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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Y761

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00253

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/18/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Pat Sheehan, Supervisor SFM 06/18/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 06/18/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00450
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/10/2015
(L33)

Posted 07/09/2015 Co.

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5492

On June 18, 2015, A Life Safety Code (LSC) Post Certification Revisit (PCR) was completed to verify correction of deficiencies cited at K0033 and K0038 pursuant to a Federal Monitoring Survey (FMS) completed on February 24, 2015 and approved for a temporary waiver with a completion date of June 30, 2015. Based on our PCR it was determined the remaining deficiencies were corrected as of June 5, 2015.

Refer to the CMS 2567b form for the results of this visit.

Protecting, Maintaining and Improving the Health of Minnesotans

June 18, 2015

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

RE: Project Number F5492024

Dear Ms. Buytendorp:

On March 10, 2015, CMS Region V Office informed you that they would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 12, 2015 and the Federal Monitoring Survey (FMS) completed on February 24, 2015. The surveys found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On May 15, 2015, we notified you that, based on our follow-up visit completed on March 27, 2015, by the Minnesota Department of Health by review of your plan of correction, and on May 11, 2015 by the Minnesota Department of Public Safety, we determined that your facility had corrected the deficiencies issued pursuant to our February 12, 2015 standard survey and the February 24, 2015 FMS, effective May 11, 2015. In addition, your request for a temporary waiver involving the Life Safety Code deficiencies cited at K033 and K0038, including the original date of completion of June 30, 2015, had been approved.

As a result of recent correspondence and submitted documentation, a follow up was conducted on June 18, 2015 and verify correction of the remaining FMS Life Safety Code deficiencies cited at K0033 and K0038 were completed on June 18, 2015 and the deficiencies were found to be corrected as of June 5, 2015. Enclosed is a copy of the Post Certification Revisit Form (CMS-2567B) from this visit.

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

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245492	A. Building B. Wing **01 - MAIN BUILDING 01**	6/18/2015

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0033	**06/05/2015**	ID Prefix Reg. # **NFPA 101** LSC K0038	**06/05/2015**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/mm	06/18/2015	03049	06/18/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:
2/24/2015

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

Meath, Mark (MDH)

From: Sheehan, Pat (DPS)
Sent: Thursday, June 18, 2015 8:20 AM
To: Whitney, Marian (DPS); Meath, Mark (MDH)
Cc: jbuytendorp@extendicare.com
Subject: FW: Correction Details
Attachments: Fire damper in Hallway.JPG; Fire damper in Hallway 1st floor.JPG; Make-Up Air Unit.JPG

Marian and Mark – effective June 5th, Richfield HC is now in compliance with K33 and K38 for which they had the temporary waiver for.

Patrick Sheehan, Fire Safety Supervisor
Office: 651-201-7205 Cell: 651-470-4416
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division Est. 1905
445 Minnesota St., Suite 145, St Paul, MN 55101-5145
FAX: 651-215-0525
Web: fire.state.mn.us

From: Buytendorp, JoAnn [mailto:JBuytendorp@extendicare.com]
Sent: Wednesday, June 17, 2015 4:00 PM
To: Sheehan, Pat (DPS)
Subject: Correction Details

Mr. Sheehan,

On June 5th, 2015 Richfield Health Center corrected K33. Fire dampers were installed on the first , second and third floor west and east stair enclosure and in the hallways. Photos are attached.

On June 5th, 2015 Richfield Health Center corrected K38. The Head room clearance at the landing on the first, second and third levels in both the west and east stairways are know with in regulation. Photos are attached.

Please let me know if you need more information. Thank you.

JoAnn Buytendorp LNHA
Administrator
Richfield Health Center
JBuytendorp@extendicare.com
612-861-1691

Please note: My email address will be changing to jbuytendorp@richfieldskillednursing.com as of July 1.

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: Y761

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/27/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gayle Lantto, Unit Supervisor 05/15/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 05/15/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00450
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/10/2015
(L33)

DETERMINATION APPROVAL

CCN: 24 5492

On March 27, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 11, 2015, the Minnesota Department of Public Safety completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 12, 2015 and an Federal Monitoring Survey (FMS) completed on February 24, 2015. We presumed, based on your plan of correction, that the facility had corrected these deficiencies as of May 11, 2015. Based on our PCR, we have determined that the facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 12, 2015 and the FMS completed on February 24, 2015, effective May 11, 2015.

As a result of the revisit findings, this Department recommended to the CMS Region V Office the following action related to the remedy outlined in their letter of March 10, 2015. The CMS Region V Office concurs and has authorized this Department to notify the facility of following action:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 12, 2015 be rescinded. (42 CFR 488.417(b)).

Correction of the Life Safety Code deficiencies cited under K33 and K38 at the time of the February 24, 2015 FMS survey, have not yet been verified. The facility's plan of correction for these deficiencies, including their request for a temporary waiver with a date of completion of June 30, 2015, has been approved. The facility's request for a continuing waiver involving the deficiency cited under K67 at the time of the February 12, 2015 has been forwarded to CMS for their review and determination. Approval has been recommended based on submitted documentation.

In accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), the facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 12, 2015, due to denial of payment for new admissions. Since the facility attained substantial compliance, the original trigger remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Refer to the CMS 2567b forms for the results of this visit.

Effective May 11, 2015, the facility is certified for 118 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24 5492

May 15, 2015

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

Dear Ms. Buytendorp:

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

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

Effective May 11, 2015 the above facility is certified for:

118 Skilled Nursing Facility/Nursing Facility Beds

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

Your request for waiver of K67 has been recommended for approval based on the submitted documentation. You will receive notification from CMS only if they do not concur with our recommendation. Your request for waiver of K33 and K38, has been approved based on the submitted documentation.

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 deficiencies or renew your request for waiver in order to continue your participation in the Medicare 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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

May 15, 2015

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

RE: Project Number S5492025 and F5492024

Dear Ms. Buytendorp:

On March 2, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 12, 2015. 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 February 24, 2015, a surveyor representing the Region V Office of the Centers for Medicare and Medicaid Services (CMS), completed a Federal Monitoring Survey (FMS) of your facility. As the surveyor informed you during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The most serious deficiencies at the time of the FMS were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), where corrections were required. On March 10, 2015, CMS forwarded the results of the LSC FMS and notified you that your facility was not in substantial compliance with the Federal requirements for nursing homes participation in the Medicare and Medicaid programs and that they were imposing the following enforcement remedy:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 12, 2015 (42 CFR 488.417(b)).

Also, the CMS Region V Office notified you in their letter of March 10, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 12, 2015.

On March 27, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 11, 2015, the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 12, 2015 and an FMS completed on February 24, 2015.

We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 11, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 12, 2015 and the FMS completed on February 24, 2015, effective May 11, 2015.

As a result of the revisit findings, this Department recommended to the CMS Region V Office the following action related to the remedy outlined in their letter of March 10, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of following action:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 12, 2015 be rescinded. (42 CFR 488.417(b)).

Correction of the Life Safety Code deficiencies cited under K33 and K38 at the time of the February 24, 2015 FMS survey, have not yet been verified. Your plan of correction for these deficiencies, including your request for a temporary waiver with a date of completion of June 30, 2015, has been approved. Your request for a continuing waiver involving the deficiency cited under K67 at the time of the February 12, 2015 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.

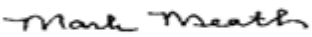
However, as CMS notified you in their letter of March 10, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 12, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance, the original trigger remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

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

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

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245492	A. Building B. Wing	3/27/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **03/18/2015**	ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **03/18/2015**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **03/18/2015**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **03/18/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **03/18/2015**	ID Prefix **F0332** Reg. # **483.25(m)(1)** LSC	Correction Completed **03/18/2015**
ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **03/18/2015**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **03/18/2015**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **03/18/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GL/mm	05/15/2015	15507	03/27/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/12/2015			

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Midwest Division of Survey and Certification
Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519

CMS Certification Number (CCN): 245492

March 10, 2015
By Certified Mail and Facsimile

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

Dear Ms. Buytendorp:

SUBJECT: FEDERAL MONITORING SURVEY RESULTS AND NOTICE OF IMPOSITION OF REMEDY
Cycle Start Date: February 12, 2015

STATE SURVEY RESULTS
On February 11, 2015, a life safety code survey and on February 12, 2015, a health survey were completed at Richfield Health Center by the Minnesota Department of Health (MDH) determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs. These surveys found that your facility was not in substantial compliance, with the most serious deficiency at scope and severity (S/S) level F, cited as follows:

- K67 -- S/S: F -- NFPA 101 -- Life Safety Code Standard

The State agency advised you of the deficiencies that led to this determination and provided you with a copy of the survey reports (CMS-2567).

FEDERAL MONITORING SURVEY
In its notice dated March 2, 2015, the Minnesota Department of Health informed you that your facility could avoid the imposition of remedies if substantial compliance was achieved by March 24, 2015. Before a revisit was conducted, however, a surveyor representing this office of the Centers for Medicare & Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility on February 24, 2015. As the surveyor informed you during the exit conference, the FMS revealed that your facility continues to not be in substantial compliance. The FMS found deficiencies, with the most serious being at S/S level F, cited as follows:

- K20 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K38 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K46 -- S/S: F -- NFPA 101 -- Life Safety Code Standard

- K48 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K52 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K54 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K62 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K66 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K67 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K144 -- S/S: F -- NFPA 101 -- Life Safety Code Standard

The findings from the FMS are enclosed with this letter on form CMS-2567.

PLAN OF CORRECTION

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (POC) for the enclosed deficiencies cited at the FMS. An acceptable POC will serve as your allegation of compliance. Upon receipt of an acceptable POC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable POC can lead to termination of your Medicare and Medicaid participation.

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

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

The POC must be signed and dated by an official facility representative. Send your POC to the following address:

Bruce Wexelberg, Safety Engineer
Centers for Medicare & Medicaid Services
Division of Survey and Certification
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

INFORMAL DISPUTE RESOLUTION

The State agency offered you an opportunity for informal dispute resolution (IDR) following its survey visits. A request for IDR will not delay the effective date of any enforcement action. However, IDR results will be considered when applicable.

CMS has established an informal dispute resolution (IDR) process to give providers one opportunity to informally refute deficiencies cited at a Federal survey, in accordance with the regulation at 42 CFR 488.331. To use this process, you must send your written request,

identifying the specific deficiencies you are disputing to, Stephen Pelinski, Branch Manager, at the Chicago address shown above. The request must set forth in detail your reasons for disputing each deficiency and include copies of all relevant documents supporting your position. A request for IDR will not delay the effective date of any enforcement action, nor can you use it to challenge any other aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

You must submit your request for IDR within the same ten (10) calendar day timeframe for submitting your POC. You must provide an acceptable POC for all cited deficiencies, including those that you dispute. We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

LIFE SAFETY CODE (LSC) WAIVERS

If you request an annual waiver for a LSC deficiency cited during the FMS, the request must indicate why correcting would impose an unreasonable hardship on the facility; if high cost is the hardship, you must include recent, bona fide cost estimates. In addition, the request must indicate how continued non-correction of the deficiency will not pose a risk to resident safety, based on additional compensating features or other reasons.

Each cited deficiency (other than those which receive annual waivers) must be corrected within a reasonable timeframe. If a reasonable correction date falls beyond your enforcement cycle's three month date, you may request a temporary waiver to allow correction by the reasonable date, and without the noncompliance leading to the imposition of remedies. Include a request for a temporary waiver as part of your POC, indicating the basis for the length of correction time needed, and include a timetable for correction. A temporary waiver may be granted if the POC date extends beyond your enforcement cycle's three month date, and if the correction timeframe is reasonable, in CMS' judgment. Your enforcement cycle's three month date is May 12, 2015.

SUMMARY OF ENFORCEMENT REMEDIES

As a result of the survey findings, we are imposing the following remedy:

- Mandatory Denial of Payment for New Medicare & Medicaid Admissions effective May 12, 2015

The authority for the imposition of remedies is contained in subsections 1819(h) and 1919(h) of the Social Security Act ("Act") and Federal regulations at 42 CFR Subpart F, Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

DENIAL OF PAYMENT FOR NEW ADMISSIONS

Mandatory denial of payment for all new Medicare admissions is imposed effective May 12, 2015 if your facility does not achieve compliance within the required three months. This action is mandated by the Social Security Act at Sections 1819(h)(2)(D) and 1919 (h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). We are notifying National Government Services that the denial of payment for all new Medicare admissions is effective on May 12, 2015. We are further notifying the State Medicaid agency that they must also deny payment for all new Medicaid admissions effective May 12, 2015.

You should notify all Medicare and Medicaid residents admitted on or after this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new Medicare admissions includes Medicare beneficiaries enrolled in managed care plans. It is your obligation to inform Medicare managed care plans contracting with your facility of this denial of payment for new admissions.

TERMINATION PROVISION

If your facility has not attained substantial compliance by August 12, 2015, your Medicare and Medicaid participation will be terminated effective with that date. This action is mandated by the Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

We are required to provide the general public with notice of an impending termination and will publish a notice in a local newspaper prior to the effective date of termination. If termination goes into effect, you may take steps to come into compliance with the Federal requirements for long term care facilities and reapply to establish your facility's eligibility to participate as a provider of services under Title XVIII of the Social Security Act. Should you seek re-entry into the Medicare program, the Federal regulation at 42 CFR Section 489.57 will apply.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $5,000.00; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by May 12, 2015, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Richfield Health Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 12, 2015. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

APPEAL RIGHTS

This formal notice imposed:

- Mandatory Denial of Payment for New Medicare & Medicaid Admissions effective May 12, 2015

If you disagree with the findings of noncompliance which resulted in this imposition, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. seq.

You are required to file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/. To file a new appeal using DAB EFile, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB EFile is restricted to the appeals for which he is a party or authorized representative. Once registered, you may file your appeal by:

- Clicking the **File New Appeal** link on the Manage Existing Appeals screen, then clicking **Civil Remedies Division** on the File New Appeal screen.
- Entering and uploading the requested information and documents on the "File New Appeal-Civil Remedies Division" form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. The DAB will set the location for the hearing. Counsel may represent you at a hearing at your own expense.

All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions for using DAB E-File in cases before the DAB’s Civil Remedies

Division can be found by clicking the button marked **E-Filing Instructions** after logging-in to DAB E-File.

For questions regarding the E-Filing system, please contact E-File System Support at **OSDABImmediateOffice@hhs.gov** or at 202-565-0146.

Please note that **all** hearing requests must be filed electronically unless you have no access to the internet or a computer. In those circumstances, you will need to provide an explanation as to why you are unable to file electronically and request a waiver from e-filing with your written request. Such a request should be made to:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, D.C. 20201

A request for a hearing must be filed no later than 60 days from the date of receipt of this notice.

It is important that you send a copy of your request to our Chicago office to the attention of Jan Suzuki.

CONTACT INFORMATION
If you have any questions regarding the Federal Monitoring LSC survey, please contact Bruce Wexelberg, Safety Engineer, at (312) 353-2859. Bruce Wexelberg's fax number is (443) 380-6756. For questions regarding this enforcement case, please contact Jan Suzuki, Program Representative, at (312) 886-5209. Information may also be faxed to (443)380-6602. All correspondence should be directed to Jan Suzuki in our Chicago office.

Sincerely,

/s/

Tamika J. Brown
Acting Branch Manager
Long Term Care Certification
& Enforcement Branch

Enclosure: Statement of Deficiencies (CMS-2567)

cc: Minnesota Department of Health
Minnesota Department of Human Services

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245492	A. Building B. Wing **01 - MAIN BUILDING 01**	5/11/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **03/20/2015**	ID Prefix	Correction Completed **05/11/2015**	ID Prefix	Correction Completed **03/16/2015**
Reg. # **NFPA 101** LSC K0018		Reg. # **NFPA 101** LSC K0020		Reg. # **NFPA 101** LSC K0021	
ID Prefix	Correction Completed **03/16/2015**	ID Prefix	Correction Completed **03/16/2015**	ID Prefix	Correction Completed **03/10/2015**
Reg. # **NFPA 101** LSC K0027		Reg. # **NFPA 101** LSC K0029		Reg. # **NFPA 101** LSC K0046	
ID Prefix	Correction Completed **03/16/2015**	ID Prefix	Correction Completed **04/01/2015**	ID Prefix	Correction Completed **03/15/2015**
Reg. # **NFPA 101** LSC K0048		Reg. # **NFPA 101** LSC K0052		Reg. # **NFPA 101** LSC K0054	
ID Prefix	Correction Completed **03/13/2015**	ID Prefix	Correction Completed **03/16/2015**	ID Prefix	Correction Completed **03/01/2015**
Reg. # **NFPA 101** LSC K0056		Reg. # **NFPA 101** LSC K0062		Reg. # **NFPA 101** LSC K0064	
ID Prefix	Correction Completed **03/15/2015**	ID Prefix	Correction Completed **05/11/2015**	ID Prefix	Correction Completed **03/11/2015**
Reg. # **NFPA 101** LSC K0066		Reg. # **NFPA 101** LSC K0067		Reg. # **NFPA 101** LSC K0069	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/mm	05/15/2015	28120	05/11/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
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(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **03/15/2015**	ID Prefix	Correction Completed **05/11/2015**	ID Prefix	Correction Completed **03/01/2015**
Reg. # **NFPA 101** LSC K0070		Reg. # **NFPA 101** LSC K0071		Reg. # **NFPA 101** LSC K0074	
ID Prefix	Correction Completed **03/23/2015**	ID Prefix	Correction Completed **05/11/2015**	ID Prefix	Correction Completed **03/01/2015**
Reg. # **NFPA 101** LSC K0076		Reg. # **NFPA 101** LSC K0143		Reg. # **NFPA 101** LSC K0144	
ID Prefix	Correction Completed **04/01/2015**				
Reg. # **NFPA 101** LSC K0147					

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/mm	05/15/2015	28120	05/11/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 2/24/2015

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

FAX to:

Number of Pages: 33

CCN: 245492

Name: Richfield Health Center

City, State: Richfield, MN

DPNA Date: 05/12/2015

Termination Date: 08/12/2015

FMS Survey Date: 02/24/2015

Fed Surveyor: BWW

Contr Surveyor:

S/S	Tag	POC Date or Temporary Waiver ("TW") Date or Waiver ("AW")
E	K18	POC 3/20/15
F	K20	POC 5/11/15
E	K21	POC 3/16/15
E	K27	POC 3/16/15
E	K29	POC 3/16/15
E	K33	**#1 & #2 TW 6/30/15**, #3 & #4 POC 3/20/15
F	K38	#1, #4, #5, #6 POC 4/30/15, **#2 & # 3 TW 6/30/15**
F	K46	POC 3/10/15
F	K48	POC 3/16/15
F	K52	POC 4/1/15
F	K54	POC 3/15/15
B	K56	POC 3/13/15
F	K62	POC 3/16/15
C	K64	POC 3/1/15
F	K66	POC 3/15/15
F	K67	#1 POC 5/11/15 **#2 AW**
D	K69	POC 3/11/15
E	K70	POC 3/15/15
E	K71	POC 5/11/15
E	K74	POC 3/1/15
E	K76	POC 3/23/15
E	K143	POC 5/11/15 Bruce W. Wexelberg

Approved: **YES** By: Bruce W. Wexelberg Date: 05/04/2015

FAX to:

Number of Pages: 2 of 2

CCN: 245492

Name: Richfield Health Center

City, State: Richfield, MN

DPNA Date: 05/12/2015

Termination Date: 08/12/2015

FMS Survey Date: 02/24/2015

Fed Surveyor: BWW

Contr Surveyor:

S/S	Tag	POC Date or Temporary Waiver ("TW") Date or Waiver ("AW")
F	K144	POC 3/1/15
D	K147	POC 4/1/15

Bruce W. Wexelberg

Approved: **YES**

By: Bruce W. Wexelberg

Date: 05/04/2015

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 _____	**02/24/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 2/24/15 following a Minnesota Department of Health Survey on 2/11/15. At this Comparative Federal Monitoring Survey, Richfield Health Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101 - 2000 edition. Richfield Health Center is a three story building with a basement of Type II (222) construction that was constructed in 1966. The building is fully sprinklered and there is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms on the first three floors. In the basement smoke detectors are located at the smoke barrier doors. The facility has 118 certified beds. All 118 beds are dually certified for Medicare and Medicaid. At the time of the survey the census was 92. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is	K 018		

RECEIVED
MAR 24 2015
CMS-V-DS&C

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

JoAnn Brynteson | Administrator | 3/20/15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245492	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	Continued From page 1 no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide corridor doors in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.6.2, 19.3.6.3.1 and 19.3.6.3.2. This deficient practice could affect approximately 30 of the 92 residents. Findings include: 1. On 2/24/15 at 1:17pm, observation revealed that the corridor door to the third floor soiled utility room by room 315 did not latch when tested three out of three times. 2. On 2/24/15 at 1:31pm, observation revealed that there were double doors in the corridor wall by room 211 and the inactive leaf was not automatically positive latching. The active leaf latches into the inactive leave. If the inactive leaf was not automatically positively latched the entire door assembly would not be positively latched.	K 018	The corridor door to the third floor soiled utility room by room 315 was repaired on 3/9/15 and it does latch. The double doors in the corridor wall by room 211 were repaired and an automatically positive latch was installed on 3/16/15. The double doors in the corridor wall by room 111 were repaired and an automatically positive latch was installed on 3/13/15. The corridor door to the employee lounge was repaired on 3/10/15. An Audit was done on all the doors in the center to ensure all doors had a positive latch. Maintenance will do similar audits quarterly to ensure future compliance. Completion date 3-20-15	

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 _____	02/24/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	Continued From page 2 3. On 2/24/15 at 1:55pm, observation revealed that there were double doors in the corridor wall by room 111 and the inactive leaf was not automatically positive latching. The active leaf latches into the inactive leave. If the inactive leaf was not automatically positively latched the entire door assembly would not be positively latched. 4. On 2/24/15 at 3:15pm, observation revealed that there were three 1/4" holes in the corridor door to the basement employee lounge. These findings were confirmed by the Facility Administrator and the Maintenance Assistant Employee E1 at the time of discovery.	K 018		
K 020 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to maintain vertical opening protection as required by NFPA 101 - 2000 edition, section 19.3.1, 19.3.1.1, 8.2.2.2, 8.2.3, 8.2.3.2.3 and 8.2.5. This deficient practice could affect all 92 residents. Findings include: 1. On 2/24/15 at 11:40am, observation revealed that the toilet exhaust vents are not protected with	K 020		

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 _____	02/24/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 020	Continued From page 3 a fire damper where the horizontal portion of the duct exits the vertical shaft. An interview with the Maintenance Assistant at the time of observation revealed that all of the resident room toilet exhausts had a similar configuration. When asked if all of the toilet exhausts were the same the Maintenance Assistant replied, "Yes," 2. On 2/24/15 at 11:42am, observation revealed that there was no fire damper protecting the first floor 12" by 30" fresh air supply vent by room 109 where it opened from the rated vertical shaft. 3. On 2/24/15 at 2:53pm, observation revealed that there was no fire damper in the 12" by 30" duct penetration of the generator room fire rated wall which was part of the fire rated enclosure of the vertical enclosure. These deficient practices were confirmed by the Facility Administrator and the Maintenance Assistant Employee E1 at the time of discovery.	K 020	It was discovered that the Bathroom exhaust system does have fire dampers where the horizontal portion of the duct exits the vertical shaft. These dampers will be inspected and exercised. The fresh air supply vent by room 109 and the duct penetration in the generator room will have fire dampers installed and tested by a qualified contractor. All of these dampers will be put on a regular schedule to inspect and exercise to meet code. Maintenance Director will monitor this for future compliance. Completion Date 5-11-15	
K 021 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed.	K 021		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 021	Continued From page 4 19.2.2.2.6, 7.2.1.8.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that all doors that were required to be self-closing were self-closing if the sprinkler system or fire alarm system activated in accordance with the requirements of NFPA 101 - 2000 edition, Section 19.2.2.2.6, 7.2.1.8, 7.2.1.8.2 and NFPA 72 - 1999 edition, section 2.10.6. The deficient practice could affect approximately 30 of the 92 residents. Findings include: On 2/24/15 at 2:35pm, observation revealed that the magnetic hold open device on the door between the kitchen and the dinning room was loose and hanging from the soffit and did not work properly when tested. This finding was confirmed the Facility Administrator and the Maintenance Assistant Employee E1 at the time of discovery.	K 021	The magnetic hold device on the door between the kitchen and the dining room was repaired on 3/9/15. An audit was done on all other magnetic hold open devices in the center to ensure no similar deficiencies were present. Maintenance will monitor these devices during daily rounds to ensure future compliance. Completion date 3-16-15	
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in	K 027		

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K 027	Continued From page 5 accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to provide and maintain doors in smoke barrier walls as required by NFPA 101 - 2000 edition, section 19.3.7, 19.3.7.1, 19.3.7.6, 8.3 and 8.3.4. This deficient practice could affect approximately 30 of the 92 residents. Findings include: 1. On 2/24/15 at 1:09pm, observation revealed that there was a 1/4" gap at the meeting edge of the smoke barrier doors by room 312. 2. On 2/24/15 at 1:23pm, observation revealed that there was a 5/16" gap at the meeting edge of the smoke barrier doors by room 209. 3. On 2/24/15 at 1:57pm, observation revealed that there was a 3/16" gap at the meeting edge of the smoke barrier doors by room 109. 4. On 2/24/15 at 2:37pm, observation revealed that there was a 3/16" gap at the meeting edge of the smoke barrier doors in the basement. These findings were confirmed by the Facility Administrator and the Maintenance Assistant Employee E1 at the time of discovery.	K 027	All smoke barrier doors were inspected and adjusted to ensure that there was no greater than a 1/8 inch gap between the doors. Maintenance will monitor for future compliance during daily rounds and during the weekly fire alarm test. Completion date 3-16-15	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 029		

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K 029	Continued From page 6 One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain hazardous areas in accordance with the requirements of NFPA 101 - 2000 edition, sections 19.3.2.1 and 8.4.1. This deficient practice could affect approximately 20 of the 92 residents. Findings include: 1. On 2/24/15 at 2:20pm, observation revealed that the door to the kitchen was blocked open with a wooden wedge and was not self-closing. 2. On 2/24/15 at 2:48pm, observation revealed that there was a 2-1/2" hole in the door to the soiled linen discharge room in the laundry room. The hardware was missing from the door. 3. On 2/24/15 at 2:57pm, observation revealed that the door to the maintenance shop rubbed on the floor and was not self-closing. These deficient practices were confirmed by the	K 029	The wooden wedge used to block the kitchen door was removed on 2/24/15. Staff education regarding this deficient practice was completed on 3/2/15. This Kitchen door will be monitored by the dietary manager for future compliance. The hardware was replaced on the door to the soiled linen discharge room in the laundry room and there are no longer any holes. This was done on 3/16/15. The door to the maintenance shop was adjusted to not rub on the floor on 3/12/15 and is now self closing. An audit of all doors was completed to make sure there were no others that were propped open, had any type of holes in them, or did not close for any reason. The Maintenance director will ensure future compliance by conducting a similar audit quarterly. Completion date 3-16-15	

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K 029	Continued From page 7 Facility Administrator and the Maintenance Assistant Employee E1 at the time of discovery.	K 029		
K 033 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the vertical opening protection required by NFPA 101 - 2000 edition, Sections 19.2.1, 19.2.2.3, 7.2.2, 7.2.2.5, 8.2.5 and 8.2.5.4. This deficient practice could affect approximately 60 of the 92 residents. Findings include: 1. On 2/24/15 between 11:26am and 3:30pm, observation revealed that there was an air duct penetration of the west stair encloure on the first, second and third floors that were not protected with a fire damper. 2. On 2/24/15 between 11:26am and 3:30pm, observation revealed that there was an air duct penetration of the east stair encloure on the first, second and third floors that were not protected with a fire damper. 3. On 2/24/15 at 12:51pm, observation revealed	K 033	For example 3, the ¼ inch gap above the duct penetration of the 3rd floor west stairwell has been properly fire stopped. For example 4, the conduit penetration on the west stair has been properly fire stopped. Both of these examples have a completion date of 3/20/15. For examples 1 and 2 the center would like to request a temporary waiver in order to correct this citation. We believe the citation should read that there are duct penetrations in these stairwells on the second and third floors as there are no ducts on the first floor. Having said that, this citation is related to citation K-038 as both will be corrected as part of one project. Because of circumstances beyond our control the center can not complete this correction in the allotted timeframe. The center has received quotes to replace the air handling units that are connected to these ducts. As	

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K 033	Continued From page 8 that there was a 1/4" gap in the rated shaft enclosure above the duct penetration of the third floor west stair. 4. On 2/24/15 at 2:17pm, observation revealed that on the first floor there was a conduit penetration of the west stair enclosure that was not properly firestopped. This finding was confirmed by the Facilty Administrator and the Maintenance Assistant Employee E1 at the time of discovery.	K 033	part of that project dampers will be installed where they penetrate the stairwell wall. Our contractors have told us that these units are typically made at the manufacturer as they are ordered and are usually 6 to 8 weeks before they are shipped to them. Once they are received the contractor says it will take a month to install these four units and in turn these dampers. We would like to request a Temporary Waiver for this citation with a completion date of 6-30-15.	
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the means of egress in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.2.1, 19.2.2, 7.1.5, 7.1.10, 7.2.1.13 and 7.7.3. This deficient practice could affect all 92 residents. Findings include: 1. On 2/24/15 at 8:30am, observation revealed that the west stair continued to the basement and there was no basement stair interruption on the level of exit discharge. 2. On 2/24/15 between 11:20am and 3:30pm,	K 038	K038 A safety swing gate has been ordered and will be installed in the west stair by 4/15/15. A safety swing gate has been ordered and will be installed in the east stair on 4/15/15. A delayed egress bar has been ordered and will be installed on the east exit locked gate by 4/30/15. The snow and ice on the discharge exit side walk was removed on 2/24/15. The maintenance department is responsible for removing all snow and Ice at all exits of the building. . The Maintenance Director/Administrator will be responsible for compliance.	

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K 038	Continued From page 9 observation revealed that the headroom clearance at the landing on the first, second and third levels in the west stair varied between 6'-8" to 5'-9" for a 32" section of the stair. 3. On 2/24/15 between 1:21pm and 3:30pm, observation revealed that the headroom clearance at the landing on the first, second and third levels in the east stair varied between 6'-8" to 5'-9" for a 32" section of the stair. 4. On 2/24/15 at 1:46pm, observation revealed that the east stair continues to the basement and there was no basement stair interruption on the level of exit discharge. 5. On 2/24/15 at 1:51pm, observation revealed that there was a locked gate in the exit discharge from the east exit stair. 6. On 2/24/15 at 1:52pm, observation revealed that the sidewalk that was the exit discharge from the east exit stair was covered with snow and ice. These findings were confirmed by the Facility Administrator and the Maintenance Assistant Employee E1 at the time of discovery.	K 038	For examples 2 and 3 of this citation the center would like to Request a temporary waiver. Because of circumstances beyond our control we cannot complete this correction in the allotted timeframe. The center has received quotes to remove the existing air handling units that are housed in the ceiling that have created the problem with the lack of headroom. Because these are heating units we cannot simply remove them until weather permits. These units will be replaced with units that will fit in the space and not create the headroom problem. Our contractors have told us that these units are typically made at the manufacturer as they are ordered and are usually 6 to 8 weeks before they are shipped to them. Once they are received the contractor says it will take a month to install these four units. We would like to request a temporary waiver with a completion date of 6/30/15.	
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on interview, the facility failed to provide and maintain emergency lighting in accordance with the requirements of NFPA 101 - 2000 edition,	K 046		

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K 046	Continued From page 10 Sections 19.2.8, 19.2.9 and 7.9. This deficient practice could affect all 92 residents. Findings include: On 2/24/15 at 10:26am, an interview with the Maintenance Assistant revealed that the facility had no documentation that the battery powered emergency lights were tested monthly for 30 seconds and annually for 90 minutes. When asked for the documentation that the battery powered emergency lights were tested monthly and annually the Maintenance Assistant Employee E1 replied. "I don't have that."	K 046	The emergency lights are tested monthly for 30 seconds and annually for 90 minutes. A form will be created that lists each emergency light in the center. The administrator will review the emergency lights testing monthly with the maintenance director to ensure compliance. The Maintenance Director/Administrator will be responsible for compliance. Completion date: 3/10/15	
K 048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to have a written fire safety plan that accurately addressed the evacuation of the smoke compartments as required by NFPA 101 - 2000 edition, Section 19.7.2.2. This deficient practice could affect all 92 residents. Findings include: On 2/24/15 at 9:10am, review of the undated document titled "Emergency Preparedness Plan - Fire Safety Plan dated "April 1995" revealed that the facility's written fire safety plan did not address evacuation of the smoke compartment.	K 048	The Emergency Preparedness Plan-Fire Safety Plan was reviewed and updated on 3/16/15 to include the evacuation of the smoke compartments. All staff will be educated on the policy and procedure by 4/1/15. All annual training and training upon hire will include the evacuation of smoke compartments. The Maintenance Director/Administrator will be responsible for compliance. Completion date: 4/1/15.	

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K 048	Continued From page 11 This finding was confirmed by the Facility Administrator and the Maintenance Assistant Employee E1 at the time of discovery.	K 048		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to properly document the maintenance of the fire alarm system in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 1999 edition, Sections 7-3, 7-3.1, 7-3.2, 7-5.2.2 and Figure 7-5.2.2. This deficient practice could affect all 92 residents. Findings include: On 2/24/15 at 10:00am, review of the document titled "Tyco Integrated Security Fire Alarm Inspection Testing Report" dated 12/5/14 revealed that the report did not include all of the required information. There was no inventory of all of the fire alarm devices that were located in	K 052	The fire alarm inspection testing was completed on 1/15/15 and includes the inventory of all of the fire alarm devices that are located in the facility. The inspection report was not in the building at the time of the survey. This will be scheduled on an annual basis to remain in compliance. The Maintenance Director/Administrator will be responsible for compliance. Completion date: 4/1/15.	

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K 052	Continued From page 12 the facility and there was no individual list of the initiating devices that were tested and the results of the test. This finding was confirmed by the Facility Administrator and the Maintenance Assistant Employee E1 at the time of discovery.	K 052		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on interview, the facility failed to test smoke detectors for sensitivity in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 1999 edition, Sections 7-3.1, 7-3.2, 7-3.2.1 and 7.5.2.2. This deficient practice could affect all 92 residents. Findings include: On 2/24/15 at 10:10am, an interveiw with the Maintenance Assistant revealed that the smoke detectors in the facility had not been tested for sensitivity within the last two years. When asked for the documentation showing that the smoke detectors had been tested for sensitivity within the last two years the Maintenance Assistant Employee E1 replied, "I don't have them."	K 054	On 1/15/15 all smoke detectors in the facility were tested for sensitivity. <u>The inspection report was not in the building at the time of the survey.</u> The administrator and maintenance director will review testing results and ensure that the testing is scheduled regularly to meet code and the documentation is correct and readily available at the center. The Maintenance Director/Administrator will be responsible for compliance. Completion date: 3/15/15.	
K 056 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is	K 056		

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K 056	Continued From page 13 installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to install the sprinkler system in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.5 and 9.7: NFPA 13 - 1999 edition, Section 5-1.1 and 6-2.3.4, This deficient practice could affect approximately 20 of the 92 residents. Findings include: 1. On 2/24/15 at 2:40pm, observation revealed that in the laundry room there was a 43" unsupported sprinkler pipe arm-over. 2. On 2/24/15 at 2:56pm, observation revealed that in the generator room there was a 32" unsupported sprinkler pipe arm-over. These findings were confirmed by the Facility Administrator Maintenance Assistant Employee E1 at the time of discovery.	K 056	On 3/13/15 a support was installed on the sprinkler pipe arm-over in the laundry room to make it compliant. On 3/13/15 a support was installed on the sprinkler pipe arm-over in the generator room to make it compliant. An audit of all other areas was completed to identify any other similar circumstances. The Maintenance Director/Administrator will be responsible for future compliance. Completion date: 3/13/15.	
K 062	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		

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K 062 SS=F	Continued From page 14 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to maintain its automatic sprinkler system in accordance with NFPA 101 - 2000 edition, Sections 19.3.5 and 9.7 and NFPA 25 - 1998 edition, Sections 2-2.1 and 2-4.1.4. This deficient practice could affect all 92 residents. Findings include: 1. On 2/24/15 at 2:15pm, observation revealed that there was paint on the sprinkler located at the entry to the the social services and nurse manager office suite. 2. On 2/24/15 at 2:36pm, observation revealed that there were not two spare sprinklers for each type used kept on site. These findings were confirmed by the Facility Administrator and the Maintenance Assistant Employee E1 at the time of discovery.	K 062	1. On 3/13/15 the sprinkler head located at the entry to the social services and nurse manager office suite was replaced. All other sprinkler heads were audited for similar paint spots. All sprinkler heads will be audited for paint on an annual basis by the maintenance director. All sprinkler heads found to have paint on them will be immediately replaced. 2. The facility will maintain two spare sprinkler heads per sprinkler head type within the facility at all times. Spare sprinkler heads were ordered and arrived on 3/16/15.The maintenance director will audit the spare sprinkler head box located in the boiler room monthly. The Maintenance Director/Administrator will be responsible for compliance. Completion date: 3-16-15	
K 064 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10	K 064		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 064	Continued From page 15 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to maintain fire extinguishers in accordance with NFPA 101 - 2000 edition, Sections 19.3.5.6 and 9.7.4.1 as well as NFPA 10 - 1998 edition, Section 1-6.10, 4-2.2, 4-3.4.1, 4-3.4.3 and 4-3.4.6. This deficient practice could affect all 92 residents. Findings include: On 2/24/14 between 10:24am and 3:30pm, review of the inspection tags on the fire extinguishers throughout the facility revealed that there was no indication that the extinguishers were inspected monthly. The Maintenance Assistant said that the tags had recently been replaced and the old tags showing if the fire extinguishers were inspected monthly were not retained by the facility. The facility had no proof that fire extinguishers were inspected monthly. This deficient practice was confirmed by the Facility Administrator and the Maintenance Assistant Employee E1 at the time of discovery.	K 064	The fire extinguishers were retagged on 2/4/15. All extinguisher tags will be kept at the center for at least 2 years after they have been removed from the extinguishers and will be readily available for inspection. The Maintenance Director/Administrator will be responsible for compliance. Completion date: 3/1/15	
K 066 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING	K 066		

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K 066	Continued From page 16 or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to have a smoking policy in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.7.4 and 19.7.4 (2). This deficient practice could affect all 92 residents. Findings include: On 2/24/15 at 9:25am, review of the document titled "MN Smoking Policy" dated "10/10" revealed that the policy does not address that residents that are assessed to not be responsible smokers are supervised when they smoke. This deficient practice was confirmed by the Facility Administrator and the Maintenance Assistant Employee E1 at the time of discovery.	K 066	The MN Smoking Policy was reviewed and updated on 3/1/15 to include the supervision of residents deemed not responsible to smoke independently. The administrator will review the updated list of dependent smokers weekly at the daily clinical meeting. The assigned staff person per resident will be verified at these meetings. The administrator and Director of Nursing will be responsible for compliance. Completion date: 3/15/15	
K 067	NFPA 101 LIFE SAFETY CODE STANDARD	K 067		

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K 067 SS=F	Continued From page 17 Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on interview, the facility failed to maintain the fire dampers in accordance with NFPA 101 - 2000 edition, Section 19.5.2.1 and 9.2.1; as well as, NFPA 90A - 1999 edition section 2-3.11.1, 3-3.4, 3-4.1 and 3-4.7. This deficient practice could affect all 92 residents. Finding include: 1. On 2/24/15 at 11:15am, an interview with the Maintenance Assistant revealed that there was no documentation listing all of the locations of fire dampers in the facility and there was no documentation that the fire dampers had been exercised within the last four years. 2. On 2/24/15 at 11:35am, an interview with the Maintenance Assistant revealed that the corridors had supply air only and the the resident rooms had no supply or return are and toilet exhaust that ran continually. When asked where the air supplied into the corridors is returned the Maintenance Assistant Employee E1 replied, "Through the rooms."	K 067	For the first example the center will complete an inventory of all the Fire Dampers in the building. The center will ensure that all of these dampers are inspected and exercised. The Maintenance Director will be responsible to ensure that all the dampers are put on a regular inspection and exercise schedule to comply with the code. Completion date 5-11-15 For example 2 the center would like to request an annual waiver. Please see the attached Annual Waiver request.	
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance	K 069		

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K 069	Continued From page 18 with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to install the kitchen range hood fire extinguishing system in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.2.6 and 9.2.3; NFPA 96 - 1998 edition, Section 7-5 and 7-5.1. This deficient practice could affect an indeterminate number of staff and an isolated number of residents. Findings include: On 2/24/15 at 2:30pm, observation revealed that the manual activation for the kitchen range hood system was located 15" from the cooking equipment and was not located in the path of exit or egress from the room. This finding was confirmed by the Facility Administrator and the Maintenance Assistant Employee E1 at the time of discovery.	K 069	The manual activation for the kitchen range hood system was moved and relocated at the point of exit from the kitchen on 3/11/15. The vendor will monitor annually to ensure that it is in good working condition. The Maintenance Director/Administrator will be responsible for compliance. Completion date: 3/11/15	
K 070 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to have a policy to regulate the use of	K 070		

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K 070	Continued From page 19 portable space heaters in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.7.8. This deficient practice could affect all 92 residents. Findings include: On 2/24/15 at 2:20pm, observation revealed that a portable space heater designed to look like a fire place was located in the main lobby. This finding was confirmed by the Facility Administrator and the Maintenance Assistant Employee E1 at the time of discovery.	K 070	The portable space heater designed to look like a fire place was dismantled on 3/1/15 and no longer works as a portable space heater. The maintenance director will conduct monthly audits through out the building to ensure no other portable space heaters are within the building. . The Maintenance Director/Administrator will be responsible for compliance. Completion date: 3/15/15	
K 071 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Rubbish Chutes, Incinerators and Laundry Chutes: (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor is sealed by fire resistive construction to prevent further use or is provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes comply with section 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, is provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute discharges into a trash collection room used for no other purpose and protected in accordance with 8.4. (4) Existing flue-fed incinerators are sealed by fire resistive construction to prevent further use.	K 071		

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K 071	Continued From page 20 19.5.4, 9.5, 8.4, NFPA 82 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the soiled linen chute in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.1, 19.5.4, 19.5.4.1, 8.2, 8.2.3.2.3.1, 9.5, 9.5.1 and 9.5.2. This deficient practice could affect approximately 50 of the 92 residents. Findings include: 1. On 2/24/15 at 1:16pm, observation revealed that on the third floor the soiled linen chute did not have a fire rated door assembly. 2. On 2/24/15 at 1:32pm, observation revealed that the second floor soiled linen chute, by room 215 was not a fire rated door assembly, the door frame was loose and there was a 1" hole in the shaft wall. 3. On 2/24/15 at 1:54pm, observation revealed that on the first floor the soiled linen chute did not have a fire rated assembly. These findings were confirmed by the Facility Administrator and the Maintenance Assistant Employee E1 at the time of discovery.	K 071	1 ½ hour rated and latching doors have been ordered and will be installed to replace each of these three door. **The door frame and the 1" hole in the shaft wall on the 2nd floor soiled linen chute was repaired.** Maintenance Director will monitor these doors on a regular schedule to ensure function and latching. The Maintenance Director/Administrator will be responsible for compliance. Completion date: 5-11-15	
K 074 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with	K 074		

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K 074	Continued From page 21 provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide drapery materials meeting the requirements of NFPA 101 - 2000 edition, Sections 19.7.5.1 and 10.3.1. This deficient practice could affect approximately 10 of the 92 residents. Findings include: On 2/24/15 at 2:50pm, observation revealed that in the physical therapy room there were two cubicle curtains that did not have tags indicating that they were flame retardant or met NFPA 701. When asked if he knew what the flame spread rating of the fabric material was the Facility Administrator, "I don't know."	K 074	The two cubical curtains located in the physical therapy room were replaced and new cubical curtains that have a flame spread rating on 2/25/15. All cubical curtains within the facility will have flame spread ratings. Cubical curtains will be audited quarterly to ensure compliance. The Maintenance Director/Administrator will be responsible for compliance. Completion date: 3/1/15	
K 076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 076		

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K 076	Continued From page 22 Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to store oxygen in accordance with NFPA 101 - 1999 edition, Sections 19.3.2. and 19.3.2.4; as well as NFPA 99 - 1999 edition, Sections 4-3.5.2.2, 4-3.5.2.2 (b) (2) and 8-3.1.11.2. This deficient practice could affect approximately 10 of the 92 residents. Findings include: 1. On 2/24/15 at 1:15pm, observation revealed that an unsecured oxygen cylinder was located in room 319. 2. On 2/24/15 at 1:20pm, observation revealed that an unsecured oxygen cylinder was located at the third floor east nurses station. These finding were confirmed by the Facility Administrator and the Maintenance Assistant Employee E1 at the time of discovery.	K 076	The oxygen cylinder was placed in the oxygen room and was properly secured on 2/24/15. All licensed staff was educated on the proper storage of oxygen cylinders on 3/23/15. The administrator and Director of Nursing will conduct daily audits on all floors to ensure proper storage of oxygen. The Administrator and Director of Nursing will be responsible for compliance. Completion date: 3/23/15	

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K 143	Continued From page 23	K 143		
K 143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to store and transfer liquid oxygen in a room that was protected in accordance with the requirements of NFPA 101 - 2000 edition, Section 19.3.2.4, as well as, NFPA 99 - 1999 edition, Section 8-6.2.5.2. This deficient practice could affect approximately 20 of the 92 residents. Findings include: 1. On 2/24/15 at 12:47pm, observation revealed that in room 302 a stuffed animal and fabric clothing were located directly on top of the liquid oxygen container.	K 143	1. On 2/24/15 the stuffed animal and the clothing found in room 302 and located on top of the liquid oxygen container was removed. All licensed staff was educated on not placing items on top of the liquid oxygen container on 3/23/15. The administrator and Director of Nursing will conduct daily audits on all floors. The Administrator and Director of Nursing will be responsible for compliance. Completion date: 3/23/15 2. A 1½ hour rated door assembly and self-closing unit has been ordered and will be installed. The maintenance director will audit all doors in building on a monthly basis to ensure that the self-closing units are in good working condition. The Maintenance Director/Administrator will be responsible for compliance. Completion date: 5-11-15	

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K 143	Continued From page 24 2. On 2/24/15 at 1:36pm, observation revealed that the liquid oxygen storage room by room 218 had a non-rated door assembly and the door was not self-closing. These deficient practices were confirmed by the Facility Administrator and the Maintenance Assistant Employee E1 at the time of discovery.	K 143		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to maintain the emergency generator in accordance with the requirements of NFPA 101 - 2000 edition, sections 19.5.1 and 9.1.3 and NFPA 110 - 1999 edition, sections 6-4, 6-4.1 and 6-4.2. This deficient practice could affect all 92 residents. Findings include: On 2/24/15 at 10:34am, review of the document titled "Generator Test Log" for the last 12 months revealed that the emergency generator was not load tested monthly at 30% of the name plate	K 144	The emergency generator is load tested monthly at 30% of the name plate rating for 60 minutes. The data for this test will be documented correctly each month and these records will be made readily available at the center. The Maintenance Director/Administrator will be responsible for compliance. Completion date: 3/1/15	

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K 144	Continued From page 25 rating for 30 minutes. This finding was confirmed by the Facility Administrator and the Maintenance Assistant Employee E1 at the time of discovery.	K 144	1. The cover for an electrical junction box located above the drywall duct enclosure in the second floor west stair was installed on 3/5/15. The maintenance director will review all work after any electrical work has been completed by an outside vendor. The Maintenance Director/Administrator will be responsible for compliance. Completion date: 4/1/15 2. The refrigerator located in the laundry room was unplugged from the power strip immediately on 2/24/15. All staff was educated on 3/23/15 on not utilizing power strips on refrigerator and microwaves. The maintenance director will conduct weekly rounds to ensure compliance. The Maintenance Director/Administrator will be responsible for compliance. Completion date: 3/1/15	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to properly install electrical wiring in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.5.1 and 9.1.2, as well as, NFPA 70 - 1999 edition section 210-8. This deficient practice could affect approximately one staff member and an isolated number of residents. Findings include: 1. On 2/24/15 at 11:21am, observation revealed that a cover was missing from an electrical junction box located above the drywall duct enclosure in the second floor west stair. 2. On 2/24/15 at 2:47pm, observation revealed that in the laundry room a refrigerator was plugged into an electrical powerstrip. These findings were confirmed by the Facility Administrator and the Maintenance Assistant Employee E1 at the time of discovery.	K 147		

Bruce W. Wexelberg, AIA
Safety Engineer
Department of Health and Human Services
Centers for Medicare and Medicaid Services
Midwest Division of Survey and Certification
Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519

Dear Mr. Wexelberg

Please accept this letter as our request for an annual waiver for K-67 cited on our recent Federal Monitoring survey. We believe it would be an undue financial hardship to correct this cite. We also believe that our residents will not suffer any adverse effect because of this citation.

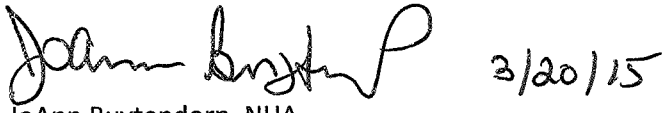
We have contacted an HVAC contractor to give us an idea of the costs that would be involved with correcting this citation. His budgetary quote is attached. You can see that his quote is $1,060,000.00. This does not take into consideration the cost of upgrading the electrical in the center to support a duct system. It also is contingent on whether it is possible to put in all the ductwork without decreasing the headroom in the corridors below the limit expressed in the code. The other contingency would be if a structural engineer would determine if it were safe to penetrate the load bearing walls to install the ducts without decreasing the structural integrity of the building.

Our center was built in 1966 which makes it almost 50 years old. The estimated life of a building of this nature is between 50 and 60 years. To upgrade with a project to this extent would not be cost effective.

We also believe that our residents will not be adversely affected if this citation is not corrected. The building is 100% sprinkled and complies with NFPA 13, 1999 edition. The existing Make up air unit completely shuts down with the activation of the fire alarm or the detection of smoke in HVAC system. All resident rooms are equipped with Smoke detection and sprinklers and the hallways are sprinkled as well as equipped with smoke detection. Our center staff is trained on fire safety upon hire and is retrained every year. We exceed the minimum standard of fire drills and conduct one each month on each shift for a total of 36 per year. Our fire alarm system is monitored and upon alarm the Richfield Fire Department is immediately dispatched. The Fire Department is 2 city blocks away from the center and typically responds within a couple of minutes to our alarm.

For these reasons we submit this letter as our request for annual Waiver of this citation.

Respectfully submitted



3/20/15

JoAnn Buytendorp, NHA

Richfield Health Center

2015 Rich. .d Health Care
Sensitivity Report

Low Voltage Contractors

Device Type	Make	Model	Description	Drift %	Range	Result	Address	Date
SMOKE(PHOTO)	Notifier	FSP-851	RESIDENT BATHROOM	048	006-093%	Passed	1D005	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ELEVATOR EQUPT RM	041	006-093%	Passed	1D006	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ELEVATOR LOBBY	052	006-093%	Passed	1D008	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ADMINISTRATOR OFFICE	046	006-093%	Passed	1D028	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	FRONT LOBBY	066	006-093%	Passed	1D030	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	MEDICAL RECORDS RM	072	006-093%	Passed	1D031	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	MAIN HALL	055	006-093%	Passed	1D033	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 106	062	006-093%	Passed	1D034	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 108	056	006-093%	Passed	1D035	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	HALL BY NURSE STAT	077	006-093%	Passed	1D036	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 110	050	006-093%	Passed	1D037	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	HALL BY NURSE STAT	072	006-093%	Passed	1D038	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	HALL BY NURSE STAT	035	006-093%	Passed	1D039	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 112	035	006-093%	Passed	1D040	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 114	053	006-093%	Passed	1D041	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 116	077	006-093%	Passed	1D042	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 118	035	006-093%	Passed	1D043	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	MAIN HALL	054	006-093%	Passed	1D044	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 120	070	006-093%	Passed	1D045	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	MAIN HALL	064	006-093%	Passed	1D046	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 122	072	006-093%	Passed	1D047	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 124	069	006-093%	Passed	1D048	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	LOUNGE	066	006-093%	Passed	1D049	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 123	035	006-093%	Passed	1D050	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 121	069	006-093%	Passed	1D051	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 119	075	006-093%	Passed	1D052	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 117	062	006-093%	Passed	1D053	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 115	046	006-093%	Passed	1D054	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 111	087	006-093%	Passed	1D055	01/15/2015

2015 Richfield Health Care

Sensitivity Report

Device Type	Make	Model	Description	Drift %	Range	Result	Address	Date
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 109	071	006-093%	Passed	1D056	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	NURSE MANAGEMENT RM	051	006-093%	Passed	1D057	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 107	082	006-093%	Passed	1D059	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 105	050	006-093%	Passed	1D060	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ADMINISTRATOR OFFICE	052	006-093%	Passed	1D061	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	BUISNESS OFFICE	063	006-093%	Passed	1D062	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	NURSE'S STATION	076	006-093%	Passed	1D065	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM BY NURSE DESK	058	006-093%	Passed	1D079	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	LOUNGE	035	006-093%	Passed	1D080	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 202	081	006-093%	Passed	1D081	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 204	035	006-093%	Passed	1D082	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	MAIN HALL	035	006-093%	Passed	1D083	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 206	078	006-093%	Passed	1D085	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	MAIN HALL	081	006-093%	Passed	1D087	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 208	035	006-093%	Passed	1D088	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 210	063	006-093%	Passed	1D090	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 212	072	006-093%	Passed	1D091	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	MAIN HALL	086	006-093%	Passed	1D092	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	MAIN HALL	075	006-093%	Passed	1D093	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 214	057	006-093%	Passed	1D094	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 216	060	006-093%	Passed	1D096	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	MAIN HALL	091	006-093%	Passed	1D097	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 218	062	006-093%	Passed	1D098	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 220	054	006-093%	Passed	1D099	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ELEVATOR 1 PIT	082	006-093%	Passed	1D100	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 222	055	006-093%	Passed	1D101	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 224	078	006-093%	Passed	1D102	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	LOUNGE	061	006-093%	Passed	1D103	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 223	058	006-093%	Passed	1D104	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 221	062	006-093%	Passed	1D105	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 219	089	006-093%	Passed	1D106	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 217	035	006-093%	Passed	1D107	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 215	053	006-093%	Passed	1D109	01/15/2015

2015 Rich. .d Health Care

Sensitivity Report

Device Type	Make	Model	Description	Drift %	Range	Result	Address	Date
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 211	073	006-093%	Passed	1D110	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 209	085	006-093%	Passed	1D111	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	NURSES OFFICE	064	006-093%	Passed	1D112	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 207	065	006-093%	Passed	1D114	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 205	058	006-093%	Passed	1D115	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 203	060	006-093%	Passed	1D116	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 201	092	006-093%	Passed	1D117	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 304	061	006-093%	Passed	1D118	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	MAIN HALL	059	006-093%	Passed	1D119	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	LOUNGE	063	006-093%	Passed	1D120	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 302	060	006-093%	Passed	1D121	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 306	070	006-093%	Passed	1D123	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	MAIN HALL	055	006-093%	Passed	1D124	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 308	063	006-093%	Passed	1D125	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 310	068	006-093%	Passed	1D127	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	MAIN HALL	060	006-093%	Passed	1D128	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 312	061	006-093%	Passed	1D129	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	MAIN HALL	058	006-093%	Passed	1D130	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 314	062	006-093%	Passed	1D131	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 316	065	006-093%	Passed	1D133	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 318	059	006-093%	Passed	1D134	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	MAIN HALL	055	006-093%	Passed	1D135	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 320	064	006-093%	Passed	1D136	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	MAIN HALL	064	006-093%	Passed	1D137	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 322	051	006-093%	Passed	1D138	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 324	062	006-093%	Passed	1D139	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	LOUNGE	053	006-093%	Passed	1D140	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	DINNING ROOM	058	006-093%	Passed	1D141	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 319	061	006-093%	Passed	1D142	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 317	064	006-093%	Passed	1D143	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 315	067	006-093%	Passed	1D145	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 311	063	006-093%	Passed	1D146	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 309	065	006-093%	Passed	1D147	01/15/2015

2015 Richfield Health Care

Sensitivity Report

Device Type	Make	Model	Description	Drift %	Range	Result	Address	Date
SMOKE(PHOTO)	Notifier	FSP-851	NURSES OFFICE	058	006-093%	Passed	1D148	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 307	056	006-093%	Passed	1D150	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 305	056	006-093%	Passed	1D151	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 303	059	006-093%	Passed	1D152	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM 301	061	006-093%	Passed	1D153	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	WEST STAIRWELL	056	006-093%	Passed	1D154	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	EAST STAIRWELL	064	006-093%	Passed	1D155	01/15/2015
SMOKE(PHOTO)	Notifier	FSP-851	ROOM BY NURSE DESK	059	006-093%	Passed	1D156	01/15/2015

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: Y761

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/12/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Facility's request for a continuing waiver involving tag K0067 is recommended.

17. SURVEYOR SIGNATURE Date :
Lisa Hakanson, HPR Dietary Specialist 03/23/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 04/10/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00450
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/10/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 5834

March 2, 2015

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

RE: Project Number S5492025

Dear Ms. Buytendorp:

On February 12, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

Email: gayle.lantto@state.mn.us
Telephone: (651) 201-3794
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 24, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 24, 2015 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that

substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 12, 2015 (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 August 12, 2015 (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 a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

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

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

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 _____	02/12/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verifcation of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	RECEIVED MAR 16 2015 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure cares were provided in a dignified manner for 1 of 5 residents (R32 and R36) reviewed for dignity. Finding include: R32's morning cares were observed on 2/11/15, at 8:44 a.m. as he was assisted by a nursing assistant (NA)-C. NA-C retrieved a pair of pants out of R32's closet for R32 to wear for the day. While NA-C was putting on R32's pants the surveyor observed the material on the pants as being very thin in some areas and noted several large open holes on the seat of R32's pants. The	F 241	POC accepted gg for tb 3/16/15 3/18/15	

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

[signature] | Administrator | 3-13-15

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

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F 241	Continued From page 1 condition of the pants was brought to the attention of NA-C who verified the large holes in R32 pants and stated that family will bring in new clothing for R32. NA-C continued to dressed R32 in the ripped pants then transferred R32 to his wheelchair. Later that day at 1:56 p.m. R32 continued wearing the same ragged pants. Following the observation, at 9:27 a.m. the licensed social worker (LSW)-A explained that R32 had a guardian who visited monthly. LSW-A stated that R32's family did not visit the resident for the past couple years, nor had LSW-A or the guardian had contact with the resident's family. The facility staff were supposed to let the LSW know if R32 needed more clothing, or if clothing was ill-fitting or worn. R32's annual Minimum Data Set dated 7/15/14, identified R32 had severely cognitive impairment and required total assistance from staff for all activities of daily living including dressing. The care plan dated 1/9/15, directed staff to anticipate all of R32's needs. There was conflicting information as to who was responsible for purchasing clothing for R32. LSW-A reported on 2/11/15, at 9:27 a.m. that he would let the resident's court appointed guardian (non-family member) know the resident was in need of clothing and she would then purchase it. LSW-A reported the staff had unsuccessfully made attempts to contact R32's family. The NAs were responsible for letting the LSWs know when a resident needed new clothing. LSW-A said R32 had available funds for clothing, and in fact, needed to spend some of the money in his account.	F 241	Disclaimer for Plan of Correction: Richfield Health Center objects to the allegation of non-compliance. Submits of this response and plan of correction in NOT a legal admission that a deficiency exists or that his statement of deficiency was correctly cited and is also NOT to be construed as an admission against interest by the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in the response and plan of correction. In addition, preparation and submission of this plan of correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Richfield Health	

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F 241	Continued From page 2 On 2/11/15, at 2:18 p.m. the laundry supervisor explained that personal laundry had been dropped off between 11:00 and noon that day. Only one pair of dark sweat pants had been delivered to R32's closet. The person who dropped of the clothing had reported she had not noticed the large holes in R32's pants. R32's guardian (Gdn)-A was interviewed via telephone on 2/12/15, at 9:46 a.m. Gdn-A reported she visited the resident monthly, and that the resident's family members did not visit. She reported back to the court annually and then sent a letter to the family regarding the resident, however, some of the letters had been returned. The facility staff were responsible for calling Gdn-A informing her of his needs and she would then approve purchases, such as clothing from R32's funds account. Gdn-A reported it had been "a while--a few months" since a request had been made for a funds withdrawal for R32. R32's closet was observed on 2/11/15 1:56 p.m. with a licensed practical nurse (LPN)-A and NA-A. The closet contained one pair of jeans and another pair of sweat pants. NA-A stated she would not have dressed R32 in pants in such poor condition. Instead, she would have gone to the laundry staff and requested a donated pair of pants for the resident. At 2:26 p.m. NA-B was changing R32's pants and had thrown the ragged pants in the trash. The laundry supervisor confirmed on 2/12/15, at 10:09 a.m. that donated clothing was available for a resident in need of clothing. A follow-up interview was conducted with LSW-A on 2/12/15, at 10:15 a.m. LSW-A said when	F 241	Center respectfully makes its allegation of compliance on all areas and has written these plans of correction to constitute the allegation. On 2/11/15 LSW-A called R32's guardian to inform them that new clothing was needed to replace the worn and ill-fitting clothing. On 3/9/15 the LSW-A removed all worn and ripped clothing from the closet of R32. On 3/13/15 Social Services will provide nursing with a communication book to request clothing needs and personal items for residents on each unit. Staff was educated on this process and to retrieve any clothing items that are worn and ripped on	

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F 241	Continued From page 3 clothing was requested from the guardian, she brought the items "right away" and he would request the clothing be purchased. A 2013 facility policy Resident Dignity indicated it was inappropriate "dressing residents in wrinkled, torn or mismatched clothing...Repair or replace torn clothing." R36 was in his room with NA-D on 2/11/15, at 9:00 a.m. as the surveyor entered with RN-D who planned to administer R36's medications. R36 was seated in his wheelchair, his upper body was unclothed, and his chin and upper neck were foamy with shaving cream. NA-D stepped aside for RN-D to administer the medication. RN-D, however, did not address a cut on R36's chin that was bleeding until the surveyor pointed it out. RN-D stepped out to retrieve a Band-Aid while NA-D then washed the shaving cream and blood from R36's face. NA-D explained the laceration happened when he was shaving the resident that morning. R36 was still without upper body clothing when RN-D returned at 9:08 to treat the resident's injury. Without explanation from either staff person, the would was cleaned and covered. RN-D said the resident [had poor understanding] and a piece of paper at the nursing desk instructed staff to give the resident "simple commands." R36's care plan dated 12/9/14, directed staff to explain all procedures, use a picture board...ask yes/no questions, and allow resident time to respond. A Care Area Assessment (CAA) dated 12/16/14, described R36 as having moderate cognitive impairment and needed assistance of one staff for activities of daily living including	F 241	3/13/15. Social Services will complete 3 random audits of resident closets to ensure there are not worn articles of clothing weekly for 4 weeks and then quarterly. All results will be brought to the monthly Quality Assurance Performance Improvement meeting and reviewed for trends. Administrator/Designee will be responsible for compliance. Completion date: 3/18/15 The Resident Dignity policy and procedure and the Resident Rights policy and procedure was reviewed and nursing staff was educated on this policy on 3/13/15. R35's care plan was reviewed and a picture board is to be used during cares. The nurse manger will observe	

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F 241	Continued From page 4 dressing and shaving. It was noted the resident understood, followed one step commands, and "will answer questions at times." The Physician's Order form dated 2/2/15, listed R36's diagnoses including dementia and Parkinson's disease. On 2/12/15, at 2:46 p.m. the director of nursing (DON) stated she expected staff to be mindful of residents' dignity when giving cares and providing treatments to include explanations of why and what procedures are being completed. The facility's Clinical Administrative Manual on Resident Rights dated 7/99, directed staff to involve residents in all aspects of care.	F 241	cares and complete 3 audits one on each floor for 4 weeks and then quarterly. All results will be brought to the monthly Quality Assurance Performance Improvement meeting and reviewed for trends. Director of Nursing /Designee will be responsible for compliance. Completion date: 3/18/15	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure bathing preferences were honored for 1 of 1 resident (R103) who reportedly requested a change in scheduled bathing. Findings include:	F 246		3/18/15

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F 246	Continued From page 5 R103 was interviewed on 2/10/15, at 9:39 a.m. When asked if she was bathed according to her preferences she replied, "no." R103 went on to explain that although she had asked for at least two baths per week, she had never been offered a bath more than once at week since her admission in 2012. On 2/12/15, at 9:40 a.m. a nursing assistant (NA)-C reported he worked the morning shift and had never assisted R103 to bathe, as it was scheduled in the afternoon. A registered nurse (RN)-C then confirmed R103's bath was scheduled every Wednesday evening. RN-C stated nurse managers made out resident bathing schedules, and she had no idea how they were determined. On 2/12/15, at 10:00 a.m. a licensed practical nurse (LPN)-B stated, "All residents are scheduled to have once a week bath unless requested by a resident or family." LPN-B denied being aware of R103's request for more frequent bathing. LPN-B stated bath preferences were usually asked during a resident's care conference, but R103 "never said anything." A review of care conference notes dated 12/1/14, indicated R103 had no cognitive impairment. The resident had declined attending her conference, but it was noted, "SS [social services] will cont [continue] to follow Res [resident] as needed." No additional notes were recorded from the licensed social worker (LSW) to show whether there had been additional follow up or whether the resident was asked about her preferences. The Care Area Assessment (CAA) dated 12/9/14, indicated R103 requires extensive assist with activities of daily living (ADLs) including bathing. The current NA	F 246	On 2/12/15 R103 was interviewed and requested to have 2 baths per week. The nurse manager scheduled the baths for Wednesday and Sunday evenings. All resident bathing preferences will be reviewed quarterly and as needed. All staff received education regarding resident choices and preferences with bathing on 3/13/15. Caring Partners will monitor resident's choices and preferences are being honored or modified as requested with weekly visits for 4 weeks and then monthly. All results will be brought to the monthly Quality Assurance	

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F 246	Continued From page 6 care sheet noted R103 required the assistance of one staff person for ADLs. On 2/12/15, at 11:08 a.m. LPN-B stated she had asked R103 about her bathing preference, and baths were going to be scheduled on both Wednesday and Sunday evenings. In a follow up interview with R103 on 2/12/15, at 1:22 p.m. R103 verbalized happiness she would "finally" be bathed twice a week. The facility's policy on residents' rights dated 7/99, indicated residents were to be involved in all aspects of their cares.	F 246	Performance Improvement meeting and reviewed for trends. Director of Nursing /Designee will be responsible for compliance. Completion date: 3/18/15	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		3/18/15

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F 279	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to develop care plan interventions for bruises 1 of 3 (R153) residents reviewed for non-pressure related skin issues. Findings include: R153 was observed while lying in bed on 2/9/15, at 2:58 p.m. A large, purple bruise was noted on the resident's right inner wrist and hand. The following day at approximately 9:00 a.m. the resident discharged from the facility. R153 was newly admitted to the facility on 2/3/15. An initial assessment Transitional Care Admission Health Partners Geriatrics, was completed by a certified nurse practitioner (CNP) the day after R153's admission noted the resident experienced a fall on 1/30/15, and was slowly declining cognitively. Additionally, a bruise with swelling was identified on R153's left knee. The a skin care assessment dated 2/3/15, showed a body diagram. The front of the body had the word "bruise" written near the abdomen and on both arms. The back side had the word "bruise" written on the back sides of both of the resident's hands. The director of nursing reported in an interview on 2/10/15, at 3:47 p.m. she expected staff to measure all alterations in skin and to document the findings on the Skin Assessment Tool. She would also expect the measurements to be noted on the TAR, or at least in the resident's care plan.	F 279	R153 was discharged from facility on 2/10/15. The policy and procedure for the Admission Process that includes a Skin Integrity Assessment, Prevention and Management Care Plan was reviewed and all licensed staff were educated on 3/13/15. All residents with skin impairment's care plans have been reviewed and updated by the nurse managers on 3/18/15. All resident's skin assessments will be reviewed and updated upon admission, quarterly and annually and/or with significant changes during clinical meetings. All results will be brought to the monthly Quality Assurance Performance Improvement meeting and reviewed for trends.	

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F 279	Continued From page 8 The DON verified the documentation was lacking regarding R153's bruising, and was not available in other records. During an interview on 2/12/15, at 2:49 p.m. the administrator stated a care plan addressing skin problems should have been completed within 24 hours of admission. The administrator verified that although a skin assessment care plan had been initiated for R153, it had not been completed. The 10/14 policy for Admission Process directed staff to complete assessments on newly admitted residents within 24 hours of the resident's admission. This was to include a Skin Integrity Assessment, Prevention and Management Care Plan. R153's skin assessment dated 2/3/14, lacked identification of any skin problems at that time.	F 279	Director of Nursing and/or Designee will be responsible for compliance. Completion date: 3/18/15	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to monitor bruises for 1 of 3 (R153) residents reviewed for non-pressure related skin issues.	F 309		3/18/15

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F 309	Continued From page 9 Findings include: R153 was observed while lying in bed on 2/9/15, at 2:58 p.m. A large, purple bruise was noted on the resident's right inner wrist and hand. The following day at approximately 9:00 a.m. the resident discharged from the facility. R153 was newly admitted to the facility on 2/3/15. An initial assessment Transitional Care Admission Health Partners Geriatrics, was completed by a certified nurse practitioner (CNP) the day after R153's admission noted the resident experienced a fall on 1/30/15, and was slowly declining cognitively. Additionally, a bruise with swelling was identified on R153's left knee. The a skin care assessment dated 2/3/15, showed a body diagram. The front of the body had the word "bruise" written near the abdomen and on both arms. The back side had the word "bruise" written on the back sides of both of the resident's hands. The documentation lacked a description including the exact location, measurements, and color of the various bruises. No other skin issues were identified on the assessment. R153's Medication Administration Record (MAR) for 2/15, directed staff to document location, type and size of skin impairment. Staff were to monitor any skin impairment daily until the area was healed. A (+) for new skin problems and a (-) for no new skin problems was to be documented The MAR included a (-) on 2/6/15, indicating no skin issues and no further notations were noted during the time the resident resided in the facility.	F 309	R153 was discharged from facility on 2/10/15. The policy and procedure for the Admission Process that includes a Skin Integrity Assessment, Prevention and Management Care Plan was reviewed and all licensed staff was educated on 3/13/15. All residents with skin impairment's care plans have been reviewed and updated by the nurse managers on 3/18/15. All resident's skin assessments will be reviewed and updated upon admission, quarterly and annually and/or with significant changes during clinical meetings. All results will be brought to the monthly Quality Assurance Performance Improvement meeting and reviewed for trends.	

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F 309	Continued From page 10 A registered nurse (RN)-B was interviewed on 2/10/15, at 3:20 p.m. RN-B stated R153 had been admitted with bruising, and the only monitoring of those bruises had been on the weekly body audits when R153 had a bath. The 10/14 policy for Admission Process directed staff to complete assessments on newly admitted residents within 24 hours of the resident's admission. This was to include a Skin Integrity Assessment, Prevention and Management Care Plan. R153's skin assessment dated 2/3/14, lacked identification of any skin problems at that time. A 1/15 policy for Weekly Skin Assessment directed staff to document location, size and type of skin impairment on the Treatment Administration Record (TAR), monitor area(s) of skin impairment daily until healed using TAR for areas including but not limited to abrasion, bruise, burn, excoriation, and rash. Additionally, staff was to monitor the areas of skin impairment weekly using the Skin Grid. No weekly skin assessment was provided for R153, although it had been documented as having been completed according to the TAR dated 2/6/15. The director of nursing reported in an interview on 2/10/15, at 3:47 p.m. she expected staff to measure all alterations in skin and to document the findings on the Skin Assessment Tool. She would also expect the measurements to be noted on the TAR, or at least in the resident's care plan. The DON verified the documentation was lacking regarding R153's bruising, and was not available in other records.	F 309	Director of Nursing and/or Designee will be responsible for compliance. Completion date: 3/18/15	

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F 309	Continued From page 11 During an interview on 2/12/15, at 2:49 p.m. the administrator stated a care plan addressing skin problems should have been completed within 24 hours of admission. The administrator verified that although a skin assessment care plan had been initiated for R153, it had not been completed.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by:	F 329		3/18/15

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F 329	Continued From page 12 Based on observation, interview and document review, the facility failed to identify parameters for the use of medication for 1 of 7 residents (R154) observed for medication administration. Findings include: R154's hospital physician discharge orders dated 2/9/15, included the medication Senokot S 8.6-50 milligrams (mg) 1-4 tablets by mouth twice daily starting 2/9/15 for constipation. On 2/12/15, at 8:08 a.m. a licensed practical nurse (LPN)-C administered R154's scheduled morning medications. Included were two tablets of Senexon-S 8.6 mg (for Senna Plus). When asked how it was determined how many tablets should be administered, LPN-C explained that the resident always requested two tablets, which was why she decided to give two (versus 1, 3, or 4). R154's Medication Administration Record (MAR) revealed two tablets of Senna Plus had been administered twice daily on 2/10/15 and 2/11/15, and then again the morning of the observation at 8:08 a.m. On 2/12/15, at 8:30 a.m. a registered nurse (RN)-B confirmed there were no parameters ordered for R154's use of Senna Plus. RN-B stated the medication order should have been reviewed and parameters set before the medication was started. On 2/12/15, at 2:23 p.m. the director of nursing (DON) stated she expected the nurses to clarify medication orders for parameters as needed when residents were admitted to facility and prior to administering medication.	F 329	On 2/12/15 R154 medications were reviewed and updated. The facility's Medication Administration policy and procedure was reviewed by the DON on 2/12/15. All licensed staff received education regarding clarification of dose ranges on medication administration orders on 3/13/15. All resident's medications will be reviewed and clarified upon admission and monthly to ensure appropriate dosage instructions for administration. All resident's medication administration orders will be audited during CCPR meetings quarterly. All results will be brought to the monthly Quality Assurance Performance Improvement meeting and reviewed for trends.	

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F 329	Continued From page 13 On 2/12/15, at 3:10 p.m. DON provided a copy of In-Service Training Record also dated 2/12/15, which directed staff to obtain clarification when orders were received that did not include parameters. The facility's 11/12, Medication Administration policy indicated the facility "strives to provide safe administration of all medications." The policy directed licensed nurse and/or medication assistant to ensure the correct dose was being administered. In addition, the facility's 1/12, Admission Orders provided that when a resident was admitted from the hospital, admission orders had to be obtained and a physician has to be "contacted for confirmation or revision of orders" when needed. The policy directed facility staff to review transfer orders with the physician or "obtain further orders as appropriate."	F 329	Director of Nursing and/or Designee will be responsible for compliance. Completion date: 3/18/15	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were administered by the correct route as ordered (R105) and with correct timing (R36) for 1 of 7 residents observed for medication administration. This resulted in a medication error rate of 13%.	F 332		3/18/15

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F 332	Continued From page 14 Findings include: R105's Nutritional Risk Care Plan (NRCP) dated 12/18/14, indicated R105 was prescribed a regular diet and could take food orally in addition to via a gastrostomy tube (G-tube--inserted into the stomach). On 2/12/15, at 11:59 a.m. a licensed practical nurse (LPN)-C administered all of R105's morning medications through the G-tube. However, the 2/15, physician's orders directed staff to administer the following morning medications by mouth: Tylenol 325 milligrams (mg) 3 tablets; aspirin 81 mg; Baclofen 10 mg 2 and ½ tablets; certavite 18 mg; Cymbalta 30 mg 3 capsules; Ferrous Sulfate 325 mg; gabapentin 300 mg; Methadone Hydrochloride 10 mg; omeprazole 20 mg (30 minutes before a meal); Miralax 17 grams (gm) dissolved in water; Senna plus 8.6 mg-50 mg 2 tablets; vitamin C 500 mg; and vitamin D3 1000 units. On 2/12/15, at 12:30 p.m. LPN-C verified the physician orders dated 2/2/15 directed staff to crush all of R105's medications and mix with "slurry," followed by 60 milliliters of water. The orders, however, did not indicate the route (by mouth or G-tube) the medications were to be administered. LPN-C also reviewed the Medication Administration Records (MAR) with surveyor and LPN-C agreed the MAR and reported it did not indicate the route, but the nurse practitioner (NP) was in the facility at the time and she would request clarification. On 2/12/15, at 2:23 p.m. the director of nursing (DON) stated her staff nurses were expected to clarify medication orders when residents were	F 332	On 2/12/15 the medication for R105 and R 36 was administered by the correct route. The Medication Administration policy and procedure was reviewed. Education on this policy was completed for the licensed nurses on 3/1/15. All residents who receive medications via G tube placement have been reviewed to ensure proper medication administration orders. 3 random medication administration audits will be completed 1 time per week for 4 weeks, then 3 times per month and then quarterly. All results will be brought to the monthly Quality Assurance Performance Improvement meeting and reviewed for trends.	

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F 332	Continued From page 15 admitted to facility or whenever a new medication was ordered. DON further stated that when medication routes were not included in orders, her staff nurses were expected to clarify the order before starting to give the medication. On 2/12/15, at 2:37 p.m. a registered nurse (RN)-B showed to surveyor the addition of "per G-tube" as route in the order dated 2/2/15. RN-B stated the NP "just" fixed the order." However, the updated order did not reflect a late entry (per standard of practice) or that addition was made as there were no initials affixed or date of entry written for the words added. R36's Physician's Order form dated 2/2/15, listed morning medications as vitamin B-12 1000 mcg by mouth daily with breakfast; vitamin D 2000 units 1 capsule by mouth with a meal; and Lantus insulin inject 15 units subcutaneously (by injection). On 2/11/15, at 9:00 a.m. RN-D was administered all of R36's morning medications except Lantus insulin. RN-D reported she had not administered the insulin because the resident did not eat breakfast. A review of nurses' progress notes dated 2/11/15, at 9:00 a.m. indicated R36 did not eat breakfast so the scheduled morning Lantus insulin was not given "per order." On 2/12/15, at 2:23 p.m. the director of nursing stated she expected the nurses to give medications as ordered and to seek clarifications if needed. The facility's 11/12, Medication Administration	F 332	Director of Nursing and/or Designee will be responsible for compliance. Completion date: 3/18/15	

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F 332	Continued From page 16 policy indicated that facility "strives to provide safe administration of all medications." The policy directed licensed nurse and/or medication assistant to check the rights of medication administration to include the right medication route and the right time of when to give the medication.	F 332		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures	F 334		3/18/15

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F 334	Continued From page 17 that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not determine pneumococcal	F 334		

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F 334	Continued From page 18 vaccination status and provide risk/benefit education for 3 of 3 newly admitted residents (R83, R85, R99) or their legal representative as required. Findings include: R83 was admitted to the facility on 9/6/14, and remained in the facility. R83's immunization record lacked the date when the pneumococcal vaccination was offered or administered. R83's immunization record also lacked evidence R83 was provided education regarding the benefits and potential side effects of the influenza and pneumococcal vaccination. R85 was admitted to the facility 12/15/14, and remained in the facility. R85's immunization record lacked evidence R85 was provided education regarding the benefits and potential side effects of the influenza and pneumococcal vaccination. R99 was admitted to the facility on 8/1/14, and remained in the facility. R99's immunization record lacked evidence R99 was provided education regarding the benefits and potential side effects of the influenza and pneumococcal vaccination. During an interview on 2/12/15, at 12:08 p.m. a registered nurse (RN)-A stated was unable to locate evidence R85 had been provided education regarding the benefits and potential side effects of the influenza and pneumococcal vaccination. During an interview on 2/12/15, at 12:37 p.m. a licensed practical nurse (LPN)-B reviewed	F 334	Residents R83, 85 and 99 have received the Vaccine Information Statements on 3/13/15. All residents will receive the current Vaccination Information Sheets from the CDC upon assessing vaccination needs upon admission, annually and as indicated. The Immunization Administration Policy and Procedure was reviewed. All licensed staff received education regarding providing and documentation of Vaccination Information Sheets on 3/13/15. All residents will be audited quarterly to ensure compliance during clinical meetings. All results will be brought to the monthly Quality Assurance Performance Improvement meeting and reviewed for trends.	

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F 334	Continued From page 19 immunization records for R83, R85 and R99 and confirmed there was no evidence that would have indicated the residents were provided education regarding the benefits and potential side effects of the influenza and pneumococcal vaccination. The facility's 11/12 Immunization Administration Procedure directed staff to ensure they "Will counsel residents on the benefits and adverse effects of each vaccine prior to administration. The residents will sign a form stating they have been informed of benefits and adverse effects. Forms will be filed in the medication record or personal health files as applicable."	F 334	Director of Nursing and/or Designee will be responsible for compliance. Completion date: 3/18/15	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors.	F 356		3/18/15

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F 356	Continued From page 20 The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to nurse staffing information was posted daily as required. This had the potentially to affect all 95 residents and visitors to the facility. Finding include: On 2/9/15, at 11:35 a.m. during the initial tour, the Daily Nurse Staffing Form was posted on the wall in a protected plastic frame next to the administrator's doorway. The information, however, was dated 2/6/15, and not the current date of 2/9/15. The forms dated 2/7/15 and 2/8/15 were also missing from the plastic frame. During an interview on 2/11/15, at 11:26 a.m. the staffing coordinator reported it was her responsibility to print out the daily nurse staffing form, and to ensure the information was placed in the plastic frame. The staffing coordinator could not say why the current information was not posted, and could not produce a copy for review. The interim director of nursing verified that the daily nursing staffing form for the current date was unavailable.	F 356	The Daily Nurse Staffing policy and procedure was reviewed and staff education was conducted and completed on 3/13/15. Administrator/Designee will audit for correct Daily Nurse Staffing posting daily for 4 weeks, then monthly for 4 months and then quarterly. All results will be brought to the monthly Quality Assurance Performance Improvement meeting and reviewed for trends. Administrator/Designee will be responsible for compliance. Completion date: 3/18/15	

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F 356	Continued From page 21 The facility's 7/08 Daily Nurse Staffing Procedure directed staff to, "Initiate the Daily Nurse Staffing Form at the start of the night shift. Post the following information on a daily basis at the beginning of each shift: facility name, current date, resident census, categories of nurse staff and actual time worked for the specified categories of direct care nursing staff."	F 356		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure microwaves used to warm food were kept clean. This had the potential to affect 61 residents who consumed their meals on the units where microwaves were unclean. Findings include: On 2/10/15, at 9:55 a.m. the inside of the microwave in the kitchenette on the first floor had reddish-brown colored stains on both sides, the back, the ceiling and the floor of the inside of the appliance. The glass rotating plate and entire	F 371		3/18/15

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F 371	Continued From page 22 inside of the microwave was heavily soiled with dried food splatters. At 12:30 p.m. the microwave in the first floor kitchenette was again observed and the interior surfaces were clean and white. A housekeeper (H)-A explained at 12:33 p.m. she had replaced the microwave. H-A stated, " It was stained and full of dried-on food." Although she had attempted to clean the appliance, she was unable to get it clean "because it was very old and dirty," so instead it was replaced with a microwave found elsewhere in the building. H-A stated the microwave was used to warm up food for the residents. On 2/10/15, at 12:13 p.m. the licensed practical nurse (LPN)-A on the third floor stated the microwave used to warm resident food was located in the locked medication storage room on the unit. She proceeded to open the room with a key. The microwave was located on a shelf approximately six feet high. LPN-A explained that staff had to use a step ladder in order to utilize the microwave. Upon climbing up two steps on the ladder to observe the inside of the microwave, it was observed to be heavily soiled. Dried food debris was on all surfaces of the appliance. A paper towel with a large amount of spillage had been left on the glass rotator plate. LPN-A stated she "had no idea" what the spillage was or why it had been left in the microwave. She then stated she thought housekeeping staff was in charge of cleaning the microwaves, but each staff person should have been cleaning it after food splatters and spillage. The following day at 11:30 a.m. LPN-A again stated the person using the microwave should have been cleaning it. The housekeeping staff "tries to catch us when we are not busy, because	F 371	Microwaves were cleaned on 2/11/15. All microwaves used to warm food for residents will be kept clean. The microwave cleaning policy and procedure was reviewed. The night shift cleaning schedule was updated to include the cleaning of the microwaves. All staff was educated on this policy on 3/13/15. Administrator/Designee will audit all microwaves daily for 4 weeks, then monthly for 4 months and then quarterly. All results will be brought to the monthly Quality Assurance Performance Improvement meeting and reviewed for trends.	

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F 371	Continued From page 23 we have to supervise them while they are in the medication storage room." At 11:37 a.m. the microwave in the medication storage room on the third floor continued to be heavily soiled with food splatters and spills. was again observed to have dried food particles on the inside walls, ceiling and glass rotator plate. The outside door of the microwave had visible food particles smeared on the surface. LPN-A verified the findings and stated she would have expected staff to have wiped the microwave down after using it. On 2/10/15, at 12:22 p.m. the second-floor microwave used to warm resident food was observed in the locked medication room. The microwave was stored on a counter. RN-A verified the rotator plate inside of the microwave as well as the ceiling and door had visible dried food particles on the surfaces. The director of nursing stated on 2/12/15, at 9:50 a.m. she expected staff to clean microwaves after each use if there was a spill and as per cleaning housekeeping cleaning schedule. The housekeeping cleaning checklist was reviewed. The checklist lacked any direction for housekeepers to clean microwaves on the first, second, or third floors. In addition, night shift duties checklist lacked direction to address the task of microwave cleaning. An interview with the district director of housekeeping on 2/12/15, at 10:47 a.m. revealed cleaning microwaves was not listed as a housekeeper responsibility. She further stated it may have been one of the things that has "fallen through the cracks" with all the changes in upper management. The director of housekeeping and	F 371	Administrator/Designee will be responsible for compliance. Completion date: 3/18/15	

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F 371	Continued From page 24 laundry (H)-B then stated he had worked at the facility for two years and had never been approached regarding microwaves. The director of maintenance (DM)-A stated at 10:58 a.m. stated he believed the housekeeping department had the responsibility of cleaning microwaves. He further stated he has worked at the facility for nine weeks and it had never been part of his responsible. At 11:17 a.m. the administrator stated she expected staff to clean the microwaves on the units after each use. She verified the facility had no cleaning schedule in place to ensure the task was being completed. The director of nursing then stated at 11:23 a.m. the task of cleaning the microwaves on the units was added to the night shift duties. The 7/10, Nutrition Service Practice Manual Sanitation Procedure directed staff to maintain the microwaves "in a clean and sanitized condition. The microwave oven will be wiped out after each use and thoroughly cleaned twice per week or more often as needed."	F 371		

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

F5492023

PRINTED: 03/02/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245492	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/11/2015**

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

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on January 16, 2014. At the time of this survey, Richfield Healthcare Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K 000	POC ok w/ AW for K67 JB 3-23-15 RECEIVED MAR 19 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 3/23/15
EXIT: 2-12-15

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

Administrator — 3-13-15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245492	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	02/11/2015

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This 3-story building was constructed in 1971 and was determined to be of Type II (222) construction. It has a full basement and is fully fire sprinklered. The facility has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 118 beds and had a census of 90 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067	K 067 Facility is requesting an annual/continuing waiver. See K067 Waiver request.	

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 _____	**02/11/2015**

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K 067	Continued From page 2 This STANDARD is not met as evidenced by: Based on observations and interviews, it could not be verified that the facility's general ventilating and air conditioning system (HVAC) is installed in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 2-3.11. A noncompliant HVAC system could affect all residents. Findings include: During the facility tour between 9:00-11:00AM on 2-11-15, observation revealed that the ventilation system for the corridors are utilizing the egress corridor as an air plenum for the resident rooms. The resident rooms are heated by hot water register. The corridors are heated by forced air. No return duct could be located in the corridors. The resident bathroom fans run continuously and exhaust to the exterior and draw their supply from the corridors through the resident rooms.	K 067		

Larson, Monica (MDH)

From: Sheehan, Pat (DPS)
Sent: Monday, March 23, 2015 12:54 PM
To: rochi_lsc@cms.hhs.gov
Cc: Rexeisen, Robert (DPS); jbuytendorp@extendicare.com; Dietrich, Shellae (MDH); Fiske-Downing, Kamala (MDH); Henderson, Mary (MDH); Johnston, Kate (MDH); Kleppe, Anne (MDH); Leach, Colleen (MDH); Whitney, Marian (DPS); Meath, Mark (MDH); Zwart, Benjamin (MDH)
Subject: Richfield Health Center (245492) 2015 K67 Annual Waiver Request - Previously Approved - No Change

This is to inform you that Richfield HC is again requesting an annual waiver for K67, corridors as a plenum. The exit date was on or about 2-11-15.

I am recommending that CMS again approve this waiver request.

Patrick Sheehan, Fire Safety Supervisor
Office: 651-201-7205 Cell: 651-470-4416
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division Est. 1905
445 Minnesota St., Suite 145, St Paul, MN 55101-5145
FAX: 651-215-0525
Web: fire.state.mn.us