DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 11, 2025

Administrator
The Villas At Richfield
7727 Portland Avenue South
Richfield, MN 55423

RE: CCN: 245492
Cycle Start Date: March 12, 2025

Dear Administrator:

On April 9, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 19, 2025

Administrator
The Villas At Richfield
7727 Portland Avenue South
Richfield, MN 55423

RE: CCN: 245492
Cycle Start Date: March 12, 2025

Dear Administrator:

On March 12, 2025, 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by June 12, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 12, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

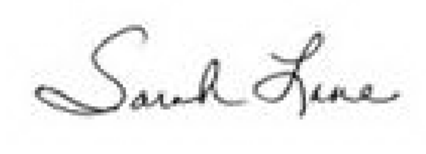
INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
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Electronically delivered

March 19, 2025

Administrator
The Villas At Richfield
7727 Portland Avenue South
Richfield, MN 55423

Re: Event ID: W6BQ11

Dear Administrator:

The above facility survey was completed on March 12, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@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 03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT RICHFIELD	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 3/11/25 and 3/12/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H54921600C (MN00111357) and H54928884C (MN00111106) with deficiencies issued at F609, F610, F622 and F684. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in	F 609		4/4/25

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

Electronically Signed | 03/24/2025

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

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F 609	Continued From page 1 serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure alleged violations of an injury of unknown origin that resulted in suspicion of serious bodily injury were immediately reported, no later than 2 hours, to the State Agency (SA) and administrator for 1 of 1 resident (R2) reviewed for abuse. Findings include: R2's Medicare 5-Day Minimum Data Set (MDS) dated 2/3/25, indicated R2 had moderate cognitive impairment. R2's provider progress note by physician's assistant (PA)-A dated 2/19/25 no time indicated, indicated R2 was seen to discuss discharge planning to return home. R2's left wrist was noted to be bruised and swollen with tenderness to palpation, with no reported falls and injuries. The	F 609	R2 has since discharged from The Villas at Richfield All residents have the potential to be affected if this requirement is not met. The Monarch Healthcare Management Abuse Prohibition / Vulnerable Adult policy has been reviewed and remains current. All necessary staff have been educated using Monarch Healthcare Managements Abuse Prohibition / Vulnerable Adult policy and the specifics of what an injury of unknown origin is and who it is reported too. A full house audit was completed to identify any injuries of unknown origin. This was done by reviewing all weekly skin checks. All new injuries were reviewed and if determined to be unknown, were investigated and reported. Compliance audits will be completed	

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F 609	Continued From page 2 provider ordered an X-Ray for the left wrist. The progress notes lacked information about a staff discovery of R2's swollen wrist. On 3/12/25 at 10:11 a.m., during an interview, social worker (SW)-A stated he was not aware of R2's wrist injury however, confirmed any injury of unknown origin should have been reported to the SA and was unsure if the report had been completed. On 3/12/25 at 3:48 p.m., during an interview, the director of nursing (DON) stated R2's wrist injury should have been reported to the SA per the policy and confirmed no report had been made to the SA. On 3/12/25 at 2:00 p.m., during an interview, registered nurse (RN)-D stated she was aware R2 had an X-Ray ordered for her wrist but was not sure why. RN-D indicated if R2 had an injury of unknown origin, the facility should have reported it to the SA. RN-D stated RN-C discovered the swollen wrist and notified the PA. On 3/12/25 at 2:36 p.m., during an interview, RN-C stated she noticed R2's wrist was swollen on 2/19/25, and told the PA who was in the facility. RN-C stated PA-A gave an order for an X-Ray to determine if the wrist was fractured. RN-C stated she knew the incident should have been reported to the SA. RN-C stated she did not report to the SA however, had reported it to the PA. On 3/12/25 at 2:51 p.m., during an interview, PA-A stated a nurse informed her about R2's swollen wrist and when PA-A assessed it, the right wrist was noted to be bruised, swollen, and	F 609	weekly for four (4) weeks to ensure all alleged violations of injury of unknown origin that resulted in suspicion of serious bodily injury were reported. In addition, an Audit of 4 staff members weekly for four (4) weeks on their understanding of reporting injuries of unknown origin. After 4 weeks, the results of these audits will be shared with facility QAPI committee for input on need to increase, decrease, or discontinue audits. Administrator or designee to monitor.	

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F 609	Continued From page 3 tender to palpate, with no related reports of falls or injuries. PA-A stated, "You could call in an injury of unknown origin." PA-A stated the injury should have been reported to the SA, and was unsure if it had been. On 3/12/25 at 3:05 p.m., during an interview, the administrator stated if a resident had a bruise of unknown source, he would report it to the SA. The administrator acknowledged he was not aware of the injury and staff had not reported it to him. The Abuse Prohibition/Vulnerable Adult policy dated 2/2025, indicated injuries of unknown injury that were not observed and suspicious because of the extent of the injury would be reported to the State Agency and investigated.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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	F 610		4/4/25

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F 610	Continued From page 4 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate an injury of unknown origin for 1 of 3 residents (R2), (R2 had a swollen, bruised, tender right wrist with no known related injuries or accidents) reviewed for abuse. Findings include: R2's Medicare 5-Day Minimum Data Set (MDS) dated 2/3/25, indicated R2 had moderate cognitive impairment. R2's provider progress note by physician's assistant (PA)A dated 2/19/25 no time identified, indicated R2 was seen to discuss discharge planning to return home. R2's left wrist was noted to be bruised and swollen with tenderness to palpation, with no reported falls and injuries. The provider ordered an X-Ray for the left wrist. On 3/12/25 at 10:11 a.m., during an interview, social worker (SW)-A stated he was not aware of R2's wrist injury however, confirmed any injury of unknown origin should have been investigated, and was not aware if it had been investigated. On 3/12/25 at 3:48 p.m., during an interview, director of nursing (DON) stated R2's wrist injury should have been investigated per the policy, and confirmed it had not been investigated. On 3/12/25 at 2:51 p.m., during an interview, PA-A stated a nurse informed her about R2's wrist and when she saw it, it was bruised, swollen, and tender to palpate, and there were no	F 610	R2 has since discharged from The Villas at Richfield All residents have the potential to be affected if this requirement is not met. The Monarch Healthcare Management Abuse Prohibition / Vulnerable Adult policy has been reviewed and remains current. All necessary staff have been educated using Monarch Healthcare Managements Abuse Prohibition / Vulnerable Adult policy and the specifics of what an injury of unknown origin is and who it is reported too. A full house audit was completed to identify any injuries of unknown origin. This was done by reviewing all weekly skin checks. All new injuries were reviewed and if determined to be unknown, were investigated and reported. Compliance audits will be completed weekly for four (4) weeks to ensure all alleged violations of injury of unknown origin that resulted in suspicion of serious bodily injury were investigated and reported. In addition, an Audit of 4 staff members weekly for four (4) weeks on their understanding of reporting injuries of unknown origin. After 4 weeks, the results of these audits will be shared with facility QAPI committee for input on need to increase, decrease, or discontinue audits. Administrator or designee to monitor.	

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F 610	Continued From page 5 falls or injuries reported related to the injury. PA-A stated, "You could call in an injury of unknown origin." On 3/12/25 at 3:05 p.m., during an interview, the administrator stated if a resident had a bruise of unknown source, he would investigate it. The administrator acknowledged he was not aware of the injury, it had not reported it to him, and it had not been investigated. The Abuse Prohibition/Vulnerable Adult policy dated 2/2025, indicated injuries of unknown injury that were not observed and was suspicious because of the extent of the injury would be reported to the State Agency and investigated.	F 610		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid	F 622		3/28/25

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F 622	Continued From page 6 under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident	F 622		

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F 622	Continued From page 7 needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c) (2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure adequate and required information was communicated and documented to a receiving healthcare facility to provide continuity of care for 1 of 3 residents (R2) reviewed for discharge. Findings include: R2's Medicare 5-Day Minimum Data Set (MDS) dated 2/3/25, indicated R2 had moderate cognitive impairment, an indwelling catheter	F 622	F622 R2 has since discharged from The Villas at Richfield. All residents have the potential to be affected if this requirement is not met. A full house audit was conducted to identify all residents with catheters. The audit included: ensuring their catheters are intact with no concerns, that there are	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 8 (used to drain urine from the bladder), a history of stroke and renal insufficiency (kidneys were not fully functioning). R2's care plan printed 3/12/25, lacked indication R2 had a catheter. R2's diagnoses list printed 3/11/25, indicated chronic kidney disease and neuromuscular dysfunction of the bladder. R2's hospital discharge summary dated 1/28/25, indicated R2 arrived to the hospital on 1/20/25, with urinary retention that was relieved with a catheter. R2's provider progress notes dated 1/29/25, indicated R2 had a catheter in the hospital for urinary retention. R2's progress notes dated 2/1/25, indicated R2 had a catheter, and catheter cares were provided. R2's orders dated 2/14/25, indicated monitor catheter output every shift, and change foley catheter monthly and as needed. R2's provider progress note by physician's assistant (PA)-A dated 2/19/25 [no time indicated], indicated R2 was seen to discuss discharge planning, to return home but had altered mentation, painful urination, suprapubic tenderness, and blood in her urine and catheter. R2's progress note dated 2/25/25, at 1:55 p.m., indicated R2's catheter had come out, two nurses were unable to reinsert the catheter, and the nurse manager was notified. The progress note indicated the second shift nurse would attempt to	F 622	orders in to chagne the catheter including size, and that size and type of ather is listed in care plan. A full house audit of all discharges was completed for all resients that dischargfed in the last 30 days. The audit included ensuring that all required information was communicated and documented to a receiving healthcare facility and that the information was accurate. Also audited to ensure that if residents had a catheter, that catheter was intact upon discharge and the disharge summary included the order regarding changing cather including the type and size of catheter. The Monarch Healthcare Managment Dischare Planning policy has been reviewed and remains current. All necessary staff have been educated using Monarch Healthcare Managements Discharge Planning policy. Audits for all discharges will be completed weekly for four (4) weeks to ensure residents with catheters discharged with catheters inserted, and that thorough and accurate communication was provided to admitted facility including orders for catheter changes including type and size of catheter. After four (4) weeks, the results of these audits will be shared with facility QAPI committee for input on need to increase, decrease or disconitnue audits. DON or designee will monitor.	

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 03/12/2025

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F 622	Continued From page 9 reinsert the catheter. R2's progress note dated 2/26/25 at 6:50 a.m., indicated three nurses attempted to reinsert R2's catheter without success, and indicated R2 had a wet brief. The progress note lacked indication the provider was notified. R2's facility Discharge Summary and Orders dated 2/25/25, indicated R2 could discharge to the assisted living (AL) facility and also included a summary of R2's care. The summary included progress notes that identified R2 had a catheter, but lacked an order for the catheter and lacked mention R2 was discharged to the AL without a catheter when R2 required a catheter. In addition, the summary lacked information about R2's urinary incontinence, bowel incontinence and mental status. On 3/11/25 at 1:33 p.m., during an interview, registered nurse (RN)-A stated R2 arrived at the AL facility on 2/26/25, without a catheter and R2 should have had one. RN-A stated R2 was having small voids and on 2/28/25, the AL facility sent R2 to the emergency room for a catheter insertion. RN-A stated the solution for the skilled nursing facility should not have been to just send her to the AL without a catheter. On 3/11/25 at 3:57 p.m. during an interview, licensed practical nurse (LPN)-A stated R2's catheter came out on 2/25/25, and several nurses tried to reinsert it, and then she and other nurses tried again on 2/26/25, prior to R2's discharge. LPN-A stated she knew R2 needed the catheter for urinary retention and could develop an infection without it.	F 622		

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F 622	Continued From page 10 On 3/12/25 at 9:18 a.m., during an interview, family member (FM)-A stated R2 had a catheter since January 2025, when it was placed in the emergency room due to urinary retention. FM-A stated R2 arrived at the assisted living facility [after discharge from the facility] in an incontinence brief instead of a catheter because staff could not reinsert it after a catheter change. On 3/12/25 at 11:08 a.m., during an interview, LPN-B stated R2 should have discharged with a catheter because it was part of her treatment plan. On 3/12/25 at 2:00 p.m., during an interview, RN-D stated R2 had an order for a catheter from standard batch orders and R2 should have discharged with a catheter. Additionally, RN-D stated she was unaware R2 left the facility without a catheter, and staff should have notified the provider if they were unable to reinsert R2's catheter. On 3/12/25 at 2:51 p.m., during an interview PA-A stated R2 discharged from the hospital with a catheter for urinary retention. The PA-A stated R2 should have discharged to the AL with a catheter and confirmed PA-A had not been notified R2 discharged without the catheter. The Discharge Planning policy dated 1/2025, indicated the discharge plan would identify resident needs, and develop and implement plans and interventions to address them. The post-discharge plan of care must indicate arrangements for follow-up care, and post-discharge medical services.	F 622		
F 684 SS=D	Quality of Care	F 684		3/28/25

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F 684	Continued From page 11 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess, develop a plan of care, and provide interventions for 1 or 1 resident (R2) reviewed for catheter care. In addition, the facility failed to notify a provider for further direction when staff were unable to re-insert the catheter. Findings include: R2's Medicare 5-Day Minimum Data Set (MDS) dated 2/3/25, indicated R2 had moderate cognitive impairment, an indwelling catheter, a history of stroke, and renal insufficiency (kidneys were not fully functioning). R2's diagnoses list printed 3/11/25, indicated chronic kidney disease and neuromuscular dysfunction of the bladder. R2's care plan printed 3/12/25, lacked indication R2 had a catheter. R2's hospital discharge summary dated 1/28/25, indicated R2 arrived to the hospital on 1/20/25, with urinary retention that was relieved with a	F 684	F684 R2 has since discharged from The Villa at Richfield. All resident ho have a catheter have the potential to be affected if this requirement is not met. A full house audit was conducted to identify all residents with catheters. The audit included: ensuring their catheters are intact with no concerns, that there are ordres to change the catheter including size, and that the type and size of catheter is listed in care plan. Education has began with all licensed nurses in regards to protocol to follow when catheter is unable to be inserted, including education on Monarch Healthcare Managment notification of change policy. All residents with catheters will be audited weekly for four (4) weeks to ensure	

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F 684	Continued From page 12 catheter and discharged to the facility on 1/28/25, with the catheter. R2's provider progress notes dated 1/29/25, indicated R2 had a catheter in the hospital for urinary retention. R2's progress notes dated 2/1/25, indicated R2 had a catheter, and catheter cares were provided. R2's orders dated 2/14/25, indicated monitor catheter output every shift, and change foley catheter monthly and as needed however, lacked orders for the type of catheter, indications for use, the size of catheter required, whether to use it intermittently or continuously, and the amount of water required to inflate the catheter balloon. R2's provider progress note by physician's assistant (PA)-A dated 2/19/25 [no time indicated], indicated R2 was seen to discuss discharge planning, but had altered mentation, painful urination, suprapubic tenderness, and blood in her urine and catheter. The provider ordered a urinalysis test, and a catheter change for R2. R2's provider progress note dated 2/25/25, indicated R2's catheter was draining yellow, cloudy urine. R2's progress note dated 2/25/25, at 1:55 p.m..., indicated R2's catheter had come out, two nurses were unable to reinsert the catheter, and the nurse manager was notified. The progress note indicated the second shift nurse would attempt to reinsert the catheter. R2's progress note dated 2/26/25 at 6:50 a.m.,	F 684	catheter is intact or that protocol was followed for any catheter that was unable to be inserted. After four (4) weeks, the results of these audits will be shared with facility QAPI committee for input on need to increase, decrease, or discontinue audits. DON or designee to monitor.	

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F 684	Continued From page 13 indicated three nurses attempted to reinsert R2's catheter without success, and indicated R2 had a wet brief. The progress note lacked indication the provider was notified or that R2's catheter was or was not reinserted. On 3/11/25 at 3:57 p.m. during an interview, licensed practical nurse (LPN)-A stated R2's catheter came out on 2/25/25, and several nurses attempted to reinsert it. LPN-A indicated she and other nurses tried again to insert a catheter into R2 on 2/26/25, prior to R2's discharge and were unsuccessful. LPN-A stated she knew R2 needed the catheter for urinary retention and could develop an infection without it. Further, LPN-A stated she did not notify the PA because R2 had a wet [incontinence] brief, and R2 was discharging. On 3/12/25 at 9:18 a.m., during an interview, family member (FM)-A stated R2 had a catheter since January 2025, when it was placed in the emergency room due to urinary retention. On 3/12/25 at 11:08 a.m., during an interview, LPN-B stated if staff were not able to reinsert R2's catheter, staff should have notified the PA or sent R2 to the emergency room. On 3/12/25 at 11:58 a.m.,during an interview, RN-B stated the facility was required to have an order for a catheter, and nurses would refer to the order when they changed the catheter to know so they would be aware of what size catheter was and how much sterile water was used to inflate the catheter balloon. On 3/12/25 at 12:50 p.m. during an interview, the director of nursing (DON) stated a catheter order	F 684		

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F 684	Continued From page 14 should have included the indications for use, the type of catheter, how often it should be changed, the balloon size and size of catheter. The DON confirmed R2 had no order for a catheter. On 3/12/25 at 3:48 p.m., in a subsequent interview, the DON stated if staff were unable reinsert the catheter, she expected staff to notify the provider. On 3/12/25 at 2:00 p.m.,during an interview, RN-D stated R2 had an order for a catheter from standard batch orders. RN-D stated the process was for the order to be on the Kardex (orders in the electronic health record used as reference for type of care required for each resident), and when the information was on the resident's care plan, it would flow to the Kardex. RN-D acknowledged R2's care plan lacked information about R2's catheter. RN-D stated staff would not know what size catheter to use if it was not identified on the resident's care plan, unless they looked at the catheter that was already in place. Further, RN-D stated staff should have notified the provider if they were unable to reinsert R2's catheter. RN-D acknowledged there was no indication in the medical record the provider had been notified. On 3/12/25 at 2:51 p.m., during an interview, PA-A stated R2 had been discharged from the hospital with a catheter for urinary retention. PA-A confirmed she expected staff to notify her if they were unable to reinsert the catheter. The Indwelling Catheter Policy was requested but not provided. The Discharge Planning policy dated 1/2025,	F 684		

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F 684	Continued From page 15 indicated the discharge plan would identify resident needs, and develop and implement plans and interventions to address them.. The post-discharge plan of care must indicate arrangements for follow-up care, and post-discharge medical services.	F 684		

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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 3/11/25 and 3/12/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure. The following complaints were reviewed during	2 000		

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2 000	Continued From page 1 the survey: H54921600C (MN00111357) and H54928884C (MN00111106) with no licensing orders issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		