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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QZKC

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00253

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/23/2012** (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 IMR	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:
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)
X 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gayle Lantto, Unit Supervisor 04/02/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 04/10/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00450
(L31)

30. REMARKS
Posted 04/11/2012 CO.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/22/2012
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

CCN #24-5492

At the time of the standard survey completed January 27, 2012, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections were required. The facility has been given an opportunity to correct before remedies are imposed.

On March 23, 2012 the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on January 27, 2012, effective March 7, 2012. Therefore, the remedies outlined in our letter dated February 15, 2012 will not be imposed. See attached CMS-2567B form for the results of the March 23, 2012 revisit.

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5492

April 10, 2012

Mr. Mathew Bedard, Administrator
Richfield Health Center
7727 Portland Avenue South
Richfield, Minnesota 55423

Dear Mr. Bedard:

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 March 7, 2012 the above facility is certified for:

118 Skilled Nursing Facility/Nursing Facility Beds

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

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

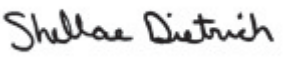
If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for this deficiency or renew your request for waiver in order to continue your participation in the Medicare Program.

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

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

Please contact me if you have any questions.

Sincerely,



Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 2, 2012

Mr. Mathew Bedard, Administrator
Richfield Health Center
7727 Portland Avenue South
Richfield, Minnesota 55423

RE: Project Number S5492022

Dear Mr. Bedard:

On February 15, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 27, 2012. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 23, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 27, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 7, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 27, 2012, effective March 7, 2012 and therefore remedies outlined in our letter to you dated February 15, 2012, will not be imposed.

Your request for a continuing waiver involving the deficiency cited under K67 at the time of the January 27, 2012 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Gayle Lantto

Gayle Lantto, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3794 Fax: (651) 201-3790
Enclosure
cc: Licensing and Certification File 5492r112.rtf

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245492	A. Building B. Wing	3/23/2012

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **03/07/2012**	ID Prefix **F0276** Reg. # **483.20(c)** LSC	Correction Completed **03/07/2012**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **03/07/2012**
ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **03/07/2012**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **03/07/2012**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **03/07/2012**
ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **03/07/2012**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **03/07/2012**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GL/sd	04/02/12	15507	03/23/12
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 1/27/2012

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: QZKC

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/27/2012** (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 IMR	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B* 5 (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Elizabeth Nelson, HFE NE II 03/09/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 03/21/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00450
(L31)

30. REMARKS
LSC AW K67 in ACO. 03/22/2012
Posted in ACO. 03/22/2012 CO.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

CCN #24-5492

At the time of the standard survey completed January 27, 2012, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections were required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 8418

February 15, 2012

Mr. Mathew Bedard, Administrator
Richfield Health Center
7727 Portland Avenue South
Richfield, Minnesota 55423

RE: Project Number S5492022

Dear Mr. Bedard:

On January 27, 2012, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

Telephone: (651) 201-3794

Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 7, 2012, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 7, 2012 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 27, 2012 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 27, 2012 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Gayle Lantto

Gayle Lantto, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3794 Fax: (651) 201-3790

Enclosure

cc: Licensing and Certification File 5492s12.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245492	A. BUILDING _____ B. WING _____	01/27/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Disclaimer For Plan of Correction Richfield Health Center objects to the allegation of non-compliance. Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiency was correctly cited, and is also NOT to be construed as an admission against interest by the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in the Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to accurately assess and ensure physician orders were obtained for 1 of 2 resident (R25) reviewed for self-administration of medications. Findings include: At 8:16 a.m. on 1/26/12, the licensed practical nurse (LPN-A) removed Advair Diskus (a inhaler medication used to treat asthma) from the medication cart and handed to R25 who was seated in a wheelchair next to medication cart. R25 was then observed to self-administer one puff of the medication.	F 176	POC accepted as is 3/15/12	

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

Matthew Beladd | Administrator | 2/24/2012

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

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	245492	A. BUILDING _____ B. WING _____	01/27/2012

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

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F 176	Continued From page 1 R25's physician orders revealed an order for Advair Diskus 500-50 mcg Disk, one puff by mouth twice daily, however, there was no physician order for the resident to self-administer the medication. The resident's care plan updated on 12/21/11, did not include information regarding self-administration of medication. During an interview with registered nurse/clinical coordinator (RN-A) at 9:13 a.m. on 1/26/12, revealed staff were unable to locate a physician order or an assessment for self-administration of medication. RN-A further indicated it would not be considered self- administration as the resident was supervised by staff while the resident depressed the dispenser to inhale the medication. At 1:21 p.m. on 1/27/12, RN-A stated she had obtained a physician order and conducted a assessment for R25. During an interview with the director of nursing at 10:25 a.m. on 1/27/12 revealed R25 should have been assessed for ability to safely self-administer medication, a physicians order obtained, and the care plan updated before the resident began self-administering medication. The facility policy for Self-Medication Assessment and Management dated 4/06, directed staff to complete an assessment if resident requests to self-administer. The procedure directed staff to review and analyze interdisciplinary assessments to determine a resident's ability to self-medicate, complete the Self-Medication Data Collection and Assessment, analyze assessment with the interdisciplinary team, discuss with physician any medication that may not be self-administered,	F 176	this allegation by the survey agency. Richfield Health Center respectfully makes its ALLEGATION OF COMPLIANCE on all areas and has written these Plans of Correction to constitute the allegation. F176 Resident R25 has had their self medication assessment and care plan reviewed. Other residents with inhalers have been reviewed for self medication assessments. The Center will re-educate licensed nurses and TMAs on MDI's The Center will complete 3 audits per week to ensure only residents assessed as competent administer their inhalers independently. Results will be communicated with the Quality Performance Improvement (QPI) Committee. Person responsible: Clinical Coordinator/Designee Completion date: March 7	3/7/12

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COMPLIANCE MONITORING DIVISION
LICENSE AND CERTIFICATION

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F 176	Continued From page 2 and enter resident's specific interventions and goals on the plan of care.	F 176		
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to re-assess a change in bladder incontinence for 1 of 3 residents (R127) in the sample who were reviewed for incontinence. Findings include: Although R127 experienced a change in urinary incontinence, a comprehensive assessment was not completed at the time of the change to include all potential contributing factors (such as medications, diagnoses, mobility, urinary voiding patterns) to determine a appropriate plan to help restore or manage the incontinence. R127 was admitted in 8/11 with diagnoses including congestive heart failure (CHF). The admission Minimum Data Set (MDS) dated 8/10/11, identified R127 as being continent of bladder and needing supervision (oversight, encouragement or cueing) and physical assistance of one with toileting needs. The quarterly MDS dated 10/19/11, identified R127	F 276	F276 Resident R127 has been comprehensively reassessed for bladder incontinence. The Clinical Coordinators and MDS nurses were re-educated on bladder. The assessments will be reviewed quarterly in our Comprehensive Care Plan Review meeting (CCPR) and results communicated with the QPI Committee. Person responsible: Director of Nursing/Designee	3/7/12

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F 276	Continued From page 3 as being occasionally incontinent of bladder (less than 7 episodes of urinary incontinence) and requiring the same level of toileting assistance. The Bladder Data Collection and Assessment form dated 8/4/11, identified R127 as being continent of urine. A three-day elimination tracking was not completed as was "not applicable." The summary statement on the form stated "Additional notes--Resident is able to use urinal independently and if requiring assistance is able to alert staff. Possible incontinence related to diuretic use." On 10/13/11 and 1/11/12, the form was signed, as a quarterly review, however no additional information was noted on the form to indicate the resident was assessed after a change in urinary continence was noted on 10/19/11 (per the MDS). The resident group sheets for the direct care staff revealed the resident was continent, kept a urinal and commode at bedside, and staff assisted to empty it. At 2:45 p.m. on 1/26/12, nursing assistant (NA-A) was interviewed and verified R127 was independent in using the bathroom and will call for assistance for emptying of his urinal and commode. NA-A further stated that R127 requested incontinent pads for dribbling. At 9:25 a.m. on 1/27/12, registered nurse/clinical coordinator (RN-B) was interviewed and stated R127 had congestive heart failure with fluid retention and needed diuresing (removal of excess fluid in the tissues) at times which could relate to incontinence and a possible need for increased toileting assistance. RN-B indicated	F 276		

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F 279	Continued From page 5 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop individualized care plans for 1 of 3 residents (R26) in the sample for behavioral issues and 1 of 1 resident (R184) in the sample for non-compliance with fluid restriction. Findings include: The plan of care for R184 lacked development of measurable goals and individualized interventions for non-compliance with a fluid restriction. R184 had a diagnosis of end stage kidney disease and received hemodialysis (a method of removing fluids and cleaning the blood due to failing kidneys). R184 had a Physician order for a 1500 cc fluid restriction. The fluid restriction was necessary to prevent unwanted fluid gains between dialysis treatments. The admission nutrition assessment dated 11/9/11, indicated that R184 consumed 240-320 ccs fluids with meals and "remained non-compliant with fluid restriction." A nutrition progress note dated 1/19/12, indicated that R184 was non-compliant with fluid restriction. The quarterly nutritional assessment completed on 1/23/12, indicated that R184 consumed from 360	F 279		

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F 279	Continued From page 6 to 580 ccs with each meal. During an interview with the registered dietitian (RD) on 1/24/12, at 2:00 p.m., she indicated that R184 was non-compliant with the fluid restriction. She explained that the plan was for dietary to provide 250 ccs Four times per day, once with each meal and at bedtime. Nursing was to provide 120 ccs three times per day between meals when giving medications and the remaining 140 ccs were to be provided as R184 wished. Fluid intake was monitored on the Medical Administration Record (MAR) and in the Care Tracker program. She explained that R184 ate meals in the dining room. The resident would often start screaming and swearing for more fluids. In an attempt to control R184's fluid intake, 1/2 full glasses were provided. When R184 demanded more fluids, the resident was reminded of the fluid restriction, but would be provided with more fluids. The RD said the resident's son had been bringing Gatorade, but believed this had stopped. On 1/25/12, at 2:00 p.m. registered nurse/clinical coordinator (RN-A) stated that R184's son would bring in Gatorade for R184 to drink, and the Gatorade had contributed to an undesirable increase in R184's potassium levels. The RN explained the son came to visit 2-3 times during the week and on the weekends. During the visits he kept the door closed and requested staff not enter the room. Staff (RN-A) stated that R184's son had not understood why Gatorade was not good for R184 even after education was provided. She stated that R184 demanded to drink what she wanted as it was her right to refuse treatment.	F 279		

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F 276	Continued From page 4 the resident was hospitalized on 11/12/11 related to CHF. RN-B further confirmed the resident was not comprehensively assessed related to the change in his urinary incontinence to develop an appropriate plan of care. At 10:35 AM on 1/27/12, the director of nursing was informed of the above findings and was unable to provide any additional information. Review of the Management of Urinary Incontinence procedure revised on 1/09, directed staff to identify residents with urinary incontinence. For suspected incontinence, complete a care tracker three-day elimination tracking using care tracker. Complete a comprehensive assessment using the Bladder Data Collection and Assessment and initiate Alteration in Urinary Continence Plan of Care to manage urinary incontinence.	F 276		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe 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	F 279	F279 Residents R26 and R184 have had their care plans revised. Other residents with fluid restrictions and who isolate in their rooms have had their care plans reviewed. Re-education of Interdisciplinary Team regarding individualized care plan goals and interventions. Care plans will be audited quarterly in CCPR and results shared with the QPI Committee Person responsible: Director of Nursing/Designee Completion date: March 7	3/7/12

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F 279	Continued From page 7	F 279		

The nutrition plan of care for R184 indicated a problem of non-compliance with fluid restriction. The format in which the care plan was written made it difficult to easily determine the relationship between goals and problems. There was a goal listed for R184 to be free of signs or symptoms of fluid overload. Interventions were items checked from the selection of pre-written options. The interventions were general items usually provided per resident care protocol: provide diet as ordered, provide a 1500 cc fluid restriction, monitor for signs or symptoms of fluid overload, monitor intake at meals, honor food preferences. The plan of care lacked identification of an individualized and measurable goal for the problem of non-compliance with the fluid restriction. Also lacking was the development of specific and individualized interventions to help R184 with non-compliance issues.

The plan of care for R26 lacked development of measurable goals and specific interventions for a behavior of isolation.

R26 was admitted to the facility on 5/3/11, with medical diagnoses included fibromyalgia, chronic pain, dementia and depression. Relevant psychosocial issues, identified on the admission social services assessment dated 5/9/11, included severe depression, weakness with de-conditioning, history of alcohol abuse, delirium secondary to infection and anxiety.

R26 exhibited behaviors of reluctance to leave his room and even to leave his bed. A social service note dated 5/10/11, indicated a care plan

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F 279	Continued From page 8	F 279		

conference was held in R26's room as he was reluctant to get up and go to the conference room. At the time of the care conference both physical therapy and occupational therapy reported that R26 had not participated in therapies outside of his bed. Therapy reported working on some strengthening, however, if he was unwilling or able to progress in therapy he would not be covered by Medicare guidelines. The note indicated that R26 admitted to feeling fearful, but wanted to progress in therapy. A care conference note dated 6/16/11, indicated that R26 had stated that he "gave up" and was "lying in bed 'feeling sorry for myself.'"

The therapeutic recreation director indicated, on 1/25/12 at 10:30 a.m., that R26 was reluctant to leave his room to attend activities, or even to sit in his wheelchair in the hallway. The registered nurse/clinical coordinator (RN-A) was interviewed on 1/26/12, at 1:30 p.m. indicated that R26 had refused to go a pain clinic appointment and an urology appointment.

The director of nursing indicated, on 1/27/12 at 1:30 p.m., that R26 was not very social and was negative when he was admitted, but he had improved and would now be friendly and engage in conversation. She indicated he remained reluctant to get up or leave his room. Although he attended therapy a few times, he was un-cooperative, and it was discontinued due to refusal to attend. The goal was for the resident to move to a less restrictive environment, and therapy continued to be offered each month.

Interview with the licensed social worker (LSW-A) on 1/25/12 indicated that R26 was making

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F 279	Continued From page 9 independent choices and would get upset if pressed. She indicated there was not a program to get him more involved he was not a "social butterfly." Review of the PHQ-9 scores (an assessment used to determine mood status) indicated that R26's mood had improved from a score of 14 on admission to a present score of 6. The plan of care for R26 consisted of a pre-written form with numerous check boxes. The mood and behavior section of the care plan indicated a problem of depression. The goal was for no negative outcomes. The interventions to implement were only those that had been checked on the pre-written form. The interventions included general protocols. The interventions included: monitor for side effects of hypotension and weight loss, monitor for drug-related cognitive/behavioral impairments, monitor for drug-related discomfort. The plan of care lacked identification of R26's problem of isolating in his room. It also lacked an individualized and measurable goals related to isolation and depression. The plan also lacked specific individualized interventions utilizing information from assessments, the resident, and the resident's family or caregivers.	F 279		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract	F 315	F315 Resident R127 has been comprehensively reassessed for bladder incontinence. The Clinical Coordinators and MDS nurses were re-educated on bladder. The assessments will be reviewed quarterly in our Comprehensive Care Plan Review meeting (CCPR) and results communicated with the QPI Committee. Person responsible: Director of Nursing/Designee Completion date: March 7	3/7/12

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F 315	Continued From page 10 infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure appropriate treatment and services for 1 of 3 residents (R127) in the sample reviewed for incontinence. Findings include: Although R127 experienced a change in urinary incontinence, a re-assessment was not completed at the time of the change to include all potential contributing factors (such as medications, diagnoses, mobility, urinary voiding patterns) to determine a appropriate plan to help restore or manage the incontinence. R127 was admitted in 8/11 with diagnoses including congestive heart failure (CHF). The admission Minimum Data Set (MDS) dated 8/10/11, identified R127 as being continent of bladder and needing supervision (oversight, encouragement or cueing) and physical assistance of one with toileting needs. The quarterly MDS dated 10/19/11, identified R127 as being occasionally incontinent of bladder (less than 7 episodes of urinary incontinence) and requiring the same level of toileting assistance. The Bladder Data Collection and Assessment form dated 8/4/11, identified R127 as being continent of urine. A three-day elimination tracking was not completed as was "not	F 315		

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F 315	Continued From page 11	F 315		

applicable." The summary statement on the form stated "Additional notes--Resident is able to use urinal independently and if requiring assistance is able to alert staff. Possible incontinence related to diuretic use." On 10/13/11 and 1/11/12, the form was signed, as a quarterly review, however no additional information was noted on the form to indicate the resident was assessed after a change in urinary continence was noted on 10/19/11 (per the MDS).

The resident group sheets for the direct care staff revealed the resident was continent, kept a urinal and commode at bedside, and staff assisted to empty it.

The care plan dated 8/5/11 identified R127 as being continent of bladder. The interventions directed staff to observe, assess, record and report signs of infection and urinary retention, provide 8 ounces of water with each meal, maintain clear pathway and grab bars on bed.

At 1:25 p.m. on 1/27/12, R127 was observed in bed with the urinal and commode noted at the bedside. The resident stated he was able to use the bathroom, the commode and urinal independently but staff need to empty for him as "I am too unsteady." The resident further stated he wore an incontinent pad all the time because of variations in output. He requested 3-4 pads at a time, which he managed himself.

At 2:45 p.m. on 1/26/12, nursing assistant (NA-A) was interviewed and verified R127 was independent in using the bathroom and will call for assistance for emptying of his urinal and commode. NA-A further stated that R127

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F 315	Continued From page 12 requested incontinent pads for dribbling. At 9:25 a.m. on 1/27/12, registered nurse/clinical coordinator (RN-B) was interviewed and stated R127 had congestive heart failure with fluid retention and needed diuresing (removal of excess fluid in the tissues) at times which could relate to incontinence and a possible need for increased toileting assistance. RN-B indicated the resident was hospitalized on 11/12/11 related to CHF. RN-B further confirmed the resident was not comprehensively assessed related to the change in his urinary incontinence to develop an appropriate plan of care. At 10:35 AM on 1/27/12, the director of nursing was informed of the above findings and was unable to provide any additional information. Review of the Management of Urinary Incontinence procedure revised on 1/09, directed staff to identify residents with urinary incontinence. For suspected incontinence, complete a care tracker three-day elimination tracking using care tracker. Complete a comprehensive assessment using the Bladder Data Collection and Assessment and initiate Alteration in Urinary Continence Plan of Care to manage urinary incontinence.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318		

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

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F 318	Continued From page 13	F 318	F318 Resident R64 is being reassessed for splints. Splints will be applied per therapy recommendations. All other residents with splints have had their splints reviewed for cleanliness and Velcro function. Registered Nursing Assistants (NARs) and Licensed Nurses have been educated on the application and maintenance of splints. All splints will be audited weekly for cleanliness and function of the Velcro straps. Results will be communicated to the QPI committee Person responsible: Clinical Coordinators/Designee Completion date: March 7	3/7/12

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to ensure bilateral elbow/hand splints were maintained/clean and available for 1 of 1 resident (R64) observed with adaptive equipment. Findings include:

R64 had diagnoses of traumatic brain injury (TBI), locked-in syndrome, spasticity tetraplegia (paralysis affecting arm movement), and bilateral contracture of upper/lower extremity. R64's physician orders dated 12/31/11, indicated "Bilateral upper extremity elbow and hand splints" on at bedtime and off in the morning. The right elbow/hand splint was not observed on R64 or in the room on all the days of the survey. The left elbow/hand splint was soiled and the velcro strap across the back of the hand no longer adhered to the splint. Passive range of motion (PROM) to bilateral upper extremities/lower extremities was observed during the survey.

Observations at 8:45 a.m. on 1/26/12, R64 was wearing a blue terrycloth left elbow/hand splint only. The velcro on the splint no longer adhered to hold the splint in place over the back of the hand. At 9:15 a.m. licensed practical nurse (LPN-A) and (LPN-B) knocked and entered the room to reposition R64. LPN-A removed the left elbow/hand splint and noted the velcro was no longer adhering. LPN-A stated the splints were usually removed when R64 received morning cares around 9:00 a.m. LPN-A and LPN-B both confirmod the left elbow/hand splint was soiled

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F 318	Continued From page 14	F 318		

and did not know when the splint was washed. When queried about the right hand splint LPN-B stated the nursing assistants must have removed the splint because R64 would sometimes scratch the back of the head. There was no other splint observed in R64's room at the time.

R64's annual Minimum Data Set (MDS) dated 7/8/11, indicated R64 was totally dependent on others for all activities of daily living, had functional limitations on both sides for upper/lower extremities, received PROM 6 days out of 7 during the assessment period and required assistance with splint/brace 5 days out of 7 during the assessment period.

The nursing assistant group sheet (no date) indicated R64 "Elbow/hand splints on at night, off in AM."

R64's care plan (CP) dated 7/7/11, indicated bilateral splints upper/lower extremities. CP reviewed 10/12/11, indicated PROM, splinting programs. CP reviewed 1/11/12, indicated persistent vegetative state, total assist with activities of daily living, and PROM.

An interview conducted with LPN-A at 1:43 p.m. on 1/25/12, revealed R64 wore foam hand splints at bedtime and were removed in the morning. (LPN-A checked the schedule to verify the information provided).

An interview conducted with nursing assistant (NA-C) at 2:00 p.m. on 1/25/12, revealed R64 had bilateral elbow/hand splints before moving from first floor to second floor, but were lost.

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F 318	Continued From page 15 An interview conducted with R64's parents and an interpreter NA-C per the parents' request at 2:00 p.m. on 1/25/12, confirmed R64 had bilateral elbow/hand splints when had room on the first floor, but had not seen them since R64 had a room on second floor. R64's parents explained they brought up concerns at care conferences and discussed with LPN-A but did not feel their concerns were addressed. An interview conducted at 10:15 a.m. on 1/26/12, with registered nurse/clinical coordinator (RN-A) verified the left elbow/hand splint was soiled and the velcro no longer adhered and did not know how the elbow/hand splints were cleaned. RN-A also confirmed the right elbow/hand splint was missing. An interview conducted at 9:14 a.m. on 1/27/12, with registered nurse/clinical coordinator (RN-B) revealed had seen both elbow/hand splints for R64 on Tuesday, 1/24/12. An interview conducted at 9:40 a.m. on 1/27/12, with NA-D revealed the right elbow/splint for R64 was unsure when was lost, but verified it was still missing.	F 318		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a	F 325		

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F 325	Continued From page 16 nutritional problem. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop the care plan to maintain acceptable parameters of nutrition for 1 of 1 resident (R184) in the sample, reviewed for dialysis. Findings include: The plan of care for R184 lacked development of measurable goals and individualized interventions for non-compliance with a fluid restriction and experienced elevated potassium levels. R184 had a diagnosis of end stage kidney disease and received hemodialysis (a method of removing fluids and cleaning the blood due to failing kidneys). R184 had a physician order for a 1500 cc fluid restriction. The fluid restriction was necessary to prevent unwanted fluid gains between dialysis treatments. The admission nutrition assessment dated 11/9/11, indicated that R184 consumed 240-320 cc fluids with meals and "remained non-compliant with fluid restriction". A nutrition progress note dated 1/19/12, indicated that R184 was non-compliant with fluid restriction. The quarterly nutritional assessment completed on 1/23/12, indicated that R184 consumed from 360 cc to 580 cc with each meal.	F 325	F325 Resident R184 has had their fluid restriction care plan reviewed and updated. Other residents with fluid restrictions have had their care plans reviewed. Re-education of staff regarding following fluid restriction. Care plans will be audited quarterly in CCPR and results shared with the QPI Committee Person responsible: Director of Nursing/Designee Completion date: March 7	3/7/12

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F 325	Continued From page 17 During an interview with the registered dietitian (RD) on 1/24/12, at 2:00 p.m., she indicated that R184 was non-compliant with the fluid restriction. She explained that the plan was for dietary to provide 250 cc four times per day, once with each meal and at bedtime. Nursing was to provide 120 cc three times per day between meals when giving medications and the remaining 140 cc's were to be provided as R184 wished. Fluid intake was monitored on the medical administration record and in the care tracker program. She explained that R184 took meals in the dining room. R184 would often start screaming and swearing for more fluids. In an attempt to control R184's fluid intake, 1/2 full glasses would be provided. When R184 demanded more fluids she would be reminded of the fluid restriction, but would be provided with more fluids. The RD believed that the son had stopped bringing in Gatorade. On 1/25/12, at 2:00 p.m. registered nurse/clinical coordinator (RN-A) stated that R184's son would bring in Gatorade for R184 to drink, and the Gatorade may have contributed to an undesirable increase in R184's potassium levels. Staff (RN-A) went on to explain that the son came to visit 2-3 times during the week and on the weekends. During the visits he would keep the door closed and request that staff not enter the room. Staff (RN-A) stated that R184's son had not understood why Gatorade was not good for R184 even after education had been provided. She stated that R184 demanded to drink what she wanted as it was her right to refuse treatment. The nutrition plan of care for R184 indicated a problem of non-compliance with fluid restriction.	F 325		

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F 325	Continued From page 18 The format in which the care plan was written made it difficult to determine easily which goal related to which problem. The problems, goals and interventions were distributed between several pages. There was a goal listed for R184 to be free of signs or symptoms of fluid overload. Interventions were items checked from the selection of pre-written options. The interventions were general items usually provided per resident care protocol: provide diet as ordered, provide a 1500 cc fluid restriction, monitor for signs or symptoms of fluid overload, monitor intake at meals, honor food preferences. The plan of care lacked identification of an individualized and measurable goal for the problem of non-compliance with the fluid restriction. Also lacking was the development of specific and individualized interventions to help R184 with her non-compliance.	F 325		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes	F 334		

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F 334	Continued From page 19 documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second	F 334	All new residents who have not received the flu vaccine this season will receive education via the Centers for Disease Control – Vaccination Information Statement (CDC VIS). Licensed Nurses will be educated on the use of the CDC VIS form. New admissions will be audited for use of the CDC VIS form. Results will be communicated to the QPI committee. Person responsible: Director of Nursing/Designee Completion date: March 7	3/7/12

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F 334	Continued From page 20 pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to ensure each resident who agreed to the influenza vaccine received the current required Center for Disease Control (CDC) vaccine information for 2011-12, having the potential to affect all residents who were vaccinated at the facility. Findings include: Residents vaccinated at the facility during the 2011-12 season were not provided the required current CDC risk/benefit information to residents and/or families prior to receiving the current influenza vaccine. The education and training director was interviewed and provided vaccination information during the afternoon of 1/26/12. A copy of the facility's Pneumococcal & Annual Influenza Vaccine Information and Request form given to residents and/or family prior to receiving the influenza vaccine at the facility was not the required form from the CDC for 2011-12 vaccination period. According to the director, each clinical manager	F 334		

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F 334	Continued From page 21 on the floors was responsible to ensure residents on their unit were offered the influenza vaccine each year. When the registered nurse/clinical coordinator (RN-D) was queried about the procedure, she provided documentation regarding the 1st floor influenza vaccine status of the residents. RN-D agreed the facility form was the educational material provided to the residents and/or their representative at the time of vaccination, and was unaware of the CDC educational requirement. According to CDC guidelines, federal law requires the official education form be provided prior to vaccination (regardless of the combination vaccine it is given in, of whether it is given by a public health clinic or a private provider, of how the vaccine was purchased, and the age of the recipient). Source: www.cdc.gov/vaccines/pubs/vis/vis-facts.htm	F 334		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		

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F 441	Continued From page 22 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to follow appropriate infection control techniques for 1 of 6 residents (R64) whose personal cares was observed. Findings include: R64 had diagnoses of filametary keratitis (right eye worse than left) and a traumatic brain injury, and was totally dependent on others for all personal cares. Observations of R64 at 1:00 p.m. on 1/24/12, the resident's eyes were closed and dried matter was noted on the resident's eyelashes. The following day at 2:00 p.m. the	F 441	F441 The identified Nursing Assistant has been re-educated on avoiding cross contamination during patient cares. All other Nursing Assistants will be educated on avoiding cross contamination during patient cares. Personal care audits will be completed on 3 residents per week. Results will be communicated to the QPI committee. Person responsible: Director of Nursing/Designee Completion date: March 7	3/7/12

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F 441	Continued From page 23	F 441		

resident was unable to open the right eye and both eyes were mattery. At 8:45 a.m. on 1/26/12, the resident was lying in bed, dried drool noted on lips and resident's eyes were closed, but no matter observed at that time.

At 9:26 a.m. on 1/26/11, NA-B checked R64's incontinent pad. The NA then washed hands and obtained gloves and a clean brief from the roommate's side of the room. The NA donned gloves, elevated the bed to working level, lowered the head of the bed, and detached the incontinent pad tabs. NA-B used a disposable wet wipe to cleanse dried drool off R64's mouth and then used the same disposable wipe to cleanse R64's eyes. No glove change or handwashing was observed. NA-B moved R64 onto left side and cleansed the back peri area. R64 was both wet and had fecal smears. NA-B placed a clean incontinent pad (no glove change or handwashing observed) and repositioned R64 back onto the right/back side, positioning with pillows. NA-B touched the bedding, gown, splint, and pillows with the same gloved hands used during the peri care and then removed the gloves.

After cares were concluded at 9:50 a.m. NA-B was asked about handwashing. The NA stated would change gloves and wash hands after the peri care was completed. NA-B verified this was not done prior to proceeding with personal cares for R64.
R64's physicians orders dated 12/31/11, indicated R64 received "Lacri-lube ointment apply to both eyes with finger four times daily (Filamentary Keratitis)--right eye worse than left--warm washcloth to clean eyelids twice daily." NA-B used disposable wet wipes instead of a warm

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F 441	Continued From page 24 washcloth. Policy/procedures requested of the director of nursing (DON) at 11:45 a.m. on 1/26/12, for glove changing and handwashing when providing peri care to a resident incontinent of bowel. At 12:45 p.m. the DON provided a copy of the policy/procedure for hand hygiene only. The policy/procedure for hand hygiene (revised 11/11) indicated "A plain soap and water handwash will be used: If hands are visibly soiled...A plain soap and water handwash or an alcohol hand rub may also be used: After contact with body fluids or excretions, mucous membranes, non-intact skin and wound dressings if the hands are not visibly soiled. During resident care if moving from a contaminated-body site to a clean body site. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the resident. After removing gloves." An interview conducted at 1:18 p.m. on 1/27/12, with the education coordinator revealed the facility expectation of glove changing and handwashing with peri care after a BM before proceeding with personal cares per the Minnesota Department of Health (MDH) recommendation.	F 441		

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Friday, March 09, 2012 3:46 PM
To: 'rochi_lsc@cms.hhs.gov'
Cc: Rexeisen, Robert (DPS); 'mbedard@extendicare.com'; 'Colleen Leach'; 'Jim Loveland'; Leppke, Susan (MDH); 'Mark Meath'; 'Mary Henderson'; 'Shellae Dietrich'; Steege, Nicole (MDH); Whitney, Marian (DPS)
Subject: Richfield Health Center (245492) K67 Annual Waiver Request

This is to inform you that Richfield Health Center is requesting an annual waiver for K67, corridors as a plenum. The exit date was 1-27-12.

I am recommending that CMS approve this waiver request.

Patrick Sheehan, Fire Safety Supervisor
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division, Est. 1905
Office: 651-201-7205, Cell: 651-470-4416
FAX: 651-215-0525
Web: fire.state.mn.us

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

PROVISION NUMBER(S)	JUSTIFICATION
K84 K067 The building Heating, Ventilation & Air Conditioning Equipment (HVAC) does not comply with LSC (00) Section 9.2 and NFPA90A, 1999 Ed., because the corridors are being used as a plenum	A. An annual/continuing waiver is being requested for K-067. Compliance with this provision will cause an unreasonable hardship in accordance with SOM 2480C because: 1,258,000.00 MB 2/29/12 1. The most recent cost estimate for a complying HVAC dated 1/4/2010 is ~~$1,030,000.00~~ and does not include costs for the required changes with 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 electrical 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 services and maintenance contracts exist to service all of the facilities fire alarm systems. 6. 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
	Fire Safety Supervisor	**State Fire Marshal**	3-9-12

Matt Rebekah N.H.A. 2-24-2012

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CANON
03/01/2012 18:20 FAX 6122430470

Richfield
HEALTH CENTER

February 29, 2012

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

Re: Richfield Health Center K067 waiver request additional information

Dear Mr. Sheehan,

When we visited on Monday regarding our K067 waiver request you requested a copy of the quote for installation of equipment. The original quote was inclusive of the HVAC costs but not all cost related to that project. You requested cost data for the totality of the project. I have obtained an updated quote from a vendor that contains all costs required to comply with K067. You had also inquired how far below the minimum ceiling height this project would make the ceiling. The vendor indicated after installation the ceiling height for this project would be seven (7) feet in the corridors.

Please feel free to contact me with any questions or clarifications at 612-861-1691 or Mbedard@extendicare.com.

Respectfully submitted,

Mat Bedard, Administrator

7727 Portland Avenue South, Richfield, MN 55423
Tel: 612.861.1691 Fax: 612.861.0186
www.richfieldskillednursing.com

KASTER CONSTRUCTION & COMMERCIAL REPAIR

Job: **Richfield Health Care Center**
7727 Portland Ave South
Richfield, Minnesota 55423

March 1, 2012

ATTENTION: Matt

WORK COMPLETED
* Proposal to upgrade 1st, 2nd & 3rd floor HVAC systems & eliminate plenum
* Remove & replace all ventilation units with energy recovery Ventilators to provide fresh air to all rooms
* Provide & install ductless split system in all tenant & aux rooms
* Replace RTUS and or ventilation units in common areas
* Install curbs
* Roofing repairs
* Lower sprinkler heads as needed
  15/floor 3 floors 45 heads
* Lower ceiling grid and tile as needed (ceiling height ±7')
* Replace lights as needed 25/floor 75 total
* Insulate interior ductwork
* Permits, Engineer & Mechanical drawings

TOTAL LABOR & MATERIALS $1,258,000.00

THANK YOU VERY MUCH! WE APPRECIATE YOUR BUSINESS!

KASTER CONSTRUCTION & COMMERCIAL REPAIR

Mike Kaster Cell: 763-227-2015 Fax: 763-493-2015
6952 East Fish Lake Road Maple Grove, Minnesota 55369

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

F5492020

PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245492	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/26/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Richfield Healthcare Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar St., Suite 145
St. Paul, MN 55101-5145
Pat.Sheehan@state.mn.us

POC ok
w/ AW for K67
FS 3-9-12

RECEIVED
MAR - 1 2012
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

Dc: 3-1-12
Exit: 1-27-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 2/27/12

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.

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

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K 000	Continued From page 1 <mailto:Pat.Sheehan@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This 3-story building was constructed in 1971 and was determined to be of Type II (222) construction. It has a full basement and is fully fire sprinklered. The facility has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 119 beds and had a census of 112 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067	K067 The facility is requesting an annual/continuing waiver. See K067 waiver request.	Annual Waiver ~~3/2/12~~

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K 067	Continued From page 2 This STANDARD is not met as evidenced by: Based on observations and interviews, it could not be verified that the facility's general ventilating and air conditioning system (HVAC) is installed in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 2-3.11. A noncompliant HVAC system could affect residents, visitors and staff. Findings include: During the facility tour between 9:30 AM and 11:30 AM on 01/26/2012, observation revealed that the ventilation system for the corridors appears to be utilizing the egress corridor as an air plenum for the resident rooms. The resident rooms are heated by hot water register. The corridors are heated by forced air. No return duct could be located in the corridors. The resident bathroom fans run continuously and exhaust to the exterior and draw their supply from the corridors through the resident rooms. This deficient practice was verified by the administrator at the time of the inspection.	K 067		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 8418

February 15, 2012

Mr. Mathew Bedard, Administrator
Richfield Health Center
7727 Portland Avenue South
Richfield, Minnesota 55423

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5492022

Dear Mr. Bedard:

The above facility was surveyed on January 23, 2012 through January 27, 2012 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, P.O. Box 64900, St. Paul, Minnesota 55164-0900. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Gayl.e Lantto, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3794 Fax: (651) 201-3790

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING _____ B. WING _____	01/27/2012

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On January 23-27, 2012 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 Certification Programs; 85 East Seventh Place, Suite 220; P.O. Box 64900, St. Paul, Minnesota 55164-0900.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by:	2 550		

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2 550	Continued From page 2 Based on observation, record review, and interview, the facility failed to re-assess a change in bladder incontinence for 1 of 3 residents (R127) in the sample who were reviewed for incontinence. Findings include: Although R127 experienced a change in urinary incontinence, a comprehensive assessment was not completed at the time of the change to include all potential contributing factors (such as medications, diagnoses, mobility, urinary voiding patterns) to determine a appropriate plan to help restore or manage the incontinence. R127 was admitted in 8/11 with diagnoses including congestive heart failure (CHF). The admission Minimum Data Set (MDS) dated 8/10/11, identified R127 as being continent of bladder and needing supervision (oversight, encouragement or cueing) and physical assistance of one with toileting needs. The quarterly MDS dated 10/19/11, identified R127 as being occasionally incontinent of bladder (less than 7 episodes of urinary incontinence) and requiring the same level of toileting assistance. The Bladder Data Collection and Assessment form dated 8/4/11, identified R127 as being continent of urine. A three-day elimination tracking was not completed as was "not applicable." The summary statement on the form stated "Additional notes--Resident is able to use urinal independently and if requiring assistance is able to alert staff. Possible incontinence related to diuretic use." On 10/13/11 and 1/11/12, the form was signed, as a quarterly review, however no additional information was noted on the form to	2 550		

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2 550	Continued From page 3 indicate the resident was assessed after a change in urinary continence was noted on 10/19/11 (per the MDS). The resident group sheets for the direct care staff revealed the resident was continent, kept a urinal and commode at bedside, and staff assisted to empty it. At 2:45 p.m. on 1/26/12, nursing assistant (NA-A) was interviewed and verified R127 was independent in using the bathroom and will call for assistance for emptying of his urinal and commode. NA-A further stated that R127 requested incontinent pads for dribbling. At 9:25 a.m. on 1/27/12, registered nurse/clinical coordinator (RN-B) was interviewed and stated R127 had congestive heart failure with fluid retention and needed diuresing (removal of excess fluid in the tissues) at times which could relate to incontinence and a possible need for increased toileting assistance. RN-B indicated the resident was hospitalized on 11/12/11 related to CHF. RN-B further confirmed the resident was not comprehensively assessed related to the change in his urinary incontinence to develop an appropriate plan of care. At 10:35 AM on 1/27/12, the director of nursing was informed of the above findings and was unable to provide any additional information. Review of the Management of Urinary Incontinence procedure revised on 1/09, directed staff to identify residents with urinary incontinence. For suspected incontinence, complete a care tracker three-day elimination tracking using care tracker. Complete a comprehensive assessment using the Bladder	2 550		

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2 550	Continued From page 4 Data Collection and Assessment and initiate Alteration in Urinary Continence Plan of Care to manage urinary incontinence. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop and/or review policies and procedures to ensure comprehensive assessments are completed at the time of the quarterly MDS. The DON or her designee could educate all appropriate staff on these policies and procedures. The DON or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.	2 550		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop individualized care plans for 1 of 3 residents (R26) in the sample for behavioral issues and 1 of 1 resident (R184) in the sample for non-compliance with fluid restriction.	2 560		

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2 560	Continued From page 5 Findings include: The plan of care for R184 lacked development of measurable goals and individualized interventions for non-compliance with a fluid restriction. R184 had a diagnosis of end stage kidney disease and received hemodialysis (a method of removing fluids and cleaning the blood due to failing kidneys). R184 had a Physician order for a 1500 cc fluid restriction. The fluid restriction was necessary to prevent unwanted fluid gains between dialysis treatments. The admission nutrition assessment dated 11/9/11, indicated that R184 consumed 240-320 ccs fluids with meals and "remained non-compliant with fluid restriction." A nutrition progress note dated 1/19/12, indicated that R184 was non-compliant with fluid restriction. The quarterly nutritional assessment completed on 1/23/12, indicated that R184 consumed from 360 to 580 ccs with each meal. During an interview with the registered dietitian (RD) on 1/24/12, at 2:00 p.m., she indicated that R184 was non-compliant with the fluid restriction. She explained that the plan was for dietary to provide 250 ccs Four times per day, once with each meal and at bedtime. Nursing was to provide 120 ccs three times per day between meals when giving medications and the remaining 140 ccs were to be provided as R184 wished. Fluid intake was monitored on the Medical Administration Record (MAR) and in the Care Tracker program. She explained that R184 ate meals in the dining room. The resident would often start screaming and swearing for more fluids. In an attempt to control R184's fluid intake,	2 560		

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2 560	Continued From page 6 1/2 full glasses were provided. When R184 demanded more fluids, the resident was reminded of the fluid restriction, but would be provided with more fluids. The RD said the resident's son had been bringing Gatorade, but believed this had stopped. On 1/25/12, at 2:00 p.m. registered nurse/clinical coordinator (RN-A) stated that R184's son would bring in Gatorade for R184 to drink, and the Gatorade had contributed to an undesirable increase in R184's potassium levels. The RN explained the son came to visit 2-3 times during the week and on the weekends. During the visits he kept the door closed and requested staff not enter the room. Staff (RN-A) stated that R184's son had not understood why Gatorade was not good for R184 even after education was provided. She stated that R184 demanded to drink what she wanted as it was her right to refuse treatment. The nutrition plan of care for R184 indicated a problem of non-compliance with fluid restriction. The format in which the care plan was written made it difficult to easily determine the relationship between goals and problems. There was a goal listed for R184 to be free of signs or symptoms of fluid overload. Interventions were items checked from the selection of pre-written options. The interventions were general items usually provided per resident care protocol: provide diet as ordered, provide a 1500 cc fluid restriction, monitor for signs or symptoms of fluid overload, monitor intake at meals, honor food preferences. The plan of care lacked identification of an individualized and measurable goal for the problem of non-compliance with the fluid restriction. Also lacking was the development of specific and individualized	2 560		

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2 560	Continued From page 7 interventions to help R184 with non-compliance issues. The plan of care for R26 lacked development of measurable goals and specific interventions for a behavior of isolation. R26 was admitted to the facility on 5/3/11, with medical diagnoses included fibromyalgia, chronic pain, dementia and depression. Relevant psychosocial issues, identified on the admission social services assessment dated 5/9/11, included severe depression, weakness with de-conditioning, history of alcohol abuse, delirium secondary to infection and anxiety. R26 exhibited behaviors of reluctance to leave his room and even to leave his bed. A social service note dated 5/10/11, indicated a care plan conference was held in R26's room as he was reluctant to get up and go to the conference room. At the time of the care conference both physical therapy and occupational therapy reported that R26 had not participated in therapies outside of his bed. Therapy reported working on some strengthening, however, if he was unwilling or able to progress in therapy he would not be covered by Medicare guidelines. The note indicated that R26 admitted to feeling fearful, but wanted to progress in therapy. A care conference note dated 6/16/11, indicated that R26 had stated that he "gave up" and was "lying in bed 'feeling sorry for myself.'" The therapeutic recreation director indicated, on 1/25/12 at 10:30 a.m., that R26 was reluctant to leave his room to attend activities, or even to sit in his wheelchair in the hallway. The registered nurse/clinical coordinator (RN-A) was interviewed on 1/26/12, at 1:30 p.m. indicated that R26 had	2 560		

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2 560	Continued From page 8 refused to go a pain clinic appointment and an urology appointment. The director of nursing indicated, on 1/27/12 at 1:30 p.m., that R26 was not very social and was negative when he was admitted, but he had improved and would now be friendly and engage in conversation. She indicated he remained reluctant to get up or leave his room. Although he attended therapy a few times, he was un-cooperative, and it was discontinued due to refusal to attend. The goal was for the resident to move to a less restrictive environment, and therapy continued to be offered each month. Interview with the licensed social worker (LSW-A) on 1/25/12 indicated that R26 was making independent choices and would get upset if pressed. She indicated there was not a program to get him more involved he was not a "social butterfly." Review of the PHQ-9 scores (an assessment used to determine mood status) indicated that R26's mood had improved from a score of 14 on admission to a present score of 6. The plan of care for R26 consisted of a pre-written form with numerous check boxes. The mood and behavior section of the care plan indicated a problem of depression. The goal was for no negative outcomes. The interventions to implement were only those that had been checked on the pre-written form. The interventions included general protocols. The interventions included: monitor for side effects of hypotension and weight loss, monitor for drug-related cognitive/behavioral impairments, monitor for drug-related discomfort. The plan of care lacked identification of R26's problem of isolating in his room. It also lacked an individualized and measurable goals related to	2 560		

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2 560	Continued From page 9 isolation and depression. The plan also lacked specific individualized interventions utilizing information from assessments, the resident, and the resident's family or caregivers. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could provide training to staff to develop a care plan to include appropriate interventions for identified resident care needs. The DON or designee could develop a monitoring program to assure ongoing and effective care plan interventions in response to resident care needs. TIME PERIOD FOR CORRECTION: Thirty (30) days.	2 560		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure bilateral elbow/hand splints were maintained/clean and	2 895		

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2 895	Continued From page 10 available for 1 of 1 resident (R64) observed with adaptive equipment. Findings include: R64 had diagnoses of traumatic brain injury (TBI), locked-in syndrome, spasticity tetraplegia (paralysis affecting arm movement), and bilateral contracture of upper/lower extremity. R64's physician orders dated 12/31/11, indicated "Bilateral upper extremity elbow and hand splints" on at bedtime and off in the morning. The right elbow/hand splint was not observed on R64 or in the room on all the days of the survey. The left elbow/hand splint was soiled and the velcro strap across the back of the hand no longer adhered to the splint. Passive range of motion (PROM) to bilateral upper extremities/lower extremities was observed during the survey. Observations at 8:45 a.m. on 1/26/12, R64 was wearing a blue terrycloth left elbow/hand splint only. The velcro on the splint no longer adhered to hold the splint in place over the back of the hand. At 9:15 a.m. licensed practical nurse (LPN-A) and (LPN-B) knocked and entered the room to reposition R64. LPN-A removed the left elbow/hand splint and noted the velcro was no longer adhering. LPN-A stated the splints were usually removed when R64 received morning cares around 9:00 a.m. LPN-A and LPN-B both confirmed the left elbow/hand splint was soiled and did not know when the splint was washed. When queried about the right hand splint LPN-B stated the nursing assistants must have removed the splint because R64 would sometimes scratch the back of the head. There was no other splint observed in R64's room at the time. R64's annual Minimum Data Set (MDS) dated 7/8/11, indicated R64 was totally dependent on others for all activities of daily living, had	2 895		

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2 895	Continued From page 11 functional limitations on both sides for upper/lower extremities, received PROM 6 days out of 7 during the assessment period and required assistance with splint/brace 5 days out of 7 during the assessment period. The nursing assistant group sheet (no date) indicated R64 "Elbow/hand splints on at night, off in AM." R64's care plan (CP) dated 7/7/11, indicated bilateral splints upper/lower extremities. CP reviewed 10/12/11, indicated PROM, splinting programs. CP reviewed 1/11/12, indicated persistent vegetative state, total assist with activities of daily living, and PROM. An interview conducted with LPN-A at 1:43 p.m. on 1/25/12, revealed R64 wore foam hand splints at bedtime and were removed in the morning. (LPN-A checked the schedule to verify the information provided). An interview conducted with nursing assistant (NA-C) at 2:00 p.m. on 1/25/12, revealed R64 had bilateral elbow/hand splints before moving from first floor to second floor, but were lost. An interview conducted with R64's parents and an interpreter NA-C per the parents' request at 2:00 p.m. on 1/25/12, confirmed R64 had bilateral elbow/hand splints when had room on the first floor, but had not seen them since R64 had a room on second floor. R64's parents explained they brought up concerns at care conferences and discussed with LPN-A but did not feel their concerns were addressed. An interview conducted at 10:15 a.m. on 1/26/12, with registered nurse/clinical coordinator (RN-A)	2 895		

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2 895	Continued From page 12 verified the left elbow/hand splint was soiled and the velcro no longer adhered and did not know how the elbow/hand splints were cleaned. RN-A also confirmed the right elbow/hand splint was missing. An interview conducted at 9:14 a.m. on 1/27/12, with registered nurse/clinical coordinator (RN-B) revealed had seen both elbow/hand splints for R64 on Tuesday, 1/24/12. An interview conducted at 9:40 a.m. on 1/27/12, with NA-D revealed the right elbow/splint for R64 was unsure when was lost, but verified it was still missing. SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review and revise the policies and procedures for the use of adaptive equipment (splint devices), educate the appropriate personnel in any changes and appoint a designee to monitor the procedures to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.	2 895		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and	2 910		

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2 910	Continued From page 13 B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure appropriate treatment and services for 1 of 3 residents (R127) in the sample reviewed for incontinence. Findings include: Although R127 experienced a change in urinary incontinence, a re-assessment was not completed at the time of the change to include all potential contributing factors (such as medications, diagnoses, mobility, urinary voiding patterns) to determine a appropriate plan to help restore or manage the incontinence. R127 was admitted in 8/11 with diagnoses including congestive heart failure (CHF). The admission Minimum Data Set (MDS) dated 8/10/11, identified R127 as being continent of bladder and needing supervision (oversight, encouragement or cueing) and physical assistance of one with toileting needs. The quarterly MDS dated 10/19/11, identified R127 as being occasionally incontinent of bladder (less than 7 episodes of urinary incontinence) and requiring the same level of toileting assistance. The Bladder Data Collection and Assessment form dated 8/4/11, identified R127 as being	2 910		

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2 910	Continued From page 14 continent of urine. A three-day elimination tracking was not completed as was "not applicable." The summary statement on the form stated "Additional notes--Resident is able to use urinal independently and if requiring assistance is able to alert staff. Possible incontinence related to diuretic use." On 10/13/11 and 1/11/12, the form was signed, as a quarterly review, however no additional information was noted on the form to indicate the resident was assessed after a change in urinary continence was noted on 10/19/11 (per the MDS). The resident group sheets for the direct care staff revealed the resident was continent, kept a urinal and commode at bedside, and staff assisted to empty it. The care plan dated 8/5/11 identified R127 as being continent of bladder. The interventions directed staff to observe, assess, record and report signs of infection and urinary retention, provide 8 ounces of water with each meal, maintain clear pathway and grab bars on bed. At 1:25 p.m. on 1/27/12, R127 was observed in bed with the urinal and commode noted at the bedside. The resident stated he was able to use the bathroom, the commode and urinal independently but staff need to empty for him as "I am too unsteady." The resident further stated he wore an incontinent pad all the time because of variations in output. He requested 3-4 pads at a time, which he managed himself. At 2:45 p.m. on 1/26/12, nursing assistant (NA-A) was interviewed and verified R127 was independent in using the bathroom and will call for assistance for emptying of his urinal and commode. NA-A further stated that R127	2 910		

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2 910	Continued From page 15 requested incontinent pads for dribbling. At 9:25 a.m. on 1/27/12, registered nurse/clinical coordinator (RN-B) was interviewed and stated R127 had congestive heart failure with fluid retention and needed diuresing (removal of excess fluid in the tissues) at times which could relate to incontinence and a possible need for increased toileting assistance. RN-B indicated the resident was hospitalized on 11/12/11 related to CHF. RN-B further confirmed the resident was not comprehensively assessed related to the change in his urinary incontinence to develop an appropriate plan of care. At 10:35 AM on 1/27/12, the director of nursing was informed of the above findings and was unable to provide any additional information. Review of the Management of Urinary Incontinence procedure revised on 1/09, directed staff to identify residents with urinary incontinence. For suspected incontinence, complete a care tracker three-day elimination tracking using care tracker. Complete a comprehensive assessment using the Bladder Data Collection and Assessment and initiate Alteration in Urinary Continence Plan of Care to manage urinary incontinence. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop and/or review policies and procedures to ensure residents receive appropriate toileting services based on their assessed needs, educate all appropriate staff members on the processes and develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Thirty (30)	2 910		

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2 910	Continued From page 16 days.	2 910		
2 940	MN Rule 4658.0525 Subp. 9 Rehab - Hydration Subp. 9. Hydration. Residents must be offered and receive adequate water and other fluids to maintain proper hydration and health, unless fluids are restricted. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to develop the care plan to maintain acceptable parameters of nutrition for 1 of 1 resident (R184) in the sample, reviewed for dialysis. Findings include: The plan of care for R184 lacked development of measurable goals and individualized interventions for non-compliance with a fluid restriction and experienced elevated potassium levels. R184 had a diagnosis of end stage kidney disease and received hemodialysis (a method of removing fluids and cleaning the blood due to failing kidneys). R184 had a physician order for a 1500 cc fluid restriction. The fluid restriction was necessary to prevent unwanted fluid gains between dialysis treatments. The admission nutrition assessment dated 11/9/11, indicated that R184 consumed 240-320 cc fluids with meals and "remained non-compliant with fluid restriction". A nutrition progress note dated 1/19/12, indicated that R184 was non-compliant with fluid restriction. The quarterly nutritional assessment completed on 1/23/12,	2 940		

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2 940	Continued From page 17 indicated that R184 consumed from 360 cc to 580 cc with each meal. During an interview with the registered dietitian (RD) on 1/24/12, at 2:00 p.m., she indicated that R184 was non-compliant with the fluid restriction. She explained that the plan was for dietary to provide 250 cc four times per day, once with each meal and at bedtime. Nursing was to provide 120 cc three times per day between meals when giving medications and the remaining 140 cc's were to be provided as R184 wished. Fluid intake was monitored on the medical administration record and in the care tracker program. She explained that R184 took meals in the dining room. R184 would often start screaming and swearing for more fluids. In an attempt to control R184's fluid intake, 1/2 full glasses would be provided. When R184 demanded more fluids she would be reminded of the fluid restriction, but would be provided with more fluids. The RD believed that the son had stopped bringing in Gatorade. On 1/25/12, at 2:00 p.m. registered nurse/clinical coordinator (RN-A) stated that R184's son would bring in Gatorade for R184 to drink, and the Gatorade may have contributed to an undesirable increase in R184's potassium levels. Staff (RN-A) went on to explain that the son came to visit 2-3 times during the week and on the weekends. During the visits he would keep the door closed and request that staff not enter the room. Staff (RN-A) stated that R184's son had not understood why Gatorade was not good for R184 even after education had been provided. She stated that R184 demanded to drink what she wanted as it was her right to refuse treatment. The nutrition plan of care for R184 indicated a	2 940		

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2 940	Continued From page 18 problem of non-compliance with fluid restriction. The format in which the care plan was written made it difficult to determine easily which goal related to which problem. The problems, goals and interventions were distributed between several pages. There was a goal listed for R184 to be free of signs or symptoms of fluid overload. Interventions were items checked from the selection of pre-written options. The interventions were general items usually provided per resident care protocol: provide diet as ordered, provide a 1500 cc fluid restriction, monitor for signs or symptoms of fluid overload, monitor intake at meals, honor food preferences. The plan of care lacked identification of an individualized and measurable goal for the problem of non-compliance with the fluid restriction. Also lacking was the development of specific and individualized interventions to help R184 with her non-compliance. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and/or review and revise policies and procedures for evaluating residents who are non-compliant with fluid restriction and provide additional training to staff. The DON or designated staff could monitor the system. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 940		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.	21375		

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21375	Continued From page 19 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the facility failed to follow appropriate infection control techniques for 1 of 6 residents (R64) whose personal cares was observed. Findings include: R64 had diagnoses of filametary keratitis (right eye worse than left) and a traumatic brain injury, and was totally dependent on others for all personal cares. Observations of R64 at 1:00 p.m. on 1/24/12, the resident's eyes were closed and dried matter was noted on the resident's eyelashes. The following day at 2:00 p.m. the resident was unable to open the right eye and both eyes were mattery. At 8:45 a.m. on 1/26/12, the resident was lying in bed, dried drool noted on lips and resident's eyes were closed, but no matter observed at that time. At 9:26 a.m. on 1/26/11, NA-B checked R64's incontinent pad. The NA then washed hands and obtained gloves and a clean brief from the roommate's side of the room. The NA donned gloves, elevated the bed to working level, lowered the head of the bed, and detached the incontinent pad tabs. NA-B used a disposable wet wipe to cleanse dried drool off R64's mouth and then used the same disposable wipe to cleanse R64's eyes. No glove change or handwashing was observed. NA-B moved R64 onto left side and cleansed the back peri area. R64 was both wet and had fecal smears. NA-B placed a clean incontinent pad (no glove change or handwashing observed) and repositioned R64 back onto the right/back side, positioning with pillows. NA-B touched the bedding, gown, splint, and pillows	21375		

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21375	Continued From page 20 with the same gloved hands used during the peri care and then removed the gloves. After cares were concluded at 9:50 a.m. NA-B was asked about handwashing. The NA stated would change gloves and wash hands after the peri care was completed. NA-B verified this was not done prior to proceeding with personal cares for R64. R64's physicians orders dated 12/31/11, indicated R64 received "Lacri-lube ointment apply to both eyes with finger four times daily (Filamentary Keratitis)--right eye worse than left--warm washcloth to clean eyelids twice daily." NA-B used disposable wet wipes instead of a warm washcloth. Policy/procedures requested of the director of nursing (DON) at 11:45 a.m. on 1/26/12, for glove changing and handwashing when providing peri care to a resident incontinent of bowel. At 12:45 p.m. the DON provided a copy of the policy/procedure for hand hygiene only. The policy/procedure for hand hygiene (revised 11/11) indicated "A plain soap and water handwash will be used: If hands are visibly soiled...A plain soap and water handwash or an alcohol hand rub may also be used: After contact with body fluids or excretions, mucous membranes, non-intact skin and wound dressings if the hands are not visibly soiled. During resident care if moving from a contaminated-body site to a clean body site. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the resident. After removing gloves." An interview conducted at 1:18 p.m. on 1/27/12, with the education coordinator revealed the facility expectation of glove changing and handwashing with peri care after a BM before	21375		

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	00253	A. BUILDING _____ B. WING _____	01/27/2012

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21375	Continued From page 21 proceeding with personal cares per the Minnesota Department of Health (MDH) recommendation. Suggested Method of Correction: The administrator or director of nursing (DON) or designee could develop and/or review policies and procedures to ensure staff are following proper infection control techniques. The administrator, DON or designee could reeducate facility staff on policies and procedures and an auditing system developed to ensure ongoing compliance. Time Period for Correction: Twenty one (21) days.	21375		
21410	MN Rule 4658.0815 Subp. 1 Employee Tuberculosis Program Subpart 1. Pursuant to Minnesota Rule 4658.0040, and as defined in Minnesota Department of Health Information bulletin 09-02 Tuberculosis Prevention and Control: Nursing Home. Minnesota Rule 4658.0815 Subpart 1 Employee Tuberculosis Program is waived. Conditions of Wavier: - Follow the U. S. Centers for Disease Control and Prevention ' s "Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005," Morbidity and Mortality Weekly Report (MMWR) 2005;54 (No. RR-17), and as subsequently amended, for infection control procedures and requirements ("CDC Guidelines"). Refer to this document for complete definitions of terms. - Assign administrative responsibility for the TB	21410		

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21410	Continued From page 22 infection control program to appropriate personnel. Administrative responsibilities include the establishment of an infection control team (one or more individuals), completion (and periodic update) of a written TB risk assessment, development (and periodic review) of a written TB infection control plan, and screening of health care workers (HCWs) for TB as discussed below. - Conduct a problem evaluation if a case of suspected or confirmed TB disease is not promptly recognized and appropriate measures are not taken. - Perform an investigation in collaboration with the local health department if health-care-associated transmission of M. tuberculosis is suspected. This MN Requirement is not met as evidenced by: Based on staff interview and document review, the facility failed to ensure their tuberculosis (TB) prevention plan was reviewed at least annually. Findings include: The facility's TB Prevention & Control Plan risk assessment process was reviewed on 3/29/10. The plan identified the facility tuberculosis	21410		

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21410	Continued From page 23 exposure risk as "medium" related to the multicultural diversity of their workforce as well as the mixed ethnicity of its residential population. Because of the medium risk designation, the facility should have at least annually reassessed and updated the written TB risk assessment. There was no documentation to support this was completed since 3/29/10. The infection control registered nurse was interviewed on 1/26/12 at 2:05 p.m. and verified the plan had not been updated, and was was unaware of the requirement. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review and revise policies and procedures pertaining to resident assessment (including changes in urinary continence) to assure they comply with the regulations, retrain staff and develop a monitoring procedure. TIME PERIOD FOR CORRECTION: Thirty (30) Days.	21410		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to accurately assess and ensure physician orders were obtained for 1 of 2	21565		

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21565	Continued From page 24 resident (R25) reviewed for self-administration of medications. Findings include: At 8:16 a.m. on 1/26/12, the licensed practical nurse (LPN-A) removed Advair Diskus (a inhaler medication used to treat asthma) from the medication cart and handed to R25 who was seated in a wheelchair next to medication cart. R25 was then observed to self-administer one puff of the medication. R25's physician orders revealed an order for Advair Diskus 500-50 mcg Disk, one puff by mouth twice daily, however, there was no physician order for the resident to self-administer the medication. The resident's care plan updated on 12/21/11, did not include information regarding self-administration of medication. During an interview with registered nurse/clinical coordinator (RN-A) at 9:13 a.m. on 1/26/12, revealed staff were unable to locate a physician order or an assessment for self-administration of medication. RN-A further indicated it would not be considered self- administration as the resident was supervised by staff while the resident depressed the dispenser to inhale the medication. At 1:21 p.m. on 1/27/12, RN-A stated she had obtained a physician order and conducted a assessment for R25. During an interview with the director of nursing at 10:25 a.m. on 1/27/12 revealed R25 should have been assessed for ability to safely self-administer medication, a physicians order obtained, and the care plan updated before the resident began self-administering medication.	21565		

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21565	Continued From page 25 The facility policy for Self-Medication Assessment and Management dated 4/06, directed staff to complete an assessment if resident requests to self-administer. The procedure directed staff to review and analyze interdisciplinary assessments to determine a resident's ability to self-medicate, complete the Self-Medication Data Collection and Assessment, analyze assessment with the interdisciplinary team, discuss with physician any medication that may not be self-administered, and enter resident's specific interventions and goals on the plan of care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise the policies and procedures for the resident self-administration assessment/protocol and care plan, educate the appropriate personnel in any changes and appoint a designee to monitor the procedures to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Thirty (30) Days.	21565		