resident request. Discharge plans will be reviewed quarterly at the resident's care conference. 3. Social services staff will be re-trained on the Discharge Planning Guideline. 4. The Director of Social Services/Designee will audit weekly for 3 weeks then monthly for 3 months to ensure compliance. All results will be brought to the monthly Quality Assurance performance Improvement meetings and reviewed for trends in quality improvement.	

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F 660	Continued From page 22 she would start working on that process today. The Director of social services (DSS) was interviewed on 8/28/19, at 11:47 a.m. and stated she had been aware R67 and FM-A wanted R67 transferred, however she was not sure where R67 was at in the discharge planning process. DSS stated shortly after R67 admitted to the facility DSS had offered a place for R67 to transfer, however FM-A declined due to location. DSS indicated at that time other facilities in the area were full and a referral had been made for a relocation worker, however DSS thought there was "something with his insurance" and needing to find an interpreter for the meeting so DSS was unsure if the county was able to screen R67. DSS stated elderly waiver asked for FM-A's contact information on 7/9/19, however DSS had not followed up since. DSS indicated on 8/14/19, she had given a list of places for FM-A to call again as they had been full. R67 was interviewed on 8/28/19, at 2:23 p.m. with interpreter present and stated he wanted to move to a different facility that wasn't as crowded and he wouldn't have to share a room. R67 stated the DSS had been helping him, however he did not have any money to pay for housing and he was waiting for someone to help him apply for money. R67's quarterly Minimum Data (MDS) dated 7/19/19, identified R67 had cognitive impairment and diagnosis which included cerebrovascular accident. The MDS indicated R67 required extensive assistance with activities of daily living. The MDS indicated there was an active discharge plan in place for R67 to return to the community, however return to community was left blank and had a referral been made to the local contact	F 660		

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agency was marked no determination had been made by R67 and the care planning team that contact was required.

R67's care plan dated 5/10/19, indicated R67 wanted to discharge to the community and directed staff to assess need for home health services prior to discharge, discuss discharge goals with resident/ family and discuss discharge status regularly with resident/ family and update on progress.

R67's Psychosocial Well-Being Care Area Assessment dated 5/17/19, indicated R67 liked his own space and preferred to be around those with similar backgrounds. R67 knew he did not have that opportunity at the current facility and had asked to move facilities.

R67's progress notes (PN) dated 5/9/19, through 8/29/19, revealed the following:
-The PN dated 5/13/19, indicated DSS spoke with R67's family who stated R67 wanted to "move;"
-The PN dated 5/29/19, indicated R67 was "clinically denied" from another facility;
-The PN dated 6/13/19, indicated R67's family was updated that "relocation coming in to help to find housing;"
-The PN dated 8/28/19, after survey began, indicated SS-A spoke with R67's family "last Friday" regarding "writer wanted to help find resident a place to live."

The director of nursing (DON) was interviewed on 8/29/19, at 11:15 a.m. and stated she expected the facilities SS department to maintain frequent and open communication regarding the discharge process and plan.

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F 660	Continued From page 24 The facility Discharge Care Plan Guideline revised 5/3/18, indicated the facility was to ensure that the resident and/ or resident representative was an active partner focusing on the resident's goals, preparation, as well as coordination to prepare for discharge. The facility should document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies. If discharge to the community was determined to not be feasible, document who made the determination and reason. In addition, the facility should update a resident's comprehensive care plan and discharge plan.	F 660		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide person centered, meaningful activities for 2 of 3 residents (R67, R44) reviewed for activities. Findings include: R67's Admission Minimum Data (MDS) dated	F 679	1. R67 and R44 are being provided with person centered and meaningful activities. Plans of care have been reviewed and uploaded. 2. All Residents who reside at Richfield a Villa Center have the potential to be affected by this practice. Residents received activity care plan reviews to	10/7/19

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F 679	Continued From page 25 5/14/19, identified R67 had moderate cognitive impairment and diagnosis which included cerebrovascular accident. The MDS indicated R67 required extensive assistance with activities of daily living. In addition, the MDS indicated it was very important for R67 to go outside to get fresh air when the weather was good. R67's Activities Care Area Assessment dated 5/16/19, indicated R67 was interested in bingo, however when invited R67 would refuse to attend, "will continue to invite resident to group activities." R67's care plan dated 5/10/19, directed staff to introduce R67 to other resident's with similar background, interests and encourage interaction. R67's Life Enrichment History and Assessment dated 5/16/19, indicated R67 had poor communication related to language barrier and that R67 would go shopping at the store weekly. The assessment indicated R67's typical evening leisure routine was to go out into the community with his daughter. R67's Planned Activities Log was reviewed from 6/30/19 though 8/27/19, and revealed R67 had attended happy hour three times, music/entertainment two times, sing-a-long one time, current events two times, church activity one time and social activity one time. However, R67's activity log lacked evidence of offered and/ or refused activities which included going outside for fresh air. R67's Progress Note dated 7/25/19, indicated R67 stated he wanted to go outside and it had been a long time since he had went out. The noted indicated the social worker sat with R67 outside for 15 minutes and enjoyed the fresh air.	F 679	ensure updates were made to provide meaningful activities that are resident specific. 3. Activity, Licensed and Non-licensed staff have been re-educated on providing residents with person centered and meaningful activities per their plan of care. 4. Administrator/Designee to audit activity logs weekly and results will be brought to the monthly Quality Assurance performance Improvement meetings and reviewed for trends in quality improvement.	

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F 679	Continued From page 26 Family member (FM)-A was interviewed via telephone on 8/28/19, at 9:16 a.m. and stated when she would come to the facility to visit R67 he would just be sitting in his wheelchair without any stimulation. FM-A stated R67 liked to go outside, socialize and play or listen to music. R67 was interviewed on 8/28/19, at 2:23 p.m. with interpreter present and stated he would like to go outside. R67 stated since he had been staying at the facility he doesn't get to go outside much. R67 explained if he could go outside just for a few minutes in the front it would help him to get some fresh air. Activities assistant (AA)-A and AA-B were interviewed on 8/29/19, at 8:40 a.m. and verified R67 had not gone outside for an activity and AA-B explained "we don't go out" while confirming R67 had not been offered to go sit outside since 6/30/19, with the exception of 7/25/19. The facility policy regarding meaningful activities was requested, however not provided. R44's face sheet indicated she was admitted on 4/1/19 with diagnosis of cerebral infarction with hemiparesis (stroke with left sided paralysis), tracheostomy (breathing tube), gastrostomy tube (feeding tube), aphonia (inability to produce voiced sound), major depressive disorder. R44's Mimimum Data Set (MDS) dated 7/8/19 indicated that going outside to get fresh air and religious practices were very important to R44 and listening to music, keeping up with news, and doing favorite activities were somewhat important to R44.	F 679		

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R44's care plan dated 4/2/19, indicated little or no activity involvement related to physical limitations and new tracheostomy with goal to participate in one to two, one to ones per week. The care plan indicated R44 enjoyed listening to music, being with family and watching the news. The care plan directed staff to invite R44 to scheduled activities and assist to activity functions. Preferred activities include manicures, social visits, Catholic volunteer visits, family visits, watching the news and Bingo when she starts to feel better.

During interview on 8/26/19, at 2:38 p.m. R44 and her family member (FM)-A, indicated that she was not involved in any activities and staff did not offer any activites to her.

On 8/28/19, at 7:30 a.m. R44 stated all she did was lay there and she was so frustrated she wanted to pull her hair out and go somewhere else.

During interview on 8/29/19, at 8:43 a.m. activity aides (AA)-A and (AA)- B indicated R44 preferences included getting her nails done, having her hair colored by the beautician and indicated R44 liked to visit.

On 8/29/19, at 9:00 a.m. nursing assistant (NA)-A stated the facility did not have an activities supervisor. NA-A stated residents who were dependent and in their rooms were not provided any activities and the activity aides don't do anything with them. NA-A stated often she would get R44 up at about 11:00 a.m. and then she laid down at 4:00 p.m. and most often staff did not get her back up after that. She tried to visit with R44 during cares as she knew that R44 enjoyed that.

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F 679	Continued From page 28 Provided activities report indicated that in July 2019, R44 had blessings by the Catholic church volunteers 4 times and attended current events once, and in August 2019, she had blessings by the Catholic church volunteer on 4 dates and a manicure once. On 8/29/19, at 2:30p.m. the administrator indicated she would expect her to have more activities offered.	F 679		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation and interview and document review the facility failed to ensure toenail care by a podiatrist was provided to 1 of 1 resident who had thick nails and received blood thinning medication therapy. Findings include: R44 was admitted to facility on 4/1/19 with diagnosis of cerebral infarction (stroke) and hemiparesis (left sided paralysis). Minimum data	F 687	1. R44's has been provided proper foot care which included toenail care by a podiatrist on 9/16/19. 2. All Residents who reside at Richfield a Villa Center who require podiatry services have the potential to be affected by this practice. 3. Licensed nurses and IDT have been re-educated on providing podiatry services. 4. The DON/Designee will conduct audits	10/7/19

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F 687	Continued From page 29 set (MDS) dated 7/8/19 and care plan dated 4/2/19 identified that R44 requires total care for personal hygiene. R44's family member (FM)-A was interviewed on 8/26/19, at 2:30 p.m. FM-A stated nursing aides do not cut her toenails and they are very long. He had told nurses and social services multiple times but they remain uncut. FM-A removed R44's socks. R44's toenails varied in length with some as long as 1/4 inch. The toenails were thick and were curling down into the toe. R44 had complained to FM-A her toes hurt. During observation and interview on 8/28/19, at 8:31 a.m., with nursing assistant (NA)-A while providing a bed bath to R44 identified R44 pointed to her toes stating they were long and they hurt. NA-A confirmed they were long. NA's would do nail care normally but R44's nails were thick and they were unable to cut them. NA-A had notified nursing several times of the thick, long toenails. Nail trims for R44 were usually done by a Podiatrist. On 8/28/19, at 10:46 a.m. registered nurse (RN)-A was shown R44's toenails and she confirmed R44 needed to be seen by podiatry. RN-A was unable to find documentation that R44 had been seen recently. She would put R44 on the list to be seen on 9/13/19. On 8/28/19, at 11:00 a.m. the medical records director confirmed R44 was scheduled to be seen on 9/13/19. The medical records director stated they had not had podiatry services for awhile and there was a new company coming for the first time on 9/13/19. The medical records director stated the last time the podiatrist had been in	F 687	weekly x 3 weeks to ensure residents requiring podiatry services are receiving services, then monthly x 3 months. All results will be brought to the monthly Quality Assurance performance Improvement meetings and reviewed for trends in quality improvement.	

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F 687	Continued From page 30 house was 6/6/19. When asked about alternatives, she stated they would only send the resident out to podiatry if it was "something serious". Review of Report of Resident Grievance/Compliments dated 7/26/19, indicated FM-A stated he had asked several times to get R44's toenails cut and they had never been cut while at the facility. A podiatry appointment was not addressed in the follow up. Interview on 8/29/19 at 2:30 p.m., the administrator stated her expectation would be that podiatry would have been consulted sooner and brought in to cut R44's toenails. There was no policy or contract related to Podiatric services provided at the time of the survey.	F 687		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor 3 of 3 residents (R42, R45, and R102) who left the facility without staff knowledge of what time they left, or ensure they had returned to ensure the	F 689	1. R42, R45 and R102 have been re-assessed to ensure they are appropriate to go out on LOA's based on cognition and MD orders. R42, R45 and R102 have been educated on the LOA	10/7/19

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F 689	Continued From page 31 safety of the residents. Findings include: Registered nurse (RN)-E was interviewed on 8/29/19, at 11:40 a.m. and stated during the evening shift on 8/28/19, three residents (R102, R42, R45) left the facility without notifying staff of their whereabouts, anticipated return time and they did not sign out in the unit leave of absence book. RN-E stated the three resident's returned later in the evening together and indicated they had been at a nearby park. RN-E stated the three resident's appeared to be under the influence of alcohol when they returned. RN-E stated this was not the first time that this happened and the director of nursing (DON) and administrator had been notified of these resident's leaving the facility to consume alcohol at the nearby park as well. R102's Minimum Data Set (MDS) dated 8/15/19, identified R102 had moderate cognitive impairment and diagnoses of seizure disorder and manic depression. The MDS further indicated R102 required supervision, oversight, encouragement or cueing with set-up help for locomotion off of the unit. R102's care plan dated 7/29/19, identified R102 was at risk for leaving against medical advice (AMA) and directed staff to assess the need for home health services prior to a potential discharge, plan family meetings as needed, and schedule follow up appointments. R102's leave of absence sign out log was requested, but not provided.	F 689	policy and the sign-out sheets. R42, R45 and R102 have been given the risk and benefit acknowledgment regarding alcohol consumption while out on LOAs and potential side effects of drinking alcohol and taking prescription medications. Resident plans of care have been updated to reflect changes. 2. All Residents who reside at Richfield a Villa Center have the potential to be affected by this practice. 3. Staff in all disciplinary departments will be re-educated on the sign out book and utilization. 4. Administrator/Designee will conduct audits on resident LOA's for the next 30 days and weekly for 3 months to ensure residents are safe in the community and any negative incident is care planned accordingly. All results will be brought to the monthly Quality Assurance performance Improvement meetings and reviewed for trends in quality improvement.	

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RN-H was interviewed on 8/29/19, at 12:13 p.m. and verified R102 did not have a sign out sheet in the unit leave of absence book.

RN-F was interviewed on 8/29/19, at 12:14 p.m. and stated it was expected all residents sign out in the leave of absence book anytime they leave the facility which included going to the park.

The DON and administrator were interviewed on 8/29/19, at 12:57 p.m.. They were not aware of residents leaving the facility without signing out in the leave of absence book. The administrator stated residents were free to come and go and were aware they needed to return by midnight. The administrator explained the facility had been instructed by the local law enforcement agency not to call until a resident had been gone for 24 hours if the resident was not at risk which was defined as alert and orientated. The DON stated there was no policy for residents signing in and out when they leave the facility. The administrator stated prior to admission, an admissions person from the corporate office would go out to the hospital to evaluate their elopement risk and if there was a risk the person would communicate that to the facility.

R42's admission MDS dated 7/4/19, identified R42 had intact cognition and diagnoses which included paraplegia, anxiety disorder and manic depression. The MDS indicated R42 did not exhibit wandering behavior during the assessment period and required set-up help with supervision, oversight, encouragement or cueing with locomotion off of the unit.

R42's Sign Out Log was last dated 7/3/19, and indicated R42 went to the store, however was left

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F 689	Continued From page 33 blank for return dated, time and signature. RN-F was interviewed on 8/29/19, at 12:14 p.m. and stated it was expected all residents sign out in the leave of absence book anytime they leave the facility which included going to the park. R45's quarterly MDS dated 7/3/19, identified R45 had intact cognition and diagnoses which included anxiety disorder and depression. The MDS indicated R45 had not exhibited any wandering behaviors during the assessment period and was independent with ambulation, transfers and locomotion on and off the unit. R45's Sign Out Log last dated 8/28/19, at 3:59 p.m. indicated R45 went to the park expected return time was not present, but the return date was 8/28/19, however lacked return time and signature. R45's PN dated 8/28/19, at 11:20 p.m. indicated at 8:00 p.m. R45 was found in her room lying on her bed bleeding from her right leg and elbow. The PN indicated R45 stated she went to the park with other residents and had "a sip of drink and while coming home, she trip and fell." RN-H was interviewed on 8/29/19, at 12:13 p.m. and verified R45 did not sign in on 8/28/19. RN-F was interviewed on 8/29/19, at 12:14 p.m. and stated it was expected all residents sign out in the leave of absence book anytime they leave the facility which included going to the park and sign back in when the resident returned. R45 was interviewed on 8/29/19, 2:01 p.m. and stated on 8/28/19, she went to the park with two	F 689		

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F 689	Continued From page 34 other residents and on her way back to the facility. R45 fell while crossing the street and two people she did not know helped her up. R45 indicated she sustained abrasions to her right elbow and knee. R45 stated she did not notify staff upon her return to the facility she had fallen, and forgot to sign back in the LOA book when she returned. R45 understood residents were supposed to sign out in the book anytime they left the facility grounds, and sign back in upon return. Sometimes she would forget to use the book, however would "usually" tell a nurse staff when she left. There was no policy related to how staff would ensure resident safety for LOA.	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding	F 693		10/7/19

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F 693	Continued From page 35 including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure licensed staff checked for patency and placement of 3 of 3 residents (R5, R25, R44) gastric(G)-tubes (a tube placed through the abdomen into the stomach) prior to medication administration. Additionally, the facility failed to ensure G-tube medications were administered according to the facilty's medication administration policy. Findings include: R5's care plan initiated on 8/7/17, indicated to check for tube placement prior to feeding and medication administration. R5's diagnoses obtained from the Order Summary Report dated 8/28/19, included gastrostomy complication, intellectual disabilities, cerebral palsy, and tracheostomy placement. The Order Summary Report also indicated to check tube placement and patency prior to each use per guidelines. During observation and interview on 8/28/19, at 8:58 a.m., with RN-A indicated R5's feeding tube and placement was not checked prior to administering medication through the G-tube. R5's medications were administered through the feeding tube by depressing the syringe plunger and did not use gravity flow to administer medications. RN-A verified she had not checked placement because she checked for placement earlier in the shift before administering enteral	F 693	1. R5,R25 and R44 medications are being administered according to the facility medication administration policy. Licensed nurses are checking for patency and placement of the gastric tube prior to medication administration. 2. All Residents who reside at Richfield a Villa Center and have gastric tubes the potential to be affected by this practice. 3. Licensed staff will be re-educated on the enteral feeding and medication administration policy and procedure. 4. The DON/Designee will conduct audits weekly for 3 weeks, then monthly for 3 months to ensure compliance. All results will be brought to the monthly Quality Assurance performance Improvement meetings and reviewed for trends in quality improvement.	

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F 693	Continued From page 36	F 693		

nutrition (liquid food) through R5's G-tube. RN-A verbalized placement was supposed to be checked by listening for bubbling on the stomach with a stethoscope while pushing air into through the feeding tube with a syringe. RN-A was unsure if placement needed to be checked before giving medications if placement was already checked during her shift. She was unsure if pushing the medications through he syringe was appropriate, but always administered G-tube medications through the feeding tube as she did during the observation.

R25's care plan initiated on 1/9/19, indicated to check for tube placement prior to feeding and medication administration.

R25's diagnoses obtained form his Order Summary Report dated 8/28/19, included dysphagia, and respiratory failure with hypoxia, anxiety, and myotonic muscular dystrophy. Additionally, the Physician Order Summary indicated to check for placement of R25's G-tube placement and patency prior to each use per guidelines.

During observation of R25's G-tube medication administration on 8/28/19, at 7:30 a.m licensed practical nurse (LPN)-A did not check for tube placement prior to administering R25's medications. R25's medications were administered through the feeding tube by depressing the syringe plunger, and not by gravity flow.

On 8/28/19, at 10:33 a.m. LPN-A indicated staff were expected to check G-tube placement before administering feed and medications. LPN-A stated G-tube placement was checked by either

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listening for air while depressing a syringe plunger with air into the G-tube or to check for residual stomach contents (undigested liquid food). LPN-A acknowledged she had not checked for placement or patency prior to administering R25's medications because placement was checked earlier in the shift before administering R25's enteral nutrition and stated R25 was an anxious person, and she wanted to administer his antianxiety medication as soon as possible. She verified placement and patency were supposed to be checked anytime the feeding tube was accessed, but was unsure of what the facility's procedure was to administer medications, and checking G-tube placement.

On 8/28/19 at 11:25 a.m., review of the faciltiy Specific Medication Administration Procedures provided by Polaris Rx Pharmacy Services dated 4/2018, with the director of nursing (DON) identified the procedure indicated to check for proper tube placement using air and auscultation (listening with a stethoscope) only. Additionally, the procedure indicated to administer medications through enteral tubing by (1) removing the plunger from a 60 milliliter (mL) syringe, (2), connect the syringe to clamped tubing using the appropriate port, (3) pour dissolved/dilute medication into the syringe, (4) unclamp the tubing and allow medication to flow into the stomach by gravity. The DON expected staff to follow pharmacy recommendations for administering medications through G-tubes. The DON verified she and the nurse managers had not performed any recent audits for medication administration through G-tubes, and the DON was unaware of any recent training provided to staff administering medications though G-tubes. Compentency documentation was requested.

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F 693	Continued From page 38 The competencies provided by the DON for Administration of Enteral Feedings did not identify staff names or and did not include dates competencies were completed. R44's care plan initiated on 4/2/19, indicated to check for tube placement prior to feeding and medication administration and to see physician orders for current feeding orders. R44's diagnoses obtained from the Order Summary Report dated 8/28/19, included dysphagia (difficulty swallowing), G-tube placement, metabolic encephalopathy, tracheostomy placement, and respiratory failure. The Order Summary Report indicated to check enteral feeding tube placement and patency prior to each use per guidelines. During observation of administration of R44's medications through her G-tube on 8/28/19, at 8:31 a.m., RN-G stopped R44's tube feeding and flushed the gastrostomy tube with 75 milliliters (ml) of water and clamped the tubing for cares. RN-G left R44's room and returned at 9:58 a.m. RN-G flushed R44's gastrostomy tube with 75 ml water, gave medication, flushed tube with more water and restarted the feeding. RN-G failed to check placement prior to administering R55's medication and restarting the feeding.	F 693		
F 880 SS=F	Infection Prevention & Control 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	F 880		10/7/19

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F 880	Continued From page 39 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 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	F 880		

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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
F 880	Continued From page 40 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 interview and document review the facility failed to implement and maintain a comprehensive infection control program that included a thorough data collection, and a comprehensive analysis of developed infections to reduce the risk of infection spread within the facility. This had the potential to affect all 110 residents residing in the facility. Findings include: During the recertification survey the infection control binder was provided which contained each months data that identified the following. JULY 2019	F 880	1. The facility has implemented a comprehensive infection prevention and control program that includes thorough data collection and analysis on developed infections that will reduce the risk of infection. 2. All Residents who reside at Richfield a Villa Center have the potential to be affected by this practice. An infection prevention and control program has been developed that tracks infections and antibiotic use. The facility will track the infections using a line listing report and review resident symptoms when antibiotics are used. Additionally, culture reports will be analyzed and a monthly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245492	A. BUILDING _____ B. WING _____	C 08/29/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 41 An order listing report identifying 12 residents had received antibiotics for the month. A form labeled Nursing Home Antimicrobial Stewardship Guide- Monitor & Sustain Stewardship was organized with several columns and rows to record the identified data and each resident's illness. The data collected included resident name, room number, admit date, prescribing clinician, prescription date and duration, antibiotic name, and prescription number. This form indicated there were a total of 8 residents during the month that received antibiotics. However, for all of the residents listed the following columns were blank, admit from, onset date, type of infection, signs and symptoms, indicate diagnostic tool used and whether criteria met, hospital/community/nursing home acquired, and x-ray or lab results. Culture and sensitivity reports for 2 urinalysis indicating one resident had the bacteria Proteus Mirabilis present in the urine and another resident had the bacteria Escherchia Coli present in the urine. One Clostridium Difficile (bacteria in stool that causes diarrhea) result that was negative. Patient infection report for 2 residents. One report indicated signs and symptoms of eye, ear, nose, or mouth infection. No symptoms were identified except patient has a diagnosis from a physician or dentist. Another report for a resident indicated cellulitis, soft tissue, wound infection. further stated if no pus present must have four of the following and only three indicators were identified, heat at site, redness at site, and swelling at site. Maps of each floor with colored dots marking where each infection was identified. There were a	F 880	review with trends will be composed. 3. All licensed and non-licensed staff have been educated on the infection control and prevention program. 4. The DON/Designee will audit the infection control and prevention program and documentation weekly for 4 weeks. 5. All results will be brought to the monthly Quality Assurance performance Improvement meetings and reviewed for trends in quality improvement.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245492	A. BUILDING _____ B. WING _____	C 08/29/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 42 total of 4 colored dots present for all 3 floors. No analysis of this data was available. AUGUST 2019 An order listing report dated august 1st 2019, identified 10 different residents had received antibiotic therapy. A form labeled Nursing Home Antimicrobial Stewardship Guide- Monitor & Sustain Stewardship was organized with several columns and rows to record the identified data and each resident's illness. The data collected included: resident name, room number, admit date, admit from, onset date, type of infection, signs and symptoms, indicate diagnosis tool used and whether criteria met, hospital/community/nursing home acquired, x-ray or lab results, prescribing clinician, prescription date and duration, antibiotic name, and prescription number. This form indicated there were 5 residents during the month that received antibiotics. Column labeled signs and symptoms was completed for only one resident indicated fever, cloudy, dark, foul smelling and column labeled diagnostic tool used and whether criteria met was completed for the same resident and indicated "7/26/19 VA". However, all of the following columns were blank: admit from, onset date, type of infection, hospital/community/nursing home acquired, and x-ray or lab results. No culture or sensitivity reports available. McGeer's (standardized guidance for infection surveillance) infection symptom tracking available for one resident indicating signs and symptoms of catheter associated urinary tract infection, new	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245492	A. BUILDING _____ B. WING _____	C 08/29/2019

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RICHFIELD A VILLA CENTER	**7727 PORTLAND AVENUE SOUTH RICHFIELD, MN 55423**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 43	F 880		

onset of pain and urine culture that was positive.

A printed tracking tool used for infection with several columns and rows to record identified data and each residents illness. There were eight residents identified to have infections. Four were identified as urinary tract infections, One as cellulitis (skin infection) and the other three lacked information. Three of the eight residents had identified symptoms, the other five lacked information. Three of the eight had onset date, the other five lacked information. One of the eight had diagnostic information including a urine specimen and positive culture, organism was not specified the other seven lacked information. All eight identified the type of antibiotic received and start/stop dates for the antibiotics. Antibiotic resistant organisms none were identified yes or no. However, during survey, surveyor found R29, in room 124, had a urinary tract infection with the bacteria ESBL klebsiella pneumoniae (a bacteria that cannot be killed by multiple antibiotics). Meets criteria indicated three yes, two no and three lacked information. Transmission based precautions identified as no for five resident, one for contact precautions and two lacked information.

Maps of each floor with colored dots marking where each infection was identified. There were a total of five colored dots present for all three floors. This included three urinary tract infections on first floor in rooms 114, 117, 124.

No analysis of this data was present.

During interview on 8/29/19, at 2:30p.m., with director of nursing (DON) and administrator, the administrator stated that if there was a problem

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	245492	A. BUILDING _____ B. WING _____	C 08/29/2019

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RICHFIELD A VILLA CENTER	7727 PORTLAND AVENUE SOUTH RICHFIELD, MN 55423

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 44 they discussed it at quality assurance and stated based on the limited data collected and lack of analysis of data, they confirmed that they would not know if there was a problem. Further stated, the infection control program needed work. The administrator stated the DON was new and they had a new medical director as well and she would have them work on the infection control and antibiotic stewardship program. The DON stated she had shown staff McGeer's criteria but staff did not consistently complete it. They confirmed that an annual review of the program was not completed.	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to implement and maintain a comprehensive antibiotic stewardship program that included a thorough data collection and a comprehensive analysis to help reduce unnecessary antibiotic use and reduce potential drug resistance. This had the potential to affect all 110 residents residing in the facility. Findings include:	F 881	1. An Antibiotic Stewardship Program that includes thorough data collection and comprehensive analysis to reduce unnecessary antibiotic use and potential drug resistance has been implemented. 2. All Residents who reside at Richfield a Villa Center have the potential to be affected by this practice. An antibiotic stewardship program has been implemented that tracks antibiotic use and	10/7/19

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	245492	A. BUILDING _____ B. WING _____	C 08/29/2019

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F 881	Continued From page 45 During the recertification survey the infection control binder was provided which contained each months data that identified the following. JULY 2019 An order listing report identifying 12 residents had received antibiotics for the month. A form labeled Nursing Home Antimicrobial Stewardship Guide- Monitor & Sustain Stewardship was organized with several columns and rows to record the identified data and each resident's illness. The data collected included resident name, room number, admit date, prescribing clinician, prescription date and duration, antibiotic name, and prescription number. This form indicated there were a total of 8 residents during the month that received antibiotics. However, for all of the residents listed the following columns were blank, admit from, onset date, type of infection, signs and symptoms, indicate diagnostic tool used and whether criteria met, hospital/community/nursing home acquired, and x-ray or lab results. Culture and sensitivity reports for 2 urinalysis indicating one resident had the bacteria Proteus Mirabilis present in the urine and another resident had the bacteria Escherchia Coli present in the urine. One Clostridium Difficile (bacteria in stool that causes diarrhea) result that was negative. Patient infection report for 2 residents. One report indicated signs and symptoms of eye, ear, nose, or mouth infection. No symptoms were identified except patient has a diagnosis from a physician or dentist. Another report for a resident indicated cellulitis, soft tissue, wound infection. further stated if no pus present must have four of the	F 881	reviews symptoms to ensure appropriate use that reduces the potential for inappropriate use that could lead to resistance. 3. All licensed nurses have been educated on the Antibiotic Stewardship Program. 4. The DON/Designee will audit antibiotic use weekly to ensure appropriate usage and tracking are in place. 5. All results will be brought to the monthly Quality Assurance performance Improvement meetings and reviewed for trends in quality improvement.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 881	Continued From page 46	F 881		

following and only three indicators were identified, heat at site, redness at site, and swelling at site.

Maps of each floor with colored dots marking where each infection was identified. There were a total of 4 colored dots present for all 3 floors.

No analysis of this data was available.

AUGUST 2019
An order listing report dated august 1st 2019, identified 10 different residents had received antibiotic therapy.

A form labeled Nursing Home Antimicrobial Stewardship Guide- Monitor & Sustain Stewardship was organized with several columns and rows to record the identified data and each resident's illness. The data collected included: resident name, room number, admit date, admit from, onset date, type of infection, signs and symptoms, indicate diagnosis tool used and whether criteria met, hospital/community/nursing home acquired, x-ray or lab results, prescribing clinician, prescription date and duration, antibiotic name, and prescription number. This form indicated there were 5 residents during the month that received antibiotics. Column labeled signs and symptoms was completed for only one resident indicated fever, cloudy, dark, foul smelling and column labeled diagnostic tool used and whether criteria met was completed for the same resident and indicated "7/26/19 VA". However, all of the following columns were blank: admit from, onset date, type of infection, hospital/community/nursing home acquired, and x-ray or lab results.

No culture or sensitivity reports available.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 881	Continued From page 47 McGeer's (standardized guidance for infection surveillance) infection symptom tracking available for one resident indicating signs and symptoms of catheter associated urinary tract infection, new onset of pain and urine culture that was positive. A printed tracking tool used for infection with several columns and rows to record identified data and each residents illness. There were eight residents identified to have infections. Four were identified as urinary tract infections, One as cellulitis (skin infection) and the other three lacked information. Three of the eight residents had identified symptoms, the other five lacked information. Three of the eight had onset date, the other five lacked information. One of the eight had diagnostic information including a urine specimen and positive culture, organism was not specified the other seven lacked information. All eight identified the type of antibiotic received and start/stop dates for the antibiotics. Antibiotic resistant organisms none were identified yes or no. However, during survey, surveyor found R29, in room 124, had a urinary tract infection with the bacteria ESBL klebsiella pneumoniae (a bacteria that cannot be killed by multiple antibiotics). Meets criteria indicated three yes, two no and three lacked information. Transmission based precautions identified as no for five resident, one for contact precautions and two lacked information. Maps of each floor with colored dots marking where each infection was identified. There were a total of five colored dots present for all three floors. This included three urinary tract infections on first floor in rooms 114, 117, 124.	F 881		

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F 881	Continued From page 48 No analysis of this data was present. During interview on 8/29/19, at 2:30p.m., with director of nursing (DON) and administrator, the administrator stated that if there was a problem they discussed it at quality assurance and stated based on the limited data collected and lack of analysis of data, they confirmed that they would not know if there was a problem. Further stated, the infection control program needed work. The administrator stated the DON was new and they had a new medical director as well and she would have them work on the infection control and antibiotic stewardship program. The DON stated she had shown staff McGeer's criteria but staff did not consistently complete it. They confirmed that an annual review of the program was not completed.	F 881		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245492	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/28/2019**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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. An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on August 28, 2019. At the time of this survey, Richfield A Villa Center 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. 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	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/24/2019

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245492	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/28/2019**

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K 000	Continued From page 1 IS NOT REQUIRED. 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 description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Richfield A Villa Center is a 3-story building with a full basement, that was built in 1964 and was determined to be of Type II (222) construction. The facility is protected throughout by an automatic fire 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. The facility has a capacity of 112 beds and had a census of 110 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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	245492	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/28/2019**

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K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall 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's heating, ventilation, and air conditioning is not in compliance with the NFPA 101 (2012), Life Safety Code sections 9.2, 19.5.2.1 and NFPA 90A (2012), Standard for the Installation of Air-Conditioning and Ventilating Systems. This deficient practice could affect all 110 residents. Findings include: On a facility tour between the hours of 11:00 AM and 3:00 PM on August 28, 2019, it was revealed that the ventilation system for the corridors are utilizing the egress corridor as an exhaust plenum for the ducted make-up air. The resident rooms are heated by hot water system 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.. This deficient practice was verified by the Director of Maintenance at the time of discovery.	K 521	Facility will be requesting an annual waiver.	9/23/19

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245492	A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____	**8/28/2019**

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 324	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 document review and staff interview, the facility did not install and maintain cooking equipment in accordance with NFPA 101 Life Safety Code 2012 edition , sections 19.3.2.5.2, 19.3.2.5.3, 19.3.2.5.4, 19.3.2.5.1, 19.3.2.5.5 and NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations 2011 edition, section 10.2.1. This deficient practice could affect any person in the serving kitchen. Findings include: On a facility tour between the hours of 11:00 AM and 3:00 PM on August 28, 2019, it was revealed that the facility did not have a sign stating that the Class-K extinguisher shall be used secondary to the wet chemical hood system. This deficient practice was verified by the Director of Maintenance at the time of discovery.

KASTER CONSTRUCTION & COMMERCIAL REPAIR

Job: Richfield Health Care

7727 Portland Ave South

Richfield, Minnesota 55423

September 23, 2019

ATTENTION: Tom Gilbride

WORK TO BE COMPLETED

- Add fresh air intake & exhaust to all patient rooms & halls
- Install new ductwork to all patient rooms & hallways
- Install new low voltage
- Install new call system to all patient rooms & hallways
- Install new electrical to all patient rooms & hallways
- Install new ceiling and ceiling tiles to all patient rooms & hallways
- Install new 2x 4 light to all patient rooms & hallways
- Lower all sprinkler heads to new ceiling heights in all patient rooms and hallways

LABOR & MATERIALS **$1,980,000.00**

THANK YOU VERY MUCH! WE APPRECIATE YOUR BUSINESS!

KASTER CONSTRUCTION & COMMERCIAL REPAIR

Name of Facility	2000 CODE
Richfield Health Center 7727 Portland Ave. South, Richfield, MN 55423	

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

PROVISION NUMBER(S)	JUSTIFICATION
K521 The building Heating, Ventilation, & Air Conditioning Equipment (HVAC) does not comply with LSC, Section 19.5.2.1 and NFPA 90A, Section 2-3.11.	An annual/continuing waiver is being requested for K521 for the following reasons: A. Compliance with this provision would impose an unreasonable hardship on the facility for the following reasons: 1. Facility was unsuccessful in obtaining multiple bids for this project due to vendors stating that the project is so costly that the facility would not be completing it anyway. One bid we were able to obtain dated 9/23/29 was $1,980,000.00 which does not include ductwork, electrical connections, roofing changes, insulation, drawings, engineering fees, permit fees, or taxes. 2. The installation of the required ductwork would reduce the headroom in the corridor below the minimum specified in LSC(00), Sec. 7.1.5. 3. The building electric system is not adequate to handle the additional HVAC equipment needed. 4. LSC(00) Sec. 9.2.1 give the AHJ the authority to allow existing HVAC systems that do not comply with NFPA 90A to be continued in service. B. There will be no adverse effect on the health and safety of the facility residents and staff as: 1. The building is protected throughout by a complete supervised automatic sprinkler system installed in accordance with NFPA 13. 2. The building has automatic shutdown of all ventilation fans upon detection of smoke or activation of the fire alarm system. 3. Resident rooms are equipped with hard-wired single station smoke detectors. 4. The facility is smoke-free and signs to that effect are prominently posted at all major entrances. 5. Annual service and maintenance contracts exist to service all of the facilities fire alarm systems. (continued on 2nd page)

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

PROVISION NUMBER(S)	JUSTIFICATION
K521 The building Heating, Ventilation, & Air Conditioning Equipment (HVAC) does not comply with LSC, Section 19.5.2.1 and NFPA 90A, Section 2-3.11.	(cont'd) 6. The facility fire alarm system is monitored to provide automatic fire alarm notification to the fire department. 7. Fire safety training is provided for all employees on an annual basis and during orientation for all new hires. 8. Fire drills are conducted monthly on each shift.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date