Electronically delivered
December 21, 2020

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

RE: CCN: 245492
Cycle Start Date: December 2, 2020

Dear Administrator:

On December 2, 2020, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 5, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 5, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 5, 2021.

You should notify all Medicare/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 admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 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 $11,160; 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 January 5, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Richfield A Villa Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 5, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

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:

Sarah Grebenc, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

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 June 2, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, 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 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

Nursing Home Informal Dispute Process

Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
December 21, 2020

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

Re: State Nursing Home Licensing Orders
Event ID: YWPT11

Dear Administrator:

The above facility was surveyed on December 1, 2020 through December 2, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

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

Sarah Grebenc, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245492	A. BUILDING _____ B. WING _____	C 12/02/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 12/1/20 and 12/2/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5492168C-MN67588, H5492169C-MN59222, H5492171C-MN50400. A deficiency was cited at F689 in relation to H5492169C-MN59222. The following complaint was found to be UNSUBSTANTIATED: H5492170C- MN67611 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		12/29/20

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

Electronically Signed | 12/21/2020

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F 689	Continued From page 1 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide appropriate fall interventions for 1 of 3 residents (R1) reviewed for accidents. This failure resulted in actual harm when R1 fell from the wheelchair and sustained a broken left clavicle (collarbone) and a subdural hematoma (when blood pools between the brain and its outmost covering). R1 subsequently died. Findings include: R1's annual Minimal Data Set (MDS) assessment dated 7/29/20, identified R1 was moderately cognitively impaired. R1's diagnoses included cerebral palsy (disorder involving movement, muscle tone and posture often developed prior to birth), spastic quadriplegia (condition that causes jerking motions and stiffness in all four limbs), hydrocephalus (fluid in the brain), schizophrenia (disorder that affects ability to think, feel, and behave clearly) and seizure disorder. R1 was wheelchair bound, required extensive assistance with activities of daily living (ADLS) and had limited range of motion (ROM) with both lower extremities. R1's care plan last revised 8/31/20, identified R1 required the use of safety devices to include: bilateral grab bars, air mattress, specialty wheelchair with seat belt and short cord on call light. R1's care plan instructed staff to "ensure proper positioning with proper body alignment while using restraining safety device" and	F 689	Corrective Action: 1. Residents that reside at Richfield a Villa Center will be reassessed for current level of Fall Risk. 2. Residents that reside at Richfield a Villa Center will be reassessed for appropriate safety devices. 3. Nursing staff will be educated on patient safety devices, placement of safety devices and following the individualized Fall Prevention Plan of Care for each resident by the DON or clinical leadership designee. Identification of other residents: Residents identified as High Falls Risk have potential to be affected by this practice. Monitoring Mechanism: Daily audits will be completed by DON or clinical designee on all High Fall Risk residents for placement of safety interventions X 30 days then, Weekly audits on all High Fall Risk residents will be completed by DON or clinical designee for placement of safety interventions X 30 days then, Audits will continue bi-weekly for placement of safety intervention X 30 days by DON or clinical designee then, The results of the audits will be reviewed by the IDT monthly in QAPI and continued	

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F 689	Continued From page 2 evaluate safety device use quarterly and PRN [as needed]: evaluate/record continuing risks/benefits, alternatives, need for ongoing use, reason for safety device use." R1's care plan further identified R1 was "at risk for falls/injury r/t [related to] impaired mobility secondary to cerebral palsy. R1's care plan instructed staff to follow seizure precautions. R1's care plan did not define seizure precautions. R1's physician order dated 6/28/18, indicated, "Ok for specialty wheelchair and cushion, ok for seatbelt I [sic] wheelchair to aide in wheelchair positioning." R1's fall assessment dated 10/28/20, indicated R1 was at high risk for falls with a score of 7. The assessment had no further information that identified fall risk interventions. R1's physician progress note dated 10/7/20, indicated R1 utilized a Hoyer for transfers and specialty wheel chair. R1's progress note dated 11/18/20, at 12:37 p.m. indicated, "Resident was in his chair eating in the dining room. Overhead alert that resident was on the floor struggling to breath. Seizure activity was expected [sic]. 911 was called. Family was called. Vitals taken. Resident was sent to the hospital." The facility Report of Resident Fall dated 11/18/20, indicated the only assistive device and intervention in use at the time of the event was a wheel chair. The check box next to seat belt was not checked. The report did not indicate whether the wheelchair was in a reclined position. When interviewed on 12/11/20, at 12:02 p.m.	F 689	90 days if needed.	

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F 689	Continued From page 3	F 689		

nursing assistant (NA)-A stated she was the first one to respond when another resident (R6) yelled that someone was on the floor. NA-A further stated the back of R1's wheel chair was in an upright position, straight up and down and it should have been reclined after lunch. NA-A further stated R1's chair was supposed to be positioned so he could be seen from the hallway when no staff were present. NA-A verified and stated no staff were in the dining area at the time when R1 fell and his chair was not positioned in view of the hallway. NA-A stated R1 did not have a seat belt on the day R1 fell from the wheel chair. NA-A further stated R1 was on falls precautions which required checks every 15-20 minutes. NA-A stated she was not aware of seizure precautions.

When interviewed on 12/1/20, at 12:13 p.m. R6 (who witnessed the event) stated R1 sat in the wheel chair in the corner of the dining room and she and R1 were talking and then R1 fell forward out of the chair onto the floor. R6 stated no staff were present so she ran and yelled for staff to come help.

When interviewed on 12/1/20, at 12:48 p.m. NA-B stated she was in a resident room assisting a resident when she heard R6 yell that someone fell. NA-B stated she ran to the dining area and saw R1 on the floor in front of his wheel chair and R1 had a bump on his head. NA-B further stated that R1 was a falls risk and that R1 should be moved to an area of the room that could be seen from the hallway after he was done with lunch. NA-B further stated the wheel chair should be straight up for meals but reclined between meals. NA-B stated R1 did not have a seat belt on that day. NA-B stated R1 was a high falls risk and she

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F 689	Continued From page 4	F 689		

would follow the care plan and perform more frequent checks on R1.

When interviewed on 12/1/20, at 1:03 p.m. NA-C stated was in the dining area assisting another resident with lunch the day R1 fell. NA-C stated NA-D assisted R 1 with lunch. NA-C further stated when she left the dining area NA-D was still there but he said was leaving to buy another resident something from the vending machine. NA-C stated, "I told him to tilt [R1] back a little when done eating." NA-C stated not remembering if R1 ever had a seat belt and not sure if R1 had one on that day.

When interviewed on 12/1/20, at 1:56 p.m. registered nurse (RN)-A stated R1 needed assistance with meals and the NA's should always stay there with him and then after meals they should either transfer him back to bed or move his wheel chair so he would be in sight. RN-A stated R1 was out of sight the day he fell and the only other person in the dining area at the time of the fall was R6. RN-A further stated that if a resident was on falls risk, staff were supposed to keep an eye on them all the time and that staff should not leave R1 in the dining area unsupervised.

When interviewed on 12/1/20, at 2:02 p.m. licensed practical nurse (LPN)-A stated being told that R1 normally ate in the dining area and then he was taken back to his room. "I heard [R6] yell. I saw him postictal [altered state of consciousness after an epileptic seizure]. I do believe it was a seizure." LPN-A further stated R1's wheel chair was in the back corner of the room and R1 was lying on the floor in front of his wheel chair.

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F 689	Continued From page 5	F 689		

When interviewed on 12/1/20, at 2:08 p.m. LPN-B stated she responded to the nurse stat call and saw R1 had been positioned on his side. R1's eyes rolled back and was non-responsive with a hematoma on forehead. R1 appeared to have suffered a seizure. LPN-B stated R1 was done with lunch and positioned in the far corner of the dining area. LPN-B further stated that the NA assisting R1 that day had been called away to assist another resident. LPN-B could not recall ever seeing a seat belt used on R1.

When interviewed on 12/1/20, at 4:10 p.m. family (F)-A stated the wheel chair was specially made for R1 to be tilted back in a 30 to 45 degree angle . F-A described a visit in August of 2020 when he was visiting during lunch and R1 was sitting upright for the meal. R1 leaned so far forward his head went to his knees. "A staff came by and said he needs to have this belt on."

When interviewed on 12/1/20, at 5:11 p.m. NA-D stated assisted R1 with lunch the day he fell. NA-D further stated he left R1 in the dining area to tend to another resident's request. NA-D stated R1's chair was supposed to be up for meals and then reclined when done. NA-D further stated he thought he remembered putting the seat belt on R1 that day when he got up in the wheel chair and that he reclined R1 that day after lunch.

When interviewed on 12/1/20, at 5:28 p.m. LPN-C stated R1 had grab bars and pillows on the bed but was not aware of any other safety devices. LPN-C further stated if a seat belt was on the care plan it should have been used.

When interviewed on 12/2/20, at 10:49 a.m. R1's

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F 689	Continued From page 6	F 689		

primary physician (P)-A stated he visited with R1 frequently and that R1 had a history of self-abuse and throwing self to ground at times. P-A stated R1 had a tilt in space wheel chair to prevent R1's epiglottis from closing. P-A further described the tilt in space wheel chair as having a higher height than a regular wheel chair which increased the chance of injury from a fall. P-A further stated that if R1 would have had a strap or seat belt on it would have prevented the fall from the wheel chair that day.

When interviewed on 12/2/20, at 12:45 p.m. director of nursing (DON) stated a resident on seizure precautions should be checked on frequently since seizures could cause falls. DON stated that the nurse manager or nurse on floor at the time of the fall would complete the report of resident fall. The report should include what assistive devices and interventions were in use at the time of the fall. DON stated she did not believe a seat belt was on R1 at the time of the fall since it was not indicated on the post fall report. "[R1] should have had a seat belt on." DON further stated they would use a seat belt on a resident if there was an order and it was care planned. DON stated anticipated R1 to return to the facility and would have reassessed his falls interventions and updated his care plan at that time.

R1 was sent to the hospital following his fall on 11/18/20. Nursing progress noted dated 11/19/20, indicated R1 had a broken clavicle due to the fall. Nursing progress notes dated 11/23/20, identified R1's family called to inform the facility that R1 died in the hospital on 11/23/20.

The facility's Fall Evaluation Safety Guideline

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	245492	A. BUILDING _____ B. WING _____	C 12/02/2020

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

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F 689	Continued From page 7 dated 11/28/17, indicated, "Fall prevention is achieved through an IDT [interdisciplinary team] approach of managing predicting factors and implementing appropriate interventions to reduce risk for falls." The policy further indicated, "Understanding contributing and predicting factors that resent will assist with determining individualized care approaches." The policy further indicated falls evaluation should include evaluation of sitting balance and should include a physical device review. The undated facility's Fall Investigation Guideline indicated the IDT should perform a post-fall huddle to discuss possible causal factors and to identify the root cause analysis which would guide modifications to the care plan interventions.	F 689		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/1/20 and 12/2/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H5492168C-MN67588, H5492169C-MN59222, H5492171C-MN50400. A licensing order was issued at 0830 in relation to H5492169C-MN59222. The following complaint was found to be UNSUBSTANTIATED: H5492170C- MN67611 The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to provide appropriate fall interventions for 1 of 3 residents (R1) reviewed for accidents. This failure resulted in actual harm when R1 fell from the wheelchair and sustained a broken left clavicle (collarbone) and a subdural hematoma (when blood pools between the brain	2 830	Corrected	12/29/20

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2 830	Continued From page 2 and its outmost covering). R1 subsequently died. Findings include: R1's annual Minimal Data Set (MDS) assessment dated 7/29/20, identified R1 was moderately cognitively impaired. R1's diagnoses included cerebral palsy (disorder involving movement, muscle tone and posture often developed prior to birth), spastic quadriplegia (condition that causes jerking motions and stiffness in all four limbs), hydrocephalus (fluid in the brain), schizophrenia (disorder that affects ability to think, feel, and behave clearly) and seizure disorder. R1 was wheelchair bound, required extensive assistance with activities of daily living (ADLS) and had limited range of motion (ROM) with both lower extremities. R1's care plan last revised 8/31/20, identified R1 required the use of safety devices to include: bilateral grab bars, air mattress, specialty wheelchair with seat belt and short cord on call light. R1's care plan instructed staff to "ensure proper positioning with proper body alignment while using restraining safety device" and evaluate safety device use quarterly and PRN [as needed]: evaluate/record continuing risks/benefits, alternatives, need for ongoing use, reason for safety device use." R1's care plan further identified R1 was "at risk for falls/injury r/t [related to] impaired mobility secondary to cerebral palsy. R1's care plan instructed staff to follow seizure precautions. R1's care plan did not define seizure precautions. R1's physician order dated 6/28/18, indicated, "Ok for specialty wheelchair and cushion, ok for seatbelt I [sic] wheelchair to aide in wheelchair positioning."	2 830		

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2 830	Continued From page 3 R1's fall assessment dated 10/28/20, indicated R1 was at high risk for falls with a score of 7. The assessment had no further information that identified fall risk interventions. R1's physician progress note dated 10/7/20, indicated R1 utilized a Hoyer for transfers and specialty wheel chair. R1's progress note dated 11/18/20, at 12:37 p.m. indicated, "Resident was in his chair eating in the dining room. Overhead alert that resident was on the floor struggling to breath. Seizure activity was expected [sic]. 911 was called. Family was called. Vitals taken. Resident was sent to the hospital." The facility Report of Resident Fall dated 11/18/20, indicated the only assistive device and intervention in use at the time of the event was a wheel chair. The check box next to seat belt was not checked. The report did not indicate whether the wheelchair was in a reclined position. When interviewed on 12/11/20, at 12:02 p.m. nursing assistant (NA)-A stated she was the first one to respond when another resident (R6) yelled that someone was on the floor. NA-A further stated the back of R1's wheel chair was in an upright position, straight up and down and it should have been reclined after lunch. NA-A further stated R1's chair was supposed to be positioned so he could be seen from the hallway when no staff were present. NA-A verified and stated no staff were in the dining area at the time when R1 fell and his chair was not positioned in view of the hallway. NA-A stated R1 did not have a seat belt on the day R1 fell from the wheel chair. NA-A further stated R1 was on falls precautions which required checks every 15-20	2 830		

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2 830	Continued From page 4 minutes. NA-A stated she was not aware of seizure precautions. When interviewed on 12/1/20, at 12:13 p.m. R6 (who witnessed the event) stated R1 sat in the wheel chair in the corner of the dining room and she and R1 were talking and then R1 fell forward out of the chair onto the floor. R6 stated no staff were present so she ran and yelled for staff to come help. When interviewed on 12/1/20, at 12:48 p.m. NA-B stated she was in a resident room assisting a resident when she heard R6 yell that someone fell. NA-B stated she ran to the dining area and saw R1 on the floor in front of his wheel chair and R1 had a bump on his head. NA-B further stated that R1 was a falls risk and that R1 should be moved to an area of the room that could be seen from the hallway after he was done with lunch. NA-B further stated the wheel chair should be straight up for meals but reclined between meals. NA-B stated R1 did not have a seat belt on that day. NA-B stated R1 was a high falls risk and she would follow the care plan and perform more frequent checks on R1. When interviewed on 12/1/20, at 1:03 p.m. NA-C stated was in the dining area assisting another resident with lunch the day R1 fell. NA-C stated NA-D assisted R 1 with lunch. NA-C further stated when she left the dining area NA-D was still there but he said was leaving to buy another resident something from the vending machine. NA-C stated, "I told him to tilt [R1] back a little when done eating." NA-C stated not remembering if R1 ever had a seat belt and not sure if R1 had one on that day. When interviewed on 12/1/20, at 1:56 p.m.	2 830		

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2 830	Continued From page 5	2 830		

registered nurse (RN)-A stated R1 needed assistance with meals and the NA's should always stay there with him and then after meals they should either transfer him back to bed or move his wheel chair so he would be in sight. RN-A stated R1 was out of sight the day he fell and the only other person in the dining area at the time of the fall was R6. RN-A further stated that if a resident was on falls risk, staff were supposed to keep an eye on them all the time and that staff should not leave R1 in the dining area unsupervised.

When interviewed on 12/1/20, at 2:02 p.m. licensed practical nurse (LPN)-A stated being told that R1 normally ate in the dining area and then he was taken back to his room. "I heard [R6] yell. I saw him postictal [altered state of consciousness after an epileptic seizure]. I do believe it was a seizure." LPN-A further stated R1's wheel chair was in the back corner of the room and R1 was lying on the floor in front of his wheel chair.

When interviewed on 12/1/20, at 2:08 p.m. LPN-B stated she responded to the nurse stat call and saw R1 had been positioned on his side. R1's eyes rolled back and was non-responsive with a hematoma on forehead. R1 appeared to have suffered a seizure. LPN-B stated R1 was done with lunch and positioned in the far corner of the dining area. LPN-B further stated that the NA assisting R1 that day had been called away to assist another resident. LPN-B could not recall ever seeing a seat belt used on R1.

When interviewed on 12/1/20, at 4:10 p.m. family (F)-A stated the wheel chair was specially made for R1 to be tilted back in a 30 to 45 degree angle . F-A described a visit in August of 2020 when he

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2 830	Continued From page 6	2 830		

was visiting during lunch and R1 was sitting upright for the meal. R1 leaned so far forward his head went to his knees. "A staff came by and said he needs to have this belt on."

When interviewed on 12/1/20, at 5:11 p.m. NA-D stated assisted R1 with lunch the day he fell. NA-D further stated he left R1 in the dining area to tend to another resident's request. NA-D stated R1's chair was supposed to be up for meals and then reclined when done. NA-D further stated he thought he remembered putting the seat belt on R1 that day when he got up in the wheel chair and that he reclined R1 that day after lunch.

When interviewed on 12/1/20, at 5:28 p.m. LPN-C stated R1 had grab bars and pillows on the bed but was not aware of any other safety devices. LPN-C further stated if a seat belt was on the care plan it should have been used.

When interviewed on 12/2/20, at 10:49 a.m. R1's primary physician (P)-A stated he visited with R1 frequently and that R1 had a history of self-abuse and throwing self to ground at times. P-A stated R1 had a tilt in space wheel chair to prevent R1's epiglottis from closing. P-A further described the tilt in space wheel chair as having a higher height than a regular wheel chair which increased the chance of injury from a fall. P-A further stated that if R1 would have had a strap or seat belt on it would have prevented the fall from the wheel chair that day.

When interviewed on 12/2/20, at 12:45 p.m. director of nursing (DON) stated a resident on seizure precautions should be checked on frequently since seizures could cause falls. DON stated that the nurse manager or nurse on floor at the time of the fall would complete the report of

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2 830	Continued From page 7	2 830		

resident fall. The report should include what assistive devices and interventions were in use at the time of the fall. DON stated she did not believe a seat belt was on R1 at the time of the fall since it was not indicated on the post fall report. "[R1] should have had a seat belt on." DON further stated they would use a seat belt on a resident if there was an order and it was care planned. DON stated anticipated R1 to return to the facility and would have reassessed his falls interventions and updated his care plan at that time.

R1 was sent to the hospital following his fall on 11/18/20. Nursing progress noted dated 11/19/20, indicated R1 had a broken clavicle due to the fall. Nursing progress notes dated 11/23/20, identified R1's family called to inform the facility that R1 died in the hospital on 11/23/20.

The facility's Fall Evaluation Safety Guideline dated 11/28/17, indicated, "Fall prevention is achieved through an IDT [interdisciplinary team] approach of managing predicting factors and implementing appropriate interventions to reduce risk for falls." The policy further indicated, "Understanding contributing and predicting factors that resent will assist with determining individualized care approaches." The policy further indicated falls evaluation should include evaluation of sitting balance and should include a physical device review.

The undated facility's Fall Investigation Guideline indicated the IDT should perform a post-fall huddle to discuss possible causal factors and to identify the root cause analysis which would guide modifications to the care plan interventions.

SUGGESTED METHOD OF CORRECTION:

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2 830	Continued From page 8 The director of nursing or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventions are being implemented and the provider is promptly notified of a change in condition. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		