

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245492	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/12/2025
NAME OF PROVIDER OR SUPPLIER  The Villas at Richfield		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44654</b></p> <p>Based on interview and document review, the facility failed to ensure alleged violations of an injury of unknown origin that resulted in suspicion of serious bodily injury were immediately reported, no later than 2 hours, to the State Agency (SA) and administrator for 1 of 1 resident (R2) reviewed for abuse.</p> <p>Findings include:</p> <p>R2's Medicare 5-Day Minimum Data Set (MDS) dated [DATE], indicated R2 had moderate cognitive impairment.</p> <p>R2's provider progress note by physician's assistant (PA)-A dated 2/19/25 no time indicated, indicated R2 was seen to discuss discharge planning to return home. R2's left wrist was noted to be bruised and swollen with tenderness to palpation, with no reported falls and injuries. The provider ordered an X-Ray for the left wrist. The progress notes lacked information about a staff discovery of R2's swollen wrist.</p> <p>On 3/12/25 at 10:11 a.m., during an interview, social worker (SW)-A stated he was not aware of R2's wrist injury however, confirmed any injury of unknown origin should have been reported to the SA and was unsure if the report had been completed.</p> <p>On 3/12/25 at 3:48 p.m., during an interview, the director of nursing (DON) stated R2's wrist injury should have been reported to the SA per the policy and confirmed no report had been made to the SA.</p> <p>On 3/12/25 at 2:00 p.m., during an interview, registered nurse (RN)-D stated she was aware R2 had an X-Ray ordered for her wrist but was not sure why. RN-D indicated if R2 had an injury of unknown origin, the facility should have reported it to the SA. RN-D stated RN-C discovered the swollen wrist and notified the PA.</p> <p>On 3/12/25 at 2:36 p.m., during an interview, RN-C stated she noticed R2's wrist was swollen on 2/19/25, and told the PA who was in the facility. RN-C stated PA-A gave an order for an X-Ray to determine if the wrist was fractured. RN-C stated she knew the incident should have been reported to the SA. RN-C stated she did not report to the SA however, had reported it to the PA.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/12/25 at 2:51 p.m., during an interview, PA-A stated a nurse informed her about R2's swollen wrist and when PA-A assessed it, the right wrist was noted to be bruised, swollen, and tender to palpate, with no related reports of falls or injuries. PA-A stated, You could call in an injury of unknown origin. PA-A stated the injury should have been reported to the SA, and was unsure if it had been.</p> <p>On 3/12/25 at 3:05 p.m., during an interview, the administrator stated if a resident had a bruise of unknown source, he would report it to the SA. The administrator acknowledged he was not aware of the injury and staff had not reported it to him.</p> <p>The Abuse Prohibition/Vulnerable Adult policy dated 2/2025, indicated injuries of unknown injury that were not observed and suspicious because of the extent of the injury would be reported to the State Agency and investigated.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44654</b></p> <p>Based on interview and document review, the facility failed to thoroughly investigate an injury of unknown origin for 1 of 3 residents (R2), (R2 had a swollen, bruised, tender right wrist with no known related injuries or accidents) reviewed for abuse.</p> <p>Findings include:</p> <p>R2's Medicare 5-Day Minimum Data Set (MDS) dated [DATE], indicated R2 had moderate cognitive impairment.</p> <p>R2's provider progress note by physician's assistant (PA)A dated 2/19/25 no time identified, indicated R2 was seen to discuss discharge planning to return home. R2's left wrist was noted to be bruised and swollen with tenderness to palpation, with no reported falls and injuries. The provider ordered an X-Ray for the left wrist.</p> <p>On 3/12/25 at 10:11 a.m., during an interview, social worker (SW)-A stated he was not aware of R2's wrist injury however, confirmed any injury of unknown origin should have been investigated, and was not aware if it had been investigated.</p> <p>On 3/12/25 at 3:48 p.m., during an interview, director of nursing (DON) stated R2's wrist injury should have been investigated per the policy, and confirmed it had not been investigated.</p> <p>On 3/12/25 at 2:51 p.m., during an interview, PA-A stated a nurse informed her about R2's wrist and when she saw it, it was bruised, swollen, and tender to palpate, and there were no falls or injuries reported related to the injury. PA-A stated, You could call in an injury of unknown origin.</p> <p>On 3/12/25 at 3:05 p.m., during an interview, the administrator stated if a resident had a bruise of unknown source, he would investigate it. The administrator acknowledged he was not aware of the injury, it had not reported it to him, and it had not been investigated.</p> <p>The Abuse Prohibition/Vulnerable Adult policy dated 2/2025, indicated injuries of unknown injury that were not observed and was suspicious because of the extent of the injury would be reported to the State Agency and investigated.</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44654</p> <p>Based on interview and document review, the facility failed to ensure adequate and required information was communicated and documented to a receiving healthcare facility to provide continuity of care for 1 of 3 residents (R2) reviewed for discharge.</p> <p>Findings include:</p> <p>R2's Medicare 5-Day Minimum Data Set (MDS) dated [DATE], indicated R2 had moderate cognitive impairment, an indwelling catheter (used to drain urine from the bladder), a history of stroke and renal insufficiency (kidneys were not fully functioning).</p> <p>R2's care plan printed 3/12/25, lacked indication R2 had a catheter.</p> <p>R2's diagnoses list printed 3/11/25, indicated chronic kidney disease and neuromuscular dysfunction of the bladder.</p> <p>R2's hospital discharge summary dated 1/28/25, indicated R2 arrived to the hospital on 1/20/25, with urinary retention that was relieved with a catheter.</p> <p>R2's provider progress notes dated 1/29/25, indicated R2 had a catheter in the hospital for urinary retention.</p> <p>R2's progress notes dated 2/1/25, indicated R2 had a catheter, and catheter cares were provided.</p> <p>R2's orders dated 2/14/25, indicated monitor catheter output every shift, and change foley catheter monthly and as needed.</p> <p>R2's provider progress note by physician's assistant (PA)-A dated 2/19/25 [no time indicated], indicated R2 was seen to discuss discharge planning, to return home but had altered mentation, painful urination, suprapubic tenderness, and blood in her urine and catheter.</p> <p>R2's progress note dated 2/25/25, at 1:55 p.m., indicated R2's catheter had come out, two nurses were unable to reinsert the catheter, and the nurse manager was notified. The progress note indicated the second shift nurse would attempt to reinsert the catheter.</p> <p>R2's progress note dated 2/26/25 at 6:50 a.m., indicated three nurses attempted to reinsert R2's catheter without success, and indicated R2 had a wet brief. The progress note lacked indication the provider was notified.</p> <p>R2's facility Discharge Summary and Orders dated 2/25/25, indicated R2 could discharge to the assisted living (AL) facility and also included a summary of R2's care. The summary included progress notes that identified R2 had a catheter, but lacked an order for the catheter and lacked mention R2 was discharged to the AL without a catheter when R2 required a catheter. In addition, the summary lacked information about R2's urinary incontinence, bowel incontinence and mental status.</p> <p>(continued on next page)</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/11/25 at 1:33 p.m., during an interview, registered nurse (RN)-A stated R2 arrived at the AL facility on 2/26/25, without a catheter and R2 should have had one. RN-A stated R2 was having small voids and on 2/28/25, the AL facility sent R2 to the emergency room for a catheter insertion. RN-A stated the solution for the skilled nursing facility should not have been to just send her to the AL without a catheter.</p> <p>On 3/11/25 at 3:57 p.m. during an interview, licensed practical nurse (LPN)-A stated R2's catheter came out on 2/25/25, and several nurses tried to reinsert it, and then she and other nurses tried again on 2/26/25, prior to R2's discharge. LPN-A stated she knew R2 needed the catheter for urinary retention and could develop an infection without it.</p> <p>On 3/12/25 at 9:18 a.m., during an interview, family member (FM)-A stated R2 had a catheter since January 2025, when it was placed in the emergency room due to urinary retention. FM-A stated R2 arrived at the assisted living facility [after discharge from the facility] in an incontinence brief instead of a catheter because staff could not reinsert it after a catheter change.</p> <p>On 3/12/25 at 11:08 a.m., during an interview, LPN-B stated R2 should have discharged with a catheter because it was part of her treatment plan.</p> <p>On 3/12/25 at 2:00 p.m., during an interview, RN-D stated R2 had an order for a catheter from standard batch orders and R2 should have discharged with a catheter. Additionally, RN-D stated she was unaware R2 left the facility without a catheter, and staff should have notified the provider if they were unable to reinsert R2's catheter.</p> <p>On 3/12/25 at 2:51 p.m., during an interview PA-A stated R2 discharged from the hospital with a catheter for urinary retention. The PA-A stated R2 should have discharged to the AL with a catheter and confirmed PA-A had not been notified R2 discharged without the catheter.</p> <p>The Discharge Planning policy dated 1/2025, indicated the discharge plan would identify resident needs, and develop and implement plans and interventions to address them. The post-discharge plan of care must indicate arrangements for follow-up care, and post-discharge medical services.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44654</b></p> <p>Based on interview and document review, the facility failed to comprehensively assess, develop a plan of care, and provide interventions for 1 or 1 resident (R2) reviewed for catheter care. In addition, the facility failed to notify a provider for further direction when staff were unable to re-insert the catheter.</p> <p>Findings include:</p> <p>R2's Medicare 5-Day Minimum Data Set (MDS) dated [DATE], indicated R2 had moderate cognitive impairment, an indwelling catheter, a history of stroke, and renal insufficiency (kidneys were not fully functioning).</p> <p>R2's diagnoses list printed 3/11/25, indicated chronic kidney disease and neuromuscular dysfunction of the bladder.</p> <p>R2's care plan printed 3/12/25, lacked indication R2 had a catheter.</p> <p>R2's hospital discharge summary dated 1/28/25, indicated R2 arrived to the hospital on 1/20/25, with urinary retention that was relieved with a catheter and discharged to the facility on [DATE], with the catheter.</p> <p>R2's provider progress notes dated 1/29/25, indicated R2 had a catheter in the hospital for urinary retention.</p> <p>R2's progress notes dated 2/1/25, indicated R2 had a catheter, and catheter cares were provided.</p> <p>R2's orders dated 2/14/25, indicated monitor catheter output every shift, and change foley catheter monthly and as needed however, lacked orders for the type of catheter, indications for use, the size of catheter required, whether to use it intermittently or continuously, and the amount of water required to inflate the catheter balloon.</p> <p>R2's provider progress note by physician's assistant (PA)-A dated 2/19/25 [no time indicated], indicated R2 was seen to discuss discharge planning, but had altered mentation, painful urination, suprapubic tenderness, and blood in her urine and catheter. The provider ordered a urinalysis test, and a catheter change for R2.</p> <p>R2's provider progress note dated 2/25/25, indicated R2's catheter was draining yellow, cloudy urine.</p> <p>R2's progress note dated 2/25/25, at 1:55 p.m ., indicated R2's catheter had come out, two nurses were unable to reinsert the catheter, and the nurse manager was notified. The progress note indicated the second shift nurse would attempt to reinsert the catheter.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R2's progress note dated 2/26/25 at 6:50 a.m., indicated three nurses attempted to reinsert R2's catheter without success, and indicated R2 had a wet brief. The progress note lacked indication the provider was notified or that R2's catheter was or was not reinserted.</p> <p>On 3/11/25 at 3:57 p.m. during an interview, licensed practical nurse (LPN)-A stated R2's catheter came out on 2/25/25, and several nurses attempted to reinsert it. LPN-A indicated she and other nurses tried again to insert a catheter into R2 on 2/26/25, prior to R2's discharge and were unsuccessful. LPN-A stated she knew R2 needed the catheter for urinary retention and could develop an infection without it. Further, LPN-A stated she did not notify the PA because R2 had a wet [incontinence] brief, and R2 was discharging.</p> <p>On 3/12/25 at 9:18 a.m., during an interview, family member (FM)-A stated R2 had a catheter since January 2025, when it was placed in the emergency room due to urinary retention.</p> <p>On 3/12/25 at 11:08 a.m., during an interview, LPN-B stated if staff were not able to reinsert R2's catheter, staff should have notified the PA or sent R2 to the emergency room .</p> <p>On 3/12/25 at 11:58 a.m.,during an interview, RN-B stated the facility was required to have an order for a catheter, and nurses would refer to the order when they changed the catheter to know so they would be aware of what size catheter was and how much sterile water was used to inflate the catheter balloon.</p> <p>On 3/12/25 at 12:50 p.m. during an interview, the director of nursing (DON) stated a catheter order should have included the indications for use, the type of catheter, how often it should be changed, the balloon size and size of catheter. The DON confirmed R2 had no order for a catheter.</p> <p>On 3/12/25 at 3:48 p.m., in a subsequent interview, the DON stated if staff were unable reinsert the catheter, she expected staff to notify the provider.</p> <p>On 3/12/25 at 2:00 p.m.,during an interview, RN-D stated R2 had an order for a catheter from standard batch orders. RN-D stated the process was for the order to be on the Kardex (orders in the electronic health record used as reference for type of care required for each resident), and when the information was on the resident's care plan, it would flow to the Kardex. RN-D acknowledged R2's care plan lacked information about R2's catheter. RN-D stated staff would not know what size catheter to use if it was not identified on the resident's care plan, unless they looked at the catheter that was already in place. Further, RN-D stated staff should have notified the provider if they were unable to reinsert R2's catheter. RN-D acknowledged there was no indication in the medical record the provider had been notified.</p> <p>On 3/12/25 at 2:51 p.m., during an interview, PA-A stated R2 had been discharged from the hospital with a catheter for urinary retention. PA-A confirmed she expected staff to notify her if they were unable to reinsert the catheter.</p> <p>The Indwelling Catheter Policy was requested but not provided.</p> <p>The Discharge Planning policy dated 1/2025, indicated the discharge plan would identify resident needs, and develop and implement plans and interventions to address them</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The post-discharge plan of care must indicate arrangements for follow-up care, and post-discharge medical services.</p>