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	05/15/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a comprehensive community safety assessment was completed to determine whether a resident could safely attend outside appointments independently and failed to maintain an effective system to account for and respond when residents did not return from outside appointments as expected for 1 of 1 residents (R1) who was unaccounted for overnight and required emergency department evaluation. Findings include:R1's face sheet dated 5/14/26, identified diagnoses of hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) and alcohol use.R1's Quarterly Minimum Data Set (MDS) dated [DATE], identified R1 had no behaviors, used a wheelchair, needed supervision for chair/bed to chair transfer, and was independent in wheelchair mobility. R1's cognition was not listed on the MDS.R1's mobility focus care plan dated 1/22/26, identified R1 had an alteration in mobility related to hemiplegia and hemiparesis following cerebral infarction (stroke). Interventions as follows:-Independent with movement in bed and supervision in and out of bed.-Supervision with transfers.-Used a wheelchair independently for locomotion. R1's physician orders dated 1/26/26, identified R1 may go on leave of absence with medications. R1's Brief Interview for Mental Status (BIMS)(a test used to identify a resident cognition level) dated 1/21/26, identified R1 was cognitively intact. R1's occupational therapy note dated 3/29/26, identified decision making ability for routine activities that R1 was moderately impaired, and safety awareness was impaired. R1's Elopement Risk Evaluation dated 4/27/26, identified R1 was not at risk for elopement.R1's Brief Interview for Mental Status dated 4/30/26, identified R1 was cognitively intact. During an interview on 5/14/26 at 10:20 a.m., licensed practical nurse (LPN)-A stated was the nurse on 5/8/26 when R1 had an appointment scheduled with an outside laboratory. LPN-A explained R1was to be taken to his appointment by a transportation service, so she assisted R1 down to the first floor to wait for his ride. LPN-A had given R1 an envelope with the name and number of the transportation company and gave him instructions to call the transportation company when he was done with his appointment. R1 had his cell phone on his person when he left for the appointment and R1 was able to make phone calls on his phone. LPN-A stated on 5/8/26 at around 5:00 p.m., she identified that R1 had not returned from his appointment and instructed the other nurse to call the outside laboratory to see if R1 was still at the appointment, however, when they called the laboratory the clinic was already closed. LPN-A further explained that the other nurse had attempted to call R1 and R1's first contact and was unable to reach either of them. LPN-A then called the nurse manager and she was told the R1 was his own person and that he must have left the appointment without calling the transportation company for a ride back and gave her instruction to follow the facility's leave of absence policy and notify the police if he did not return after 24 hours. LPN-A stated when she returned to work the next day on 5/9/26, R1 was still not in the facility, so had called 911 and filed a missing person report with the police. R1's progress note dated 5/9/26 at 9:37 a.m., identified a state agency report was completed due to resident not returning from an appointment. Facility staff completed a missing person's report with the police department. R1's progress note dated 5/9/26 at 11:06 a.m., identified physician was notified of R1 not (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	returning to the facility. R1's emergency department (ED) note dated 5/10/26 at 1:04 a.m., identified R1 was brought to the ED after he was found using his wheelchair in a crosswalk with difficulty prompting a bystander to call emergency management systems (EMS). R1 had a left knee wrapped and an abrasion to his left elbow. R1 had difficulty providing details of the event, but is alert and oriented to person, place, time, and event. R1's biggest concern was his left elbow pain and left hip pain. History was limited secondary to R1's intermittent altered mental status. R1 denied being in significant distress. R1 stated he had consumed alcohol. Alcohol level checked and was negative. R1 was admitted to the hospital due to fluctuating cognitive levels, an elevated white cell counts with an admitting diagnosis of adult failure to thrive. During an interview on 5/14/26 at 10:11 a.m., nursing assistant (NA)-A stated the facility had assigned staff to attend appointments with residents that are identified as needing an escort due to not being able to go independently and this is marked on the calendar each day on who would need an escort. NA-A stated R1 was alert and orientated and did not need an escort to appointments. During an interview with police department on 5/15/26 at 2:22 p.m., stated the facility had contacted the department on 5/9/26 to report a resident that had not returned from an appointment on 5/8/26. The department took the report and when the investigator contacted the facility to complete the report, R1 had already been found by that time. During an interview on 5/14/26 at 11:52 a.m., registered nurse/nurse manager (RN-NM) stated she decides if a resident needs to have an escort to any outside appointment and will ensure that a resident has staff accompany them if needed. RN-NM stated that the facility does not perform a formal community safety assessment to ensure they are safe to go independently and will use the elopement risk and the Brief Interview for Mental Status assessment to make the determination. RN-CM further explained R1 was independent in his decision making and they believed when he left for his appointment on 5/8/26, he chose to not call the transportation service and went on a leave of absence, however, R1 had not signed out or contacted the facility saying he was not returning per the facility policy. During an interview on 5/14/26 at 12:11 p.m., registered nurse (RN)-A stated R1 left for an appointment on 5/8/26 with a transportation service around 9:00 a.m., and when he did not return around 5:00p.m., the facility attempted to call the outside laboratory to see if R1 could be located, however, the lab was already closed for the day. RN-A stated she believed R1 was his own person and assumed he must have not contacted the transportation service and decided to go on a leave of absence (LOA), however, R1 had not signed himself out or called the facility to inform the facility he would not be returning. RN-A stated when a resident is admitted to the facility she will complete an elopement assessment and review the BIMS score to make a determination if a resident is safe to go to appointments alone, however, the facility does not perform a community assessment prior to making this determination. During an interview on 5/15/26 at 10:31 a.m., DON stated R1 had not had a community safety assessment completed to determine if he was safe to go out to an appointment independently and he should have had this completed. DON further explained the facility is going to change the process of determining if residents need to have a staff escort by having the interdisciplinary team (IDT) review a resident's diagnosis, cognition, and safety awareness to ensure the resident is safe to go out in the community for things like outside appointments. Currently the facility does not do community safety assessments on each resident going out in the community independently, however, will be doing this going forward. Review of the facility's Resident Leave of Absence Policy dated 11/25, identified the purpose of the policy was to establish guidelines and a procedure for appropriate communication and documenting leave of absence requirements. Prior to leaving the facility the resident or resident representative will be instructed to sign out prior to going out on LOA to include when they will be returning with approximate date and time. Request a policy for outside appointments but did not receive.