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	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at Richfield	7727 Portland Avenue South Richfield, MN 55423

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43367 Based on observations, interviews and record review the facility failed to provide care and services to promote dignity for 2 of 3 residents (R1, R4) who required assistance with activities of daily living (ADLs) and reported feeling embarrassed by their hygiene appearance. Findings include: R1's admission Minimum Data Set (MDS) dated [DATE], identified intact cognition and no behaviors. R1 had impaired strength bilaterally lower extremities, dependent on staff for toileting hygiene, all transfers, and placement of footwear. R1 required partial to moderate assistance to go from sitting on edge of bed to lying and substantial to maximum assistance for personal hygiene. R1's care plan dated 4/23/24, identified ADL's self-care performance deficit related to paraplegia, MS, depression, and anxiety and directed staff to provide total assistance with all personal hygiene. R1's Kardex care sheet dated 5/30/24, identified R1 required total assistance with all personal hygiene care, assist of one for bathing, and explain new routines or tasks to resident to avoid confusion. R1's shower schedule identified she was to receive one shower a week, on Sunday evening. R1's weekly skin inspection documents from 4/29/24, through 5/26/24, identified: -4/29/24 bed bath given; -5/4/24 shower given; -5/12/24 refused shower; -5/20/24 no bath indicated; -5/26/24 bed bath given. (continued on next page)

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.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 5/30/24 at 8:20 a.m., R1 sat in an electric wheelchair, fully dressed and hair appeared oily and uncombed. R1 stated staff assisted her up this morning but would feel much better if she was cleaned up more often, and more than just her bottom half (peri-area). R1 stated she was unable to complete her own personal hygiene and had a hard time getting staff to assist her. R1 also stated she required staff assistance to set up brushing her teeth and rinsing her mouth out. R1 stated she felt gross, grungy, and occasionally her head itched from a dirty scalp. R1 also indicated other residents had commented that her hair looked bad, greasy, and she felt embarrassed by that. R1 stated she would prefer at least two showers a week. Adding, her boyfriend had to start giving her showers and now she felt as if the facility relied on him to give her showers, but he was unable to keep doing that due to responsibilities at home with the two children. R1 indicated her last shower was 5 days ago. R4's quarterly MDS dated [DATE], identified cognition intact and no behaviors. R4 was dependent on staff for toileting hygiene, shower/bathing, upper and lower body dressing, personal hygiene, sit to lying and lying to sitting, transfer from chair to chair. R1 diagnoses included diabetes mellitus (DM), renal failure, post-traumatic stress (PTSD), anxiety, and depression. R4's care plan dated 5/21/24, identified targeted behaviors such as isolation, loss of interest, low mood, hopelessness, and feeling of sadness. R4 was also identified as at risk for alteration in mood/behavior related to PTSD, depressive mood, fear, and low self-esteem. Staff are encouraged to allow R4 to talk and encourage her to express feelings. R4's Kardex care sheet dated 6/4/24, identified R4 required assist of one with bathing weekly and as needed (PRN). R4 preferred bed bath and uses shower cup to wash hair. R4 transferred with assist of two and a Hoyer lift. R4's shower schedule identified she was to have received her shower on Wednesday during day shift. During interview on 5/30/24 at 1:42 p.m., nursing assistant (NA)-C stated R1 was assisted to get up this morning at around 10:00 a.m. by herself and NA-D. by setting up R1 to wash her face, under arms, and staff completed peri cares. NA-C added R1 was not set up to brush her teeth, as she had brushed them on Tuesday (two days ago). NA-C also indicated how busy the day had been because he was training his new co-worker NA-D. NA-C also indicated R1 usually received a shower once a week but relied on her boyfriend for that. During interview on 5/30/24 at 1:55 p.m., (NA)- D stated first day of work at this facility. NA-D stated around 10:00 a.m. R1 wanted to get up and NA-C assisted with the Hoyer lift and dressed her. NA-D stated no cares were completed, none. NA-D stated R1 did not ask for any cares to be completed, and he worked under the supervision of NA-C. NA-D stated there was no conversation about cares to have been completed, R1 was dressed and lifted off of bed with a Hoyer lift and then placed in wheelchair. NA-D stated R1 received a shower once a week but unaware if her shower was scheduled for today. NA-D stated once R1 was placed in wheelchair both (NA-C and NA-D) left her room and helped another resident. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 5/30/24, at 4:11 p.m., R4 laid in bed, pajamas on, with a sheet covering her. R4 appeared alert and oriented. R4 stated she was incontinent at times and that she received a shower once a week. R4 also indicated staff did not wash her hair the other day and that it was, not okay with me. R4 indicated she usually does not ask staff to wash her hair and that it was hard for her to ask staff for helpR4 added her scalp felt itchy and her hair was usually not oily but was today. R4 stated really wanted someone to help her wash it. R4 stated she always had clean hair and was embarrassed how it looked and felt today, which was itchy and oily. During an interview on 5/31/24 11:45 a.m., registered nurse (RN)-A stated staff were expected to help residents who were unable to do it for themselves so that they received the care they are here for. RN-A also stated R1 received showers and when she was absent from the building frequently on her shower day, staff would be expected to offer another shower for a later date/time. RN-A expected staff to document additional information when this occurred. During an interview on 5/31/24 at 1:53 p.m., licensed social worker (LSW) stated when staff notice a resident's hair was dirty/oily they should offer a shower. LSW stated dirty/oily hair care could affect resident's wellbeing and self-confidence. During an interview on 5/31/24, at 2:00 p.m., NA-B stated R1 received a completed bed bath this morning and confirmed R1's hair appeared dirty and oily, but they only washed hair on shower days. NA-B stated because R1's hair appeared oily; he should have offered to wash it. During an interview on 5/31/24 at 3:00 p.m., director of nursing (DON) stated staff should offer services such as cares, washing up, and brush teeth every day to resident. DON added when the resident's assessment was completed, they were asked what their preference was for frequency of showers and that information was brought to the resident's care conference. Facility Dignity policy requested informed facility did not have one. Facility policy titled Activities of Daily Living/Maintain Abilities Policy dated 5/9/24, identified the facility was responsible to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, all shifts, and departments, understand the principle of quality of like, and honor and support these principles for each resident; and that the care and services provided are person-centered, and honor and support each resident's preferences, choices, values, and beliefs. A resident unable to carry out activities of daily living will receive necessary services to maintain grooming and personal hygiene.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43367 Based on interview and document review the facility failed to administer and discharge/assess timely a nebulizer treatment according to standards of for 1 of 1 resident (R2) who was left alone during administration of a nebulizer treatment for administration (15 minutes) and an additional 105 minutes following the treatment. Findings include: R2's annual Minimum Data Set (MDS) dated [DATE], identified R2 was cognitively intact with no behaviors. R2 had diagnoses of traumatic spinal cord injury, seizure disorder, quadria pelagic (paralysis that affects all four limbs and torso from neck down), and depression. R2 had impairment of bilaterally lower extremities, and dependent on staff for toileting hygiene, shower/bathing, clothing and shoes placed on, personal hygiene, sit to lying and lying to sit. R2 required substantial to maximum assistance required to roll left and roll right. R2 was dependent on staff for be to chair transfers, unable to walk, and had a motorized wheelchair. R2's physician orders indicated: -Acetylcysteine Inhalation Solution 20 % (a solution used to help break up thick, sticky mucus that could form in airways) 2 milliliters (ml) inhale orally four times a day for shortness of breath (SOB), active date 5/29/24. -Ipratropium-Albuterol Inhalation Solution (0.5-2.5 (3) milligrams (MG)/3 ML (Ipratropium-Albuterol) 3 ml inhale orally four times a day for SOB, active date 5/29/24. R2's Electronic Medication Administration dated 5/30/24, at 12:00 a.m. two separate inhalation nebulizer treatment medications were administered and signed off by LPN-C: Ipratropium-Albuterol and Acetylcysteine both medications were started on 5/29/24, at 12:00 a.m. R2's progress note on 5/24/2024, at 1:34 p.m. indicated alert and oriented (A & O) per baseline and required help with care and transfers. R2 requested staff to put pressure on his abdomen, then he starts to cough to clear his throat. R2 was at risk of aspiration with his saliva. R2's progress note on 5/24/2024, at 9:10 p.m. R2 was in bed with head of bed (HOB) elevated. A & O and called for staff assist with call light. R2 had copious sputum production. Contacted provider and received order to send to emergency department (ED) for assessment. R2's progress note on 5/28/24, at 6:56 p.m. R2 readmitted back to facility and treated at hospital for SOB. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's previous hospital admission document dated 5/24/24, identified R2 presented with SOB and coughing. R2 had oxygen saturation levels (SaO2) of 85% (90% or higher is normal), had similar symptoms for the past week and had lots of secretions and was not able to cough up on his own. R2's assessment showed hypoxia (low levels of oxygen in your body tissues causes symptoms like confusion, restlessness difficulty breathing, rapid heart rate, bluish skin, and can be life threatening, with Sa02 in mid 80's, and required 10 liters (L) nonrebreather (an oxygen mask that gave a lot of oxygen in an emergency). R2's chest x-ray showed atelectasis (partial collapse of a lung or part of a lung due to loss of air in the air sacs). During an interview on 5/30/24 at 8:56 a.m., R2 stated on 5/24/24 he was hospitalized for breathing problems, and then came to the nursing home on 5/28/24. R2 stated he had only been out of the hospital for two days and this morning the night nurse placed a mask on his face, turned machine (Nebulizer) on at 1:00 a.m., and left the room. R2 stated was very tired, fell asleep, and much later, was awakened by NA-A to find the mask remained on his face and the nebulizer machine was still turned on and was loud. R2 indicated his roommate told him the nurse never came back to remove his mask and turn the machine off, which kept him awake, so sometime after 2:30 a.m. he placed his call light on, and alerted NA-A that R2 needed assistance. R2 stated with the way his hands were now he was unable to grab things to remove a mask from his face and required assistance. R2 stated NA-A came in and removed the mask from his face and turned the machine off. During an interview on 5/31/24 at 2:30 a.m., NA-A stated last her shift started on 5/29/24 and ended 5/30/24; during the night shift licensed practical nurse (LPN)-C placed a nebulizer treatment (mask) on R2's face around 12:00 a.m. NA-A stated two hours later (at 2:00 a.m.) during her rounds, R2's roommate placed his call light on, came out in the hallway and got her attention. NA-A stated R2's roommate informed her R2's nebulizer machine and the mask remained on his face since 12:00 a.m. NA-A stated R2 was sleeping, and his face mask was removed, and machine turned off just after 2:00 a.m. NA-A stated she was very surprised, informed LPN-A right away and she indicated she forgot about it. NA-A added, LPN-C should have checked on R2 and removed the mask earlier. NA-A stated R2 would not be able to remove the mask by himself, because he had difficulty grabbing things. During an interview on 5/31/24 at 9:34 a.m., LPN-B stated administrating nurses were expected to assess the resident before and after the administration of a nebulizer. LPN-B stated the nebulizer treatment usually took about 10 minutes and the nurse was expected to stay with the resident and make sure they received the full dose without any side effects, such as a change in respiratory condition, then remove the mask. LPN-B added, a mask left on a resident for a length of time may have caused a negative effect on their breathing. During an interview on 5/31/24 at 11:20 a.m., LPN-A stated the administrating nurse was expected to check the resident's heart rate and respirations before and after a nebulizer treatment. LPN-A stated she would have placed the mask on the resident, stayed with resident until the nebulizer treatment was completed, usually 15 minutes, and mask should have been removed. LPN-A verified nebulizer treatments could have caused a change in respiratory status and a nurse would be expected to monitor the resident. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/31/24 at 11:45 a.m. registered nurse/floor manager (RN)-A stated the nurse would be expected to complete a respiratory assessment before and after administration of a nebulizer treatment (e. g. respirations, hear rate, and oxygen saturation levels) and document in the progress notes. RN-A also stated the nurse would be expected to have remained with the resident in his room during the administration of the nebulizer treatment, monitor and recognize any side effects, and/or change in respiratory status and mask should be removed when treatment was completed. During a telephone interview on 5/31/24 at 12:25 p.m., LPN-C stated she completed a respiratory assessment before and after she administered R2's Ipratropium-Albuterol inhalation just after 12:00 a.m. LPN-C stated she had placed the mask on R2's face and turned on the machine and left R2's room. LPN-C was located outside R2's room when another resident requested assistance. LPN-C stated she entered R2's room over 25 minutes later and thought she removed the mask from R2's face. LPN-C stated NA-A had approached her after 12:30 a.m., not exactly sure what time, and informed her the R2's mask remained on his face with the nebulizer machine on. LPN-C stated she should have stayed with R2 until the nebulizer treatment was completed to monitor breathing and response to the treatment. LPN-C indicated she usually stayed with resident during a nebulizer treatment unless someone needed help. During a telephone interview on 5/31/24, at 2:32 pm pharmacy consultant (PC) stated unless the resident had been assessed to self-administer the nebulizer treatment the nurse should have remained with the resident during the administration of both treatments. PC also stated both of R2's nebulizer treatments (Acetylcysteine Inhalation Solution and Ipratropium-Albuterol Inhalation Solution) could have caused adverse side effects and the nurse would have been expected to stay with R2 and monitored for change in respiratory status, assessed how R2 tolerated the treatments, and ensured the mask stayed in place. During an interview on 5/31/24 at 3:00 p.m., director of nursing (DON) stated R2 was not assessed to self-administer his nebulizer treatments. DON stated LPN-C should have stayed in the room with R2 while she administered the nebulizer treatments to monitor for respiratory distress. DON stated both of the nebulizer treatments were new for R2, which made it even more important to monitor him. DON verified on 5/30/24, at 12:00 a.m. LPN-C signed off she administered Ipratropium/albuterol inhalation first then administered Acetylcysteine nebulizer second treatments via mask. Facility document titled Specific Medication Administration Procedures, dated 2006, provided by the PC indicated purpose was to allow for safe, accurate, and effective administration of medication using a nebulizer. Instructions included: once the medication was placed in the nebulizer cup, turn machine on and remain with the resident for the treatment unless had been assessed and authorized to self-administer. Monitor for medication side effects, including rapid pulse, restlessness, and nervousness throughout the treatment. Administer therapy until medication gone, when completed, turn off nebulizer, and rinse and disinfect the nebulizer equipment. Obtain post-treatment pulse, respiratory rate, and lung sounds and documents findings on the medical record (EMAR) or medical record.