Electronically delivered December 20, 2019

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

RE: CCN: 245492
Cycle Start Date: December 27, 2019

Dear Administrator:

On November 27, 2019, survey was completed at your facility by the Minnesota Department(s) of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 15, 2020.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 15, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 15, 2020.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits

approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by February 15, 2020, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Richfield A Villa Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 15, 2020. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.
However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor

Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Phone: 651-201-3784
Fax: (507) 344-2723

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 27, 2019, (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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 11/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 11/26/19 and 11/27/19 an abbreviated survey was completed at your facility to conduct complaint investigations. Your facility was found NOT to be in compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H#5492134C. Deficiency issued at F689. The following complaint was found unsubstantiated: H#5492135C.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess and develop interventions to provide adequate supervision and safety for an unsupervised smoker for 1 of 3 residents (R1) reviewed for accidents. R1 sustained burns to her right leg after intentionally starting her socks and pants on fire. Findings include:	F 689	1. Resident R1 was reassessed and was deemed an unsafe smoker. R1 is not allowed to smoke at the facility or have any smoking materials within the facility. Care plan was updated and new smoking risk evaluation was completed. 2. All residents who are smokers will be assessed for safety upon admission, readmission and after a significant change in condition. New smoking risk evaluations have been completed for all	1/17/20

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

Electronically Signed | 12/30/2019

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F 689	Continued From page 1 R1's Admission Record dated 10/18/19, indicated R1 is diagnosed with encephalopathy (brain disease, damage, or malfunction), severe bipolar disorder (extreme mood swings) with psychotic features (delusions, or false beliefs/false perceptions, and hallucinations), and anxiety disorder. R1's hospitalization record dated 9/24/19, indicated R1 has a diagnosis of suicidal ideation, major neurological disorder due to multiple etiologies with behavioral disturbance, tobacco abuse, mood disorder, and metabolic encephalopathy. R1's care plan printed 11/26/19, identified an admission date of 10/18/19 and indicated R1 has behavior problems related to refusing medications and yelling/screaming at staff and other residents; impaired cognitive function and thought process; mood problems related to adjustment to placement; bipolar disease, depression, and anxiety; receiving antipsychotic medications; receiving mood stabilizer medications for bipolar disease; was recently hospitalized due to psychosis; history of chemical dependency with narcotics; at risk for injury when smoking; and had a history of attempting to hurt self and/or verbalized attempts at hurting self. R1's admission Minimum Date Set (MDS) assessment dated 10/28/19, indicated R1's brief interview for mental status scored eleven on a scale of fifteen, indicating R1 was cognitively moderately impaired. The MDS also indicated R1's PHQ-9 mood assessment scored eighteen of twenty seven, indicating R1 as moderately depressed severe, which warrants active treatment with psychotherapy, medications, or combination. R1's MDS assessment of behaviors	F 689	residents who smoke and care plans updated as appropriate. All residents will be safe while smoking in the facility. 3. The facility smoking policy and procedure have been reviewed and revised to include how cigarettes and lighters will be stored. Residents have been given a copy of the revised smoking policy. Staff have been educated on the revised smoking policy. 4. Audits will be completed daily by the NHA or designee to ensure smoking materials are stored in a locked area. Social Services or designee will audit smoking assessments weekly for completion for all admissions, readmissions and significant changes. Any changes will be brought to IDT for review. The audits will continue weekly for 3 months. All results will be brought to the monthly Quality Assurance improvement meeting and reviewed for trends in quality improvement by NHA or designee.	

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F 689	Continued From page 2	F 689		

indicated R1 has worsening verbal behaviors directed towards others and other behaviors such as vocal symptoms exampled by screaming. R1's MDS functional status indicated R1 required limited to extensive assistance with all activities of daily living.

R1's admission Target Behavior Documentation interventions, effective date 10/23/19, directed staff to monitor and intervene for impaired judgement and impulsiveness.

R1's admission to the facility Smoking Risk Evaluation tool dated 10/18/19, indicated R1 was a safe smoker. The Smoking Risk Evaluation tool did not direct that R1 would be authorized to keep her own cigarettes and lighter. No additional Smoking Risk Evaluations were completed. The facility's Smoker's List displayed at each nurses' station dated 11/26/19, identified R1 as a smoker. The Smoking Risk Evaluation tool did not describe a system for how cigarettes and lighters would be accounted for.

Document review of a civil commitment by Ramsey County Court dated 9/4/19, findings of fact documented, due to R1's mental illness, indicated serious physical harm to herself was likely and physical harm had been attempted.

R1's physician Order Summary Report dated 10/27/19, directed staff to monitor behaviors such as impulsiveness and behaviors.

A physician progress note dated 10/29/19, at 10:14 a.m. indicated [R1] "refused all of her medications this morning stating that she is not supposed to take medications from anybody,"

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F 689	Continued From page 3 which R1 claimed she was warned by the doctors. A behavioral incident was documented 11/30/20 at 2:44 p.m. when the Social Services staff entered R1's room to find her undressed, and the resident reported it would be easier to defecate on the bed instead of using the bathroom. Additionally, a social service late entry progress note dated 10/29/19, at 11:54 a.m. indicated social services (social services staff not identified) spoke with R1 during evaluations and R1 had reported she had thoughts of hurting herself and wishing she were dead. A progress note dated 11/19/19, at 11:14 p.m. described a situation from 11/19/19, at 5:50 p.m. where the fire alarm was activated, and during the resident's room search, one of the nursing assistants (not specifically identified) found R1 sitting in her chair with a lighter in her hand, and her right pant leg was on fire. The indicated registered nurse (RN)-A arrived and observed R1 was still pointing the lighter at her pants and trying to relight the lighter. RN-A and the nursing assistant evacuated resident from her room due to the room being full of smoke. RN-A assessed R1's right leg and it was found to be burned. The note indicated R1 had stated, "I don't feel anything." On 11/19/19, at 6:10 p.m. R1 was transported to Hennepin County Medical Center (HCMC) Burn Unit. A progress note dated 11/20/19, at 1:58 p.m. indicated RN-B from HCMC had reported R1 would have surgery the following day and there was no hospital discharge plan at that time.	F 689		

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F 689	Continued From page 4 The facility Event Manager Report investigation by the director of nursing (DON) dated 11/26/19, at 9:22 a.m. indicated R1 had stated her socks were too tight, and she was trying to stretch them out with the lighter. The Event Manager Report further indicated that on 11/17/19 two staff members (not identified) had previously observed R1 cutting her socks because they were too tight. The report indicated the two staff members had replaced the socks but had not reported the concern of the socks being too tight to the charge nurse. Observation on 11/26/19, at 1:16 p.m. identified a patio at the backside of the building as the smokers' patio. Numerous residents could be observed independently walking and self-propelling their wheelchairs to and from the smokers' patio. During observations on 11/26/19, at 1:16 p.m. and on 11/27/19, at 8:30 a.m., no staff were present on the smokers' patio with residents smoking. During interview on 11/27/19, at 8:49 a.m. nursing assistant (NA)-A stated, "[R1] is not a smoker and if someone who is a smoker wants a cigarette, they have to come to the medication cart and get their cigarette(s) and a lighter. The resident can then go to the patio to smoke." NA-A further stated, "If a resident does not have a lighter they will use someone else's lighter at the smoking patio. Smokers are identified in their chart as smokers." NA-A did not address whether residents could store their own cigarettes and/or lighters. During interview on 11/27/19, at 8:53 a.m. the	F 689		

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F 689	Continued From page 5 maintenance director stated the patio is the designated smoking area for the facility and added, "It's secured by a fence, so the Wanderguard at the door has been disabled. Residents are free to come and go to smoke." During interview on 11/27/19, at 11:23 a.m. the DON stated the facility interviewed staff right after the burn incident and an incident report was completed. The DON stated there were no new interventions identified to keep R1 safe from an accident but there will be when R1 returns. DON further stated R1 was deemed a safe smoker so she was allowed to keep her cigarettes and lighter in her room. When asked about the facility's directive for Smoking Guidelines to securely store cigarettes and lighters, the DON replied, "Some residents can have their cigarettes and lighters in their room and others have to have them in the medication cart." DON further stated she was unaware that R1 had any behaviors that would exclude her from being a safe smoker. Villa Healthcare Smoking Guidelines dated 11/28/17, directed: The evaluation will be used at the time of admission and with changes of condition. Although the guidelines directed that lighters and cigarettes would be securely stored, they did not indicate whether residents could store their own cigarettes and lighter.	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 20, 2019

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

Re: State Nursing Home Licensing Orders
Event ID: Q4N911

Dear Administrator:

The above facility was surveyed on November 26, 2019 through November 27, 2019 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF

CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

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

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Phone: 651-201-3784
Fax: (507) 344-2723

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

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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 11/27/2019

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A complaint investigation was conducted on 11/26/19 to 11/27/19, to investigate complaint H#5492134C and H#5492135C. As a result the following was identified: The complaint was found to be substantiated: H#5492134C with licensing orders issued.	2 000		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 The complaint was found to be unsubstantiated: H#5492135C. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess and develop interventions to provide adequate supervision and safety for an unsupervised smoker for 1 of 3 residents (R1) reviewed for accidents. R1 sustained burns to her right leg after intentionally starting her socks and pants on fire.	2 830	Corrected.	1/17/20

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	00253	A. BUILDING: _____ B. WING _____	C 11/27/2019

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2 830	Continued From page 2 Findings include: R1's Admission Record dated 10/18/19, indicated R1 is diagnosed with encephalopathy (brain disease, damage, or malfunction), severe bipolar disorder (extreme mood swings) with psychotic features (delusions, or false beliefs/false perceptions, and hallucinations), and anxiety disorder. R1's hospitalization record dated 9/24/19, indicated R1 has a diagnosis of suicidal ideation, major neurological disorder due to multiple etiologies with behavioral disturbance, tobacco abuse, mood disorder, and metabolic encephalopathy. R1's care plan printed 11/26/19, identified an admission date of 10/18/19 and indicated R1 has behavior problems related to refusing medications and yelling/screaming at staff and other residents; impaired cognitive function and thought process; mood problems related to adjustment to placement; bipolar disease, depression, and anxiety; receiving antipsychotic medications; receiving mood stabilizer medications for bipolar disease; was recently hospitalized due to psychosis; history of chemical dependency with narcotics; at risk for injury when smoking; and had a history of attempting to hurt self and/or verbalized attempts at hurting self. R1's admission Minimum Date Set (MDS) assessment dated 10/28/19, indicated R1's brief interview for mental status scored eleven on a scale of fifteen, indicating R1 was cognitively moderately impaired. The MDS also indicated R1's PHQ-9 mood assessment scored eighteen of twenty seven, indicating R1 as moderately depressed severe, which warrants active	2 830		

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2 830	Continued From page 3 treatment with psychotherapy, medications, or combination. R1's MDS assessment of behaviors indicated R1 has worsening verbal behaviors directed towards others and other behaviors such as vocal symptoms exampled by screaming. R1's MDS functional status indicated R1 required limited to extensive assistance with all activities of daily living. R1's admission Target Behavior Documentation interventions, effective date 10/23/19, directed staff to monitor and intervene for impaired judgement and impulsiveness. R1's admission to the facility Smoking Risk Evaluation tool dated 10/18/19, indicated R1 was a safe smoker. The Smoking Risk Evaluation tool did not direct that R1 would be authorized to keep her own cigarettes and lighter. No additional Smoking Risk Evaluations were completed. The facility's Smoker's List displayed at each nurses' station dated 11/26/19, identified R1 as a smoker. The Smoking Risk Evaluation tool did not describe a system for how cigarettes and lighters would be accounted for. Document review of a civil commitment by Ramsey County Court dated 9/4/19, findings of fact documented, due to R1's mental illness, indicated serious physical harm to herself was likely and physical harm had been attempted. R1's physician Order Summary Report dated 10/27/19, directed staff to monitor behaviors such as impulsiveness and behaviors. A physician progress note dated 10/29/19, at 10:14 a.m. indicated [R1] "refused all of her medications this morning stating that she is not	2 830		

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2 830	Continued From page 4 supposed to take medications from anybody," which R1 claimed she was warned by the doctors. A behavioral incident was documented 11/30/20 at 2:44 p.m. when the Social Services staff entered R1's room to find her undressed, and the resident reported it would be easier to defecate on the bed instead of using the bathroom. Additionally, a social service late entry progress note dated 10/29/19, at 11:54 a.m. indicated social services (social services staff not identified) spoke with R1 during evaluations and R1 had reported she had thoughts of hurting herself and wishing she were dead. A progress note dated 11/19/19, at 11:14 p.m. described a situation from 11/19/19, at 5:50 p.m. where the fire alarm was activated, and during the resident's room search, one of the nursing assistants (not specifically identified) found R1 sitting in her chair with a lighter in her hand, and her right pant leg was on fire. The indicated registered nurse (RN)-A arrived and observed R1 was still pointing the lighter at her pants and trying to relight the lighter. RN-A and the nursing assistant evacuated resident from her room due to the room being full of smoke. RN-A assessed R1's right leg and it was found to be burned. The note indicated R1 had stated, "I don't feel anything." On 11/19/19, at 6:10 p.m. R1 was transported to Hennepin County Medical Center (HCMC) Burn Unit. A progress note dated 11/20/19, at 1:58 p.m. indicated RN-B from HCMC had reported R1 would have surgery the following day and there was no hospital discharge plan at that time.	2 830		

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2 830	Continued From page 5 The facility Event Manager Report investigation by the director of nursing (DON) dated 11/26/19, at 9:22 a.m. indicated R1 had stated her socks were too tight, and she was trying to stretch them out with the lighter. The Event Manager Report further indicated that on 11/17/19 two staff members (not identified) had previously observed R1 cutting her socks because they were too tight. The report indicated the two staff members had replaced the socks but had not reported the concern of the socks being too tight to the charge nurse. Observation on 11/26/19, at 1:16 p.m. identified a patio at the backside of the building as the smokers' patio. Numerous residents could be observed independently walking and self-propelling their wheelchairs to and from the smokers' patio. During observations on 11/26/19, at 1:16 p.m. and on 11/27/19, at 8:30 a.m., no staff were present on the smokers' patio with residents smoking. During interview on 11/27/19, at 8:49 a.m. nursing assistant (NA)-A stated, "[R1] is not a smoker and if someone who is a smoker wants a cigarette, they have to come to the medication cart and get their cigarette(s) and a lighter. The resident can then go to the patio to smoke." NA-A further stated, "If a resident does not have a lighter they will use someone else's lighter at the smoking patio. Smokers are identified in their chart as smokers." NA-A did not address whether residents could store their own cigarettes and/or lighters. During interview on 11/27/19, at 8:53 a.m. the maintenance director stated the patio is the	2 830		

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2 830	Continued From page 6 designated smoking area for the facility and added, "It's secured by a fence, so the Wanderguard at the door has been disabled. Residents are free to come and go to smoke." During interview on 11/27/19, at 11:23 a.m. the DON stated the facility interviewed staff right after the burn incident and an incident report was completed. The DON stated there were no new interventions identified to keep R1 safe from an accident but there will be when R1 returns. DON further stated R1 was deemed a safe smoker so she was allowed to keep her cigarettes and lighter in her room. When asked about the facility's directive for Smoking Guidelines to securely store cigarettes and lighters, the DON replied, "Some residents can have their cigarettes and lighters in their room and others have to have them in the medication cart." DON further stated she was unaware that R1 had any behaviors that would exclude her from being a safe smoker. Villa Healthcare Smoking Guidelines dated 11/28/17, directed: The evaluation will be used at the time of admission and with changes of condition. Although the guidelines directed that lighters and cigarettes would be securely stored, they did not indicate whether residents could store their own cigarettes and lighter. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review the resident smoking assessment to ensure assessment is comprehensive and includes provision for safe keeping of smoking material. The DON or designee could educate staff on the policy. The DON or designee could conduct periodic audits to ensure policy is being	2 830		

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2 830	Continued From page 7 followed. The results of the audits could be reported to the quality assurance committee. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 830		