DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 15, 2021

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 21, 2020, we notified you a remedy was imposed. On January 13, 2021 the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 12, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective January 5, 2021 be discontinued as of January 12, 2021. (42 CFR 488.417 (b))

However, as we notified you in our letter of December 21, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 5, 2021.

This does not apply to or affect any previously imposed NATCEP loss.

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

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

January 5, 2021

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 21, 2020, we informed you of imposed enforcement remedies.

On December 17, 2020, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On December 17, 2020, the situation of immediate jeopardy to potential health and safety cited at F880 was removed. However, continued non-compliance remains at the lower scope and severity of D.

As a result of the survey findings:

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

- Directed plan of correction, Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

This Department continues to recommend that CMS impose a 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.

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.

As we notified you in our letter of December 21, 2020, 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 January 5, 2021.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. 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.

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

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded

by an "E" tag), i.e., the plan of correction should be directed to:

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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 (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.

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/ 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 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

A Directed Plan of Correction (DPOC) is imposed in accordance with 42 CFR § 488.424. Your facility must include the following in their POC for the deficient practice cited at F880:

- In order to assist with identifying appropriate corrective actions and implementing systemic changes, the facility must contract with an infection control consultant to provide consultation and oversight for infection prevention and control within the facility.

- The consultant shall exercise independent judgement in the performance of all duties under the consultant contract. The consultant shall meet the independent judgement requirement if the consultant is not presently and has not within a five (5) year period immediately preceding June 1, 2020 directly or indirectly affiliated with the facility, facility's owner(s), agent(s), or employee(s).

- The consultant shall have completed infection prevention and control training from a recognized source, such as the Centers for Disease Control and Prevention or American Health Care Association.

- The consultant will be contracted to work with the facility for a minimum of two (2) months.

- The consult will assist the facility in completing the CMS infection control self-assessment. If this assessment was completed prior to the June 4, 2020 survey, the assessment should be reviewed to determine if it is an accurate reflection of the facility's infection control program. The self-assessment can be found in the CMS publication QSO-20-20-All: Prioritization of Survey Activity: https://www.cms.gov/files/document/qso-20-20-all.pdf,

Infection control consultant responsibilities must include, but are not limited to, the following:

- Work with the facility to conduct a Root Cause Analysis (RCA) to identify and address the reasons for noncompliance identified in the CMS-2567.
- The facility's Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee, must participate in the completion of the RCA. Information regarding RCAs can be found in the CMS publication Guidance for Performing Root Cause Analysis (RCA) with Performance Improvement Projects (PIPs):

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf.

- Take immediate action to implement an infection prevention plan consistent with the requirements at 42 CFR § 483.80 for the affected residents impacted by the noncompliance identified in the CMS-2567 to include identification of other residents that may have been impacted by the noncompliant practices. This plan must include but is not limited to implementation of procedures to ensure:

COHORTING RESIDENTS/TRANSMISSION BASED PRECAUTION "ISOLATION"

- 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.

POLICIES/PROCEDURES/SYSTEM CHANGES:

- The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing shall complete the following:

- Grouping of residents, or "cohorting," should be done when possible to separate residents with an infectious disease (positive residents) from residents who are not affected. Plans to cohort should be carefully established in advance and should be centered on implementation of infection control practices.
- Dedicate a unit or part of a unit as the care location for residents with disease, including those with or without current symptoms of illness. Anticipate ways to close off units to prevent spread of illness from ill residents to non-ill residents (e.g., for symptomatic COVID-19, recovered COVID-19 residents, non-COVID-19 suspected residents).
- Confine symptomatic residents and exposed roommates to their rooms. If they must leave their room, ensure the resident is wearing a mask.
- Provide dedicated equipment for areas, as able.

When a resident is placed on transmission-based precautions, the staff should implement the following:

- Clearly identify the type of precautions and the appropriate PPE to be used.
- Place signage in a conspicuous place outside the resident's room (e.g., the door or on the wall next to the door) identifying the CDC category of transmission-based precautions (e.g., contact, droplet, or airborne), instructions for use of PPE, and/or instructions to see the nurse before entering. Ensure that signage also complies with residents' rights to confidentiality and privacy.
- Make PPE readily available near the entrance to the resident's room.
- Don appropriate PPE upon entry into the environment (e.g., room or cubicle) of resident on transmission-based precautions (e.g., contact precautions).
- Use disposable or dedicated noncritical resident-care equipment (e.g., blood pressure cuff, bedside commode). If noncritical equipment is shared between residents, it will be cleaned and disinfected following manufacturer's instructions with an EPA-registered disinfectant after use.
- Clean and disinfect objects and environmental surfaces that are touched frequently (e.g., bed rails, over-bed table, bedside commode, lavatory surfaces in resident bathrooms).

TRAINING/EDUCATION:

- Provide education to residents (to the degree possible/consistent with the resident's capacity) and their representatives or visitors on the use of transmission-based precautions.

- Refer to CDC Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
- Refer to MDH COVID-19 Infection Prevention and Control and Cohorting in Long-term Care. https://www.health.state.mn.us/diseases/coronavirus/hcp/ltcipchohort.pdf
- MDH: Interim Guidance for Hospital Discharge to Home or Admission to Congregate Living Settings and Discontinuing Transmission-Based Precautions. https://www.health.state.mn.us/diseases/coronavirus/hcp/hospdischarge.pdf

CDC RESOURCES:
Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html
CDC: Isolation Precautions Guideline:
https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/
Healthcare Infection Prevention and Control FAQs for COVID-19:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:
Personal Protective Equipment (PPE) for Infection Control:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html
MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf
Interim Guidance on Facemasks as a Source Control Measure (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf
Interim Guidance on Alternative Facemasks (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf
Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):
https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf
Droplet Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html
Airborne Precautions:
https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist and other facility leadership will verify the placement of each new admission and location and audit for transmission based precautions are being appropriately implemented.
- Conduct a Root Cause Analysis (RCA) which will be done with assistance from the Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee and Governing Body. The RCA should be incorporated into the intervention plan. Information regarding RCAs can be found in the document: Guidance for Performing Root Cause Analysis (RCA)with Performance Improvement Projects (PIPs)
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforR

CA.pdf

In accordance with 42 CFR § 488.402(f), the DPOC remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed before or after that date. A revisit will not be approved prior to receipt of documentation confirming the DPOC was completed. To successfully complete the DPOC, the facility must provide all of the following documentation identified in the chart below.

Documentation must be uploaded as attachments through ePOC to ensure you have completed this remedy.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies (including F880) within 10 days after receipt of the Form CMS 2567.

Item	Checklist: Documents Required for Successful Completion of the Directed Plan
1	Consultant name and credentials meeting the criteria outlined above
2	Executed contract with the consultant
3	Documentation demonstrating that the RCA was completed as described above
4	List of facility policies and procedures reviewed by the consultant.
5	Infection control self-assessment
6	Summary of all changes as a result of the RCA and consultant review – to include a summary of how staff were notified and trained on the changes
7	Content of the trainings provided to staff to include a Syllabus, outline, or agenda as well as any training materials used and provided to staff during the training
8	Names and positions of all staff to be trained
9	Staff training sign-in sheets
10	Summary of staff training post-test results, to include facility actions in response to any failed post-tests
11	Summary of follow-up employee supervision and work performance appraisal to include when employees were observed, what actions were observed, and an evaluation of the effectiveness of any new policies and procedures.

In order to speed up our review, identify all submitted documents with the number in the "Item" column.

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 12/17/2020

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
E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted on 12/15/20, through 12/17/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was IN full compliance Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 12/15/20, through 12/17/20, a COVID-19 Focused Infection Control survey was completed at your facility by the Minnesota Department of Health. Your facility was found NOT in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. The survey resulted in findings of immediate jeopardy (IJ), at F880, when it was determined the facility failed to follow Centers of Disease Control (CDC) guidance related to not cohorting COVID-19 positive residents with COVID-19 negative residents. The administrator and director of nursing (DON), registered nurse (RN)-A and RN-B, were notified of the IJ on 12/16/20, at 4:33 p.m. The IJ was removed on 12/17/20, at 1:55 p.m., but noncompliance remained at the lower scope and severity level of D, which indicated no actual harm with potential for more than minimal harm that is not IJ. In addition, an abbreviated survey was completed at your facility to conduct a complaint	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/11/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 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: MN68069-H5492172C MN66851-H5492173C 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. Upon receipt of an acceptable electronic POC, a revisit of your facility will be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or	F 600		1/12/21

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F 600	Continued From page 2 physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on document and interview, the facility failed to protect a resident from physical abuse for 2 of 2 residents (R1, R4) who were reviewed for resident to resident abuse. Findings include: R1's face sheet printed 11/2/20, indicated diagnoses of encephalopathy (disease that affects brain function), altered mental status and dementia with behavioral disturbance. R1's annual Minimum Data Set (MDS) dated 12/14/20, identified R1 had problems with short and long term memory, had physical behavioral symptoms directed toward others and other behavioral symptoms not directed towards others. R1 was also noted to wander 1-3 times out of 7 days . R1's care plan dated 3/6/20, indicated R1 had a behavior problem related to wandering and R1 wandered into to other residents' rooms. One of R1's target behaviors had been wandering and staff were to redirect R1 away from other residents' rooms. R1's care sheet printed 12/17/20, directed staff to visually observe R1 due to continuous removal of wanderguard device. R1's Skin Observation dated 11/2/20, at 12:31 p.m. identified an abrasion on the nose measuring 1 x 0.3 centimeters (cm) and stitches on left upper lip measuring 1.5 cm.	F 600	1. R1 and R4 have received a comprehensive chart review to ensure appropriate target behaviors and interventions are identified and in place. 2. Like residents with identified behaviors that agitate others have received a comprehensive chart review to ensure appropriate target behaviors are identified and in place. 3. Leadership reviewed Villa Abuse and Neglect Prevention Policy and it remains appropriate. No changes needed. 4. Richfield facility staff have been educated on types of abuse and identifying resident behaviors. Identification of like residents: Residents with known behaviors that may agitate others. Monitoring Mechanism: Behavioral interventions will be monitored by the IDT daily for effectiveness x2 weeks, then monthly x3 months. Results will be reviewed at the monthly QAPI x90 days for continued process improvement.	

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F 600	Continued From page 3	F 600		

R1's physician order dated 11/2/20, directed staff to monitor stitches on left upper lip; abrasion on nose for signs and symptoms of infection.

R4's face sheet printed 11/2/20, indicated diagnoses of Wernicke's Encephalopathy (a neurological condition causing delerium and confusion).

R4's annual MDS assessment dated 12/9/20, identified R4 had problems with short and long term memory, had verbal behavioral symptoms directed toward others and behavioral symptoms which put others at risk for physical injury.

R4's care plan dated 12/17/20, identified R4 demonstrated physical behavioral problems towards staff and other residents related to poor impulse control; a history to hit other residents; and a target behavior of physical aggression toward other residents. Staff were directed to remove other residents from the area, and to leave the room if R4 was agitated and encourage R4 to seek out staff when agitated.

R4's Skin Observation dated 11/2/20, at 5:26 p.m. identified an abrasion on R4's left forehead measuring 1 x 1 cm. R4 had 2 abrasions on his left cheek, close to his lip which measured 1 x 2 cm and 1 x 1 cm.

R4's progress note dated 11/2/20, at 3:13 p.m. indicated R4 had an abrasion on his left side forehead and left cheek near his mouth.

An addendum to the investigation summary dated 11/6/20, stated the director of nursing (DON) and regional support discussed the event and

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F 600	Continued From page 4	F 600		

possible triggers to behavioral outcomes including R4 had difficulty controlling his behavior when other residents are in his space and R4 had previous physical altercations with residents. R4 had been denied other placement options due to his negative behaviors and social services continued to look for appropriate housing.

The Interview/Statement Record dated 11/2/20, with R4 indicated R1 came in his room and attacked him. R4 denied hitting R1.

An Interview/Statement Record, undated, with TMA-A indicated, TMA-A had been in another resident room at the time of the incident. TMA-A heard a noise and then saw R1 come out of R4's room. R1 had blood running down his face.

An Interview/Statement Record, undated, with NA-B indicated she heard a noise and ran to R4's room. R1 and R4 both had been bleeding.

An Interview/Statement Record, undated, with LPN-A indicated NA-B told her two residents had been in a fight. The two residents were separated immediately. R4 said that R1 came into his room and tried to take his shoes and when he tried to stop him R1 hit him.

During an interview on 12/16/20, at 3:33 p.m. R1's guardian reported he recently brought R1 to the emergency room for stitches due to an incident with another resident. There had been 6 different incidents in less than a year. R1's guardian, stated the reason R1 had been at the facility had been for the need of 24 hour supervision to prevent injuries. He did not want R1 to have to leave but felt he may need to keep him safe.

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F 600	Continued From page 5 During an interview on 12/17/20, at 10:45 a.m. social worker (SW)-A reported he had been gone at the time of the incident but from what he understood R1 went into R4's room and that was what started the altercation. The intervention to the incident was to put R4 on one to ones although R1 appeared to have been the root cause. SW-A also indicated R1 should have been provided an intervention as he had been the one to wander into R4's room. During an interview on 12/17/20, at 11:08 a.m. the director of nursing (DON) and registered nurse (RN)- B stated R1 wandered into R4's room. R4 reported that R1 tried to take his shoes and they ended up getting into and altercation. The facility put R4 on one to ones after the incident and had been looking for a placement that would be appropriate for R4. R4 did not like people who came into his personal space and had behavioral problems. R1 wandered often and staff are to redirect him due to his dementia and encephalopathy. R1 required one to ones and activities he enjoyed to keep him busy to prevent him from wandering. The facility policy Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property dated 9/11/20, identified the facility would protect each resident from abuse while they reside within the facility. No abuse or any type of harm will be tolerated and residents will be monitored for protection.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse,	F 609		1/12/21

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F 609	Continued From page 6 neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report, no later than 24 hours, an injury of unknown origin to the State Agency (SA) for 1 of 1 resident (R1) who was dependent on staff for activities of daily living. Findings include: R1's Order Review History Report printed 12/7/20, indicated R1 had diagnoses that	F 609	1. R1's injury of unknown origin was reported to the local state department. 2. Residents identified with injuries of unknown origin will be reported to the state agency within the required time frame. 3. Leadership reviewed Villa Abuse and Neglect Prevention Policy and it was appropriate. No changes needed. 4. Richfield staff have been educated on	

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F 609	Continued From page 7 included encephalopathy, unspecified dementia with behavioral disturbance, altered mental status, and alcohol dependence with alcohol induced persisting dementia. R1's quarterly Minimum Data Set (MDS) dated 10/9/20, indicated R1 was severely cognitively impaired and required extensive assistance with dressing, hygiene, and toileting. R1 required supervision with transfers and was independent with ambulation. R1's Progress Note dated 12/8/20, at 6:20 a.m., stated that R1 had sudden bleeding and was noted to have a 1 inch laceration to the back of R1's head; near the neck. Staff applied ice to the area until laceration stopped bleeding. Staff notified the on call physician and informed of laceration and that staff were unaware as to how R1 obtained it. Staff were advised by the on call physician to cover the laceration with a bandage. Staff also notified family of incident. R1's care plan initiated 7/8/20, identified R1 to be at risk for falls related to diagnosis of dementia. The care plan goal stated R1 would be free of minor injury and directed staff to anticipate and meet resident's needs. During interview on 12/16/20, at 8:45 a.m., registered nurse (RN)-C stated sometime during the night of 12/8/20, she was in the process of completing rounds for the third floor non-COVID-19 dementia unit with nursing assistant (NA)-A. RN-C and NA-A walked into R1's room where R1 was standing in the middle of the room and blood was noted on the floor near R1's feet. RN-C stated that the unit was very quiet and if R1 would have fallen in the room she	F 609	the abuse reporting including injuries of unknown origin. Identification of other residents: Current Richfield Villa residents are at risk for injuries of unknown origin. Monitoring Mechanism: 1. Nursing staff will monitor resident skin during daily cares and through weekly skin assessments to ensure residents with injuries are identified and reported appropriately. 2. DON/designee will audit POC daily skin alerts and weekly skin checks daily for 2 weeks then 3 times monthly x3 months. 3. Results will be reviewed at the monthly QAPI x90 days for continued process improvement.	

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would have heard it. RN-C stated she assessed R1 and noted that R1 had what appeared to be a 1 inch laceration at the back of R1's head; by the neck. RN-C stated she immediately applied pressure as the area was bleeding; RN-C also had NA-A obtain an ice pack to apply to the laceration. NA-A returned with ice pack and RN-C applied to the laceration on R1's back of head until the bleeding stopped. RN-C stated that she was not aware as to how R1 obtained the laceration and stated she was extremely busy being the only nurse scheduled to work on both the third floor COVID-19 dementia unit and the third floor non-COVID-19 dementia unit. RN-C stated she had to go back and forth between units which were sectioned off by closed double doors and there were times she was not present on the unit that R1 resided on. RN-C also stated R1 should have had one to one staff monitoring (this was not found in R1's care plan or physician orders) but that was not possible as there was not enough staff to provide that type of monitoring for R1. RN-C stated that as soon as the bleeding had ceased she contacted and notified the on call physician of the laceration and was instructed to cover the area with a bandage. RN-C stated she then contacted and updated R1's son of the incident. During shift change, RN-C stated she notified the on-coming nurse, RN-D, of the incident with R1 (RN-C did not know the name of the nurse she notified). RN-C did not notify the supervisor, RN-B (the nurse manager for the dementia unit), the director of nursing (DON), or the administrator of the incident.

During interview on 12/17/20, at 2:20 p.m., RN-B stated she had been informed by RN-D, who was working the day shift (6:00 a.m. to 2:30 p.m.), after the incident with R1. RN-B stated she

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assessed R1 and could not identify a laceration to the back of the head as was indicated by RN-D. RN-B stated there was a minor abrasion but the skin was intact. RN-B stated that the nurse practitioner had visually assessed R1 that morning of 12/8/20, and noted there was not a laceration. RN-B did not report this to the DON as she did not feel that this was a reportable incident and that R1 did not have an injury.

During interview with R1's son on 12/17/20, at approximately 3:25 p.m., son stated that the facility did notify him the night that the incident with R1 was noted. Son stated the nurse contacted him and notified him that R1 was found to have a laceration to the back of the head and staff were not sure how R1 obtained. Son stated nurse advised him that the on call provider had been contacted and that nurse was instructed to apply a bandage to the laceration.

Review of R1's medical record lacked documentation from the on-call provider and lacked a progress note from R1's nurse practitioner (NP). RN-B stated that she would look for the progress note from nurse practitioner (NP) as well as any documentation from the on-call provider.

During interview on 12/17/20, at 2:45 p.m., the DON stated she and the administrator were responsible for reporting facility incidents to the SA. The DON also stated she was not notified of an incident occurring with R1 on 12/8/20.

During interview on 12/17/20, at 3:02 p.m., the administrator stated she was not aware of, nor notified of, an incident that occurred on 12/8/20, involving R1.

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F 609	Continued From page 10 An email received from the NP to the DON on 12/18/20, at 4:52 p.m. stated the NP noted a horizontal superficial laceration approximately 2.5cm in length to the upper nape of R1's neck; low crown of the head. The NP stated in the email that the lesion was not bleeding or draining and that there was no surrounding erythema, edema, bruising, tenderness, or open areas to skin. The facility Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Resident Property policy effective 11/28/17, directed staff that if alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source are to be reported immediately, but not later than 2 hours after the allegation is made, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including state survey agency and adult protective services where state law provides for jurisdiction in long term care facilities).	F 609		
F 880 SS=J	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		1/12/21

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and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed

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F 880	Continued From page 12 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Centers for Disease Control (CDC) guidance to prevent or minimize the transmission of COVID-19 was followed when 1 of 1 resident (R3) who had been negative for COVID-19 was placed in a room with a COVID-19 positive resident for 12 days. This resulted in an immediate jeopardy (IJ) for R3 who was exposed to R2 for 12 days which resulted R3 to contract COVID-19. The IJ began on 12/3/20, when R3's roommate tested positive for COVID-19 and was not separated from R3, who had tested negative for COVID-19. The administrator and director of nursing (DON), registered nurse (RN)-A and RN-B, were notified of the IJ on 12/16/20, at 4:33 p.m. The IJ was removed on 12/17/20, at 1:55 p.m. Findings include: Current Centers for Disease Control (CDC)	F 880	1. Upon notification of cohort deficient practice, R3 was immediately moved to a private room for a 14-day quarantine due to Covid-19 exposure on 12/16/2020. 2. Richfield Villa residents in-house and residents pending hospital return were evaluated for appropriate room placement, transmission-based precautions and appropriate cohort practices as of 12/16/2020. 3. Nursing staff educated on appropriate cohort practices, guidelines for transmission based precautions, and appropriate donning and doffing of PPE. 4. Richfield Villa leadership developed a contract with an Infection Control (IC) consultant with five years of experience, with no organizational affiliation with the Villa organization in the past five years and has received appropriate IC training from a recognized source x 60 days. 5. Infection preventionist consultant, DON and Administrator completed a root cause	

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F 880	Continued From page 13 guidance indicated nursing home residents are at high risk of being affected by respiratory pathogens like COVID-19 due to older age and underlying chronic medical conditions. Patients with prolonged close contact with SARS CoV-2 infection should quarantine for 14 days. These patients should not be cohorted with positive COVID-19 patients unless they are also confirmed to have COVID-19 through testing. During an interview on 12/15/20, at 12:20 p.m. the director of nursing (DON) reported the facility kept R2 and R3 together even though R3 tested negative. They did not separate R2 and R3 because R3 had already been exposed to R2. Since R2 had been positive they moved both R2 and R3 to the COVID-19 unit on 12/9/20, despite R3 negative test result. During an interview on 12/16/20, at approximately 2:15 p.m. the administrator verified R3 had now tested positive. R2's face sheet dated 12/3/20, indicated COVID-19 diagnosis onset. R2's significant change Minimal Data Set (MDS) dated 11/5/20, identified R2 had diagnoses of hypertension (HTN), chronic kidney disease (CKD), diabetes mellitus (DM), chronic obstructive pulmonary disease (COPD), and respiratory failure which made her susceptible to complications from COVID-19. R2's progress note on 12/3/20, at 5:43 p.m. indicated the facility notified R2 of her positive COVID-19 results and "initiated quarantine."	F 880	analysis to identify the problems that resulted in this deficiency and developed interventions and was reviewed by IDT and QAPI. 6. The IC consultant completed/facilitated an CMS infection control facility assessment, support and review systematic IC policy review/change, implement appropriate corrective actions, provide consultation, oversight and support of IC practices and facility systems. 7. Infection Prevention consultant, administrator and DON reviewed policies and procedures for Infection Prevention and Control Guideline and CDC Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Covid-19 in Healthcare settings. Identification of other-like residents: Richfield Villa residents are reviewed for Covid-19 symptoms and PCR results to ensure appropriate cohort practices and placement of transmission-based precautions. Monitoring Mechanism: 1. Richfield Villa residents are tested per guidance, Covid-19 test results will be reviewed to ensure appropriate transmission-based precaution are in place and appropriate cohorting practices are being utilized and monitored by Infection Control nurse or designee daily. 2. Transmission-based precautions, and appropriate cohort processes, will be	

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F 880	Continued From page 14 R2's physician note dated 12/4/20, stated R2 tested positive for COVID on 12/3/20, and respiratory symptoms had been stable at baseline. R2's physician orders dated 12/7/20, indicated to place R2 on contact and droplet isolation. R2's care plan dated 12/4/20, identified R2 had a positive diagnosis of COVID-19. Staff were directed to encourage R2 to stay in room with door closed until symptoms resolved or 14 days had been exceeded. R3's quarterly MDS dated 9/29/20, indicated had a diagnosis of COVID-19 which made her susceptible to complications from COVID-19. R3's physician's orders dated 12/3/20, directed staff to "Initiate COVID-19 precautions every shift as roommate tested positive. R3 must remain under quarantine." R2 had been R3's roommate. R3's progress note dated 12/3/20, at 5:38 p.m. indicated R3 had been notified her roommate tested positive for COVID-19. R3's progress note dated 12/3/20, at 5:38 p.m. indicated R3 had been updated her roommate tested positive for COVID-19. R3's progress note dated 12/6/20, at 7:50 a.m. indicated R3's COVID-19 test identified COVID 19 was not detected. R3's progress note dated 12/9/20, at 8:53 p.m. indicated R3 indicated to temporarily move from the non-COVID unit to the COVID unit due to	F 880	monitored by Infection Preventionist daily for five days, then twice weekly for two weeks, until compliance is met. The audits will be taken to the QAPI meeting and the team will decide when audits can be discontinued. 3. Resident room assignments will be reviewed daily by infection Preventionist for appropriate room placement prior to admission; or room transfer daily for five days, then twice a week for two weeks, until compliance is met. The audits will be taken to the QAPI meeting and the team will decide when audits can be discontinued. 4. Staff assigned to residents on transmission-based precautions will be audited for appropriate PPE Donning/Doffing and Hand Hygiene daily for 5 days and then weekly times four. The audits will be taken to the QAPI meeting and the team will decide when audits can be discontinued.	

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COVID 19 exposure to R2. Although R3 had not tested COVID 19 positive, she was still transferred to the COVID unit with R2.

R3's progress note on 12/14/20, at 11:44 p.m. indicated R3 had a COVID-19 test sent to the lab.

R3's progress note on 12/16/20, at 8:53 p.m. indicated R3 tested positive on 12/15/20, at 9:30 p.m. and staff transferred R3 to the COVID unit.

R3's care plan dated 12/16/20, indicated R3 had been diagnosed with COVID-19 on 12/15/20. Staff were directed to encourage R3 to stay in her room with door closed until symptoms resolve or 14 days has been exceeded. On 10/12/17, the care plan indicated potential for altered respiratory status related to smoking.

During an interview on 12/15/20, at 10:02 p.m. the administrator reported R2 and R3 had shared a room. R2 tested positive for COVID-19 on 12/3/20. R3 had rapid COVID-19 tests taken when residents on R3's floor (second floor) became positive. A polymerase chain reaction (PCR) test (test to detect COVID-19 by looking for traces of the virus' genetic material) on 12/6/20, indicated R3 had been negative for COVID-19. The administrator stated since R3 had been exposed to R2 they kept them together. R2 and R3 were on the COVID unit but had planned to move R3 later that day to the first floor to quarantine for 14 days since she had no detection of COVID-19 on 12/6/20 when the PCR test was completed.

During an interview on 12/15/20, at 2:12 p.m. the DON and registered nurse (RN)-A reported the thought process behind keeping R3, who tested

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	245492	A. BUILDING _____ B. WING _____	C 12/17/2020

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 880	Continued From page 16	F 880		

negative, and R2, who tested positive together was because R3 had already been exposed to R2. The facility wanted to get more test results for R3 and wanted to make sure R3 did not have any symptoms before they moved R3 to the first floor quarantine unit to monitor and quarantine.

During an interview at 12/15/20, at 2:15 p.m. the DON and RN-A reported the facility moved both R2 and R3 together to the COVID-19 unit on 12/9/20, since R2 had tested positive.

During an interview on 12/15/20, at 2:21 p.m. RN-A reiterated that even though R3 had been negative the facility kept her with R2 as she had been exposed. R3 had been negative on all COVID-19 tests and had been waiting for the results of a PCR test. They wanted to make sure R3 was negative before they moved her to possibly expose another resident.

During an interview on 12/15/20, at 3:25 p.m. the DON and RN-A reported each day they had gotten more and more cases and their plan to move a resident kept changing. Although R3 received negative test results on 12/6/20, they wanted confirmation R3 continued to test negative by giving another PCR before moving R3 since she had been exposed to R2 (confirmed positive).

During an interview on 12/16/20, at 1:16 p.m. the DON and RN-B verified that it is not acceptable to have to have positive and negative COVID-19 residents together and it was not acceptable to continue to expose an exposed resident to a positive resident since they had been roommates. The DON reported R2 and R3 had been roommates from 12/3/20, until 12/15/20. R2 and

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F 880	Continued From page 17	F 880		

R3 were moved together to the COVID-19 unit on 12/9/20.

During an interview on 12/16/20, at 1:20 p.m. the DON and RN-B indicated they had considered some alternative placement presented for R2 or R3. However at the time of the interview the DON could not verify why some alternative placements were not considered. She indicated she would return with that information.

During an interview at 12/16/20, at 3:30 p.m. the DON verified she was not able to provide reasoning why the facility did not use any of the eight alternatives presented to separate R2 and R3 earlier.

The facility Infection Prevention and Control Guideline dated 3/25/20, identified the goal to control the infections of residents with the need for a process to manage a resident when a private room is not available. Additionally, the guideline defined cohorting as the practice to group residents infected or colonized with the same infectious agent together and to prevent contact with susceptible residents.

According to the Centers for Disease Control (CDC)'s recommendations, dated 4/30/20, residents with confirmed COVID should be moved to a dedicated unit, in a private room if possible, and the exposed roommate should be kept in a private room, if possible, or cohorted with other residents who had been exposed to COVID.

The immediate jeopardy that began on 12/16/20, was removed and the deficient practice corrected on 12/17/20, when the facility began to educate

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F 880	Continued From page 18 staff and completed competency testing on content provided. Education included regulation and guidance on how to cohort residents. Additionally, all residents had been assessed for appropriate infection control practices and appropriate cohort processes and there had been no possible residents cohorting with negative residents or sharing a bathroom within the facility as of 12/16/20.	F 880		

Electronically delivered
January 5, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: I9T111

Dear Administrator:

The above facility was surveyed on December 15, 2020 through December 17, 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:

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING: _____ B. WING _____	C 12/17/2020

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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 12/15/20, through 12/17/20, surveyors of this Department's staff visited the above provider for an abbreviated survey complaint investigation to investigate complaint: H5492172C and H5492173C. No correction orders were issued.	2 000		

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

Electronically Signed | 01/11/21

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2 000	Continued From page 1 The facility is enrolled in the electronic Plan of Correction (ePOC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		