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	05/20/2026

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 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** Based on observation, interview, and document review the facility failed to provide a dignified dining experience for 1 of 1 resident (R87).Findings include: R87's significant change Minimum Data Set (MDS) dated [DATE], indicated severely impaired cognition and diagnoses of liver cell carcinoma (cancer of the liver) and severe protein-calorie malnutrition. It further indicated R87 required substantial assistance with eating. R87's care plan dated 2/23/26, indicated self-care deficit related to liver cell carcinoma with an intervention of assist of 1 staff with eating. During observation on 5/18/26 at 12:09 p.m., R87 was sitting in his wheelchair in his room. The lights were off; his bedside table was in front of him and the MDS coordinator was standing up next to his wheelchair assisting him to eat. During interview on 5/19/26 at 7:05 a.m., nursing assistant (NA)-G was unable to determine whether they should be standing or sitting when assisting a resident to eat stating that's not something that has been generally trained, but the lights should be on, and I would sit down and have a conversation with them. I don't think it's trained that you're supposed to be standing over them. During interview on 5/19/26 at 7:20 a.m., the MDS coordinator stated they usually don't assist with feeding residents and was unable to determine whether they should be sitting or standing when assisting a resident to eat, stating I will have to check with the director of nursing (DON).During interview on 5/19/26 at 7:35 a.m., NA-L stated nursing staff should be sitting down next to the resident and having a conversation with them while assisting them to eat. NA-L further stated the lights should also be on because it provides a more dignified experience, instead of just shoving food in their mouth. During interview on 5/20/26 at 11:00 a.m., the DON stated the nursing staff (NA's and nurses) should be assisting residents to eat at the resident's eye level and the lights should be on unless the resident preferred to eat in the dark. The DON further stated R87's chair sit's up higher so that's why the MDS coordinator was assisting him to eat while standing up. If R87's chair wasn't elevated, staff would've been expected to sit next to the resident while assisting him to eat. A facility policy regarding dignity was requested but not received.

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

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	05/20/2026

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to provide appropriate clothing (socks) to 1 of 1 resident (R96) who requested them. Findings include:R96's quarterly Minimum Data Set (MDS) dated [DATE], indicated intact cognition and diagnoses of heart failure and type II diabetes.During observation and interview on 5/17/26 at 11:40 a.m., R87 was sitting in his wheelchair in his room. He was barefoot and stated he had asked staff (unknown) for socks several times and they won't give me any. During observation on 5/18/26 at 8:59 a.m., R96 was sitting in his wheelchair in his room, barefoot. Nursing Assistant (NA)-M stated he would have to wait to get socks until some came up from laundry and left the room. At 9:15 a.m., the physical therapist (PT)-A entered R96's room and R96 stood up so PT-A could put the gait belt on him. Then they proceeded to exit the room and walk down the hallway to the elevator. R87 was barefoot. At 9:43 a.m., PT-A and R96 came back to his room and as they passed by, licensed practical nurse (LPN)-B stated, They haven't found you any socks yet? and then LPN-B entered another resident's room, without getting him any socks. R96 went back to his room and PT-A left him sitting in his wheelchair, barefoot. During interview on 5/18/26 at 9:55 a.m., LPN-C verified R96 was walking in the hallway barefoot and shouldn't be, especially in the hallways and on the elevator stating they (facility) have plenty of socks, in all different sizes. During interview on 5/19/26 at 7:05 a.m. NA-G stated the residents should always be wearing socks, especially when walking in the hallways and on the elevator. There are always gripper socks available, if not in the linen closet, then in the storage closet. During interview on 5/19/26 at 7:35 a.m., NA-L stated if they saw a resident was walking around with bare feet and/or asked them for socks, they would get them for the resident. Residents shouldn't be walking around barefoot, especially in the hallways or on the elevator. NA-L stated gripper socks were always available but sometimes laundry had a hard time keeping up with washing them. During interview on 5/20/26 at 7:44 a.m., registered nurse (RN)-D stated all of the staff were responsible for ensuring the residents had socks and the residents shouldn't be walking in the hallways or going on the elevator barefoot. They have plenty of extra socks and are readily available. During interview on 5/20/26 at 9:12 a.m., physical therapist (PT)-A stated R96 had physical therapy 3-5 times per week. R96 often was not wearing socks (barefoot). PT-A was unable to determine the reason why. During interview on 5/20/26 at 11:00 a.m., the director of nursing (DON) stated her expectation was for residents to be wearing socks, especially when walking in the hallway or going on the elevator. This was important for infection control and also because R96 was diabetic and was more susceptible to getting wounds and skin alterations. The DON further stated, there are always gripper socks available and if for some reason they weren't, the nursing assistants were expected to let the nurse know, so they could get some more. A facility policy was requested; however the facility doesn't have a policy that addresses these concerns.

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	05/20/2026

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure personal privacy during toileting for 1 of 1 residents (R71) reviewed for privacy.Findings include:R71's admission Minimum Data Set (MDS) dated [DATE], indicated R71's cognition was not assessed, required supervision or touching assistance for most activities of daily living (ADLs) including toilet hygiene and transfer, and was always continent of bowel and bladder. R71's diagnoses include hemiplegia and hemiparesis (weakness and paralysis affecting one side of the body), aphasia (condition affecting speech), and depression.R71's care plan dated 5/14/26, identified R71 was at risk for elopement due to cognitive impairment and previous attempt to leave the facility.R71's provider orders dated 5/17/26, indicated, Resident on 1:1 monitoring.During observation on 5/17/26 at 12:15 p.m., R71 was in his room with nursing assistant (NA)-F providing 1:1 supervision. NA-F assisted R71 into the bathroom and transferred to the toilet. The bathroom door was left open. R71's roommate (R13) had a visitor, who had direct line of sight to R71 on the toilet. R13 had a privacy curtain that could have been pulled to prevent visitor from observing R71, but was left open. During interview on 5/18/26 at 12:58 p.m., R71 stated he did not understand why he was receiving 1:1 supervision. R71 further stated it bothered him that a visitor could observe him while he was on the toilet and would prefer privacy.During interview on 5/18/26 at 1:03 p.m., NA-F stated residents should be provided privacy while in the bathroom. NA-F stated she did not want R71 to escape through the adjoining room so she left the bathroom door open to continue 1:1 supervision. NA-F stated she should have pulled the privacy curtain to protect R71's privacy.During interview on 5/19/26 at 11:11 a.m., licensed practical nurse (LPN)-B stated would expect all residents to be provided privacy as appropriate when in the bathroom and that the NA should have pulled the privacy curtain.During interview on 5/19/26 at 11:25 a.m., director of nursing (DON) stated expectation for resident's privacy to be respected and R71 should have been given privacy by shutting the door or using a privacy curtain.Facility policy on personal privacy was requested but not provided.

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	05/20/2026

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to offer or provide individual or group activities for 1 of 2 residents (R62).Findings include:R62's quarterly Minimum Data Set (MDS) dated [DATE], indicated severely impaired cognition and diagnoses of vascular dementia, adult failure to thrive, and muscle weakness. It further indicated R62 required substantial assistance with bed mobility and was dependent on staff for transfers. R62's annual MDS dated [DATE], indicated listening to music was very important to her. It further indicated participating in her favorite activities, participating in group activities, participating in religious services, and going outside were somewhat important. R62's care plan dated 5/12/26, indicated R62 was dependent on staff for activities, cognitive stimulation, social interaction, and well-being related to cognitive deficits and immobility. It further indicated the following interventions: -Allow for periods of rest-Inform resident early of scheduled programs to allow resident time to digest and make choices-Thank resident for attendance at activity function.During observations made on 5/17/26 between 11:51 a.m. and 2:29 p.m., R62 was lying in bed with the lights on without any music, television, or interactions from staff aside from required care (medications, turning, and repositioning) services from staff. During observations made on 5/18/26 between 9:26 a.m. and 2:06 p.m., R62 was lying in bed with the lights on without any music, television, or interactions from staff aside from required care (medications, turning, and repositioning) services from staff. During observations made on 5/19/26 between 7:26 a.m. and 1:00 p.m., R62 was lying in bed with the lights on without any music, television, or interactions from staff aside from required care (medications, turning, and repositioning) services from staff. During observations made on 5/20/26 between 7:50 a.m. and 9:51 a.m., R62 was lying in bed with the lights on without any music, television, or interactions from staff aside from required care (medications, turning, repositioning, and wound care) services from staff. During interview on 5/19/26 at 7:05 a.m., nursing assistant (NA)-G stated R62 didn't get out of bed because she didn't want to. The only time she would get out of bed was on her shower days. NA-G further stated R62 did not attend group activities and didn't participate in individualized activities. During interview on 5/19/26 at 7:56 a.m. NA-L verified they don't turn on the television or radio in R62's room because it was too loud and they only get her out of bed for group activities if the nurse tells them to, which wasn't very often. During interview on 5/20/26 at 7:44 a.m., registered nurse (RN)-D stated therapeutic recreation, and social services were responsible for providing activities to residents whether it be in their room or bringing them to group activities. Nursing staff was not responsible for providing residents activities. During interview on 5/20/26 at approximately 10:00 a.m., therapeutic recreation (TR)-A stated one way the residents were made aware of group activities was by handing out a paper called the Daily Chronicle that listed the day's activities. They also have their main group of people that come regularly to the activities, and they will also go around and ask residents individually if they want to attend. The TR-A further stated for individual activities, they work together with the nursing staff to make sure their television, or radio is on or they're provided with other individual activities of their choice (books, newspaper, puzzles, etc.). If the resident was non-verbal or unable to express whether they would like to attend an activity or not, they will bring them to the activity for socialization and if it doesn't work or the resident appears to be overstimulated, they will bring them back to their room. TR-A stated R62 had a 1:1 visit every other day (for one hour) and there was a Tea Party every Tuesday they would usually bring her to. TR-A was unable to determine what individual activities were provided to R62 each day when she was in her room as they also work with nursing staff to provide those activities. During interview on 5/20/26 at 11:00 a.m., the director of nursing (DON) stated an assessment was completed with each resident regarding their activity preferences and their preferences should be added to the care plan. Staff (nursing and activity) were then expected to follow those preferences. The facility policy regarding activities was requested but not received.

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	05/20/2026

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to utilize available resources for 1 of 1 resident (R40) who requested eyeglasses.Findings include: The National Eye Institute website dated 9/11/25, identified the following resources to obtain eyeglasses, including but not limited to:VSP Eyes of Hope provided children and adults with no-cost eye care and eyeglasses. This program was for people with limited income who don't have health insurance. To apply for Eyes of Hope, you'll need help from a school nurse or a community partner organizationLions Clubs International offers help paying for eye care through its local clubs. Some clubs may also provide eyeglasses.New Eyes provides prescription eyeglasses to children and adults who can't afford them. A social worker or someone at a community health center may be able help you apply.R40's quarterly Minimum Data Set (MDS) dated [DATE], identified vision was adequate with no glasses or corrective lenses. R40 could understand, make herself understood, was independent with eating, and required set up for oral hygiene. Diagnoses included stroke, high blood pressure and hemiplegia (one-sided paralysis). R40's communication care plan dated 4/30/26, identified her primary language was Spanish and she was able to understand and speak in English. The goals included residents' needs will be anticipated and met by staff. There were no vision interventions. R40's Doctor of Optometry (DO) visit note dated 2/6/25, identified eyeglasses were requested. R40 was diagnosed with myopia (distant objects look blurry) and age-related cataracts (when the lens of your eye becomes cloudy, affecting your ability to see). R40's DO visit note dated 8/15/25, identified eyeglasses were requested again. R40's nurse practitioner visit note dated 4/8/26, identified R40 complained of her left eye vision worsening and requested to see the eye doctor, so an order was placed.R40's MHM Hearing/Vision Form dated 4/13/26, identified she could see in adequate light with glasses or other visual appliances, and no corrective lenses were in place, which conflicted with R40's recent statement to the NP on 4/8/26, about left eye vision worsening with a request to see the eye doctor. R40's order dated 4/15/26, identified ophthalmology apt (appointment) pt (patient) complains of vision changes in left eye. R40's progress notes and care conference notes dated 2/6/25 through 5/17/26, lacked notation that R40 was assisted with the eyeglasses request. During an interview on 5/18/26 at 2:52 p.m., R40 stated her left eye was getting worse, she would get a headache when reading and needed eyeglasses. During an interview on 5/18/26 at 3:03 p.m., the health information manager (HIM) stated she coordinated ancillary services. The HIM stated eyeglasses were not covered on R40's emergency medical assistance (EMA).During an interview on 5/18/26 at 3:18 p.m., the social services director (SS)-D stated he was not aware of resources for someone on EMA to obtain eyeglasses and he was not aware of a request of R40's for eyeglasses. During an interview on 5/20/26 at 12:44 p.m., the administrator stated social services could look into eyeglasses resources for residents on EMA, and he did not have any specific resources or policies.During a follow up interview on 5/20/26 at 12:56 p.m., the SS-D stated there was no specific policy for resources on the acquisition of eyeglasses for residents on EMA.

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	05/20/2026

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 observation, interview, and document review, the facility failed to ensure fall interventions were in place for 1 of 2 residents (R44) reviewed who were at risk for falls. Findings include:R44's quarterly Minimum Data Set (MDS) dated [DATE], indicated R44 had moderate cognitive impairment, required setup/clean-up assistance with meals, and was dependent on staff for personal hygiene, dressing, and mobility. R44's diagnoses included spondylosis of the lumbar region (degeneration of spine which can cause pain and affect mobility), and syncope and collapse (temporary loss of consciousness and muscle control). R44's care plan dated 4/16/26, identified R44 was at risk for falls due to low back pain and weakness. R44's care plan instructed staff to keep call light within reach, bed low, and mat on floor next to bed while resident in bed. R44's Fall Review Evaluation dated 5/17/26, indicated R44 had 1-2 falls in the last six months, was oriented to person but not always oriented to place, and was unable to independently come to standing position. R44's post fall Incident Review and Analysis dated 1/26/26, indicated R44 was found on floor, and he could not explain what had happened. Intervention identified, Floor mat next to the bed while the resident is in bed. During observation and interview on 5/17/26 at 4:45 p.m., R44 was in bed lying on his right side with his back to the wall. The bed was against the wall, and the call light was under his bed with the cord stuck between the bed and the wall. R44 stated he could use the call light if he needed help but did not know where his call light was at that time. R44 stated he did not know what he would do if he needed assistance and could not reach the call light. During observation and interview on 5/17/26 at 5:36 p.m., nursing assistant (NA)-D stated R44 was able to use his call light and was regularly encouraged to do so. NA-D into R44's room to deliver dinner and confirmed call light was under R44's bed and out of his reach. During observation on 5/18/26 at 8:19 a.m., R44 was asleep in bed. R44's bed was not in the lowest position, and the floor mat was folded up and standing on edge next to the privacy curtain. During interview on 5/19/26 at 9:30 a.m., NA-E stated residents at risk for falls should have falls interventions in place at all times. NA-E stated R44 required his bed to be low, a mat on the floor next to the bed, and his call light within reach. During interview on 5/19/26 at 11:11 a.m., licensed practical nurse (LPN)-B stated would expect fall interventions to be in place such as call light in reach, bed low and mat on floor next to bed. During interview on 5/19/26 at 11:25 a.m., director of nursing (DON) expected fall interventions to be in place as indicated on the care plan. Facility policy Fall Prevention and Management dated 11/2025, Facility staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling.

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	05/20/2026

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to ensure nutritional supplements were provided as ordered for 1 of 1 resident (R74) reviewed who had nutritional supplements ordered. Findings include: R74's 5-day Minimum Data Set (MDS) dated [DATE], identified moderately impaired cognition, no rejection of care and impairment on one side of upper and lower extremities. R74 was dependent on staff for eating and had diagnoses of encephalopathy (altered mental status), hemiplegia (one-sided paralysis) and malnutrition. R74's nutritional assessment dated [DATE], identified she was at risk for malnutrition. R74's admission weight on 4/25/26, was 138.2 pounds (lbs) and most recent weight on 5/11/26, was 135 lbs (a 3.2% loss). R74's order dated 5/14/26, identified provide 120 cc (cubic centimeters) Med Pass or Mighty Shake (nutritional supplement) after meals. R74's care plan dated 4/27/26, identified current nutritional status was less than 75%. R74 had swallowing issues and altered diet texture with goals to maintain adequate nutritional status. Interventions included provide nutritional supplement per MD (Medical Doctor) and record nutritional intakes per facility protocol. During an observation and interview on 5/17/26 at 11:22 a.m., R74 had two 120 cc warm unopened chocolate Mighty Shakes on the tables in her room. R74 stated she did not know how often she was supposed to have them, but staff did not open the shakes, otherwise she would have drank them. R74 stated she had paralysis on her left hand, had a splint on, and that was why she could not open the shakes. R74 thought she had some weight loss since she was admitted . During an observation and interview on 5/17/26 at 11:31 a.m., nursing assistant (NA)-A entered R74's room and observed the two unopened Mighty Shakes. NA-A stated they should probably be thrown away since they were warm. The labels printed on the shakes were dated 5/14/26 (3 days ago) and one from today 5/17/26. NA-A put the shakes in the garbage. During another observation on 5/18/26 at 10:49 a.m., R74 was in her room, and another unopened Mighty Shake was on the bedside table. During an observation and interview on 5/18/26 at 11:54 a.m., NA-B entered R74's room to bring her outside and did not address the unopened Mighty Shake. When surveyor asked R74 if she wanted her Mighty Shake, she replied please and with a straw and to let the nurse know. During an interview on 5/18/26 at 11:58 a.m., registered nurse (RN)-B stated nursing staff provided the Mighty Shakes to residents. RN-B accompanied surveyor to R74's room to observe the unopened Mighty Shake. RN-A followed us in. The Mighty Shake was observed to have the date 5/18/26 AM. RN-A stated staff should have opened R74's Mighty Shakes due to her limited use of both hands. During an interview on 5/18/26 at 12:22 p.m., the RD stated she expected staff to accurately document nutritional supplement so she could measure progress. The RD stated she could update the order to identify for nursing to open the shake or put it in a cup and measure the drink after R74 finished. During an interview on 05/20/26 at 12:21 p.m., the director of nursing (DON) stated she expected staff to assist residents as needed to ensure nutritional supplements were consumed as ordered. The facility's Nutritional Supplements policy dated 9/2012, identified nursing personnel deliver, serve and/or feed or assist the resident as needed and record intake of supplements. All supplements would be listed on the medication administration record and nursing would record in amounts the amount consumed by the resident on the medication treatment sheets.

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	05/20/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure staff followed proper infection control practices for hand hygiene for 1 of 2 residents (R4) observed for personal cares. Findings include:R4's annual Minimum Data Set (MDS) assessment dated [DATE], indicated R4 was cognitively intact, had impairment of one side of upper body, and bilateral amputation of lower extremities. R4 was dependent on staff for total body care, bed mobility, and transfers. It also indicated R4 had a diagnosis of cerebral infarction.R4's physician orders dated 2/9/26, directed staff to follow enhanced barrier precautions (EBP) while providing wound cares and other high contact care activities.R2's care plan dated 4/28/26, directed staff follow EBP when providing high contact cares. Additionally, R4 was incontinent of bowel and bladder and needed to be checked and changed, provided incontinence cares as needed.During observation on 05/18/26 10:06 a.m., nursing assistant (NA)- K and licensed practical nurse (LPN)- B donned gown and gloves and entered R4's room. R4 was in bed and NA-K, and LPN-B explained cares. NA-K and LPN-B lowered pants checked pad and determined R4 had a bowel movement. NA-K cleaned front of peri area and turned R4. NA-K then wiped R4's bottom which had feces with wipes. Without changing gloves or completing hand hygiene, NA-K then applied cream to bottom and peri area, opened and applied a new brief. R4 was assisted onto her back and NA-K and LPN-B closed brief then pulled up pants. As R4 was repositioned for offloading, NA -K proceeded to touch pillow, blankets and tray table with the same contaminated gloves.During interview on 5/18/26 10:16 a.m., NA-K stated they did not change gloves between dirty and clean cares and should have. NA-K verified they wore one pair of gloves for all cares provided.During interview on 5/20/26 at 9:13 a.m., LPN-B stated the expectation was to remove dirty gloves, wash hands and put on a new clean pair of gloves. The importance of proper hand hygiene decreased the spread of infections.During interview on 5/20/26 at 11:00 a.m. director of nursing/infection preventionist (DON/IP) expected staff to perform hand washing before putting the gloves on, go from clean to dirty, after dirty or soiled cares were completed, staff should remove gloves and sanitize their hands. DON/IP further stated it was not acceptable to clean feces and then reposition resident and touch pillows, or any other items. A policy titled Handwashing dated 2/2004, directed staff to use proper hand-washing techniques should be used to protect the spread of infection. Hand washing shall be completed changing incontinent products or cleaning up after someone who has used the toilet. Additionally, when conducting a procedure requiring the use of gloves, proper hand washing shall be completed before donning gloves and after removing gloves.