MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
Richfield Health Center	H5492097	January 4, 2017
Facility Address:	**Time of Visit:**	**Date Concluded:**
7727 Portland Avenue South	7:30 a.m. - 3:45 p.m.	February 23, 2017
Facility City:	**Investigator's Name and Title:**	
Richfield	Debora Palmer, RN/Special Investigator	

State:	ZIP:	County:
Minnesota	55423	Hennepin

☒ **Nursing Home**

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

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 Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☐ Abuse ☒ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ Individual(s) and/or ☒ Facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The facility's system for discharge planning was insufficient to ensure that residents were properly and

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: ☒ 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: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

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

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:

- [x] Medical Records
- [x] Care Guide
- [x] Medication Administration Records
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Treatment Sheets
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Social Service Notes
- [x] Therapy and/or Ancillary Services Records
- [x] ADL (Activities of Daily Living) Flow Sheets
- [x] Other, specify: Psychology Assessments & Progress Notes

Other pertinent medical records:

☒ Hospital 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 ○ No ○ N/A

Specify:

If unable to contact complainant, attempts were made on:

Date:	Time:	Date:	Time:	Date:	Time:

Interview with family: ○ Yes ◉ 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

Total number of staff interviews: Six

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ◯ Yes ◯ No ◉ N/A Specify: _____

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:
_____	_____	_____	_____	_____	_____

If unable to contact was subpoena issued: ◯ Yes, date subpoena was issued _____ ◯ 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
☒ Facility Tour

Was any involved equipment inspected: ◯ Yes ◯ No ◉ N/A

Was equipment being operated in safe manner: ◉ Yes ◯ No ◯ N/A

Were photographs taken: ◯ Yes ◉ No Specify: _____

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

Richfield City Attorney

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 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	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 An abbreviated standard survey was conducted to investigate case's #H5492097 and #H5492098. As a result, the following deficiency is issued related to case H5492097. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 204 SS=D	483.15(c)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG (c)(7) Orientation for Transfer or Discharge A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that staff adequately prepared residents for safe discharge to the community, for 1 of 4 residents reviewed (R1), who was discharged from the facility without an assessment of his ability to self-administer medications and without the name or contact number of the Home Health agency. 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	F 204		

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

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 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	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 204	Continued From page 1 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 02/01/16 through R1's time of discharge on 12/08/16. There was no evidence that facility staff ever reassessed R1's ability to self-administer medications prior to discharge. At the time of discharge on 12/08/16, R1's physical abilities had improved but R1 was still experiencing occasional falls and occasional mood swings which had been followed by pyschology services and controlled with several medications. R1's nursing and social service care plan from 02/01/16 - 12/08/16 did not include an assessment of R1's discharge needs to achieve successful community placement. There was no evidence that R1's abilities to safely function in the community were assessed by either social service staff or nursing staff. There was no evidence of patient education regarding medications and no evidence of a medication competency evaluation. The last nursing progress note was dated 11/22/16, at which time staff were still administering R1's medications. There was no nursing discharge summary. The social service discharge summary, dated 12/08/16, indicated that R1 was discharged on 12/08/16 to a private community home and transportation to the community residence was provided by R1's landlord (documented with landlord' first name only, no last name). The discharge summary indicated that the facility made a referral to a Home Health agency but the	F 204		

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 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	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 204	Continued From page 2 discharge summary did not list the name or phone number of the Home Health agency. The discharge summary included the name and follow-up appointment time with a medical provider and the name and phone number of a community pharmacy. There was no other information on the discharge summary. A copy of R1's medication list was attached to the discharge summary, which included 22 medications. The incomplete discharge summary and medication list entailed the only written information R1 received at the time of discharge on 12/08/16. An interview was conducted with Licensed Social Worker (LSW)/E on 01/04/17 at 9:45 a.m. LSW/E stated that a resident's discharge plan begins on admission and includes ongoing assessment of the resident's needs, abilities, and any services or equipment the resident requires after discharge to facilitate success. It is a joint effort between social service staff and nursing staff to prepare a resident for discharge. LSW/E performed the final discharge process for R1 on 12/08/16, due to the absence of LSW/D who was R1's primary social worker. LSW/E was not familiar with R1's specific needs. LSW/E did not know if R1 had any medical needs. No medical needs were earmarked on R1's care plan. R1 was alert and oriented and seemed to understand the discharge paperwork. R1's landlord came to the facility on the day of discharge to transport R1 to R1's community living residence, which was a residential home that the landlord also lived in. The landlord said he could assist R1 with medication administration. The landlord's competency to administer all 22 of R1's medications was not evaluated.	F 204		

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 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	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 204	Continued From page 3	F 204		

An interview was conducted with LSW/D on 01/04/17 at 10:45 a.m. LSW/D stated that R1 was his own guardian, desired discharge from the facility, and wanted to return to his former residence, which was a private home owned by his friend/landlord, who also lived there. LSW/D spoke to the landlord several times and the landlord indicated that R1 could move back in any time. R1 was alert, oriented, independent with activities of daily living, and had no medical needs at the time of discharge that required community 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 the resident. 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 the resident 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

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 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	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 204	Continued From page 4 01/04/17 at 1:05 p.m. RN/B stated that nursing staff are responsible to educate 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 the resident's functional status, verbal and written education provided, and specific community disposition. Social service staff are responsible for the coordination of the resident's discharge process and a detailed summary that includes the resident's specific community resources. RN/B acknowledged that this facility practice was deficient during the discharge of R1. An interview was conducted with Home Health Case Manager (CM)/G on 01/05/17 at 1:10 p.m. CM/G performed R1's in-home assessment on 12/11/16. R1 appeared very weak and was needing physical support from the landlord for some activities of daily living such as transferring and gait stability. R1 did not have an understanding of his medication schedule and was unable to independently manage his medications. R1 was reliant on the landlord for assistance and significant oversight to ensure R1 received all 22 medications accurately. CM/G's nursing services do not include medication administration because medication administration by Nursing is not covered by Medicare. CM/G focused on education of R1 about his medications, which is covered by Medicare, but R1 was unreliable and could not accurately self-administer the medications. R1's physical and cognitive needs overwhelmed the landlord. Within a week of placement, R1 was hospitalized on 12/15/16 with acute mental health issues complicated by cognitive decompensation. At the time of R1's hospital discharge on	F 204		

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 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	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 204	Continued From page 5 12/29/16, R1 required a higher level of care than the prior community placement. R1 was discharged from the hospital to another skilled care facility where R1 currently resides. The facility's procedure Discharge Management - Unit Manager, revised July 2016, indicated "Ensure all self-care instructions/education have been accomplished, including resident/care giver's understanding regarding teaching needs. Communicate the discharge plan/recommendations to the Interdisciplinary team (IDT). Coordinate the precertification of home care, durable medical equipment, outpatient services, etc., with the resident 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 the resident. 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."	F 204		

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 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	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) COMPLETE DATE
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: Complaint investigations were conducted to investigate complaints #H5492097 and #H5492098. As a result the following correction 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	2 000	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.	

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

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 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	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) COMPLETE DATE
2 000	Continued From page 1 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. 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.	2 000	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 which are in violation of the state statute after the statement, "This Rule 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.	
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional	21850		

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 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	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) COMPLETE DATE
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 by: 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 02/01/16 through R1's time of discharge on 12/08/16. There was no evidence that facility staff	21850		

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 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	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) COMPLETE DATE
21850	Continued From page 3 ever reassessed R1's ability to self-administer medications prior to discharge. At the time of discharge on 12/08/16, R1's physical abilities had improved but R1 was still experiencing occasional falls and occasional mood swings which had been followed by psychology services and controlled with several medications. R1's nursing and social service care plan from 02/01/16 - 12/08/16 did not include an assessment of R1's discharge needs to achieve successful community placement. There was no evidence that R1's abilities to safely function in the community were assessed by either social service staff or nursing staff. There was no evidence of patient education regarding medications and no evidence of a medication competency evaluation. The last nursing progress note was dated 11/22/16, at which time staff were still administering R1's medications. There was no nursing discharge summary. The social service discharge summary, dated 12/08/16, indicated that R1 was discharged on 12/08/16 to a private community home and transportation to the community residence was provided by R1's landlord (documented with landlord' first name only, no last name). The discharge summary indicated that the facility made a referral to a Home Health agency but the discharge summary did not list the name or phone number of the Home Health agency. The discharge summary included the name and follow-up appointment time with a medical provider and the name and phone number of a community pharmacy. There was no other information on the discharge summary. A copy of R1's medication list was attached to the discharge summary, which included 22 medications. The incomplete discharge summary	21850		

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 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	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) COMPLETE DATE
21850	Continued From page 4 and medication list entailed the only written information R1 received at the time of discharge on 12/08/16. An interview was conducted with Licensed Social Worker (LSW)/E on 01/04/17 at 9:45 a.m. LSW/E stated that a resident's discharge plan begins on admission and includes ongoing assessment of R1's needs, abilities, and any services or equipment R1 requires after discharge to facilitate success. It is a joint effort between social service staff and nursing staff to prepare a resident for discharge. LSW/E performed the final discharge process for R1 on 12/08/16, due to the absence of LSW/D who was R1's primary social worker. LSW/E was not familiar with R1's specific needs. LSW/E did not know if R1 had any medical needs. No medical needs were earmarked on R1's care plan. R1 was alert and oriented and seemed to understand the discharge paperwork. R1's landlord came to the facility on the day of discharge to transport R1 to R1's community living residence, which was a residential home that the landlord also lived in. The landlord said he could assist R1 with medication administration. The landlord's competency to administer all 22 of R1's medications was not evaluated. An interview was conducted with LSW/D on 01/04/17 at 10:45 a.m. LSW/D stated that R1 was his own guardian, desired discharge from the facility, and wanted to return to his former residence, which was a private home owned by his friend/landlord, who also lived there. LSW/D spoke to the landlord several times and the landlord indicated that R1 could move back in any time. R1 was alert, oriented, independent with activities of daily living, and had no medical needs at the time of discharge that required community	21850		

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 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	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) COMPLETE DATE
21850	Continued From page 5 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 educate 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	21850		

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 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	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) COMPLETE DATE
21850	Continued From page 6 acknowledged that this facility practice was deficient during the discharge of R1. An interview was conducted with Home Health Case Manager (CM)/G on 01/05/17 at 1:10 p.m. CM/G performed R1's in-home assessment on 12/11/16. R1 was very weak and was needing physical support from the landlord for some activities of daily living such as transferring and gait stability. R1 did not have an understanding of his medication schedule and was unable to independently manage his medications. R1 was reliant on the landlord for assistance and significant oversight to ensure R1 received all 22 medications accurately. CM/G's nursing services do not include medication administration because medication administration by Nursing is not covered by Medicare. CM/G focused on education of R1 about his medications, which is covered by Medicare, but R1 was unreliable and could not accurately self-administer the medications. R1's physical and cognitive needs overwhelmed the landlord. Within a week of placement, R1 was hospitalized on 12/15/16 with acute mental health issues complicated by cognitive decompensation. At the time of R1's hospital discharge on 12/29/16, R1 required a higher level of care than the prior community placement. R1 was discharged from the hospital to another skilled care facility where R1 currently resides. The facility's procedure Discharge Management - Unit Manager, revised July 2016, indicated "Ensure all self-care instructions/education have been accomplished, including resident/care giver's understanding regarding teaching needs. Communicate the discharge plan/recommendations to the Interdisciplinary	21850		

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 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	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) COMPLETE DATE
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 service staff and nursing staff. (3) Conduct routine audits of discharge records to ensure compliance. (4) Document all corrective action taken.	21850		

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 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	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) COMPLETE DATE
21850	Continued From page 8 Time Period for Correction: Thirty (30) days.	21850		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245492	A. Building B. Wing	2/2/2017

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0204 Reg. # 483.15(c)(7) LSC	Correction Completed 02/02/2017	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/6/2017	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00253 Y1	A. Building B. Wing Y2	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 Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 21850 Reg. # MN St. Statute 144.651 Subd. 14 LSC	Correction Completed 02/02/2017	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 1/6/2017	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

EVENT ID: 0EHD12

STATE FORM: REVISIT REPORT (11/06)