

Office of Health Facility Complaints Investigative Report PUBLIC

Facility Name: Richfield Health Center Facility Address: 7727 Portland Avenue South			Report Number: H5492097	Date of Visit: January 4, 2017 Date Concluded: February 23, 2017	
			Time of Visit: 7:30 a.m 3:45 p.m.		
Facility City: Richfield			Investigator's Name and Debora Palmer, RN/Spe		
State:	ZIP:	County:			
Minnesota	55423	Hennepin —			

Allegation(s):

It is alleged that a resident was neglected when facility staff failed to provide adequate discharge planning prior to the resident discharge from the facility. In addition, the resident was financially exploited when the facility failed to return the resident his/her money upon discharge.

- Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- ▼ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- **▼** State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, neglect occurred when the facility discharged the resident to the community without a safe discharge plan, without an assessment of the resident's ability to self-administer medications, and without sufficient community resources to facilitate successful placement. Within a week of discharge, the resident decompensated, was hospitalized, and was then discharged from the hospital to another skilled care facility due to his/her need for a higher level of care.

The resident was admitted to the facility for rehabilitation due to weakness, back pain, and depression. Prior to facility admission, the resident resided in the community in a private home, where the landlord also resided. The discharge plan was for the resident to return to this same setting, per the resident's wishes.

On admission, facility staff conducted a self-medication assessment of the resident's ability to take medications independently which established that the resident was "unable to safely administer" his/her own medications. As a result, staff administered the resident's medications during the resident's facility stay of ten months. At the time of discharge, there was no evidence that the facility staff ever reassessed the resident's ability to self-administer medications. The resident's physical abilities had improved, however the resident was still experiencing occasional falls, and occasional mood swings, which had been followed by psychology services and managed with several medications.

Neither the resident's nursing, nor social service discharge care plan included an assessment of the

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resident's functional capacity, discharge needs, or abilities to safely function in a residential community placement. There was no evidence of patient education regarding medications, and no evidence of a medication competency evaluation. There was no nursing discharge summary, and the last nursing progress note was written two weeks prior to the resident's discharge, at which time staff were still administering the resident's medications.

The social service discharge summary indicated that the resident was discharged to a private community home, and transportation to the community residence was provided by the resident's landlord. The discharge summary indicated the facility made a referral to a home health agency, but the discharge summary did not list the name or phone number of the agency. A copy of the resident's medication list was attached to the discharge summary, which included 22 medications. The incomplete discharge summary and medication list was the only written information facility staff provided to the resident at the time of discharge. Facility staff stated that the resident's landlord agreed to assist the resident with medication administration after discharge, however staff did not assess the landlord's competency to accurately administer all 22 of the resident's medications.

Three days after facility discharge, the home health registered nurse conducted an in-home assessment of the resident. The resident was weak, and needed physical support from the landlord for transferring and gait stability. The resident did not have an understanding of his/her medication schedule, and was unable to independently manage medication administration. The resident was reliant on the landlord for assistance and significant oversight to ensure that the resident received all 22 medications accurately. The resident's physical and cognitive needs overwhelmed the landlord. Within a week of placement, the resident was hospitalized with acute mental health issues complicated by cognitive decompensation. The resident required a higher level of care than the prior community placement, and was discharged from the hospital to another skilled care facility where the resident currently resides.

There was no evidence that the facility financially exploited the resident. The facility had followed appropriate standards regarding management of the resident's funds, including the return of monies to the resident and/or proper government agencies at the time of discharge.

Minnesota Vulnerab	Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)										
Under the Minnesota	a Vulnerable Adults Act (Minn	esota Statutes, section 626.557):									
☐ Abuse	Neglect Neglect	☐ Financial Exploitation									
Substantiated Sub	☐ Not Substantiated	☐ Inconclusive based on the following information:									
Mitigating Factors:											
The "mitigating fact	ors" in Minnesota Statutes, sec	tion 626.557, subdivision 9c (c) were considered and it was									
determined that the	☐ Individual(s) and/or ☒ Face	cility is responsible for the									
☐ Abuse	Neglect ☐ Financial Exp	loitation. This determination was based on the following:									
The facility's system	for discharge planning was in	sufficient to ensure that residents were properly and									

Facility Name: Richfield Health Center Report Number: H5492097 safely prepared for discharge. The facility did not ensure the resident had proper medication administration teaching, or care and services set up for community placement prior to discharge. The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C. Compliance: State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) - Compliance Met The facility was found to be in compliance with State Licensing Rules for Nursing Homes (MN Rules Chapter 4658). No state orders were issued. State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Met The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557. No state licensing orders were issued. Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) - Compliance Not Met The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met. Deficiencies are issued on form 2567: X Yes □ No (The 2567 will be available on the MDH website.) State Statutes Chapters 144 & 144A - Compliance Not Met - Compliance Not Met The requirements under State Statues for Chapters 144 &144A were not met. State licensing orders were issued: X Yes П No (State licensing orders will be available on the MDH website.) **Compliance Notes: Facility Corrective Action:** The facility took the following corrective action(s):

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

Definitions:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including

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but not limited to, food, clothing, shelter, health care, or supervision which is:

- (1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
 - (2) which is not the result of an accident or therapeutic conduct.
- (b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- Care Guide
- Medication Administration Records
- Nurses Notes
- **X** Assessments
- | Physician Orders
- **▼** Treatment Sheets
- **X** Physician Progress Notes
- Social Service Notes
- Therapy and/or Ancillary Services Records
- ADL (Activities of Daily Living) Flow Sheets
- 🗖 Other, specify: Psychology Assessments & Progress Notes

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Other pertinent medical records:
Additional facility records:
Staff Time Sheets, Schedules, etc.
Facility Policies and Procedures
▼ Other, specify: Resident Concern Forms
Number of additional resident(s) reviewed: Three
Were residents selected based on the allegation(s)? Yes No N/A Specify:
Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?
○ Yes ● No ○ N/A
Specify: The resident was discharged.
Interviews: The following interviews were conducted during the investigation: Interview with complainant(s) Yes
·
Interview with family: O Yes O No N/A Specify: The resident was his/her own guardian.
Did you interview the resident(s) identified in allegation:
Yes ● No ○ N/A Specify: The resident was discharged.
Did you interview additional residents? Yes No
Total number of resident interviews: Five
Interview with staff: Yes No N/A Specify:
Tennessen Warnings Tennessen Warning given as required: Yes No Tetal words or of stoff integrileurs. Six
Total number of staff interviews: Six
Physician Internious de OVer
Physician Interviewed: Yes No Nurse Practitioner Interviewed: No

Interview with Alleged Perpetrator(s):

Yes \bigcirc No N/A Specify: Attempts to contact: Time: Time: Date: Time: Date: Date: If unable to contact was subpoena issued: () Yes, date subpoena was issued O No Were contacts made with any of the following: ☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify Observations were conducted related to: | Personal Care **▼** Nursing Services ▼ Medication Pass ▼ Dignity/Privacy Issues Safety Issues X **x** Facility Tour Was any involved equipment inspected:

Yes O No N/A Was equipment being operated in safe manner: • Yes O No \bigcirc N/A Specify: Were photographs taken: Yes No cc: **Health Regulation Division - Licensing & Certification Minnesota Board of Examiners for Nursing Home Administrators** The Office of Ombudsman for Mental Health and Developmental Disabilities The Office of Ombudsman for Long-Term Care **Richfield Police Department Hennepin County Attorney**

Report Number: H5492097

Facility Name: Richfield Health Center

Richfield City Attorney

PRINTED: 01/12/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245492	245492 B. WING		•		C 06/2017
	PROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE 7727 PORTLAND AVENUE SOUTH RICHFIELD, MN 55423	1 01/	00/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	rs	F	000			
F 204 SS=D	to investigate case' As a result, the folk related to case H52 in ePOC and there at the bottom of the form. Electronic suused as verification 483.15(c)(7) PREP SAFE/ORDERLY T (c)(7) Orientation for A facility must prov preparation and ori safe and orderly trafacility. This orientate form and manner thunderstand. This REQUIREMED by: Based on interview facility failed to ensprepared residents community, for 1 or who was discharge assessment of his medications and wnumber of the Homeon Findings include: R1's medical reconsidered admitted to the factor admitted to the factor admitted to the factor admission, R1 residents in endication and significant admission, R1 residents.	ARATION FOR RANSFER/DISCHRG or Transfer or Discharge ide and document sufficient entation to residents to ensure ansfer or discharge from the ation must be provided in a mat the resident can NT is not met as evidenced and document review, the area that staff adequately for safe discharge to the forward 4 residents reviewed (R1), and from the facility without an ability to self-administer ithout the name or contact the Health agency.	F2	204			
LABORATOR	 Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	L NATURE		TITLE		(X6) DATE

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.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		CONSTRUCTION		SURVEY PLETED	
		245492	B. WING				06/2017	
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F 204	A Self-Medication on 02/01/16 indicasafely administer" result, staff admini 02/01/16 through F12/08/16. There wever reassessed Fmedications prior to discharge on 12/06 improved but R1 were falls and occasionabeen followed by prontrolled with seven followed by R1's landications and providence of patient medications and provided by R1's I landicated 12/08/16, indicated 12/08/16, indicated 12/08/16 to a private transportation to the provided by R1's I landicated first namical discharge summan landicated summan discharge summan landicated	Assessment conducted by staff ated that R1 was "unable to his own medications. As a stered R1's medications from R1's time of discharge on as no evidence that facility staff R1's ability to self-administer to discharge. At the time of R1's physical abilities had was still experiencing occasional all mood swings which had byschology services and reral medications. Social service care plan from 6 did not include an real service care plan from 6 did not include an reassessed by either social rsing staff. There was no the ducation regarding to evidence of a medication ation. The last nursing progress 1/22/16, at which time staff ering R1's medications. There		204				

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F 204	phone number of the discharge summary follow-up appointment provider and the national community pharmal information on the CR1's medication list discharge summary medications. The irrand medication list information R1 received on 12/08/16. An interview was concluded with the conclusion and inclusion and incl	did not list the name or the Home Health agency. The vincluded the name and the time with a medical me and phone number of a cy. There was no other discharge summary. A copy of twas attached to the vincluded 22 the complete discharge summary entailed the only written eived at the time of discharge on ducted with Licensed Social to 10/04/17 at 9:45 a.m. LSW/E nt's discharge plan begins on udes ongoing assessment of standard and nursing staff to prepare a tyle. LSW/E performed the final for R1 on 12/08/16, due to the who was R1's primary social standard in nursing staff to prepare a tyle. LSW/E performed the final for R1 on 12/08/16, due to the who was R1's primary social standard in nursing the discharge care plan. R1 was alert and the discharge to the transport R1 to R1's esidence, which was a at the landlord also lived in. the could assist R1 with stration. The landlord's ninister all 22 of R1's		204			

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 204	An interview was on 01/04/17 at 10:45 a his own guardian, of facility, and wanted residence, which whis friend/landlord, spoke to the landlo landlord indicated to time. R1 was alert, activities of daily livat the time of disch services. LSW/D whome Health Services. LSW/D whome Health Services and the resident. Lhealth agency RN assessment of R1'know when the infeconducted or if the medication managifacility nurses to deself-medication managifacility n	conducted with LSW/D on a.m. LSW/D stated that R1 was desired discharge from the left to return to his former was a private home owned by who also lived there. LSW/D and several times and the shat R1 could move back in any oriented, independent with wing, and had no medical needs warge that required community was unsure why a referral for sees was initiated. A liaison with agency came to the facility et with R1 but LSW/D did not cussed between the liaison SW/D assumed the home would conduct an in-home is needs but LSW/D did not nome assessment was being assessment include ement. It is the role of the etermine a resident's ability for inagement and to teach the	F 2			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIER	245492	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	01/0	06/2017
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F 204	staff are responsibled discharged to home management to end competency. Nursing for writing a detailed captures the reside and written education community disposition responsible for the discharge process includes the resider resources. RN/B accorded and gait stability. An interview was concase Manager (CMCM/G performed R 12/11/16. R1 appeareding physical susome activities of dand gait stability. Runderstanding of his was unable to independications. R1 was unable to independication by Nedicare. CM/G for about his medication was unable to independicated. Within a whospitalized on 12/i issues complicated	m. RN/B stated that nursing e to educate residents being e about medication sure resident or care givering staff are also responsible discharge summary that nt's functional status, verbal on provided, and specific ion. Social service staff are coordination of the resident's and a detailed summary that nt's specific community exhowledged that this facility ent during the discharge of R1. Inducted with Home Health 1/1/G on 01/05/17 at 1:10 p.m. 1's in-home assessment on ared very weak and was apport from the landlord for aily living such as transferring 1 did not have an s medication schedule and bendently manage his as reliant on the landlord for nificant oversight to ensure R1 dications accurately. CM/G's onot include medication	F2	204			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER (SUBBLIER (CLASS))

	DIDENTIFICATION NUMBER:		LE CONSTRUCTION	COMPLETED			
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F 204	12/29/16, R1 requires the prior community discharged from the care facility where the care facility is procesularly accomplished, inclusively accomplished, inclusively accomplished, inclusively accommunicate the collan/recommendate team (IDT). Coordishome care, durable outpatient services Plan, as appropriate. The facility's procesularly services the team under the Discuss the available resources in the colland to ensurate the colland to ensurate for, and schedisease managem social service ager. Communicate resident care plan. Counsel community reinteg support systems at meet physical, mer resident/caregiver.	red a higher level of care than y placement. R1 was e hospital to another skilled R1 currently resides. dure Discharge Management - sed July 2016, indicated as/education have been uding resident/care giver's arding teaching needs. discharge ions to the Interdisciplinary nate the precertification of e-medical equipment, etc., with the resident Health		204			

PRINTED: 01/12/2017 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _____ C B. WING 01/06/2017 00253 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7727 PORTLAND AVENUE SOUTH RICHFIELD HEALTH CENTER RICHFIELD, MN 55423 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 2 000 Initial Comments 2 000 *****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.

Minnesota Department of Health

INITIAL COMMENTS:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Complaint investigations were conducted to

#H5492098. As a result the following correction

investigate complaints #H5492097 and

order is issued. The facility has agreed to

participate in the electronic receipt of State licensure orders consistent with the Minnesota

Department of Health Informational Bulletin

TITLE

Minnesota Department of Health is

Correction Orders using federal software. Tag numbers have been assigned to

Minnesota state statutes/rules for Nursing

documenting the State Licensing

(X6) DATE

Homes.

(X3) DATE SURVEY

Minnesota Department of Health

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:			COMPLETED	
		00253	B. WING		C 01/06/2017		
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2 000	obul.htm The State delineated on the archeological Department of Heal electronically. Althous necessary for State the word "corrected Then indicate in the process, under the date your orders will	rate.mn.us/divs/fpc/profinfo/infecticensing orders are stached Minnesota th orders being submitted ough no plan of correction is Statutes/Rules, please enter in the box available for text. The electronic State licensure heading completion date, the I be corrected prior to itting to the Minnesota	2 000	The assigned tag number appears far left column entitled "ID Prefix The state statute/rule number and corresponding text of the state statut out of compliance is listed in the "Summary Statement of Deficienci column and replaces the "To Comportion of the correction order. The column also includes the findings are in violation of the state statute statement, "This Rule is not met as evidenced by." Following the survindings are the Suggested Method Correction and the Time Period Following Correction. PLEASE DISREGARD THE HEAD THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TFEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE.	Fag." the tute/rule les" ply" his which after the s veyors d of or DING OF		
21850	Residents of HC Fa Subd. 14. Freedo Residents shall be	om from maltreatment. free from maltreatment as	21850	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION VIOLATIONS OF MINNESOTA ST STATUTES/RULES.	N FOR		
	"Maltreatment" mea section 626.5572, s intentional and non- physical pain or inju	erable Adults Protection Act. Ins conduct described in Insubativision 15, or the Intherapeutic infliction of Iry, or any persistent course of Iry produce mental or emotional					

(X2) MULTIPLE CONSTRUCTION

Minnesota Department of Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: C B. WING 01/06/2017 00253 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 7727 PORTLAND AVENUE SOUTH RICHFIELD HEALTH CENTER RICHFIELD, MN 55423 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) 21850 21850 Continued From page 2 distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced Based on interview and document review, the facility failed to ensure 1 of 4 resident's reviewed (R1), was free from maltreatment when the facility discharged R1 to the community without a safe discharge plan, without an assessment of R1's ability to self-administer medications, and without sufficient community resources to facilitate successful placement. Within a week of discharge to the residential placement, R1 decompensated with acute mental health issues and needed hospitalization. Findings include: R1's medical record indicated that he was admitted to the facility on 02/01/16 for rehabilitation due to muscle weakness, low back pain, and significant depression. Prior to facility admission, R1 resided in the community and rented a room in a friend's private home. The discharge plan was for R1 to return to this same setting, per R1's wishes. A Self-Medication Assessment conducted by staff on 02/01/16 indicated that R1 was "unable to safely administer" his own medications. As a result, staff administered R1's medications from

Minnesota Department of Health

02/01/16 through R1's time of discharge on 12/08/16. There was no evidence that facility staff

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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RICHFIE	LD HEALTH CENTER		TLAND AVE D, MN 5542	NUE SOUTH		
260 15	CUMMADVCTA		1	PROVIDER'S PLAN OF CORRECTI	ON	(VC)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21850	Continued From pa	ge 3	21850			
	ever reassessed R medications prior to discharge on 12/08 improved but R1 w falls and occasional been followed by pocontrolled with seven R1's nursing and so 02/01/16 - 12/08/16 assessment of R1's successful communevidence that R1's the community wer service staff or nurse evidence of patient medications and no competency evaluations was dated 11	1's ability to self-administer of discharge. At the time of /16, R1's physical abilities had as still experiencing occasional I mood swings which had sychology services and eral medications. Docial service care plan from 6 did not include an 6 discharge needs to achieve nity placement. There was no abilities to safely function in 6 e assessed by either social sing staff. There was no education regarding of evidence of a medication ation. The last nursing progress /22/16, at which time staff ring R1's medications. There				
	12/08/16, indicated 12/08/16 to a private transportation to the provided by R1's la landlord' first name discharge summar made a referral to a discharge summar phone number of the discharge summar follow-up appointment provider and the national community pharmal information on the R1's medication list discharge summar follow-up appointment of the R1's medication list discharge summar follow-up appointment of the R1's medication list discharge summar follow-up appointment of the R1's medication list discharge summar follow-up appointment of the R1's medication list discharge summar follow-up appointment of the R1's medication list discharge summar follow-up appointment of the R1's medication list discharge summar follow-up appointment of the R1's medication list discharge summar follow-up appointment of the R1's la landlord' first name discharge summar follow-up appointment of the R1's medication list discharge summar follow-up appointment of the R1's medication list discharge summar follow-up appointment of the R1's medication list discharge summar follow-up appointment of the R1's medication list discharge summar follow-up appointment of the R1's medication list discharge summar follow-up appointment of the R1's medication list discharge summar follow-up appointment of the R1's medication list discharge summar follow-up appointment of the R1's medication list discharge summar follow-up appointment of the R1's medication list discharge summar follow-up appointment of the R1's medication list discharge summar follow-up appointment of the R1's medication list discharge summar follow-up appointment of the R1's medication list discharge summar follow-up appointment of the R1's medication list discharge summar follow-up appointment of the R1's medication list discharge summar follow-up appointment of the R1's medication list discharge summar follow-up appointment of the R1's medication list discharge summar follow-up appointment of the R1's medication list discharge summar follow-up appointment of the R1's medicatio	discharge summary, dated that R1 was discharged on the community home and the community residence was andlord (documented with only, no last name). The sy indicated that the facility at Home Health agency but the sy did not list the name or the Home Health agency. The sy included the name and time with a medical arme and phone number of a structure. There was no other discharge summary. A copy of the was attached to the sy, which included 22 nocomplete discharge summary.				

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Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7,110 1 2 111			A. BUILDING:			
		00253	B. WING 01		01/06	6/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
RICHFIE	RICHFIELD HEALTH CENTER			NUE SOUTH		
		RICHFIEL	D, MN 5542		T	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21850	Continued From pa	age 4	21850			
	and medication list	entailed the only written eived at the time of discharge				
	Worker (LSW)/E of stated that a reside admission and including the state of the sta	onducted with Licensed Social n 01/04/17 at 9:45 a.m. LSW/E ent's discharge plan begins on udes ongoing assessment of s, and any services or aires after discharge to a joint effort between social ursing staff to prepare a rge. LSW/E performed the final for R1 on 12/08/16, due to the who was R1's primary social s not familiar with R1's specific not know if R1 had any medical needs were care plan. R1 was alert and ed to understand the discharge ndlord came to the facility on ge to transport R1 to R1's esidence, which was a nat the landlord also lived in the could assist R1 with stration. The landlord's minister all 22 of R1's ot evaluated.				
	01/04/17 at 10:45 a his own guardian, facility, and wanted residence, which w his friend/landlord, spoke to the landlo landlord indicated time. R1 was alert, activities of daily live	conducted with LSW/D on a.m. LSW/D stated that R1 was desired discharge from the d to return to his former was a private home owned by who also lived there. LSW/D ord several times and the that R1 could move back in any, oriented, independent with ving, and had no medical needs harge that required community				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:						
00253 B. WING 01/06/20	017					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
RICHFIELD HEALTH CENTER 7727 PORTLAND AVENUE SOUTH RICHFIELD, MN 55423						
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CO	(X5) OMPLETE DATE					
Services. LSW/D was unsure why a referral for Home Health Services was initiated. A liaison from the home health agency came to the facility on 12/07/16 to meet with R1 but LSW/D did not know what was discussed between the liaison and R1. LSW/D assumed the home health agency RN would conduct an in-home assessment of R1's needs but LSW/D did not know when the in-home assessment was being conducted or if the assessment include medication management. It is the role of the facility nurses to determine a resident's ability for self-medication management and to teach R1 any skill deficits. An interview was conducted with LPN/C on 01/04/17 at 2:50 p.m. LPN/C stated she worked on R1's unit on 12/08/16 when R1 was discharged. The nurse manager, who no longer works at the facility, was the individual responsible for R1's discharge teaching. LPN/C printed R1's list of medications and gave it to R1. A nursing assessment of R1's understanding of when to take the medications and his ability to do so safely was not completed because R1 said he was able to self-administer all of the medications. An interview was conducted with RN/B on 01/04/17 at 1:05 p.m. RN/B stated that nursing staff are responsible to deucate residents being discharged to home about medication management to ensure resident or care giver competency. Nursing staff are also responsible for writing a detailed discharge summary that captures R1's functional status, verbal and written education provided, and specific community disposition. Social service staff are responsible for the coordination of R1's discharge process and a detailed summary that includes R1's specific community resources. RN/B						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00253		B. WING		C 01/06/2017	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
RICHFIELD HEALTH CENTER 7727 PORTLAND AVENUE SOUTH RICHFIELD, MN 55423						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21850	acknowledged that deficient during the An interview was or Case Manager (CN CM/G performed P 12/11/16. R1 was very physical support from activities of daily living gait stability. R1 did his medication schein independently man reliant on the landle significant oversigh medications accurated medication administ covered by Medical education of R1 absoluted medications. R1's poverwhelmed the liplacement, R1 was acute mental health cognitive decompendent hospital discharge higher level of care placement. R1 was to another skilled or resides. The facility's proce Unit Manager, revisite all self-care instruction accomplished, includerstanding regard communicate the self-care instruction accomplished, includerstanding regard communicate the self-care instruction accomplished, includerstanding regard.	this facility practice was discharge of R1. Inducted with Home Health M)/G on 01/05/17 at 1:10 p.m. It's in-home assessment on very weak and was needing om the landlord for some ring such as transferring and of not have an understanding of edule and was unable to age his medications. R1 was ord for assistance and at to ensure R1 received all 22 ately. CM/G's nursing services dication administration because stration by Nursing is not re. CM/G focused on out his medications, which is re, but R1 was unreliable and by self-administer the physical and cognitive needs andlord. Within a week of a hospitalized on 12/15/16 with his sues complicated by insation. At the time of R1's on 12/29/16, R1 required a enthan the prior community and discharged from the hospital eare facility where R1 currently dure Discharge Management seed July 2016, indicated ins/education have been uding resident/care giver's arding teaching needs.	21850			

Minnesota Department of Health

PRINTED: 01/12/2017 **FORM APPROVED** Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING 00253 01/06/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7727 PORTLAND AVENUE SOUTH **RICHFIELD HEALTH CENTER** RICHFIELD, MN 55423 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) 21850 21850 Continued From page 7 team (IDT). Coordinate the precertification of home care, durable medical equipment, outpatient services, etc., with R1 Health Plan, as appropriate." The facility's procedure Discharge Management -Social Worker, effective July 2015, indicated "Schedule services/equipment recommended by the team under the direction of the Unit Manager. Discuss the availability of the recommended resources in the community with R1. Involve outside agencies as soon as need is confirmed to ensure continuity of care. Identify need for, and schedule appropriate home health, disease management, community mental health, social service agencies, and/or support groups. Communicate resident goals and status on the care plan. Counsel resident/caregiver about community reintegration services, centers, and support systems available in the community to meet physical, mental, and psych-social needs of resident/caregiver. Summarize the finalized discharge plan in the Social Service section of the chart." A Suggested Method of Correction: (1) Develop and implement a streamlined discharge process that includes comprehensive assessment of the resident's discharge needs, appropriate patient education, and sufficient community resources to facilitate successful placement: educate all staff involved in the discharge process. (2) Review and revise current policies to include specific discharge tasks designated for social

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service staff and nursing staff.

ensure compliance.

(3) Conduct routine audits of discharge records to

(4) Document all corrective action taken.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/S		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	(X3) DATE S COMPL				
		00253	B. WING		C 01/06/2017			
NAME OF F	PROVIDER OR SUPPLIER	STREET A		STATE, ZIP CODE				
RICHFIE	LD HEALTH CENTER		RTLAND AVE LD, MN 5542					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
21850	Continued From pa	ge 8	21850					
		rrection: Thirty (30) days.						
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			POST-0	CERTIFIC	CATIO	N REVISIT F	REPORT				
	R / SUPPLIER		MULTIPLE CON	STRUCTION					DATE C	F REVISIT	
245492	CATION NUMB		A. Building B. Wing					Y2	2/2/201	17 _{Y3}	
NAME OF FACILITY					STREET ADDRESS, C	CITY, STATE, ZIP C	ODE				
RICHFIELD HEALTH CENTER					7727 PORTLAND AVE						
						RICHFIELD, MN 55423	3				
program corrected provision	, to show thos I and the date	e deficie such co the ident	ncies previously rrective action	y reported on th was accomplish	e CMS-256 ed. Each c	Medicaid and/or Clinica 67, Statement of Defici deficiency should be fu he CMS-2567 (prefix o	encies and Plan Illy identified usin	of Correct g either th	ion, that ie regula	have been ation or LSC	
ITE	VI		DATE	ITEM		DATE	ITEM			DATE	
Y4			Y5	Y4		Y5	Y4			Y5	
ID Prefix	F0204		Correction	ID Prefix		Correction	ID Prefix			Correction	
Reg. #	483.15(c)(7)		Completed	Reg. #		Completed	Reg. #			Completed	
LSC			02/02/2017	LSC			LSC				
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FOLLOWUP TO SURVEY COMPLETED ON 1/6/2017				CORRECTED DEFICIEN ICIENCIES (CMS-2567)			YES	в □ но			

STATE FORM: REVISIT REPORT MULTIPLE CONSTRUCTION PROVIDER / SUPPLIER / CLIA / DATE OF REVISIT **IDENTIFICATION NUMBER** A. Building B. Wing 00253 2/2/2017 **Y3** NAME OF FACILITY STREET ADDRESS, CITY, STATE, ZIP CODE RICHFIELD HEALTH CENTER 7727 PORTLAND AVENUE SOUTH RICHFIELD, MN 55423 This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form). ITEM DATE ITEM DATE ITEM DATE Y4 Y5 Υ4 Y5 Y4 Y5 ID Prefix 21850 **ID Prefix ID Prefix** Correction Correction Correction MN St. Statute 144.651 Reg. # Completed Reg. # Completed Reg. # Completed Subd. 14 LSC 02/02/2017 LSC LSC **ID Prefix** Correction **ID Prefix ID Prefix** Correction Correction Reg. # Completed Reg. # Reg. # Completed Completed LSC LSC LSC ID Prefix Correction ID Prefix Correction ID Prefix Correction Reg. # Completed Reg. # Completed Reg. # Completed LSC LSC LSC **ID Prefix** Correction **ID Prefix** Correction **ID Prefix** Correction Reg. # Completed Completed Reg. # Completed Reg. # LSC LSC LSC **ID Prefix ID Prefix** Correction **ID Prefix** Correction Correction Reg. # Completed Reg. # Completed Reg. # Completed LSC LSC LSC **REVIEWED BY REVIEWED BY** DATE SIGNATURE OF SURVEYOR DATE (INITIALS) STATE AGENCY **REVIEWED BY REVIEWED BY** DATE TITLE DATE CMS RO (INITIALS) FOLLOWUP TO SURVEY COMPLETED ON CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? 1/6/2017 YES NO

Page 1 of 1

EVENT ID: