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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: XMQB

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00253

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **12/01/2017**
6. DATE OF SURVEY **07/23/2018** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date:
Susanne Reuss, Unit Supervisor 08/10/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Douglas Larson, Enforcement Specialist 10/04/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06301
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/13/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245492

August 10, 2018

Ms. Jo Ann Buytendorp, Administrator
Richfield A Villa Center
7727 Portland Avenue South
Richfield, MN 55423

Dear Ms. Buytendorp:

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

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

Effective July 17, 2018 the above facility is certified for:

112 Skilled Nursing Facility/Nursing Facility Beds

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

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K521.

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

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

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

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 10, 2018

Ms. Jo Ann Buytendorp, Administrator
Richfield A Villa Center
7727 Portland Avenue South
Richfield, MN 55423

RE: Project Number S5492028

Dear Ms. Buytendorp:

On June 25, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 7, 2018 that included an investigation of complaint number H5492109. 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 July 23, 2018, 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 June 7, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 17, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 7, 2018, effective July 17, 2018 and therefore remedies outlined in our letter to you dated June 25, 2018, will not be imposed.

Your request for a continuing waiver involving the deficiency(ies) cited under K521 at the time of the June 7, 2018 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.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health

Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: XMQB

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00253

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245492**

2.STATE VENDOR OR MEDICAID NO.
(L2) **080343000**

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

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

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

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

6. DATE OF SURVEY **06/07/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date:
Lou Anne Page, HFE NE II 07/12/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 08/13/2018 (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.
06301
(L31)

30. REMARKS
LSC K521 Annual Waiver Request to ROCHI 08132018

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 25, 2018

Ms. Jo Ann Buytendorp, Administrator
Richfield A Villa Center
7727 Portland Avenue South
Richfield, MN 55423

RE: Project Numbers S5492028 and H5492109

Dear Ms. Buytendorp:

On June 7, 2018, 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 electronically attached CMS-2567 whereby corrections are required. In addition, at the time of the June 7, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number H5492109 that was found to be unsubstantiated.

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

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

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 17, 2018, 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 July 17, 2018 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

Your ePoC must:

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the

Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition

of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 7, 2018 (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 December 7, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245492	A. BUILDING _____ B. WING _____	C 06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on June 4 through June 7, 2018 during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted June 4, 2018 through June 7, 2018 and complaint investigation H5492109 was also completed at the time of the standard survey. The complaint H5492109 was found to be unsubstantiated. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-	F 584		7/17/18

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

Electronically Signed | 07/03/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245492	A. BUILDING _____ B. WING _____	C 06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 1 §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain a sanitary environment in the first floor shower room and resident rooms; 108, 304, 311, 317 and 318. This had the potential to affect all residents using the	F 584	1. The first floor shower room floor and tile grout on the wall were cleaned and the missing tile pieces were fixed. Rooms 108,317 and 318 sink cabinets were removed and replaced with new cabinets.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245492	A. BUILDING _____ B. WING _____	C 06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 2 first floor shower room, the residents residing in the five rooms identified and residents residing on the secured unit. Findings include: On 6/4/18, during the initial tour of the facility, the following environmental concerns were observed: - The first floor shower room floor was dirty, there was a black substance in the tile grout on the wall, and missing pieces of tile in the corner of the wall just inside the door to the right. - Room 108, the sink cabinet had moisture damage around the bottom of the side of the cabinet and was missing a piece of the wood in the bottom corner against the wall. - Room 304, the protective plate on the door was detached on the bottom left corner, and at the end of the first bed on the floor was a green substance. - Room 311, there was a tan substance staining the wall over the bed nearest to the door. - Room 317, the sink cabinet had moisture damage and exposed the particle board underneath. - Room 318 the left window blind had 2 broken slats leaving gaps in the blind and the broken slats had jagged edges; finally in the third floor dining room the sink cabinet finish was peeling off exposing the particle board underneath and on the wall next to the sink there was exposed sheet rock in an area approximately four inches by two inches in size.	F 584	Room 304 door protective plate was repaired. Room 311 wall was cleaned. Room 318 window blind was repaired. The magnetic lock doors on third floor are securing and functioning correctly. 2. All Residents who reside at Richfield a Villa Center who are in need of utilizing the showers, room sinks and the secure unit have the potential to be affected by this practice. Maintenance and Housekeeping personnel will complete preventive maintenance rounds and observations of rooms per policy. Housekeeping will provide extra cleaning in the rooms that require more assistance. 3. Maintenance, Housekeeping and department heads will be re-educated on the facility's policy and procedure on communication of needed repairs using PCC on 7/3, 7/5 and 7/6/18. 4. Maintenance Director, Housekeeping Director and the Administrator will complete daily rounds times 4 weeks, then 2 times monthly for 3 months, to ensure compliance and will log results into the TELS system. 5. Trends of reviews and audits will be forwarded to the Quality Assurance Performance Improvement meeting for 3 months.	

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	245492	A. BUILDING _____ B. WING _____	C 06/07/2018

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F 584	Continued From page 3 On 6/5/18, at 10:16 a.m. housekeeper (H)-A was shown the wall and cabinet and acknowledged not being able to clean those areas. H-A stated the protocol was to fill out a maintenance request and turn it into the supervisor. On 6/6/18, the magnetic lock doors on the third floor between the east and west sides were not functioning to secure the east side. H-A was shown the door and stated it needed to get reported right away. H-A did report it to the nursing staff on east side of the hall. The administrator and maintenance director (MD)-A were also notified. When MD-A was asked about how the doors were checked, MD-A stated there was not a system for checking the doors. On 6/7/18, at 9:00 a.m. tour of the facility was completed with MD-A, environmental services supervisor (ESS)-A and the Administrator. The concerns noted above were discussed. The administrator and ESS-A stated the sink cabinets and exposed sheet rock in the third floor dining room were not cleanable surfaces and would need to be replaced or repaired right away. MD-A stated the process for checking rooms was three rooms were checked for concerns daily. MD-A stated being able to check every room each month. MD-A stated the rooms were check for lights, temperature, water temperature and any other concerns. When asked about the common areas such as the dining room on third floor east, MD-A stated he had not been checking those areas. MD-A stated the facility was attempting to order new window blinds for room 318, but was unable to provide a maintenance request or any document showing the facility had ordered the blinds, but the blinds were back ordered.	F 584		

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F 584	Continued From page 4 At 9:40 a.m. MD-A was shown first floor shower room. MD-A noted the missing tile corner and stated that needed to get fixed right away. At 9:45 a.m. ESS-A stated the showers were deep cleaned monthly and it was time for the shower room to be deep cleaned. On 6/7/18, the log of room checks from April and May 2018, were reviewed. There were no notations of sink cabinets being damaged nor was there a place to make notation of common areas to be checked. On 6/7/18, at 12:20 p.m. during and interview the administrator stated all staff received education on filling out a maintenance request when they are hired, along with customer service and stated ensuring rooms were in good repair and clean was part of the customer service training. Staff were supposed tell the supervisor immediately of any repair or housekeeping need and fill out a maintenance request. The administrator stated the checks system was in place and maintenance requests were tracked by her for completion.	F 584		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2	F 609		7/17/18

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F 609	Continued From page 5 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of resident to resident altercations were reported immediately to the administrator and the state agency (SA) for 2 of 2 residents (R96, R20) who were involved in altercations with another resident. Findings include: R20's Admission Record identified a diagnosis of Wernicke's encephalopathy (lesions of the central nervous system) caused by Vitamin B deficiency. R20's quarterly Minimum Data Set (MDS) dated 3/24/18, indicated he had moderately impaired cognition and displayed verbal behavioral symptoms. On 6/4/18, at 1:16 p.m. during interview R20	F 609	1. The incident between R96 and R97 was reported to the state agency on 5/29/18. R96 was moved off the unit to prevent recurrence. The incident between R97 and R20 was reported to the state agency on 6/6/18. R97 was placed on continuous supervision until transferred to an acute psych facility on the morning of 6/6/18 to prevent recurrence. R97 has been discharged from the facility eliminating the potential to affect other residents. 2. All residents who reside at Richfield a Villa Center on the secure unit have the potential to be affected by this practice. Policies and procedures have been reviewed and are current. 3. All staff received re-education on the	

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F 609	Continued From page 6 stated he was afraid of a "guy on the floor." R20 stated the other resident came into his room in the middle of the night and tried to fight with him. After the interview R20 walked down the hall and pointed to R97's name on the door of room 318. Review of R20's nursing Progress Notes did not identify an incident with R97. R97's Admission Record indicated diagnosis that included dementia with behavioral disturbance, anxiety disorder, and major depressive disorder. R97's admission MDS dated 5/31/18, indicated he was severely cognitively impaired and displayed physical and verbal behaviors. R97's facility Progress Notes dated 6/3/18, indicated R97 was agitated and was going into other resident rooms, waking them up and trying to fight with them. The Progress Note indicated R97 was not able to be redirected. During interview on 6/6/18, at 8:50 a.m. registered nurse (RN)-B was asked about the incident between R97 and R20. RN-B described a another incident that occurred between the two residents on 6/5/18, during the supper meal. RN-B stated R97 had grabbed R20's right arm and caused skin tears. RN-B stated the protocol for reporting resident to resident incidents was to notify the guardian, family, or responsible party, the director of nursing (DON) or Administrator and the resident's primary care provider. RN-B stated a Team Strategy Incident Report was filled out regarding the incident on 6/5/18, and an investigation was started. RN-B stated the DON was the one to call the SA and make the report. RN-B was asked about the incident between R97 and R20 on 6/3/18, when R97 went into R20's	F 609	facility Policy and Procedure for reporting requirements for allegations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property on 7/3, 7/5 and 7/6/18. 4. The DON/Administrator will ensure that they were informed immediately after each incident has been logged into the reporting system. This will be audited daily for 30 days and the weekly for 3 months. 5. All results will be brought to the Quality Assurance Performance Improvement meetings and reviewed for trends in quality improvement for 3 months.	

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room at night and tried to fight. RN-B stated not being aware of the incident.

A review of Facility Reported Incidents (FRIs) identified a report to the SA dated 6/6/18, at 10:00 a.m regarding the resident to resident altercation between R97 and R20 that occurred during supper on 6/5/18, at 5:30 p.m.

On 6/7/18, at 12:05 p.m. the DON stated the incident between R97 and R20 during supper on 6/5/18 should have been reported to her on 6/5/18. The DON stated she did not find out about the incident until 6/6/18, the day after the incident occurred. The DON further stated she had not been informed at all about the incident between the two residents on 6/3/18, where R97 entered R20's room at night and tried to start a fight.

R96's admission MDS dated 5/30/18, indicated severely impaired cognition and wandering behaviors that placed him at risk.

Further review of R97's medical record identified other incidents involving R97 and other residents. A Progress Note dated 5/28/18, indicated R97 had been going into other resident rooms, taking items from them and refused to return them. The Progress Note indicated R97 had hit R96 in room 320, and caused a skin tear on R96's left arm.

Further review of FRI's identified a report to the SA dated 5/29/18, at 9:11 a.m. that described the resident to resident altercation between R97 and R96 that occurred on 5/28/18, at 1:15 p.m.

On 6/7/18, at 12:05 p.m. the DON stated she did not find out about the incident between R97 and R96 until 5/29/18, the day after the incident

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occurred. The DON stated the expectation was for staff to report the incident to the supervising nurse and the supervising nurse was to report to the DON or Administrator immediately. The DON stated that resident to resident altercations were supposed to be reported to the SA within two hours of the incident and stated staff received training on hire and annually on abuse reporting and there was a binder at each nursing station with the procedure to follow if an incident occurred.

On 6/7/18, at 12:20 p.m. the administrator stated the requirement for reporting a resident to resident altercations to the SA was two hours, and the facility had not reported the incident on 6/5/18, (between R97 and R20) or 5/28/18, (between R97 and R96) according to that requirement.

Review of the Villa's Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property policy dated 11/28/17, indicated "The Nursing Home Administrator or designee will report abuse to the state agency per State and Federal requirements immediately." The policy also indicated occurrences, patterns and trends that may constitute abuse will be investigated. In section E.(a) of the policy the staff is instructed when an incident or suspected incident of "abuse" is reported, the Administrator or designee will investigate the incident with the assistance of appropriate personnel. In the section F (a)(iii) indicated "if the alleged perpetrator is a facility resident he staff member will immediately removed the perpetrator from the situation and another staff member will stay with the alleged perpetrator and wait for further instruction from the administration, if possible." In section G.(a)

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F 609	Continued From page 9 the staff are instructed to report any abuse or suspicion of abuse immediately to the Administrator.	F 609		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to	F 623		7/17/18

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allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and

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F 623	Continued From page 11 advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the ombudsman was notified of hospital transfers for 4 of 4 residents (R98, R46, R55, R1) reviewed for hospitalization. Findings include: R98's diagnoses included heart failure, coronary artery disease, hypertension, renal insufficiency, renal failure and diabetes mellitus obtained from the admission Minimum Data Set (MDS) dated 4/9/18. In addition the MDS identified R98 had intact cognition and had been discharged to a hospital on 5/11/18. A review of the interdisciplinary notes revealed on	F 623	1. The Ombudsman has been notified with regards to the hospital discharges for R98,R46, R55 and R1. 2. All residents who reside at Richfield a Villa Center that acutely transfer out of the facility have potential to be affected by this practice. Communication has been set up with the Ombudsman to ensure that all acute transfers will be communicated as appropriate. 3. All nurses and social workers will be re-educated on this policy and procedure and will notify the Ombudsman for every transfer to the hospital on 7/3, 7/5 and 7/6/18. 4. The DON/Director of Social Services	

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F 623	Continued From page 12 5/11/18, a staff nurse had noted it was difficult to keep R98's oxygen level above 93% on 4-5 liters per minute and staff had concern for potential medication reaction. The note further indicated the ambulance had been called at 12:05 a.m to transport R98 to the hospital. A review of the medical record lacked documentation the regional ombudsman had been informed of the facility initiated transfers to an acute care facility for R98. R46's diagnoses included fracture, coronary artery disease, hypertension, thyroid disorder and depression obtained from the admission MDS dated 4/15/18. In addition, the MDS identified R46 had intact cognition. During further review it was revealed a discharge MDS had been completed on 4/26/18, when R46 was transferred to the hospital. During a review of a interdisciplinary progress note dated 4/27/18, it was revealed the emergency medical service (EMS) had transported R46 out from facility at 11:45 p.m. for evaluation related to symptoms of lethargy, hypotension and general malaise. On 6/7/18, at 11:18 a.m. the social worker designee stated she had not been notifying the ombudsman regarding any resident transfers to the hospitals as she had always thought the only time the ombudsman was notified was when a resident was discharged from the facility. On 6/6/18, at 12:32 p.m. the social worker designee reviewed the spread sheet sent to the ombudsman for April and May 2018, and verified the regional ombudsman had not been notified of	F 623	will ensure that this policy and procedure is followed by auditing medical records after each transfer daily for 30 days and then weekly for 3 months. 5. All results will be brought to the Quality Assurance Performance Improvement meetings and reviewed for trends in quality improvement for 3 months.	

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F 623	Continued From page 13 R98, R46, R55, and R1's facility initiated transfers to an inpatient facility. On 6/6/18, at 1:26 p.m. the director of social services (DSS) and social services designee both acknowledged the ombudsman had not been notified of R98,R46, R55, R1's transfers. DSS stated she was going to resend the list after adding residents. Both acknowledged these were facility initiated transfers and did not understand the regulation. R55 had diagnoses including kidney failure and diabetes indicated on the quarterly MDS dated 4/23/18. During a review of the medical record it was revealed R55 had discharge MDS's with return to the facility anticipated to a acute care facility on 2/10/18, 3/21/18, 4/5/18 and 5/21/18. On 6/6/18 at 10:45 a.m. an interview with LPN-A was revealed R55 was hospitalized for stomach issues, and had several hospitalizations for medical issues initiated by R55 however, no evidence the ombudsman had been notified for the facility initiated transfers. R1 had a diagnosis of multiple fractures indicated on the face sheet dated 5/7/18. The census record indicated R1 had been admitted on 2/23/18, and the progress note dated 5/4/18 identified R1 had been transported to the hospital for respiratory distress. The facility census records indicated R1 remained hospitalized from 5/4/18- 5/12/18 for a respiratory infection, however no documentation was in the medical record to indicate the ombudsman had been notified for the facility initiated transfer to an acute	F 623		

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F 623	Continued From page 14 care facility.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 3 residents (R98, R55, R1) or legal representatives had been informed of bed hold rights at the time of	F 625	1. The state bed hold policy has been reviewed with R98, R55 and R1 and will be given to them prior to their next hospitalization if needed.	7/17/18

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

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F 625	Continued From page 15 hospitalizations. Findings include: R98's diagnoses included heart failure, coronary artery disease, hypertension, renal insufficiency, renal failure and diabetes mellitus, obtained from the admission Minimum Data Set (MDS) dated 4/9/18. In addition the MDS identified R98 had intact cognition and had been discharged to a hospital on 5/11/18. A review of the interdisciplinary notes revealed on 5/11/18, a staff nurse had noted it was difficult to keep oxygen level above 93% on 4-5 liters per minute and staff had concern for potential medication. The note further noted the ambulance had been called at 12:05 a.m to transport R98 to the hospital. Review of the interdisciplinary notes lacked evidence of the facility providing or attempting to inform R98 or the responsible representative of the bed hold during the hospital transfer. On 6/6/18, at 12:22 p.m. when asked when bed hold notices were provided to residents, the business office manager (BOM) stated at the time of admission all residents were provided admission information which included the facility bed hold policy which they all signed. When asked if bed hold notices were provided to residents at the time of a discharge to the hospital, BOM stated the social workers were supposed to follow up with the residents and/or their representative, ask if they wanted the bed to be held and then document it. R55 had diagnoses including kidney failure and	F 625	2. All residents who reside at Richfield a Villa Center have potential to be affected by this practice. The facility will provide the resident and their representative written notice of the state bed hold policy for every transfer to the hospital. This will then be documented in the resident's medical record. 3. All nurses and social workers will be re-educated on the Bed Hold policy and procedure on 7/3, 7/5 and 7/6/18. 4. The DON/Director of Social Services will ensure that this policy and procedure is followed by auditing medical records after each transfer daily for 30 days and then weekly for 3 months. 5. All results will be brought to the Quality Assurance Performance Improvement meetings and reviewed for trends in quality improvement for 3 months.	

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F 625	Continued From page 16	F 625		

diabetes indicated on the quarterly MDS dated 4/23/18.
During an interview with LPN-A on 6/6/18 at 10:45 a.m. it was revealed R55 was hospitalized for stomach issues.

R55 had discharge MDS completed for hospitalizations on 2/10/18, 3/21/18, 4/5/18 and 5/21/18. The progress notes did not have documentation that a bed hold notice for these dates had been provided and there were no signed forms for bed holds on these dates.

The signed admission agreement for R55 dated 2/3/17 indicated the facility's bed hold policy for the number of days a bed was held, the notice of bed hold for the resident was not addressed.

During an interview on 6/6/18 at 10:45 a.m. Social worker (SW-B) indicated that R55 did not receive a bed hold notice from her, this was done by the business office.

During an interview on 6/06/18 at 1:10 p.m. with the BOM, she stated that with Medical assistance the resident/family would not be contacted until they were hospitalized for 18 days, the bed would be held. There was no system to ask about bed hold for Medicaid residents until after 18 days. She verified there were no copies of bed hold notices for this resident.

R1 had a diagnosis of multiple fractures, indicated on the face sheet dated 5/7/18, the census record indicated R1 had been admitted on 2/23/18 and hospitalized from 5/4/18- 5/12/18 for a respiratory infection.

The record did not include a bed hold notice or a

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F 625	Continued From page 17 progress note that bed hold had been discussed with R1. The BOM verified on 6/6/18 at 1:10 p.m. that a bed hold notice had not been completed with R1, The signed admission agreement for R1 dated 2/23/18 indicated the facility's bed hold policy for the number of days a bed was held, the notice of bed hold for the resident was not addressed. The facility policy for bedhold and return (undated) indicated residents or their representative would be provided with a written notice of the bed hold at the time of transfer to a hospital.	F 625		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns.	F 636		7/17/18

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F 636	Continued From page 18 (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by:	F 636		

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F 636	Continued From page 19 Based on observation, interview, and document review the facility failed to assess for appropriate use of grab bars for 2 of 3 residents (R85, R97) observed to have grab bars. Findings include: A review of R85's record on 6/5/18, identified R85 had a diagnoses of Huntington's disease and cognitive impairment. Care Area Assessment (CAA) for falls dated 3/1/18, indicated R85 had difficulty with balance and was a fall risk. R85's room was observed on 6/4/18, at 12:05 p.m. Grab bars were observed on the bed of R85. At 6:40 p.m. R85 was observed lying in the bed with both grab bars detached on one side. Nursing assistant (NA)-G was asked about the grab bars and stated the grab bars were always like that. A Safety Device Data Collection and Assessment dated 8/16/17, did not indicate any alternative devices or interventions were attempted prior to installing grab bars to the bed. R85's During an interview on 6/6/18, at 8:41 a.m. registered nurse (RN)-B stated not being sure if R85 could get up and out of bed without a grab bar and needed to be reassessed. RN-B stated she planned to discuss the issue with the director of nursing (DON) and maintenance director (MD)-A. R97's diagnoses diagnoses included dementia with behavioral disturbance, mood disorder and idiopathic peripheral autonomic neuropathy. During observation of R97's room, on 6/5/18, at	F 636	1. R85 has been re-assessed for appropriate safety devices and care plans were updated as appropriate. R97 has had grab bars removed from bed and has been discharged. 2. All residents who reside at Richfield a Villa Center have the potential to be affected by this practice. Residents who benefit from grab bars will have a current Safety Device Data Collection and Assessment completed. A house audit was completed for safety devices to ensure appropriate use and functioning. 3. Licensed staff will be re-educated on the Villa Bed Inspection Policy which includes screening, risk and benefits and informed consent for safety devices on 7/3, 7/5 and 7/6/18. 4. DON/Nurse Manager/Designee will audit all new admissions, quarterly reviews, annual reviews and significant changes for completion of a Safety Device Data Collection and Assessment 3 times weekly for 4 weeks and then 1 time per month for 3 months to ensure compliance. 5. All results will be brought to the Quality Assurance Performance Improvement meetings and reviewed for trends in quality improvement for 3 months.	

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F 636	Continued From page 20 8:52 a.m. bilateral grab bars were observed to be attached to R97's bed. R97 was asked about the grab bars, but did not respond to questions. A Safety Device Data Collection and Assessment for R97 was unable to be located. On 6/6/18, at 8:37 a.m. RN-B was interviewed regarding R97's grab bars and asked about an assessment. RN-B stated, "I missed his assessment." RN-B added remembering R97 did not have grab bars on his bed, but had them put on because grab bars are on the house standing orders. RN-B further stated an assessment needed to be done. During an interview with the DON on 6/7/18, at 12:05 p.m. the DON stated assessments needed to be done on admission, quarterly and with significant change. The DON added that assessment needed to include safety devices and alternative interventions tried. The Villa Bed Inspection Policy dated 11/28/17, indicated the resident was to be screened on admission, readmission, and with change of condition for level of independent bed mobility, special equipment or accessories (e.g. side rails) to include evaluate for appropriate alternatives and entrapment risk. Also the risks and benefits and informed consent must be obtained.	F 636		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.	F 645		7/17/18

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F 645	Continued From page 21 §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission	F 645		

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F 645	Continued From page 22 to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide accurate information related to a long standing history of schizophrenia for 1 of 1 resident (R87) on PASARR level I, resulting in a failure to complete a PASARR level 2. The Senior Linkage Line Pre Admission Screening failed to identify the long standing history of Schizophrenia and mental illness, failing to identify the need for a PASARR Level II. Findings include: R87 was admitted to the facility on 8/18/17. Admission diagnoses included: schizophrenia (a serious mental disorder that affects how a person	F 645	1. The level 2 PASARR was completed for R87 through the assistance from the Senior Linkage Line. 2. All Residents for who reside at Richfield a Villa Center that require a level 2 screening have the potential to be affected by this practice. A house audit was completed to ensure residents have the correct PASARR. The Director for Social Services will ensure that the diagnosis correlates with the PASARR level for all admissions and will initiate a level 2 screen as deemed necessary. 3. The Social Service and Admissions department will be re-educated on this	

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F 645	Continued From page 23 thinks, feels and acts, difficulty distinguishing real vs. imaginary), other symbolic dysfunctions (a communication disorder related to speech, language and auditory processing), and encephalopathy (abnormal brain function or structure). R87 received psychotropic medication for management and treatment of schizophrenia. Staff observe resident for potential side effects, effectiveness of medications and any mood/behavioral indicators. Although R87 had a long standing history of Schizophrenia, the Senior Linkage Line Pre Admission Screening form completed on 8/18/17, did not address the diagnosis of Schizophrenia at all, and instead identified primary medical diagnosis as encephalopathy and permanent placement in skilled nursing for needs of dressing, grooming, bathing, eating, bed mobility, transferring, walking, toileting supervision. tube feeding and clinical monitoring once every 8 hours, totally disoriented, does not know time, place identity. Meets level of care for purposes of MA (medical assistance) payment of long term care. The screening also indicated no developmental disability and no mental illness (defined as diagnosable as listed in the Diagnostic and Statistical Manual of Mental Disorders, marked as no major mental disorder, no impaired functioning, no psychiatric intensive treatment in the past, no issues in the last 2 years. R87's admission MDS dated 8/25/17, indicated R87 received psychotropic medications for management and treatment of schizophrenia. Staff observed resident for potential side effects, effectiveness of medications and any mood/behavioral indicators. Monitored per MD	F 645	policy and procedure on 7/6/18. 4. Social Services/Designee will audit all admissions for 30 days and then weekly for 3 months. 5. All results will be brought to the Quality Assurance Performance Improvement meetings and reviewed for trends in quality improvement for 3 months.	

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F 645	Continued From page 24 and facility policy. On 6/5/18, 10:47 a.m. during interview with the 2nd floor social worker (SW-2), she stated she would check into the PASARR. On 6/7/18, 8:41 a.m. an interview was conducted with the director of social service (DSS). DSS stated on 6/5/18, SW-2 had called senior linkage line, to request a new screening, since R87 had clear diagnoses of mental illness. DSS further stated the usual process was that admissions screener was supposed to do this for Level 1 screening, prior to admission, and the back up was for social service to follow up to make sure screening was done correctly.	F 645		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R3) who had a pressure ulcer was repositioned	F 686	1. R3 was on comfort care and expired on 6/23/18. 2. All residents who reside at Richfield a	7/17/18

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F 686	Continued From page 25 timely. In addition, failed to ensure proper hand hygiene and glove use was maintained during wound care for 1 of 1 resident (R3) reviewed for pressure ulcers. Findings include: R3's diagnoses included dementia, arthritis, diabetes mellitus and osteoporosis obtained from the significant Minimum Data Set (MDS) dated 3/7/18. In addition, the MDS identified R3 had an unstageable pressure ulcer; was on a turning/repositioning schedule program and required extensive physical assistance of two staff with toilet use and completing personal hygiene. R3 had severely impaired cognition. R3's care plan dated 6/5/18, identified a pressure ulcer on the coccyx related to immobility. Care plan directed staff to turn and reposition R3 every 2 hours. In addition, the care plan identified R3 had an alteration in bowel elimination/continence related to Alzheimer's disease. The care plan directed staff to check R3 every two hours and assist with toileting as needed. R3's pressure ulcer Care Area Assessment (CAA) dated 3/7/18, identified an unstageable pressure area on the coccyx. The CAA directed staff to turn and reposition R3 every two hours. On 6/6/18, at 7:18 a.m. during a continuous observation for two hours and 41 minutes the following was observed: -At 7:19 a.m. R3 was observed seated on a wheelchair which was parked at the table in the secured unit dining where staff brought her for meals. R3 sat at the table with two other residents. When approached and asked how she	F 686	Villa Center who require wound care and/or on a positioning program have the potential to be affected by this practice. Residents that receive wound care and/or are care planned to be on a positioning program have received care plan reviews and updates as appropriate. 3. Licensed staff have been re-educated on facility policy and procedure for wound care, repositioning, proper hand hygiene and glove use on 7/3, 7/5 and 7/6/18. 4. DON/Nurse Manager/Designee will conduct audits of licensed staff completing wound care and Q2hr turning and repositioning 3 times weekly for 4 weeks and then 1 time per month for 3 months to ensure compliance. 5. All results will be brought to the Quality Assurance Performance Improvement meetings and reviewed for trends in quality improvement for 3 months.	

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F 686	Continued From page 26	F 686		

had slept, R3 looked at surveyor, smiled and started to mumble. When asked if she had any pain R3 did not answer.
-At 7:28 a.m. nursing assistant (NA)-D came into the dining room, approached R3 and left the room.
-At 8:21 a.m. to 8:57 a.m. NA-D assisted R3 with the breakfast meal in the dining room.
-At 8:59 a.m. NA-D wheeled R3 out of the secured unit to her room which was located in a different unit, parked R3 in front of the bed and left the room without offering R3 repositioning.
-At 9:00 a.m. to 9:21 a.m. R3 remained in the room with the door wide open. No staff went to room at this time.
-At 9:22 a.m. NA-B was observed to peek his head into R3's room and then left the room and pulled the door shut.
-At 9:25 a.m. NA-B was observed to walk past R3's room and then went and sat at the nursing station.
-At 9:32 a.m. the activities director went to R3's room and wheeled R3 out of room to the dining room at the end of the hallway. She did not offer R3 repositioning before wheeling her out of the room.
-At 9:33 a.m. to 9:42 a.m. R3 remained in the dining room in the activity with no repositioning offered.
-At 9:43 a.m. to 9:48 a.m. NA-C was observed sitting at the nursing station charting.
-At 9:49 a.m. when NA-C was asked about R3's repositioning schedule she stated they were supposed to reposition a resident based on the care plan in the computer. When asked what time R3 had been transferred to the wheelchair, NA-C stated "Today was [R3's] shower day and we had completed the bed bath between 6:30-7:00 a.m. and then had gotten [R3] up right after to the

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F 686	Continued From page 27	F 686		

wheelchair. Am not sure of the time we got her up to the wheelchair."
-At 9:54 a.m. NA-C stated the activities director had taken R3 out of the room for an activity before they repositioned R3.

On 6/6/18, at 9:55 a.m. registered nurse (RN)-B stated he would expect the NA's to offer, turn and reposition residents as directed by the care plan. RN-B stated R3 had a stage III pressure ulcer and staff was to follow the care plan to prevent further tissue break down.

-At 10:00 a.m. NA-B and NA-C were observed to tilt the wheelchair seat back and both NA's slid R3 back in the wheelchair, reached to the sides and adjusted R3's body. When asked about the observation both NA's stated R3 was sliding down in the wheelchair and so they had to reposition her. When asked if that was repositioning both NA's stated they would usually lay R3 down to offload her.
-At 10:08 a.m. NA-C and NA-B transferred R3 into bed.
-At 10:09 a.m. RN-B entered the room to inspect R3's skin. RN-B then went into the bathroom and washed his hands, applied gloves then came to R3's bedside.
-At 10:11 a.m. licensed practical nurse (LPN)-D came into R3's room with an alcohol wipe and handed it to RN-B. RN-B was then observed to un-wrap the alcohol wipe then with left hand pulling on the soiled dressing started to wipe the skin and edges of the dressing with his right hand to remove the dressing from the wound located on the coccyx. RN-B then inspected the skin and stated was normal. As he removed the incontinent pad, stool was observed in the pad and on R3's bottom. At 10:14 a.m. LPN-D left the

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F 686	Continued From page 28 room to get wound supplies. -At 10:16 a.m. LPN-D came back to R3's room with supplies and RN-B removed gloves and applied another pair without washing his hands. RN-B then used gauze and wound cleanser to clean the wound area then with the same gloves un-wrapped two packets of skin prep and used the wipes one after the other to wipe the skin outside the wound edges. RN-B then removed his gloves and applied another pair of gloves still without washing hands and measured the wound, except for the depth. -At 10:20 a.m. LPN-D left R3's room again to get a Q-tip. -At 10:21 a.m. LPN-D returned and RN-B measured the depth then with the same gloves un-wrapped the clean dressing and applied it on the wound and removed gloves and washed hands at 10:22 a.m., as LPN-D dated the dressing. On 6/6/18, at 1:43 p.m. the director of nursing (DON) stated she would expect RN-B to remove gloves, wash hands before continuing with the wound care between dirty and clean tasks. On 6/7/18, at 10:50 a.m. when asked what repositioning meant the DON stated "you have to off load." When asked for how long the DON stated "I will have to look at our policy."	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		7/17/18

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F 689	Continued From page 29 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility did not asses and update care plan interventions for community access for one of one resident (R38) after an episode of acute confusion and return to the facility by law enforcement. Findings include: R38's face sheet dated 2/2/18 indicated diagnoses including malignant cancer, depression, adjustment disorder, and mood disorder. The admission Minimum Data Set (MDS) dated 1/5/18 indicated disorganized thinking and inattention, the brief inventory of mental status (BIMS) indicated R38 was cognitively intact. R38's care area assessment for cognition function indicated R38 had times of confusion and changes in mood, and R38's thinking was unpredictable as topics waiver during conversation. The plan of care dated 6/4/2018 did not address R38's ability to access the community alone. The physician's orders dated 2/22/18, indicated "may go out on pass with supervision". An order dated 5/29/18, noted R38 needed assist to schedule rides for appointments and it was not reasonable for R38 to take the bus. The progress note dated 3/27/18, indicated "Resident was brought in the building with the police. Police found her at the gas station very	F 689	1. R38 is currently in a Psychiatric unit at St. Joseph's hospital. Resident's ability to leave the building on an LOA will be reassessed upon readmission. Resident sign-out books have been placed and made available for all residents at each nurse's station. 2. All Residents who reside at Richfield a Villa Center that go out on pass and/or have cognition impairments have the potential to be affected by this practice. A house audit was completed for residents to ensure that community assessments have been completed, MD orders have been obtained and care plans have been updated for residents who desire to go out on pass. Residents who are appropriate to go out on pass have been re-educated on the sign out policy and books have been made available at each nurses station. 3. Licensed nurses will be re-educated on the Leave of Absence/Excursion Day Pass policy 7/3, 7/5 and 7/6/18. 4. DON/Nurse Manager/Designee will conduct audits on new admissions times 30 days to ensure appropriate plans of care have been formulated for residents that wish to go out on pass and that sign out books are available and being utilized. 5. All results will be brought to the Quality Assurance Performance Improvement meetings and reviewed for trends in quality improvement for 3 months.	

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F 689	Continued From page 30 confused and brought her home." The physician progress note dated 3/27/18, at 2:34 p.m. indicated "thinking is intermittent, R38 was out for a walk and got lost within a block of the facility." During an interview on 6/5/18, at 9:50 a.m. R38 stated she was afraid to go too far when she left the facility alone because of confusion at times due to a high ammonia level. She stated twice she was not able to find her way back. She said she leaves the facility to walk to a store and around the neighborhood but does not sign out, just tells the nurse. At 12:50 p.m. the resident sign out sheet was not on the unit for R38, and the nurse manager located a sign out sheet on another floor for R38, however, it did not have R38 signed out of the facility on 3/27/18, or since 5/16/18. The unit social worker (SW- B) and nurse manager (LPN-A) were interviewed on 6/6/18, at 11:00 a.m. and stated that R38 frequently went on walks to the local store and neighborhood, The social worker stated that the BIMS assessment identified if residents were safe in the neighborhood. The nurse manager stated R38 could become confused due to a high ammonia level and that would be real clear for the nurse to notice. The nurse said there was no assessment completed for R38 to determine supervision needed in the community. During an interview with the administrator on 6/6/18, at 1:00 p.m. she stated it would not be an elopement if R38 was in the community and brought back by the police, and would be considered an incident only if the the resident was injured. She indicated the community access	F 689	5. All results will be brought to the Quality Assurance Performance Improvement meetings and reviewed for trends in quality improvement for 3 months.	

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F 689	Continued From page 31 would not always be in the care plan. The director of nursing stated on 6/6/18, at 1:20 p.m. that the confusion for R38 was caused by a medical condition and the orders were changed to treat the medical condition. The facility Leave of Absence/Excursion Day Pass policy dated July 2015, indicated a log book indicating the departures and return of resident off the unit will guide the staff in determining who is off the unit at any given time. A day pass procedure may be used if resident was cognitively intact, had a physician's order, and signed out of the facility.	F 689		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers'	F 700		7/17/18

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F 700	Continued From page 32 recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to adequately assess for appropriate use and alternative interventions for 2 of 3 residents (R85, R97) observed to have grab bars on their beds. Findings include: R85's room was observed on 6/4/18, at 12:05 p.m. The grab bar on R85's bed were detached on one side and moved 90 degrees from the locked position. At 6:40 p.m. R85 was observed lying in the bed with both grab bars detached on one side and able to move away from the lock position. Nursing assistant (NA)-G was asked about the grab bars and stated the grab bars were always like that. NA-G explained that staff would lock them in place and R85 would unlock them. NA-G stated she would notify the nurse regarding the grab bar. A review of R85's record on 6/5/18, identified diagnoses of Huntington's disease and cognitive impairment. R85's fall Care Area Assessment (CAA) dated 3/1/18, indicated R85 had difficulty with balance and was a fall risk. A Safety Device Data Collection and Assessment dated 8/16/17, did not indicate alternative devices or interventions were attempted prior to installing the grab bars. During interview on 6/6/18, at 8:41 a.m. registered nurse (RN)-B stated the grab bars are only attached on one side because the resident	F 700	1. R85 has been re-assessed for appropriate safety devices and care plans were updated as appropriate. R97 has had grab bars removed from bed and has been discharged. 2. All residents who reside at Richfield a Villa Center have the potential to be affected by this practice. Residents who benefit from grab bars will have a current Safety Device Data Collection and Assessment completed. A house audit was completed for safety devices to ensure appropriate use and functioning. 3. Licensed staff will be re-educated on the Villa Bed Inspection Policy which includes screening, risk and benefits and informed consent for safety devices on 7/3, 7/5 and 7/6/18. 4. DON/Nurse Manager/Designee will audit all new admissions, quarterly reviews, annual reviews and significant changes for completion of a Safety Device Data Collection and Assessment 3 times weekly for 4 weeks and then 1 time per month for 3 months to ensure compliance. 5. All results will be brought to the Quality Assurance Performance Improvement meetings and reviewed for trends in quality improvement for 3 months.	

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F 700	Continued From page 33	F 700		

insisted on having them that way. RN-B also stated the care plan needed to be updated to include that. RN-B stated it was not okay to have the grab bar partially detached. RN-B further stated not being sure if R85 could get up and out of bed without a grab bar and needed to be reassessed. RN-B planned to discuss the issue with the director of nursing (DON) and maintenance director (MD-A).

The Joerns Assist Handle Two-Position Model F026 manufacturer's user manual for the grab bars being used copywrite date of 2015, was reviewed and indicated the grab bar needed to be in the locked position prior to leaving the resident unattended.

During observation on 6/5/18, at 8:52 a.m. bilateral grab bars were observed to be attached to R97's bed. R97 was asked about the grab bars, but did not respond to questions.

On 6/6/18, at 8:37 a.m. RN-B was interviewed regarding R97's grab bars and asked about a side rail assessment. RN-B stated, "I missed his assessment." RN-B added remembering R97 had them put on because grab bars are on the house standing orders. RN-B stated an assessment should have been done.

On 6/6/18, at 12:35 p.m. a review of R97's record identified R97 was admitted to the facility with diagnoses of dementia with behavioral disturbance, mood disorder and idiopathic peripheral autonomic neuropathy. Review of R97's care plan dated 5/29/18, did not indicate R97 used bilateral grab bars.

During an interview on 6/7/18 at 12:05 p.m. the

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F 700	Continued From page 34 DON stated assessments needed to be done on admission, quarterly and with significant change. The DON added the assessment needed to include safety devices and show that alternative interventions were tried. Review of the Villa Bed Inspection Policy dated 11/28/17 indicated the resident was to be screened on admission, readmission, and with change of condition for level of independent bed mobility, special equipment or accessories (e.g. side rails) to include evaluate for appropriate alternatives and entrapment risk. Also the risks and benefits and informed consent must be obtained.	F 700		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.	F 732		7/17/18

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F 732	Continued From page 35 (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the staff posting was updated with changes in staffing and failed to ensure staff postings were kept for the required time frame 18 months. Findings include: On 6/7/18, at 1:58 p.m. to 2:42 p.m. the sufficient staffing interview was completed with the administrator, director of nursing and registered nurse (RN)-E who did staffing. During the interview at 2:26 p.m. when interviewed about the staffing posting and the staff schedules RN-E stated "I have to be honest and say we have not been updating them to reflect the true hours worked by staff in the last 2 weeks I have been covering for the staffing coordinator." She stated at times the staff who had worked the previous day would come the next day late to accommodate them however this was not	F 732	1. The staff posting will be updated with changes in staffing/census throughout each shift and the staff postings will be kept at the facility for 18 months. 2. All residents and visitors who reside or visit Richfield a Villa Center have the potential to be affected by this practice. Posted Nurse staffing policy and procedure have been reviewed and is current. Designated individuals have been appointed as leads to update staffing information as necessary. 3. The DON, Nurse Manager and Staffing Coordinator will be re-educated on this policy on 7/6/18. 4. Administrator/Designee will audit the staff postings for 30 days and then weekly for 3 months to ensure compliance. 5. All results will be brought to the Quality Assurance Performance Improvement meetings and reviewed for trends in	

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F 732	Continued From page 36 reflected in the staff posting. During a review multiple randomly selected days of the actual Daily Nurse Staffing Forms and Nursing Daily Schedules for the last three months it was revealed changes in staffing were not updated in the Daily Nurse Staffing Forms for the following days: - 5/13/18, evening shift there were 10 assistants (NA's) scheduled however, one NA came late and one called-in sick but was never replaced. -5/20/18, one of the three night nurses had a no call no show (NCNS) and the nurse was replaced by a trained medication aide (TMA) instead. -5/22/18, day shift 10 NA's were scheduled to work however, one called in sick and was never replaced. In addition on the evening shift nurse came in at 3:00 p.m. which was not reflected on the Daily staffing Nurse Form. -5/26/18, day shift the TMA on 3rd floor worked until 1:00 p.m. which was not reflected on the Daily staffing Nurse Form. -5/29/18, day shift nurse called in on first floor and was never replaced. In addition, same day evening shift nurse who was coming in at 3:00 p.m. was "unable" to work and was never replaced. -6/3/18, evening shift revealed there was supposed to be a total of 10 nursing assistants however 1 had been pulled to the kitchen and not replaced. On 6/7/18, at 2:28 p.m. the administrator verified the Daily Nurse Staffing Forms for 5/17/18, 5/13/18, 5/26/18, 5/28/18, 5/29/18 were missing. The administrator acknowledged the facility was supposed to retain the forms for 18 months. The administrator and RN-E both stated the actual hours staff worked was never updated on the	F 732	quality improvement for 3 months.	

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F 732	Continued From page 37 daily staffing posting even though staff were replaced for the call-in's. The administrator acknowledged she knew the facility was supposed to retain the daily staffing posting for 18 months and stated, "we will do better moving forward."	F 732		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880		7/17/18

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F 880	Continued From page 38 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate hand hygiene and glove changes during cares	F 880	1. R3 was on comfort care and expired on 6/23/18. R95 and R51 will receive cares from staff who engage in proper	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245492	A. BUILDING _____ B. WING _____	C 06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 39 and dressing changes for 3 of 3 residents (R95, R3, R51) observed during cares for infection control practices. Findings include: R95 was admitted on 10/3/11 with current admission diagnoses that included: cerebrovascular accident (CVA-stroke) with hemiplegia (loss of use of left side of the body) and seizure disorder. R95 was totally dependent on staff for transfers, and required extensive assistance of two staff for bed mobility, dressing and toilet use. On 6/7/18, 9:18 a.m. nursing assistant (NA-A), handed a washcloth to R95 and R95 washed her face. NA-A then assisted with removing R95's shirt and proceeded through the bath by washing R95's hands, arms and chest area. NA-A then took the wash cloth, wrung it out over R95's periarea, and cleaned the periarea. Instead of starting at the top of R95's body and working down to the perineal area/buttock area, NA-A removed her gloves, threw them away, applied clean gloves and washed R95's upper back, lower back and buttocks area. The water in the basin had not been changed during the process. When bathing was completed, NA-A removed gloves and washed her hands. NA-A acknowledged the steps she took in the bathing process and stated it should have been done differently. R3's diagnoses included dementia, arthritis, diabetes mellitus and osteoporosis obtained from the significant Minimum Data Set (MDS) dated 3/7/18. In addition, the MDS identified R3	F 880	hand hygiene and glove changes. 2. All residents who reside at Richfield a Villa Center have the potential to be affected by this practice. Infection control policies and procedures will be enforced by licensed staff and nurse managers. 3. Licensed staff and nursing assistants will be re-educated on the Villa Infection Control policies and procedures with an emphasis on hand hygiene and glove changes on 7/3, 7/5 and 7/6/18. 4. DON/Nurse Manager/Designee will conduct audit staff during cares 3 times weekly for 4 weeks and then weekly for 3 months to ensure compliance. 5. All results will be brought to the Quality Assurance Performance Improvement meetings and reviewed for trends in quality improvement for 3 months.	

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

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F 880	Continued From page 40	F 880		

required extensive physical assistance of two staff with toilet use and completing personal hygiene and R3 had severely impaired cognition.

On 6/6/18, at 10:25 a.m. NA-B came into R3's room asked registered nurse (RN)-B if resident needed to be changed and RN-B stated "yes."
-At 10:26 a.m. NA-B approached R3 unfastened the pad.
-At 10:27 a.m. NA-B was observed do pericare in the front then turned R3 to the wall side; wipe stool off R3's bottom then took a dry towel and pat dried the area. NA-B then went to the bathroom and washed hands.
-At 10:30 a.m. NA-B applied a pair of gloves then approached R3; turned R3 to the side and applied barrier cream on R3's bottom then applied a clean pad under R3 and laid R3 on her back. Still with the same gloves used to apply barrier cream and with visible cream turned R3 right hip to turn her and fastened the pad. NA-B then proceeded to adjust R3's clothing, pillow and blankets with the same gloves. NA-B then reached out for the bed remote with his right gloved hand he had used to apply cream to R3's bottom, to lower the bed then reached for the call light and set it on top of R3's chest.
-At 10:34 a.m. NA-B was observed to remove gloves and wash his hands.
-At 10:36 a.m. surveyor requested NA-B to wipe the bed remote and the call light which he had touched with the same gloves used to apply barrier cream to R3's bottom.

On 6/6/18, at 10:39 a.m. RN-B acknowledged he had not completed proper hand hygiene and glove use during cares for R3. RN-B stated staff were supposed to change gloves and wash hands with cares "I will do education for the staff

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F 880	Continued From page 41	F 880		

and myself."

On 6/6/18, at 1:43 p.m. the DON stated NA-B should have removed the greased gloves and washed hands before he continued to touch other surfaces.

R51's admission record indicated current diagnosis of dementia and Parkinson's disease. R51's admission MDS dated 4/19/18, indicated severe cognitive impairment and required extensive physical assist of two person for toileting.

During a random observation on 6/4/18, at 6:43 p.m., for incontinence care, NA-F and NA-C donned gloves and used a mechanical lift to transport R51 from wheelchair into bed. NA-F and NA-C removed transport sling from under R51, NA-F left room with mechanical lift and closed door. NA-C removed R51's pants, unfastened incontinence brief and rolled front part of brief below R51, exposing peri area. NA-C used wet washcloth to wipe R51's peri area then wiped dry with another washcloth. R51 was rolled to right side and NA-C removed incontinence brief and wiped R51's buttocks with wet washcloth. NA-C observed not to change gloves. NA-C tucked new incontinence brief under R51, rolled onto left side then on back and fastened brief. NA-C put R51's gown on and placed a pillow under legs. NA-C covered R51 with a blanket, raised head of bed at 30 degrees, lowered bed to lowest position and placed the floor mat parallel to R51's bed. NA-C tied up the dirty bag and placed new plastic bag into garbage can. NA-C opened R51's door and walked into the hallway towards the dirty utility. NA-C removed right hand glove, opened dirty utility with key and placed plastic bag containing

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F 880	Continued From page 42	F 880		

dirty washcloth in bin, removed left glove. NA-C observed to walk into another resident's room to wash hands.

During an interview on 6/4/18, at 7:16 p.m., when asked if gloves changed during incontinence care, NA-C stated "no." When asked when should gloves be changed during incontinence care, NA-C indicated after changing brief. When asked if NA-C had changed gloves after providing peri-care to R51, NA-C indicated did not change gloves after peri-care.

The Infection Prevention and Control Guideline dated 11/28/17, indicated:
g. The hand hygiene procedures to be followed by staff involved in direct resident contact.
h. Resident Care Activity procedures including
b. Wound care, incontinence care and skin care.
I. Environmental cleaning and disinfection
b. Cleaning/disinfection of resident care equipment, including shared equipment

On 6/7/18, at 1:31 p.m. director of nursing (DON), and consultant nurse (CN) were interviewed regarding hand hygiene and glove change expectations for staff providing cares and dressing changes. DON stated staff are to wash their hands after removing gloves and before donning new gloves. Staff should follow the policy for hand hygiene.

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 _____	**06/06/2018**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on June 06, 2018. At the time of this survey, Richfield A Villa Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/03/2018

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

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K 000	Continued From page 1 IS NOT REQUIRED.	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
Marian.Whitney@state.mn.us and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Richfield A Villa Center is a 3-story building with a full basement, that was built in 1964 and was determined to be of Type II (222) construction. The facility is protected throughout by an automatic fire sprinkler system, and has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridors that is monitored for automatic fire department notification.

The facility has a capacity of 116 beds and had a census of 95 at time of the survey.

The requirement at 42 CFR, Subpart 483.70(a) is

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility's heating, ventilation, and air conditioning in not in compliance with the 2012 LSC NFPA 101 9.2, 19.5.2.1 and NFPA 90A. This deficient practice could affect all 95 residents. Findings include: On a facility tour between at 12:04 PM on June 06, 2018, it was revealed that the ventilation system for the corridors are utilizing the egress corridor as an exhaust plenum for the ducted make-up air. The resident rooms are heated by hot water system and the corridors are heated by forced air. The resident bathroom fans run continuously and exhaust to the exterior and have dampers located in them. This deficient practice was verified by the Director of Maintenance at the time of discovery.	K 521	Facility will be requesting a waiver and completing the CMS-2786R form. This completed form will be sent to the State Fire Marshal Division.	7/17/18

Name of Facility		2000 CODE
Richfield Health Center	7727 Portland Ave. South, Richfield, MN 55423	245492

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

PROVISION NUMBER(S)	JUSTIFICATION
K521 The building Heating, Ventilation, & Air Conditioning Equipment (HVAC) does not comply with LSC, Section 19.5.2.1 and NFPA 90A, Section 2-3.11.	An annual/continuing waiver is being requested for K521 for the following reasons: A. Compliance with this provision would impose an unreasonable hardship on the facility for the following reasons: 1. Facility was unsuccessful in obtaining multiple bids for this project due to vendors stating that the project is so costly that the facility would not be completing it anyway. One bid we were able to obtain dated 1/4/2010 was $1,030,000.00, which does not include ductwork, electrical connections, roofing changes, insulation, drawings, engineering fees, permit fees, or taxes. 2. The installation of the required ductwork would reduce the headroom in the corridor below the minimum specified in LSC(00), Sec. 7.1.5. 3. The building electric system is not adequate to handle the additional HVAC equipment needed. 4. LSC(00) Sec. 9.2.1 give the AHJ the authority to allow existing HVAC systems that do not comply with NFPA 90A to be continued in service. B. There will be no adverse effect on the health and safety of the facility residents and staff as: 1. The building is protected throughout by a complete supervised automatic sprinkler system installed in accordance with NFPA 13. 2. The building has automatic shutdown of all ventilation fans upon detection of smoke or activation of the fire alarm system. 3. Resident rooms are equipped with hard-wired single station smoke detectors. 4. The facility is smoke-free and signs to that effect are prominently posted at all major entrances. 5. Annual service and maintenance contracts exist to service all of the facilities fire alarm systems. (continued on 2nd page)

Surveyor *(Signature)*	Title	Office	Date

Fire Authority Official *(Signature)*	Title	Office	Date
Thomas Linhoff 12424	Fire Safety Supervisor	State Fire Marshal	07-12-2018

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

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

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	**Title**	**Office**	**Date**
Thomas Linhoff 12424	Fire Safety Supervisor	State Fire Marshal	07-12-2018

KASTER CONSTRUCTION & COMMERCIAL REPAIR

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

January 10, 2017

ATTENTION: Tom Gilbride

WORK TO BE COMPLETED

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

LABOR & MATERIALS $1,060,000.00

THANK YOU VERY MUCH! WE APPRECIATE YOUR BUSINESS!

KASTER CONSTRUCTION & COMMERCIAL REPAIR

Electronically delivered
June 25, 2018

Ms. Jo Ann Buytendorp, Administrator
Richfield A Villa Center
7727 Portland Avenue South
Richfield, MN 55423

Re: State Nursing Home Licensing Orders - Project Numbers S5492028 and H5492109

Dear Ms. Buytendorp:

The above facility was surveyed on June 4, 2018 through June 7, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number H5492109 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Susanne Reuss, Unit Supervisor at (651) 201-3793 or susanne.reuss@state.mn.us.

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,

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

cc: Licensing and Certification File

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 _____	C 06/07/2018

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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 June 4, 2018 through June 7, 2018 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,	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.	

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

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2 000	Continued From page 1 Licensing and Certification Program, Susanne Reuss, Unit Supervisor, PO Box 64882, St Paul, MN 55164-0882.	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.	
2 505	MN Rule 4658.0300 Subp. 1 A-E Use of Restraints Subpart 1. Definitions. For purposes of this part, the following terms have the meanings given. A. "Physical restraints" means any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of	2 505		7/17/18

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2 505	Continued From page 2 movement or normal access to one's body. Physical restraints include, but are not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, and wheelchair safety bars. Physical restraints also include practices which meet the definition of a restraint, such as tucking in a sheet so tightly that a resident confined to bed cannot move; bed rails; chairs that prevent rising; or placing a resident in a wheelchair so close to a wall that the wall prevents the resident from rising. Bed rails are considered a restraint if they restrict freedom of movement. If the bed rail is used solely to assist the resident in turning or to help the resident get out of bed, then the bed rail is not used as a restraint. Wrist bands or devices on clothing that trigger electronic alarms to warn staff that a resident is leaving a room or area do not, in and of themselves, restrict freedom of movement and should not be considered restraints. B. "Chemical restraints" means any psychopharmacologic drug that is used for discipline or convenience and is not required to treat medical symptoms. C. "Discipline" means any action taken by the nursing home for the purpose of punishing or penalizing a resident. D. "Convenience" means any action taken solely to control resident behavior or maintain a resident with a lesser amount of effort that is not in the resident's best interest. E. "Emergency measures" means the immediate action necessary to alleviate an unexpected situation or sudden occurrence of a serious and urgent nature. This MN Requirement is not met as evidenced by: Based on observation, interview, and document	2 505	Corrected	

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2 505	Continued From page 3 review the facility failed to adequately assess for appropriate use and alternative interventions for 2 of 3 residents (R85, R97) observed to have grab bars on both sides of their beds. Findings include: R85's room was observed on 6/4/18, at 12:05 p.m. The grab bar on R85's bed were detached on one side and moved 90 degrees from the locked position. At 6:40 p.m. R85 was observed lying in the bed with both grab bars detached on one side and able to move away from the lock position. Nursing assistant (NA-G) was asked about the grab bars and stated the grab bars were always like that. NA-G explained that staff would lock them in place and R85 would unlock them. NA-G stated she would notify the nurse regarding the grab bar. A review of R85's record on 6/5/18, identified R85 had a diagnoses of Huntington's disease and cognitive impairment. A Safety Device Data Collection and Assessment dated 8/16/17, did not indicate alternative devices or interventions were tried. R85's fall Care Area Assessment (CAA) dated 3/1/18, indicated R85 had difficulty with balance and was a fall risk. During interview on 6/6/18, at 8:41 a.m. with registered nurse (RN-B) stated the grab bars are only attached on one side because the resident insisted on having them that way. RN-B also stated the care plan needed to be updated to include that. RN-B stated the grab bar was not ok to be partially detached. RN-B stated not being sure if R85 could get up and out of bed without a grab bar and needed to be reassessed. RN-B planned to discuss the issue with the director of nursing (DON) and maintenance director (MD-A).	2 505		

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2 505	Continued From page 4 The Joerns Assist Handle Two-Position Model F026 manufacturer's user manual for the grab bars being used copywrite date of 2015 was reviewed and indicated the grab bar needed to be in the locked position prior to leaving the resident unattended. R97's , on 6/5/18, at 8:52 a.m. bilateral grab bars were observed to be attached to R97's bed. R97 was asked about the grab bars, but did not respond to questions. On 6/6/18, at 8:37 a.m. RN-B was interviewed rearding R97's grab bars and asked about a side rail assessment. RN-B stated, "I missed his assessment." RN-B added remembering R97 had them put on because grab bars are on the house standing orders. RN-B stated an assessment should have been done. On 6/6/18, at 12:35 p.m. a review of R97's record identified R97 was admitted to the facility with diagnoses of dementia with behavioral disturbance, mood disorder and idiopathic peripheral autonomic neuropathy. Review of R97's care plan dated 5/29/18, did not indicate R97 used bilateral grab bars. During an interview with the DON on 6/7/18 at 12:05 p.m. the DON stated assessments needed to be done on admission, quarterly and with significant change. The DON added the assessment needed to include safety devices and show that alternative interventions were tried. Review of the Villa Bed Inspection Policy dated 11/28/17 indicated the resident was to be screened on admission, readmission, and with change of condition for level of independent bed	2 505		

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2 505	Continued From page 5 mobility, special equipment or accessories (e.g. side rails) to include evaluate for appropriate alternatives and entrapment risk. Also the risks and benefits and informed consent must be obtained. SUGGESTED METHOD OF CORRECTION: The Administrator, DON or designee, could develop and implement policies and procedures related to assessment of resident for use of side rails or grab bars and alternative interventions. The Administrator, DON or designee, could provide training for all nursing staff related to the policies and procedures. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 505		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must	21426		7/17/18

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21426	Continued From page 6 be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the agency failed to ensure 2 of 5 residents (R403, R88) and 3 of 6 employees (E-3, E-4, E-6) were properly screened for Tuberculosis (TB) per State regulation. Findings include: R403 was admitted to the facility on 5/25/18. The medical record indicated R403's had a symptom screen completed on 5/25/18, however, the medical record revealed R had not received TST, chest x-ray or blood test completed to check for TB within 48-72 hours as directed by the State regulation. R88 was admitted to the facility on 5/10/18. The medical record indicated R88 was administered a first and second step TST on 5/11/18, and 5/21/18, respectively however, the medical record revealed no symptom screen questionnaire had been completed within 48-72 hours as directed by the State regulation. On 6/5/18, at 12:15 p.m. registered nurse (RN)-D verified and stated the staff was supposed to have administered R the TST and she was going to schedule it. RN-D further stated the staff nurses were supposed to complete a symptom screen form for each new admit before administering the TST per the TB regulation.	21426	Corrected	

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21426	Continued From page 7 E-3's personnel file identified a hire date of 1/16/18. Review of the file indicated E-3 had a chest x-ray due past positive TB test however, the file lacked documentation E-3 had completed a symptom screen as directed by the State regulation. E-4's personnel file identified a hire date of 3/25/18, however, the file revealed E-4 lacked documentation of any TB screening as directed by the State regulation before providing direct care. E-6's personnel file identified a hire date of 5/27/18, however, the file revealed E-6 lacked documentation of any TB screening as directed by the State regulation before providing direct care. On 6/6/18, at 2:24 p.m. the administrator stated she had not been able to find the TB screening information for all the staff and all the staff were being screened since the concern was brought to her attention. SUGGESTED METHOD OF CORRECTION: The Director of nursing and/or designee could review and revise policies and procedures, train staff and monitor to assure Tuberculin Skin Tests (TST) are read, results documented; and assure that employees are screened for tuberculosis (TB) using a symptom screen, and by either a single step IGRA (Interferon Gamma Release Assay blood test) or a two-step TST and documented appropriately per State regulation. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21426		

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21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain a sanitary environment in the first floor shower room and resident rooms; 108, 304, 311, 317 and 318. This had the potential to affect all residents using the first floor shower room, the residents residing the the five rooms identified and residents residing on the secured unit. Findings include: On 6/4/18, during the initial tour of the facility, the following environmental concerns were observed: - The first floor shower room floor was dirty, there was a black substance in the tile grout on the wall, and missing pieces of tile in the corner of the wall just inside the door to the right. - Room 108, the sink cabinet had moisture damage around the bottom of the side of the cabinet and was missing a piece of the wood in the bottom corner against the wall. - Room 304, the protective plate on the door was detached on the bottom left corner, and at the end of the first bed on the floor was a green substance. - Room 311, there was a tan substance staining	21665	Corrected	7/17/18

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21665	Continued From page 9 the wall over the bed nearest to the door. - Room 317, the sink cabinet had moisture damage and exposed the particle board underneath. - Room 318 the left window blind had 2 broken slats leaving gaps in the blind and the broken slats had jagged edges; finally in the third floor dining room the sink cabinet finish was peeling off exposing the particle board underneath and on the wall next to the sink there was exposed sheet rock in an area approximately four inches by two inches in size. On 6/5/18, at 10:16 a.m. housekeeper (H)-A was shown the wall and cabinet and acknowledged not being able to clean those areas. H-A stated the protocol was to fill out a maintenance request and turn it into the supervisor. On 6/6/18, the magnetic lock doors on the third floor between the east and west sides were not functioning to secure the east side. H-A was shown the door and stated it needed to get reported right away. H-A did report it to the nursing staff on east side of the hall. The administrator and maintenance director (MD)-A were also notified. When MD-A was asked about how the doors were checked, MD-A stated there was not a system for checking the doors. On 6/7/18, at 9:00 a.m. tour of the facility was completed with MD-A, environmental services supervisor (ESS)-A and the Administrator. The concerns noted above were discussed. The administrator and ESS-A stated the sink cabinets and exposed sheet rock in the third floor dining room were not cleanable surfaces and would need to be replaced or repaired right away. MD-A	21665		

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21665	Continued From page 10 stated the process for checking rooms was three rooms were checked for concerns daily. MD-A stated being able to check every room each month. MD-A stated the rooms were check for lights, temperature, water temperature and any other concerns. When asked about the common areas such as the dining room on third floor east, MD-A stated he had not been checking those areas. MD-A stated the facility was attempting to order new window blinds for room 318, but was unable to provide a maintenance request or any document showing the facility had ordered the blinds, but the blinds were back ordered. At 9:40 a.m. MD-A was shown first floor shower room. MD-A noted the missing tile corner and stated that needed to get fixed right away. At 9:45 a.m. ESS-A stated the showers were deep cleaned monthly and it was time for the shower room to be deep cleaned. On 6/7/18, the log of room checks from April and May 2018, were reviewed. There were no notations of sink cabinets being damaged nor was there a place to make notation of common areas to be checked. On 6/7/18, at 12:20 p.m. during and interview the administrator stated all staff received education on filling out a maintenance request when they are hired, along with customer service and stated ensuring rooms were in good repair and clean was part of the customer service training. Staff were supposed tell the supervisor immediately of any repair or housekeeping need and fill out a maintenance request. The administrator stated the checks system was in place and maintenance requests were tracked by her for completion.	21665		

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21665	Continued From page 11 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		
21925	MN St. Statute 144.651 Subd. 29 Patients & Residents of HC Fac.Bill of Rights Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a	21925		7/17/18

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21925	Continued From page 12 reasonable effort to accommodate new residents without disrupting room assignments. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the ombudsman was notified of hospital transfers for 4 of 4 residents (R98, R46, R55, R1) reviewed for hospitalization. Findings include: R98's diagnoses included heart failure, coronary artery disease, hypertension, renal insufficiency, renal failure and diabetes mellitus obtained from the admission Minimum Data Set (MDS) dated 4/9/18. In addition the MDS identified R98 had intact cognition and had been discharged to a hospital on 5/11/18. A review of the interdisciplinary notes revealed on 5/11/18, a staff nurse had noted it was difficult to keep R98's oxygen level above 93% on 4-5 liters per minute and staff had concern for potential medication reaction. The note indicated the ambulance had been called at 12:05 a.m to transport R98 to the hospital. A review of the medical record lacked documentation the regional ombudsman had been informed of the facility initiated transfers to an acute care facility for R98. R46's diagnoses included fracture, coronary artery disease, hypertension, thyroid disorder and depression obtained from the admission MDS dated 4/15/18. In addtion, the MDS identified R46 had intact cognition. During further review it was revealed a discharge MDS had been completed on 4/26/18, when R46 was transferred to the	21925	Corrected	

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21925	Continued From page 13 hospital. During a review of a interdisciplinary progress note dated 4/27/18, it was revealed the emergency medical service (EMS) had transported R46 out from facility at 11:45 p.m. for evaluation related to symptoms of lethargy, hypotension and general malaise. On 6/7/18, at 11:18 a.m. the social worker designee stated she had not been notifying the ombudsman regarding any resident transfers to the hospitals as she had always thought the only time the ombudsman was notified was when a resident was discharged from the facility. R55 had diagnoses including kidney failure and diabetes indicated on the quarterly MDS dated 4/23/18. During a review of the medical record it was revealed R55 had discharge MDS's with return to the facility anticipated to a acute care facility on 2/10/18, 3/21/18, 4/5/18 and 5/21/18. On 6/6/18 at 10:45 a.m. an interview with LPN-A was revealed R55 was hospitalized for stomach issues, and had several hospitalizations for medical issues initiated by R55 however, no evidence the ombudsman had been notified for the facility initiated transfers. R1 had a diagnosis of multiple fractures indicated on the face sheet dated 5/7/18. The census record indicated R1 had been admitted on 2/23/18, and the progress note dated 5/4/18 identified R1 had been transported to the hospital for respiratory distress. The facility census records indicated R1 remained hospitalized from 5/4/18- 5/12/18 for a respiratory infection, however no documentation was in the medical	21925		

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21925	Continued From page 14 record to indicate the ombudsman had been notified for the facility initiated transfer to an acute care facility. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could assure the ombudsman is notified of residents who are discharged to the hospital and that residents and representatives are informed of bed hold rights at the time of hospitalizations. The director of nursing could review policies and procedures, train staff and monitor to assure the facility is in compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21925		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of resident to resident altercations were reported immediately to the administrator and the state agency (SA) for 2 of 2 residents (R96, R20) who were involved in	21995	Corrected	7/17/18

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 _____	C 06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 15 altercations with another resident. Findings include: R20's Admission Record identified a diagnosis of Wernicke's encephalopathy (lesions of the central nervous system) caused by Vitamin B deficiency. R20's quarterly Minimum Data Set (MDS) dated 3/24/18, indicated he had moderately impaired cognition and displayed verbal behavioral symptoms. On 6/4/18, at 1:16 p.m. during interview R20 stated he was afraid of a "guy on the floor." R20 stated the other resident came into his room in the middle of the night and tried to fight with him. After the interview R20 walked down the hall and pointed to R97's name on the door of room 318. Review of R20's nursing Progress Notes did not identify an incident with R97. R97's Admission Record indicated diagnosis that included dementia with behavioral disturbance, anxiety disorder, and major depressive disorder. R97's admission MDS dated 5/31/18, indicated he was severely cognitively impaired and displayed physical and verbal behaviors. R97's facility Progress Notes dated 6/3/18, indicated R97 was agitated and was going into other resident rooms, waking them up and trying to fight with them. The Progress Note indicated R97 was not able to be redirected. During interview on 6/6/18, at 8:50 a.m. registered nurse (RN)-B was asked about the incident between R97 and R20. RN-B described a another incident that occurred between the two residents on 6/5/18, during the supper meal.	21995		

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21995	Continued From page 16 RN-B stated R97 had grabbed R20's right arm and caused skin tears. RN-B stated the protocol for reporting resident to resident incidents was to notify the guardian, family, or responsible party, the director of nursing (DON) or Administrator and the resident's primary care provider. RN-B stated a Team Strategy Incident Report was filled out regarding the incident on 6/5/18, and an investigation was started. RN-B stated the DON was the one to call the SA and make the report. RN-B was asked about the incident between R97 and R20 on 6/3/18, when R97 went into R20's room at night and tried to fight. RN-B stated not being aware of the incident. A review of Facility Reported Incidents (FRIs) identified a report to the SA dated 6/6/18, at 10:00 a.m regarding the resident to resident altercation between R97 and R20 that occurred during supper on 6/5/18, at 5:30 p.m. On 6/7/18, at 12:05 p.m. the DON stated the incident between R97 and R20 during supper on 6/5/18 should have been report to her on 6/5/18. The DON stated she did not find out about the incident until 6/6/18, the day after the incident occurred. The DON further stated she had not been informed at all about the incident between the two residents on 6/3/18, where R97 entered R20's room at night and tried to start a fight. R96's admission MDS dated 5/30/18, indicated severely impaired cognition and wandering behaviors that placed him at risk. Further review of R97's medical record identified other incidents involving R97 and other residents. A Progress Note dated 5/28/18, indicated R97 had been going into other resident rooms, taking items from them and refused to return them. The	21995		

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21995	Continued From page 17 Progress Note indicated R97 had hit R96 in room 320, and caused a skin tear on R96's left arm. Further review of FRI's identified a report to the SA dated 5/29/18, at 9:11 a.m. that described the resident to resident altercation between R97 and R96 that occurred on 5/28/18, at 1:15 p.m. On 6/7/18, at 12:05 p.m. the DON stated she did not find out about the incident between R97 and R96 until 5/29/18, the day after the incident occurred. The DON stated the expectation was for staff to report the incident to the supervising nurse and the supervising nurse was to report to the DON or Administrator immediately. The DON stated that resident to resident altercations were supposed to be reported to the SA within two hours of the incident and stated staff received training on hire and annually on abuse reporting and there was a binder at each nursing station with the procedure to follow if an incident occurred. On 6/7/18, at 12:20 p.m. the administrator stated the requirement for reporting a resident to resident altercation to the SA was two hours, and the facility had not reported the incident on 6/5/18, (between R97 and R20) or 5/28/18, (between R97 and R96) according to that requirement. Review of the Villa's Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property policy dated 11/28/17, indicated "The Nursing Home Administrator or designee will report abuse to the state agency per State and Federal requirements immediately." The policy also indicated occurrences, patterns and trends that may constitute abuse will be investigated. In section E.(a) of the policy the staff is instructed	21995		

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21995	Continued From page 18 when an incident or suspected incident of "abuse" is reported, the Administrator or designee will investigate the incident with the assistance of appropriate personnel. In the section F (a)(iii) indicated "if the alleged perpetrator is a facility resident he staff member will immediately removed the perpetrator from the situation and another staff member will stay with the alleged perpetrator and wait for further instruction from the adminsitration, if possible." In section G.(a) the staff are instructed to report any abuse or suspicion of abuse immediately to the Adminstrator. SUGGESTED METHOD OF CORRECTION: The Administrator, DON or designee, could develop and implement policies and procedures related to reporting allegations of resident to resident altercations. The Administrator, DON or designee, could provide training for all nursing staff related to the policies and procedures. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21995		